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Central and Eastern Europe and the  
Commonwealth of Independent States  
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## *DEVELOPMENT OF FOOD AND NUTRITION ACTION PLANS IN SOUTH EAST EUROPE*

Report on a Second Workshop  
Sofia, 8-11 October 2001

## ABSTRACT

The first consultation on development of food and nutrition action plans in the countries of southeastern Europe took place in Slovenia in June 2000. This second consultation provided the opportunity for these countries to present their draft food and nutrition action plans. These were discussed and advice was given on how to finalize action plans. Participants were keen to set up a nutrition network. The 50 participants came from 11 countries (Annex 3) and represented the health, welfare, environment and agriculture sectors. The workshop was jointly organized by WHO, UNICEF and FAO. This show of interest and commitment across sectors demonstrates that the vital cross-sectoral links between nutrition, food safety and social concerns are being recognized and acted upon by policy-makers.

## KEYWORDS

NUTRITION POLICY  
REGIONAL HEALTH PLANNING  
STRATEGIC PLANNING  
FOOD HYGIENE  
FOOD CONTAMINATION - prevention and control  
EUROPE, SOUTHERN  
EUROPE, EASTERN

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*WHO Regional Office for Europe, Copenhagen*

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The enthusiastic participation of all the professionals from Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Hungary, Romania, Slovakia, Slovenia, the Former Yugoslav Republic of Macedonia and Yugoslavia who attended the consultation was greatly appreciated.

Finally, sincere thanks are due to Tiina Mutru, Technical Officer, Department of Nutrition for Health and Development (NHD), WHO Headquarters, for agreeing at such short notice to act as Rapporteur and compile this workshop report.

## 2. Foreword

This report summarizes the proceedings of a southeastern European consultation, held in October 2001 at the Hotel Rodina in Sofia, Bulgaria. It was jointly organized by the Nutrition and Food Security Unit at the WHO Regional Office for Europe, the FAO and UNICEF. Arrangements at the course site were excellently coordinated by Professor Stefka Petrova, Nutrition Counterpart for Bulgaria, assisted by Dr Dora Mircheva, WHO Liaison Office, Bulgaria.

The purpose of the consultation was to hear about and document the southeast European countries' progress in developing food and nutrition action plans. This consultation was a follow-up to the intersectoral food and nutrition policy workshop for the southeast European countries held in Slovenia in June 2000. Meeting sessions were accompanied by working groups at which participants developed proposals for implementing their National Food and Nutrition Action Plans.

The purpose of bringing together countries of the southeast European region in this initiative was to:

- build on natural advantages and the geo-economic position of the southeastern European region in relation to food and nutrition policy;
- promote sustainable development in the southeastern European region as well as regional cohesion through development of food and nutrition policies and action plans; and
- improve skills needed to develop intersectoral policies in relation to food and nutrition.

The participants came from 11 countries (Annex 1) and represented the Health, Agriculture, Nutrition, Food safety, Labour and Social Policy, and Education and Science sectors, thanks to our hosts and the FAO. This show of interest and commitment across sectors demonstrates that the vital cross-sectoral links on nutrition, food safety and sustainable and social concerns are being recognized and acted upon by policy-makers.

The majority of participants attended the whole workshop and completed evaluation forms at the end of the workshop (Annex 3). Everyone gave constructive feedback, both formally and informally, on the relevance, quality and usefulness of the workshop. The feedback from participants will be used to improve subsequent consultations of this kind and to build on the tool, Intersectoral food and nutrition policy development for decision-makers.

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

### **Bulgarian newspaper article**

“The Ministry of Health is in the process of preparing a national food and nutrition action plan. Professor Stefka Petrova from the health administration announced that this action plan must be endorsed in 2002. The document requires that all institutions in charge of food quality have to strengthen their collaboration, the population must be informed about healthy nutrition guidelines and recommendations and there should not be a deficit of food supplies. The national action plan will be financed with resources from the World Bank and the Stability Pact, which will pay for the Bulgarians to eat healthy food. That was what Dr Aileen Robertson, the main organizer of the workshop, said yesterday when the meeting started. The meeting will continue until 11 October in Sofia. This meeting has been organized as a follow-up to a resolution on national food and nutrition action plans, which was signed two years ago in Malta by the Ministers of Health of 51 countries.”

(translated from Bulgarian by Dr Maria Haralanova, WHO Regional Office for Europe)

### **3. Opening speeches**

#### **3.1 Dr Lubomir Koumanov, Deputy Minister and Chief State Sanitary Inspector, Ministry of Health, Bulgaria**

I have the pleasure on behalf of the Ministry of Health and myself to welcome the participants of the Second workshop on development of Food and Nutrition Action Plans in southeastern European countries.

The Ministry of Health supports the initiative of WHO for implementation of a European Food and Nutrition Action Plan. This plan sets the essential guidelines and strategies that could serve as a basis for each country to develop its National Food and Nutrition Action Plan corresponding to the particular situation and capacity.

The recent surveys on the nutrition of the Bulgarian population reveal serious problems in dietary and nutritional status, particularly for some risk groups – children, adolescents, pregnant women, the elderly, unemployed, single mothers and families with many children. The principle unfavorable characteristics of the national dietary model are associated with both excessive energy, fat intake and obesity, as well as malnutrition. There is a growing number of people who are underweight, consume a limited variety of foods and intake inadequate amounts of vitamins and minerals significantly below the reference dietary values.

The great importance and complexity of the problems concerning the supply of safe and variable of foods with good quality, accessible for the whole population; the negative tendencies in food consumption, as well as the high morbidity and mortality rate of diet related non-communicable diseases require a unified national food and nutrition policy and a national action plan incorporating coordinated intersectoral activities. Taking account of this and conforming to its responsibilities a partnership with all institutions, governmental and non-governmental organizations in the country is necessary for development and implementation of a National Food and Nutrition Action Plan.

Good balanced nutrition and food safety are of utmost importance for each nation's health. The socioeconomic changes in the countries of the region and their related impact on nutrition of the populations are similar, thus suggesting similar approach to problem management. This forum is a great possibility for our countries to establish a background for partnership and collaboration in developing and implementing national policies and Food and Nutrition Action Plans.

I would like to express the Ministry of Health's and my gratitude to the representatives of WHO for the support and assistance in organizing this international forum and in forthcoming work on developing National Food and Nutrition Action Plans in the countries of the region.

May I wish you all successful and fruitful work.

Dr. L. Kumanov  
Deputy Minister  
Ministry of Health



### **3.2 Representative of the Ministry of Agriculture and Forestry, Bulgaria**

Unfortunately his text is not available.

### **3.3 Mr Oliver Petrovic, UNICEF, Belgrade, Federal Republic of Yugoslavia delivered the following speech:**

I am happy to be here with you on behalf of the UNICEF Regional Office for Central and Eastern Europe, the Commonwealth of Independent States and the Baltic States to participate with you in this workshop on the development of “Food and Nutrition Action plans in countries of Central and Eastern Europe”. I would like to thank Dr Aileen Robertson for her invitation to the UNICEF Regional Office to address you at this meeting and highlight the issues UNICEF holds important; the improvement of the health and well being of mothers and children. We look forward to further enhance our collaboration with WHO under the umbrella of the Nutrition Action Plans with specific emphasis on the improvement of feeding of infants and young children and the elimination of micronutrient deficiencies.

To start with, let us not forget that good nutrition is a human right. It is guaranteed for children in the Convention on the Rights for the Child, which is nearly universally ratified, and in CEDAW (Convention on the Elimination of all Forms of Discrimination Against Women) which contains similar provisions with respect to the health and nutrition of women. Taking all necessary action to fulfil this right is, therefore, a binding obligation of all countries and imperative to international cooperation.

Improving the health and nutrition of children is a major objective that UNICEF is pursuing in the CEE/CIS and Baltic Region.

According to recent statistics, the nutritional status of children in most countries has declined; not only due to increased poverty but also due to the interruption of fortified food supplies. This is true among the general population and even more so among immigrants, ethnic minorities and children affected by conflicts. Iron deficiency anaemia is believed to affect 40-60% of children under five years of age, vitamin D deficiency is on the increase and iodine deficiency disorders have reappeared.

Reports reflect that respiratory infections and diarrhoeal diseases are the main contributors to the mortality of infants and children under five. In the majority of countries, they occur in a context of increased poverty and malnutrition.

The trends in the health status of children also show the importance of perinatal mortality in several countries, which is mainly related to the poor health of mothers and to the deterioration of health services.

In response to these needs, the UNICEF Regional Office for CEE/CIS and the Baltic Region, in collaboration with relevant partners such as WHO, has focused its efforts on several major issues.

The first is essential newborn care and essential antenatal, perinatal and postpartum care. In an attempt to improve quality of care, UNICEF and WHO have developed and implemented a training package to improve skills of health care practitioners in newborn and obstetric care.

The second priority programme is iron deficiency anaemia, a growing problem in this region. The UNICEF Regional Office for CEE/CIS and the Baltic Region, in collaboration with WHO/EURO, convened a consultation with participation of representatives from most of the 27 countries served

by the UNICEF Regional Office. Its purpose was to accelerate and expand efforts to prevent and control iron deficiency anaemia, including how to improve complementary feeding of infants and young children. The joint consultation recommended that an integrated strategic approach be used and the following interventions should be included in programme design:

- improving complementary feeding of infants;
- promoting positive dietary change in women;
- widespread fortification of cereals and weaning foods with iron;
- broadened use of oral iron supplementation;
- better control of injections (where appropriate); and
- ongoing programme monitoring.

It was also agreed that these interventions should be functionally linked with public health programmes such as family planning, breastfeeding promotion, improved maternal health and the programme for Integrated Management of Childhood Illness (IMCI).

Concerted efforts are needed if we are to control and manage iron deficiency anaemia and its complications, which take a high toll not only in individual health but also in terms of economic productivity and learning.

The elimination of disorders caused by another important micronutrient deficiency, iodine deficiency, was one of the goals of the 1990 World Summit for Children. Universal Salt Iodization (USI) was the policy subsequently adopted by WHO, UNICEF and ICCIDD in order to achieve this goal and much work has been done in the CEE/CIS and The Baltic region advocating for USI.

Despite this, information from WHO/UNICEF joint publications in 1999 and 2000 clearly show that this region is lagging behind the rest of the world in terms of iodized salt production and importation. From nearly universal coverage a decade ago, it is now the region with the highest proportion of people unprotected against retarded growth and mental development. In fact, salt situation analyses conducted during 1999 indicate that up to 70% of the region's population were at risk of iodine deficiency through inadequate dietary intake of this vital micronutrient. However, we have a couple of successes from the countries participating in this workshop: Yugoslavia, the former Yugoslav Republic of Macedonia, Slovakia and Czech Republic. I believe there should be a plan for a national verification to document this success.

Also, learning from successful programmes in other regions of the world, the UNICEF Regional Office, with support from ICCIDD, WHO, MI and PAMM, organized a Regional Salt Producers Meeting in late 1999. The main purpose of this meeting was to provide an opportunity for members of the salt industry in the region to jointly explore and address issues related to their role and responsibility in national salt iodization programmes.

The meeting resolution and action plan committed the salt sector to work together as well as with national governments and international organisations to pursue USI within the next 12 months.

In this context the UNICEF Regional Office also held a specific meeting for the Baltic States on the elimination of IDD. The objective of the meeting was to reach an agreement on the most appropriate national strategies and action plans required to achieve universal salt iodization and the elimination of IDD. This meeting brought together policy-makers and professionals in health and nutrition with private salt importing companies and international experts in the field to consider how to fully protect the intellectual potential of the Baltic States population through universal access to, and consumption of iodized salt.

UNICEF, in collaboration with partners, has been actively working on issues related to this commitment at both regional and country levels and the current regional strategy focuses on the elimination of IDD and its sustainability through several activities.

Working in close collaboration with WHO, national governments, the salt industry and other partners, we are confident that progress towards USI will be achieved in the Baltic States and all other Member States over the next 12 months.

This is an area that needs concerted efforts among all, including government commitments to enact and enforce necessary legislations that will ensure production, marketing and distribution of iodized salt.

Another key programme that UNICEF is actively pursuing in the region is breastfeeding promotion and BFHI. Breastfeeding is an essential element of nutrition for young children. However, breastfeeding remains at risk from the aggressive marketing practices of infant formula producers, which is why we call on you to ensure that commitments made to implement the Innocenti Declaration of 1990 and to enact national legislation to implement the International Code of Marketing of Breast-milk Substitutes are included in the Nutrition Action Plans.

UNICEF offices throughout the region are working with all partners to enhance a supportive environment for breastfeeding and to ensure that breastfeeding promotion is an integral part of primary health care. Efforts are also continued on the Baby Friendly Hospital Initiative (BFHI) through the implementation of the “Ten Steps to Successful Breastfeeding” and the certification of hospitals. To date, there are approximately 470 baby friendly hospitals in Europe with Sweden and Turkey taking the lead. All three Baltic States are actively engaged in BFHI and we are counting on you to ensure that achievements made so far are not lost by including this component in the Nutrition Action Plans.

In the promotion of breastfeeding, we are taking into consideration the finding that HIV is transmitted through breast-milk. We are presently working with governments, WHO and UNAIDS to develop appropriate strategies for the region to educate, counsel and support HIV positive women in making decisions about how to nourish their infants. This will be part of a comprehensive approach, both to HIV prevention and care and to antenatal, perinatal and postnatal care and support.

Here I would also like to emphasize the importance of the Code implementation. The Code applies to all countries. As its name suggests, the Code is international and applies globally. Parents of infants in Europe and North America have the same right to protection from inappropriate marketing as parents in Asia, Africa and South America.

Apart from helping to prevent spillover of replacement feeding to the majority of infants who will benefit from breastfeeding, Code implementation protects artificially fed infants. It ensures that the choice of replacement feeding is made on the basis of non-commercial information, and that all products are clearly labelled to ensure that they will be prepared and given safely.

UNICEF has also worked to ensure that Code implementation is recognized by the United Nations Committee on the Rights of the Child as an appropriate measure in implementing the Convention on the Rights of the Child (CRC). Since breastfeeding is an important component in assuring the child’s right to the highest attainable standard of health, governments are obliged by Article 24 of the CRC to ensure that all sectors of society know about the benefits of breastfeeding. To achieve this, they must also protect parents from misinformation, through implementation of the Code.

The improvement of complementary feeding is another priority that UNICEF and WHO are working on. Joint guidelines have been developed and shared with all the countries of the Region. We hope that these guidelines will provide the basis for national guidelines and policies to promote good complementary feeding practices.

Once more, I would like to reiterate again the importance of integrating the work on improving the feeding of infants and young children into Nutrition Action Plans to include breastfeeding promotion, the continuation in the Baby Friendly Hospital Initiative and Code implementation. This also includes necessary measures to eliminate micronutrient deficiencies, with emphasis on iodine through USI and iron deficiency through multi-pronged approach that will also include education.

Finally, I would like to thank all of you and take this opportunity to point out that your work in the development of the Action Plans can make a real difference to safeguard achievements made and continue with the work to achieve the desired goals. This is the right time to ensure that the health and nutrition strategies gain greater visibility and political traction in the political agendas.

### **3.4 Dr. Valeria Menza, Food and Agriculture Organization, Rome, Italy**

Dr. Menza expressed pleasure at being in Bulgaria and having the opportunity to meet and work, once again, the many participants who attended the First workshop on Food and Nutrition Action Plans in southeast Europe in Slovenia in June 2000.

On behalf of the FAO Food and Nutrition Division, she welcomed the participants and reconfirmed the importance that FAO attaches to collaborating with WHO and UNICEF. She noted the long history of collaboration between FAO and WHO in many areas related to nutrition, emphasizing the particularly strong collaboration between the two agencies on follow-up activities to the jointly sponsored 1992 International Conference on Nutrition. She emphasized the importance of these kinds of workshops, especially when organized jointly with sister organizations.

She highlighted two main points to be emphasized during the workshop deliberations: the importance of intersectoral collaboration and the need to strive for the successful implementation of National Food and Nutrition action plans. In reference to collaboration, she noted that experience in many countries clearly indicates that intersectoral collaboration within countries, including line ministries, the academic community, civil society and the private sector, is essential for the development of appropriate national plans and for the sustainable implementation of those plans. The important role that these workshops have in enabling colleagues from the same country and across countries in the same region to meet, exchange ideas and experiences and to collaborate in an intersectoral manner was also stressed. In addition, she expressed her keen interest in learning from participants how the development and implementation of the action plans has proceeded in the past year and how countries have managed to work in an intersectoral manner at country level, away from the workshop setting. She pointed out that the experiences shared by the participants could provide valuable insight to other countries outside the eastern European Region as they develop and implement their own national plans.

With regard to implementation, she emphasized that the primary goal of all participants should be the effective and timely implementation of their national plans and indicated that a fundamental aspect of the workshop was to discuss and explore the steps necessary to achieve this. Acknowledging the difficulty of this task, she emphasized that plan implementation requires setting priorities, developing programmes with improved food security and nutritional status as primary objectives, targeting of programmes and activities to specific vulnerable population

groups, and allocation or re-allocation of resources. As a last point, she noted that the action plans should not be seen as static, but as plans that should and need to be continually reassessed and readjusted according to the current needs and situations of a country.

Lastly, she reminded participants that the main focus of the workshop programme and activities would be on group work and participation, and encouraged participants to seize the opportunity to freely share their experiences on what has and what has not worked in their countries in the process of developing and/or implementing their action plans and expressed her hope that all participants would find it to be a beneficial and fruitful exchange of ideas and experiences.

### **3.5 Dr Aileen Robertson, WHO Regional Office for Europe, Copenhagen, Denmark**

Dr Robertson welcomed participants on behalf of the Regional Director, Dr Marc Danzon. She referred to the Fiftieth Session of the WHO Regional Committee for Europe held in September 2000 at which all 51 Member States, and thus the governments of all the participating countries of this workshop, unanimously endorsed the First Food and Nutrition Action Plan for the WHO European Region. She emphasized that this universal endorsement of the resolution commits governments and WHO alike to support countries in their endeavour to develop and implement their National Food and Nutrition Action Plans and thus to improve their nutrition situation. Dr Robertson also pointed out that the way WHO Regional Office for Europe was undertaking the development of these action plans was unique to WHO and that the European experience could provide valuable information to be shared by other regions.

She reminded participants that the resolution endorsing the Action Plan confirmed that there will also be a WHO Ministerial Conference in 2005. This conference will provide the opportunity to assess the progress made during the next five years by the WHO Regional Office for Europe and Member States.

On a personal level she introduced Cristina Tirado (Food Safety Regional Adviser, WHO) and emphasized that she looked forward to collaborating with her. She further thanked Professor Stefka Petrova (Nutrition Counterpart for Bulgaria), Professor Dora Mircheva (WHO Liaison Officer, Bulgaria), Dr Marija Kisman (WHO Liaison Officer, the former Yugoslav Republic of Macedonia), Dr Antoinette Kaic-Rac (newly appointed WHO Liaison Officer for Croatia) and Tiina Mutru (WHO, Headquarters) for their help and collaboration. Additionally, she thanked both FAO and UNICEF for their collaboration and support and the local organizers for the excellent organization of the workshop. Finally, she emphasized the importance of the presence of both the Bulgarian Ministry of Health and the Ministry of Agriculture and Forestry at the workshop.

## 4. Country presentations

### 4.1 Albania

Presented by Dr Marita Afezulli

#### Report on the development of a Food and Nutrition Action Plan

Our country is committed to developing an Food and Nutrition Action Plan. During the last year we have taken the following steps to achieve this goal:

- June 25, 2000: the Order on the preparation of the National Food and Nutrition Action Plan (FNAP) was signed by the Minister of Health.
- The working group on the development of the FNAP was set up with representatives from the Ministries of Health, Food and Agriculture, Economic Cooperation and Commerce, Tourism, Finance, Education and Science, National Environmental Agency, Mass media
- January 2001: the first meeting of the working group on FNAP development was held
- February 2001: the second meeting of the working group on FNAP development was held
- February 2002: the deadline for the first draft
- The draft will be sent for revision, suggestions and recommendations to other sectors, interested institutions and organizations in March 2002
- January 2001: set up of the Interministerial Steering Committee
- April 2002: approval of the draft by the Steering Committee
- June 2002: endorsement of the document by the government

The draft is almost prepared, and is still only in Albanian. The first part of the draft is the Analysis of Food and Nutrition Situation in Albania and the second part is the Objectives and Action Plan for 2002-2007.

#### Contents

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    - ii. Food contamination (chemical, pesticides, heavy metals, dioxins)
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### **Different activities organized on the framework of the FNAP development**

#### **1. Round Table on the celebration of the World Nutrition Day (October 2000)**

The aim of the Round Table has been to promote healthy nutrition and raise public awareness on food and nutrition issues. Representatives from NGOs, the Ministry of Health, Institute of Public Health, mass media, Promotion and Education Centre of Tirana, hygienists from Tirana and Durres participated in this activity.

The most important part of the activity was focused on the feeding and nutrition of infants and young children and the recommendations made by WHO for this issue. The need for education and promotion of these issues as soon as possible for the general population and to raise the awareness of dental health are stressed as priority. Another important issue discussed in the Round Table was the problem of breastfeeding education and promotion. Actual legislation was also discussed. Finally, malnutrition and the importance of nutrition for children's development and the importance of setting up a nutrition information system was also brought up.

#### **2. Meeting in two elementary schools**

In November 2000 the Ministry of Health, in collaboration with WHO, organized meetings in two elementary schools to discuss the problems of nutrition in the context of World Health Day. The aim of this activity was to promote healthy nutrition and raise public awareness on food and nutrition issues in the younger generation. Participants included pupils from two different elementary schools, teachers, representatives of the Ministry of Health, National Centre for Health Education, Promotion and hygienists from Tirana, and Mass media.

We followed recommendations from the WHO document, Healthy English school children: A new approach to physical activity and food (Rowett Institute, Aberdeen, October 1997). We prepared all messages for our children based on our needs and situation. Our intention was to use the young generation as a pressure to their parents on promoting healthy diet. We organized this activity based on the actual situation and conditions in the country.

#### **3. Hazard Analysis and Critical Control Point (HACCP) food safety workshop**

Organized by the Ministry of Health, Primary Health Care Department, within the framework of the implementation of the Food Safety Strategy within the Food and Nutrition Action Plan in collaboration with WHO (April 2001)

This meeting was organized by the Ministry of Health and WHO. Representatives of the Ministry of Health and Ministry of Agriculture and Food dealing with food safety issues

participated. The aim of the meeting was to strengthen inter-ministerial collaboration and promote the food safety strategy as highlighted in the FNAP.

During the workshop theoretical and practical aspects of the techniques (including the general principles of food hygiene as prerequisites) as food safety management tools were transferred to the participant. The Codex Alimentarius General Principles of Food Hygiene were presented during the workshop and the need for a multidisciplinary approach including expertise in agronomy, veterinary health, production, microbiology, medicine, public health, food technology, environmental health, chemistry and engineering.

It was agreed to produce a booklet with guidelines for HACCP based inspections by health and agricultural inspectors. The discussions focused on Codex Alimentarius activity and on inter-ministerial collaboration to strengthen Food Safety within the framework of the National FNAP.

A team of specialists from the Ministry of Health and MFA have prepared guidelines for inspectors based on the document Codex Alimentarius Basic Texts on Food Hygiene.

In September 2000, the Minister of Health signed the order to support the national committee for IDD, and to monitor the Council of Ministers Decision on Iodized Salt. In June 2001, HACCP guidelines were edited. In September 2001, the International Conference on Food Quality and Safety (Ministry of Health, MFA, IPH, Veterinary Institute) was held.

## 4.2 Bosnia and Herzegovina

Presented by Dr Aida Filipovic-Hadziomeragic

### 1. Inequity and poverty leading to food and nutrient deficiency

#### Undernutrition

Source: FAO Report on State of Food Insecurity in World, 2000  
Population 10 %

Lowest percentages found during the war (WHO Survey):

adults 5%  
elderly 7.5%

#### Children

Multiple Cluster Indicator Survey, MICS, 2000 sponsored by UNICEF

Undernutrition, percentage of children		
	Federation BH	Republika Srpska
Weight for Age	8	8
Height for Age	13	11
Weight for Height	5	2

#### Policy approach for solving problem

Draft of the Integrated Plan for Public Health (jointly done by both entities with technical assistance of Phare and Andalusian School of Public Health) - recommendations for priorities in nutrition:

- development of action plan for nutrition
- development of systematic monitoring of nutritional status and dietary intake of population



## **Iodine deficiency**

Prospective IDD Survey, 1999 based on WHO and ICCIDD recommendations, sponsored by UNICEF

<b>Prevalence of Goitre %</b>		
	Federation BH no. 5521	Republika Srpska
1 degree	24.72	21.42
2 degree	2.33	2.05
Total	27.06	23.47

<b>Distribution of salt samples in relation to iodine content (mg/kg)</b>			
	less than 10 mg/kg %	10 - 20 mg/kg %	more than 20 mg/kg %
Federation BH	23.3	58.7	18
Republika Srpska	6.83	53.96	39

### **Policy approach for solving problem**

Recommendations of IDD working group:

- establishment of a national committee for IDD to develop detailed strategy for IDD management
- iodization of salt with 20 - 30 mg/kg of iodine, using  $KJO_3$

### **Present activities:**

Low on iodization of salt to be issued in FBH within two months by the Ministry of Energy, Mining and Industry

## **2. Food safety**

FBIH, 2000:

- Foodborne diseases are at the 9<sup>th</sup> place on 10 leading ineffective diseases list.
- Alimentary toxicoinfections morbidity rate: 38.28 %
- Epidemics - alimentary toxicoinfections: 4 and enterocolitis: 16

### **Main problems**

- domestic food production only 37-40%
- lack of inspection control on borders of imported goods (only 5%)
- lack of interentity control of exchange of goods
- insufficient control of production and exchange of goods within one entity
- laboratories for control of food contamination insufficiently equipped especially for chemical contaminants
- disrespect of existing regulation and insufficient implementation of penalties
- law and regulations on food safety and quality insufficient, not harmonized with international regulations

### **Policy approach for solving problem**

- Draft of NEHAP entity level - to be finalized by the end of 2001
- Draft of the Integrated Plan for Public Health (jointly done by both entities with technical assistance of Phare and Andalusian School of Public Health) - summary of recommendations:
  - revision and harmonization of legislation
  - improvement of monitoring and control of whole food safety system

- equipping and certification of referral laboratories

### Present activities

- New organization on boundaries (14 entrances and 3 customs) - implementation expected by the end of 2001
- Certification of laboratories in progress

## 3. Infant, young child and maternal nutrition

### Breastfeeding and complementary feeding practices

Breastfeeding Survey, 1999 sponsored by UNICEF, done at both entities

<b>Breastfeeding and complementary feeding practices</b>		
	Federation BH	Republika Srpska
% exclusive breastfeeding up to 4 <sup>th</sup> months	8.1	1.46
% exclusive breastfeeding up to 6 <sup>th</sup> months	5.5	0.58
% predominant breastfeeding up to 6 <sup>th</sup> months	77.3	54.62
Introduction of solid food before 6 months of age	81.3	43.55
Continuing breastfeeding during 1 <sup>st</sup> year	40.7	23.46

### Baby friendly hospital initiative

No. of BF hospitals: Federation BH 4  
 Republika Srpska 4

4 hospitals awaiting assessment

Goal: all hospitals become BF by the year 2004

### International code of marketing of breast-milk substitutes

Republika Srpska: adopted as law in whole

Federation BH: not adopted

### Policy approach for solving problem

Joint FBH and RS Protocol on Infant Feeding, 2000 Breastfeeding Committee and Ministry of Health - official recommendations on breastfeeding and introduction of complementary feeding and supplementation

### Present activities

- Preparation of activities for Breastfeeding week (22-28 October) - IBFAN breastfeeding improvement group, PHI cantonal, federal
- Breastfeeding course for mothers in refugee centres, UNICEF and IBFAN group
- Preparations for Lobby Training for NGOs, IBFAN Group and WEMOS

## 4. Noncommunicable diseases and related risk factors

### List of leading noncommunicable diseases in FBiH in 2000:

1. Diseases of circulatory system
2. Diseases of muscles bones and connective tissues
3. Mental and behaviour disorders
4. Chronic diseases of digestive tract
5. Iron deficiency anaemia

6. Chronic obstructive pulmonary disease
7. Diabetes
8. Thyroid gland disorders
9. Malignant neoplasm

### **Obesity**

**Adults:** high percentages found even during the war (WHO 1995)

Questionnaire on height and weight (self-reported) distributed at Knoll presentations for health professionals.

#### **Average BMI**

Sarajevo: 26.8

Tuzla: 27.6

Zenica: 29

**Children:** Multiple Cluster Indicator Survey, MICS, 2000 sponsored by UNICEF

<b>Obesity among children, %</b>		
	Federation BH	Republika Srpska
Overweight	12	21
Obese	5	5

### **Smoking and alcohol**

UNDP Survey on Lifestyles Among Adolescents in BH, 2000

- 46% smoke regularly
- 11% consume alcohol

#### **Policy approach for solving problem**

- Draft of the Integrated Plan for Public Health (jointly done by both entities with technical assistance of Phare and Andalusian School of Public Health) - recommendations for priorities in nutrition:
  - development of action plan for nutrition
  - development of systematic monitoring of nutritional status and dietary intake of population
  - development of action plan for improvement of physical activity

#### **Present activities:**

- Survey “Health monitoring of lifestyles” on population 19-65 years within CINDI program, supported by WHO in both entities (questions on nutrition, smoking, alcohol, physical activity, health symptoms, socio-demographic factors)

### **5. Sustainable production and distribution**

War damages in Federation of Bosnia & Herzegovina:

- 70% of equipment for agricultural production destroyed
- 60% of cattle fond destroyed
- 15% of agricultural land and 20% of forests not accessible due to minefields

### **Policy approach for solving problem**

Two complementary strategies drafted by entity expert Committees with FAO technical and financial assistance

- Mid term strategy of sustainable development of agriculture in Federation of Bosnia and Herzegovina
- Mid term strategy of sustainable development of agriculture in Republika Srpska

### **Goals**

- increase of agricultural production by measures that increase efficiency, profitability of production, processing and marketing
- promotion of rural development and non-agricultural employment
- optimal use of land and protection of natural resources
- institutional capacity building
- sustainable agricultural development

### **Present activities**

Federation of Bosnia & Herzegovina - drafting of Law on Healthy Production of Food lead by the Ministry of Agriculture in process, other involved ministries: Ministry of Environment, Ministry of Energy, Mining and Industry, Ministry of Foreign Trade and Economic Relations, Ministry of Health

## **4.3 Bulgaria**

**Presented by Professor Stefka Petrova**

### **Main current problems**

#### **1. Food safety**

##### **Microbiological contamination of foods**

- Many small private enterprises emerged - poor hygiene and manufacturing practice, lack of systems for internal control
- Introduced HACCP system - only large enterprises with international participation
- High food home-processing - increased risk for microbiological contamination
- Morbidity rate of food-borne diseases – no alarming tendencies determined, increased outbreaks with unidentified etiology: problems in diagnosis and reporting

##### **Chemical contamination of foods**

- Heavy metals- 5 “hot spots” in areas of metal producing and processing plants (Pb, Cd, Mn, Cu, As); common Pb pollution - wide use of leaded gasoline
- Pesticides – dramatically decreased use: concentrations exceeding MRL are rarely found
- Mycotoxins – the climate and the inadequate storage facilities benefit their production; not identified in full

#### **Food safety control**

- Almost full overlapping along the food chain of activities of both state control bodies - Ministry of Health (MoH) and Ministry of Agriculture and Forestry (MAF) - not well defined and coordinated functions
- Disturbances of the national monitoring of main food pollutants as a result of economical problems during the transition period

## **Risk assessment**

- Lack of sufficient and properly structured data for assessment of exposure to chemical contaminants in foods
- Lack of uniform methodology and associated training in the field of biological risk assessment
- Lack of uniform body to be responsible for developing risk analysis

## **2. Nutrition**

### **Malnutrition**

- Shortage in consumption of staple foods, food poverty and inadequate micronutrient intakes mainly among:
  - Unemployed
  - Families with many children
  - Households with five or more members
  - Disabled persons
  - People aged over 70
- Poor maternal nutrition among socially deprived groups
- Increased rate of low birth weights
- Inadequate complimentary feeding of infants in low income families
- Increased prevalence of underweight among risk population groups – infants, children, adolescents, young women and elderly people
- Inadequate and unbalanced nutrition in kindergartens, school canteens, orphanages, homes for elderly and disabled people

### **Obesity and non-communicable disease related to nutrition**

- Overweight and obesity – high prevalence including among children and adolescents
- Diseases of the circulatory system – high prevalence, leading causes of death
- Dilipidemias -wide distribution (16-62% of adults)
- Malignancies - significantly increased morbidity/mortality rates of breast, prostate, colon and stomach cancer
- Diabetes - increased morbidity rate by 80% (1980-2000)
- Osteoporosis – a serious problem for Bulgarian women

### **Unfavorable characteristics of the current diet related to non-communicable diseases**

- High total fat, high saturated fatty acids' content
- Low intake of vegetables and fruits in winter / spring seasons
- Low fish consumption
- Very high consumption of salty foods
- Insufficient intake of milk and dairy products
- Insufficient consumption of whole grain breads

## **3. Food Security**

- Sustainable food supply can prevent disease and promote health ensuring sufficient food of good quality, while helping to stimulate rural economics and promote social cohesion within rural societies.
- The agricultural production, the stock of animal and the production of animal products declined considerably during the transition period
- Import a large amount of agrifood products - locally produced food is undercut by cheaper import
- The bulk of small farmers produce mostly for own consumption - about 44% are pensioners; 45% of the workforce are women: no skills and techniques suitable for commercial farming
- Urban agriculture - traditionally wide spread but is not promoted
- Entire agricultural production is privatized and is not subsidized by the state

- Health considerations in agriculture and food production policies are neglected

## **Current Food and Nutrition Policy**

### **1. Food safety**

- Legislation (recent years)
  - Food Law
  - Veterinary Law
  - Plant Protection Law
  - Fodder Law
  - Regulations and ordinances under these laws, harmonized with EU requirements, since 1999
  - Law on Public Health, exercises state sanitary food control of MoH
  - National Environmental Health Action Plan, 1998
- Activities, supporting the introduction of HACCP - based food system (seminars, training courses), since 1998
- National Council on Food Safety at the MoH, 2000
- Monitoring of heavy metals in the “hot spots” by MAF (plant products, milk, fodder, soils), since 1999
- Monitoring of pesticide residues in products of plant and animal origin by MAF - beginning in 2001
- Information system under Ministry of Health for data on food sector, including Register of food products- undergoing
- National Food Safety Strategy, 2001

### **2. Nutrition**

- A governmental decree and national program for IDD control, 1994:
  - Universal salt iodization
  - Trade policy stimulating the import of iodized table salt
  - Prohibition of sale of non-iodized salt
  - Laboratory control of iodine in salt at market level
  - Monitoring of ioduria at population level
  - Promotion and education
  - Establishment of an Interagency Commission under MoH
  - New salt standard (19-38 ppm J)
- Successfully implemented:
  - Increase of median ioduria - 58.5 µg/L in 1994-, 145 µg /L in 2001
  - Decrease in prevalence of ioduria below 100 µg/L - 86% in 1994, 23.3% in 2001
- CINDI Programme - started in 1994, already performed in 7 regions, successfully implemented
- Nutrition Surveillance Programme - 2 national surveys of the whole population, 4 national surveys of risk groups, since 1997
- Establishment of departments “Health Promotion and Disease Prevention” at Hygiene and Epidemiology Inspectorates, 1999
- Incorporation of food and nutrition policy issues in Public Health Law, 2000
- Promotion of breastfeeding - baby friendly hospitals, training of health professionals, mother support groups, legislation protecting breastfeeding among working mothers, since 1998
- Regulations on requirements for infant formula and baby foods, harmonized with EU directives, 2000
- Decree related to improvement of schoolchildren’ nutrition through mass catering (school canteens and refreshment bars), 2000
- Prevention of osteoporosis (training of health professionals, public education), since 2000

### **3. Food security**

Legislation - Food Quality

- Food related laws, regulations and ordinances under these laws
- Endorsement of ISO standards in regards with food quality

#### **Programme**

Draft Urban food and nutrition action plan

#### **Development of National Food and Nutrition Action Plan**

- Draft of National Food and Nutrition Policy, 1992 - not endorsed by the Government
- Development of a National Food and Nutrition Action Plan - start in 2001
- Establishment of a Multisectoral Working Group including 20 members, Leading institution - Ministry of Health
- Establishment of Multisectoral Expert groups - specific programs in the field of food safety, nutrition and food security
- Development of National Food and Nutrition Action Plan

#### **Collaboration between**

- Ministry of Health
- National Centers under MOH related to Health Prophylactics
- Hygiene & Epidemiology Inspectorates under MoH
- Ministry of Agriculture and Forestry, State Veterinary Control
- Ministry of Labor and Social Policy;
- Ministry of Education and Science
- Ministry of Economics; Ministry of Finance
- National Institute of Statistics
- National Center for Health Information
- National Institute of Statistics
- Medical University
- Health Insurance Fund
- Non governmental organizations
- WHO, UNICEF and FAO

#### **Food and Nutrition Action Plan**

##### **1. Food Safety**

- National System for Monitoring the contamination of foods with: heavy metals
- Pesticides, mycotoxines, radiation contaminants
- Improvement of microbiological safety of foods and public education
- Establishment of a national information system on food safety

##### **2. Nutrition**

Programs related to nutrition include:

- Improvement of nutrition and nutritional status of vulnerable groups with special aspect towards socially unequal groups/individuals: pregnant and lactating women, infants and small children, children in kindergardens, school-aged children and elderly people
- CINDI program - expanding of implementation: sustainable reducing of the risk of diet related chronic noncommunicable diseases
- Sustainable elimination of iodine deficiencies
- National nutrition information system - using current existing health/food information structures
- Nutrition monitoring

### **3. Food security**

- Corresponding to national dietary guidelines
- Multisectoral approach
- Incorporation of the objectives in other programs in the field
- Strategies directed towards making food of good quality more accessible to the poor and improving household food production

#### **Main approaches in development of the action plan**

- Integrated multisectoral approach
- Situation analysis, identifying the problems, setting objectives
- Determining priorities, strategies and activities - realistic approach
- Estimation of resources and funding available
- Mechanisms to ensure political commitment, coordination of activities
- Partnership at different levels
- Progress measurement and evaluation

#### **The future**

- First draft of the Bulgarian Food and Nutrition Action Plan - end of 2001
- Discussions in related sectors and the community - winter/spring 2002
- Revision, edition, translation, coordination with international organization - autumn 2002
- Endorsement by the Council of Ministries - end of 2002

### **4.4 Croatia**

**Presented by Dr Antoinette Kaic-Rak, Human Nutrition Department, Institute of Public Health, Zagreb**

#### **Steps**

- 1992 International Conference on Nutrition - Rome
- 1995 "Croatian agriculture at crossroads" / strategic document
- 1996 World Food Summit
- 1996 Nutrition Board of the Croatian Academy of Medical Sciences + National Health Council of the Ministry of Health of Croatia initiated preparation of Food and Nutrition Policy
- 1996 ICN Follow up Conference in Warsaw
- 1999 Croatian Food and Nutrition Policy prepared, signed by Ministry of Health and published

#### **Multisectoral approach in developing food and nutrition policy - participants from different sectors**

- food producers
- food industry
- food safety
- education
- consumer associations
- health / nutrition
- environment protection
- Chamber of commerce

#### **Croatian strategy for the improvement of food quality and nutrition**

The WHO and FAO recommendations and guidelines and the national situation analysis served as basis for setting of national food and nutrition policy



### **Goals 2005 - specific objectives and targets**

- To increase by 20% the proportion of the population with an adequate body weight (weight for height) in all age groups, which should result in a reduction of the number of under- or overweight persons.
- To improve nutritional awareness and achieve an early age knowledge about healthy nutrition, healthy nutrition habits and dietary requirements in all population segments.
  - To modify dietary habits in order to achieve:
    - 20% reduction in salt consumption
    - 15% reduction in total fat consumption, (particularly a 25% reduction in animal fats)
    - reduction in refined carbohydrates
    - 25% increase in fresh fruit and vegetable consumption
    - 25% increase in milk and dairy products consumption
    - higher consumption of fresh fish.
- To reduce by 20% the prevalence of iron deficiency anemia, particularly in the vulnerable population such as preschool and school-aged children, pregnant and lactating women.
- To eliminate iodine deficiency.
- To increase the percentage of mothers who exclusively breastfeed their children up to the age of about six months from the present 30% to 50% or more.
- To decrease the incidence, and, where possible, to eliminate the occurrence of foodborne diseases (food infections, intoxications and other complications caused by contaminated foodstuffs and dishes).
- Ensure that food safety measures are a priority throughout the food chain (process, distribution and preparation) by applying the HACCP and GMP.
- Decrease the incidence of tooth caries.

### **Strategy**

- Provide a proper education for professionals in the field of nutrition at all levels.
- Give priority to nutrition policy objectives in the field of public health programmes targeting prevention and controlling specific micronutrient deficiencies (reevaluation of iodine prophylaxis, prevention of iron deficiency anemia etc.).
- Collaborate with the food industry in implementing different programmes (food fortification, production of healthier foodstuffs such as reduced sodium content, decrease in saturated fats etc.).
- Update and expand national food composition database.
- Conduct food quality and food safety controls in line with the international quality and procedure standards (EU and Codex Alimentarius Commission WHO/FAO).
- Establish a continuous national monitoring of food contaminants and their intakes in order to assess possible health risks for different population segments according to ADI (acceptable daily intake) and PTWI (provisional tolerable weekly intake).
- Ensure the implementation of an HACCP practice along the whole food processing chain.
- Taking care of the socioeconomically disadvantaged and nutritionally vulnerable groups by providing them with an adequate diet (refugees, poor people, elderly people, etc.). It is necessary to address the problem of organized distribution or preparation of meals for the single living elderly residing in remote areas and villages.
- Ensure adequate nutrition for children in elementary and high schools through organized catering and delivery of school lunch programs.

- Improve workers' nutrition via organized meal catering at the workplace.
- Promote the healthy diet and ensure consumer information about the nutritional value of served meals in hotels and restaurants, especially in tourist areas. Since Croatia is a Mediterranean country, this also presents an opportunity to promote the traditional Mediterranean diet as a healthy diet.
- Implement the national breastfeeding strategy, which observes the International Code.
- Continue monitoring the nutritional status and diets of different population groups.
- Continuously conduct public health nutrition education and promotion of healthy lifestyles (healthy nutrition, physical activity, not smoking, etc.) with the aim of preventing leading noncommunicable chronic diseases, such as cardiovascular and cerebrovascular disease, hypertension, osteoporosis, diabetes and some types of cancer.

### **From the plan of activities - realized**

#### **Health sector**

- Programme of health measures include: monitoring of IDD, nutritional assessment programme, health promotion and health education activities related to nutrition (school curricula, campaigns, workshops etc.), National Policy for Breastfeeding Promotion, CEECFOODS, food fortification/in collaboration with food industry, nutritional standards for institutional nutrition

#### **Agricultural sector**

- Strategy for development of agriculture / horizons 2010
- Ecologically Safe Agricultural production Act - adopted
- Harmonization and adoption of EU legislation on food safety activities

#### **On-going activities**

Ministry of Health, Ministry of Agriculture, Forestry and Fishery, Ministry for the Environment Protection and Physical Planning, Ministry of Science and Technology:

- 2000/2001 Food law - in the process of adoption
- Provision concerning the Banning of GMOs - in the process of adoption
- Establishment of National Food and Nutrition Council

#### **Evaluation**

- Monitoring the population's nutritional status with a focus on vulnerable groups
- Monitoring of dietary habits, food availability and food intake
- Monitoring of food safety indicators
- Analysis of health statistical data and monitoring of mortality and morbidity trends in certain dietary habit-related diseases

#### **Obstacles**

- Timely administrative procedures
- Coordination between sectors
- Conflict of interests among different sectors
- Insufficient financial resources

## **4.5 Czech Republic**

**Presented by Professor Zuzana Brázdová, Department of Preventive Medicine, School of Medicine, Brno**

#### **Overall goal**

To improve the health status of the population living in the Czech Republic and to reduce the incidence of nutrition related handicaps, diseases and death.

### **Targets for 2001 – 2003**

- Survey of prevalence of the nutrition related diseases
- Description of dietary habits and nutritional status
- Healthy food production, sustainable agriculture
- Nutrition counselling and systematic education
- Announcement of Czech dietary guidelines
- Monitoring of food quality according to the EU standards
- Early risk factors related to nutritional status
- Pro-health model of agriculture and food production

### **Description of dietary habits and nutritional status in the Czech Republic**

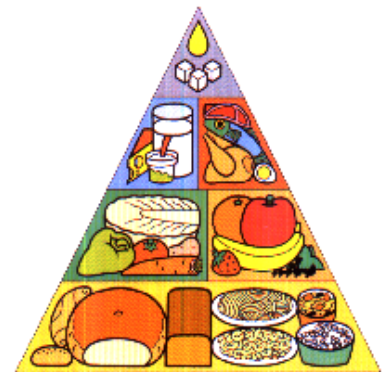
- Include vulnerable groups, children, adolescents, women, elderly people, ethnic groups, refugees
- By-product: food and nutrition database and RDI
- What do we know about modern Czech dietary habits and Czech people eat.

### **Czech National Health Plan**

- Equity in access to healthy food
- Breastfeeding support
- Prevention of CVD and cancer
- Prevention of caries
- Prevention of obesity
- ID solution

### **Czech dietary guidelines**

- Cereals, bread, rice, pasta: 3-6 servings
- Vegetables: 3-5 servings (of 100 g)
- Fruit: 2-4 servings (of 100 g)
- Milk and dairy products: 2-3 servings (equivalent to 300 mg Ca)
- Meat, fish, poultry, pulses: 1-3 servings
- Others: 1+1 serving (equivalent 10 g fat or sugar)



### **National health programmes**

- 40 millions Czech crowns = 1 million USD from national budget each year
- Additional 20 million CZK (approximately) from other sources

### **National health programs - obesity programme**

- Target groups: Czech children, Roma children
- Involved collaborators: schools, GPs, NGOs

### **National Health Programmes - Programme of BF support**

Ministry of Health, Ministry of Education, UNICEF, NGOs

### **National Health Programmes - Cancer prevention programmes**

- Anti-smoking programmes (schools, workplaces, community)
- Nutrition-oriented programmes
- Counseling

## **Czech Epilog**

People should eat what they like. But they have to learn to like healthy foods.

## **4.6 Hungary**

**Presented by Dr Gabor Zajkas, Deputy Director, OKK-OETI, Budapest**

### **Preliminaries**

- 1993 Food and Nutrition Policy in Hungary (G. Zajkás), *Magyar Tudomány (Hungarian Science)*, 38, 1304-1211
- 1997 Food and Nutrition Policy (Study sponsored by the Ministry of Agriculture)
- 1999 Basic Elements of Food and Nutrition Policy (Study made by the Nutrition Working Group of Food Science Committee of the Hungarian Academy of Sciences)

### **Public Health Programme for the Healthy Nation 2001-2010**

#### **Five national goals until 2010**

- Population activity
- Healthy growth of young people
- Increase of healthy years
- Increase of life expectancy at birth
- Decrease the social inequity

#### **Ten national tasks**

- Education for healthy life
- Introduction of targeted population surveys
- Propagation of healthy nutrition
- Propagation of healthy physical activity
- Fighting against harmful dependencies
- Creation of equal chance for healthy life
- Strengthening epidemiological safety
- Improvement of food safety
- Creation of a healthy environment
- Improvement of the health provision system

#### **17 Sub-programmes**

- Decrease the AMI mortality
- Decrease the CVD morbidity and mortality
- Decrease the cancer mortality
- Improve mental health
- Decrease LMS diseases
- Equal chance for healthy beginning of life
- Improving the situation of high risk people
- Creation of a healthy environment
- Improving epidemiological safety
- Improving food safety
- Decrease of mortality caused by injuries
- Extension of population surveys
- Promotion of healthy nutrition
- Decrease of smoking rate
- Health promotion in education

- Promoting an exercise-rich life
- Decrease alcohol and drug abuse

### **Sub-programmes are constructed in the following way**

- Current situation
- Goals
- Indicators
- Actions
- Budget

### **Promotion of healthy nutrition**

#### **Goals up to 2010**

- To reduce energy intake from fat from the current rate of 38% to 35%
- To reduce the ratio of energy intake from saturated fatty acids in total daily energy intake to 15%
- To reduce the cholesterol levels in adult population from 5.7 mmol/l to 5.3 mmol/l, i.e. by 7%
- To stop the growing incidence of overweight and obesity at the current levels of 60% of men and 50% of women, respectively
- To stop the growth trend of diabetes at the current rate of 5%
- To force back the occurrence of malnutrition
- To increase the consumption of vegetables and fruits from the current average of 300g/day to 400 g/day
- To increase the consumption of whole-grain cereals by 50%
- To increase the consumption of low-fat milk and dairy products by 10%

#### **Indicators**

- Mortality
- Morbidity
- Food purchase and household availability statistics
- Vegetable, fruit, cereals availability, kg/capita/year
- purchase of total/plant/animal fats, kg/capita/year
- Nutrition studies
- fat energy percentage
- Fat, cholesterol, salt, fibre intake, g/mg/day;
- Consumption of low-fat milk, whole-grain cereals and products low in fat and salt (g/day)
- Blood cholesterol level
- Body weight

#### **Actions**

- Set up Food and Nutrition Board to launch and control the nutrition program over a longer period
- Work out the National Food and Nutrition Policy
- Launch and operate in the long run the National Food and Nutrition Policy
- Conduct a representative dietary survey of the population
- Nutritional study on high-risk population groups
- Publish and distribute booklet titled “Dietary Guidelines”
- Wide-scale education of the population (healthy, disease-preventing nutrition) from kindergarten age to old age (family programs, training of women and housewives)
- Extend the education program for fifth-graders to include all pupils in the fifth form of primary school education (125 000 pupils)
- Include education on healthy nutrition in the system of advising on family planning

- Promote the manufacture of food products of preferred ingredients suitable for consumption in healthy diets and expand the available choice of such products
- Ensure that food ingredients, nutrients and energy content are indicated on the label as facts essential for healthy nutrition
- Continually expand the existing food data bank to include the results of new analyses
- Check diets used in school catering and increase the number of children using this form of catering
- Study the diets used in mass catering and recommend reference diets that result in healthy nutrition
- Regular training of catering managers

### **Participants**

- Office of Chief Medical Officer/Public Health Service (ÁNTSZ),
- Fodor József National Centre for Public Health, Institute of Food Hygiene and Nutrition (OKK-OÉTI)
- Ministry of Health (MOH) (EüM)
- Ministry of Agriculture and Regional Development (FVM)
- Education Ministry (OM)
- Ministry for Youth and Sports (ISM)
- Ministry of Interior (BM)
- Defence Ministry (HM)
- Finance Ministry (PM)
- Ministry for Social and Family Affairs
- Central Food Research Institute (KÉKI)
- National Association of Catering Managers
- Non-government organizations
- Society For a Healthy Hungary (EME)
- Nutrition Council

## **4.7 Romania**

**Presented by Dr Daniela Nuta, Institute of Public Health, Bucharest**

### **1. Food and nutrition activities in Romania**

The surveillance of the nutrition state of the Romanian population during the last 10 years by dietary assessments and measuring biochemical indicators in different areas of the country has led to the following conclusions:

- Existence of iodine, iron and calcium deficiency
- Low intake of fruit and vegetables
- Insufficient intake of milk and dairy products, especially in children
- High consumption of alcohol

### **Monitoring the food quality and food contaminants has revealed the following issues:**

- Heavy metals food contamination (Pb, Cd, Zn, Cr, Cu) related to the industrial activity and large urban areas
- Foodborne outbreaks especially by contamination with Salmonella and enterotoxigenic staphylococcus
- Insufficient laws/settlements regarding food control and food qualitative pointers
- Limited laboratory control of food contaminants (mycotoxins, pesticides other than organochlorides, vet drugs residues, aromatic polycyclic hydrocarbons, dioxin) because of insufficient technical endowment of laboratories.

Official statistical data and epidemiological studies referring the chronic nutrition diseases have revealed the incidence of obesity, heart and blood vessels diseases, high blood pressure, diabetes mellitus, digestive diseases, cancer, tuberculosis.

## **2. Politics in supervising the food quality and the nutrition state for the next years**

For the next period (2000-2005) we are able to meet the following objectives, keeping in mind that most of the WHO Food and Nutrition Action Plan objectives are partly included into the National Romanian Program for Health related to the environment:

- Monitoring the nutrition state, food intake, nutrition diseases and dietary problems
- Sanitary education in our population to increase fruit and vegetables consumption
- Strengthening the legislation regarding eliminating the iodine deficiency in our population by making universal the iodination of salt
- Harmonizing our legislation to the EC Directives
- Control measures in vulnerable places: rural areas, street trade
- Legislation on RDAs of nutrients (dietary national guidelines)
- Participation of the Ministry of National Education to sanitary educational activities in schools, regarding food hygiene and healthy food consumption
- Going on collaborating with WHO programmes:
  - GEMS/FOOD
  - WHO Surveillance Programme for Control of Foodborne Infections and Intoxications in Europe
- Participation to other food and nutrition programmes initiated by other departments of the Ministry of Health or by other institutions
- Training by participating to the WHO, FAO, EC, UNICEF, etc. sessions

## **3. Impediments in food and nutrition politics in Romania**

Although there is a great wish for our country to achieve a food and nutrition programme together with the other European countries, there are still some difficulties because of Romania's actual economical stage, such as:

- Low participation of food producers to food security programmes, such as the HACCP system
- Difficulties to implement the market economy legislation, because of the lack of economic structures and technical endowment
- Lack of financial support for Romanian specialists to participate at WHO, EC, Codex Alimentarius Committees sessions
- Insufficient financial support for an educational programme on a healthy way of nourishment and life

### **Short history of IDD in Romania**

1947 – first epidemiological study showed rich thyroid pathology

1949 – administration of potassium iodine tablets in children and pregnant women

1962 – official regulation to distribute iodised salt in goitre regions (30 districts)

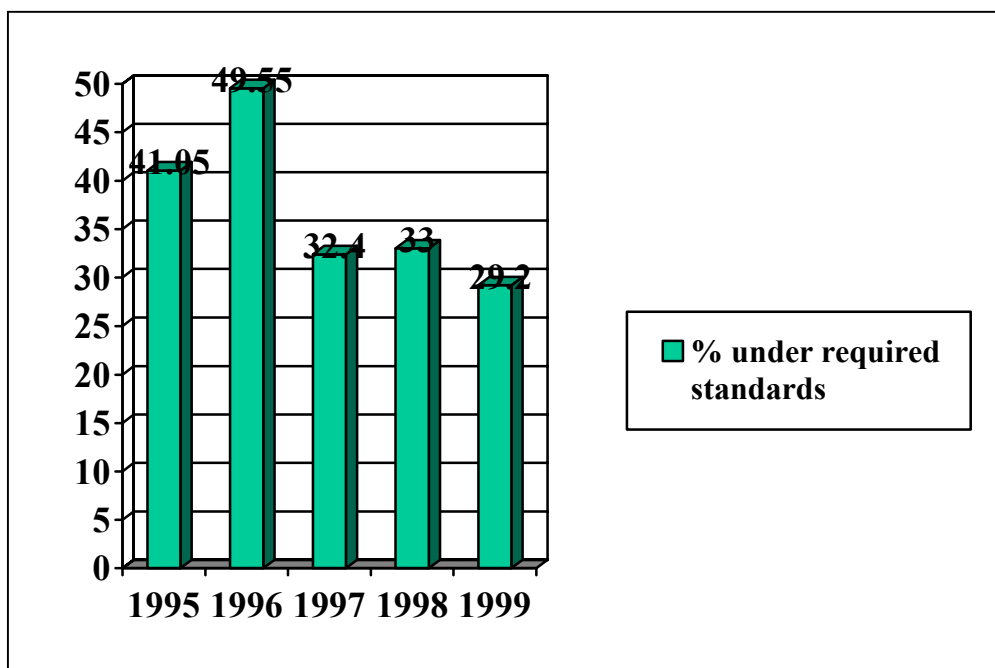
1970 – 1980 – studies revealed high goitre prevalence in Carpathian mountains (>60%)

After 1990 – WHO/UNICEF studies showed that the present iodine deficiency is visible in the form of endemic goitre, affecting 35% of the population

1995 – Government ordinance 779 stipulates that “iodised salt should be consumed throughout the entire country” and the iodine level of salt should be of 40-50 ppm.

1998 – Ministry of Health states that 80% of Romanians regularly receive less than the minimum recommended amount of iodine through their food.

**Figure 1: Monitoring the quality of Romanian iodized salt**



#### **4.8 Slovakia**

**Presented by Dr Milan Kovac, Food research Institute, Bratislava**

##### **Food and Nutrition Action Plan – Slovakia**

The nutrition policy of Slovakia was created in accordance with the National Health Support Programme (adopted by government in 1992 and updated in 1995). The section that deals with nutrition is entitled the Programme for Nutrition Improvement of the Slovak Population (parliamental and governmental levels). This is done through collaboration with the Ministries of Health, Agriculture, Economy, Education, the State Health Institute, the Research Institute for Labour, Social Affairs and Family, the Food Research Institute, and special experts in other relevant sectors.

The aim of the Programme for Nutrition Improvement of the Slovak Population is to change dietary habits and attitudes on health of the Slovak people. Specific targets have been defined until 2010.

The tools for implementation of this programme are:

- Creation of a scientific base for primary production and food processing
- Recommendations for individual sections of food industry
- Legislative regulations affecting food industry development and related activities
- New concept of catering development
- Scientifically based recommended daily intakes
- Support of advisory centre activities
- Broad publication of relevant information using mass media
- Involvement of health insurance companies in preventive activities
- Backing of relevant nongovernmental organizations, communities and bodies

Monitoring programme efficiency implies following information on changes, i.e. on intake of essential nutrients and consumption of defined foodstuffs. This creates baselines information for investigating of new ways for nutritional prevention some diseases.



## 4.9 Slovenia

Presented by Dr Jožica Maučec Zakotnik

### Legal basis for Food and Nutrition Action Plan in Slovenia

- The framework law “Health suitability of foods, materials and articles intended to come into contact with foods act” was adopted in June 2000
- “National Health Plan to 2004” (also adopted in 2000)

### Food and Nutrition Policy will be developed on the basis of data evidence on

- Food safety
- Nutrition related to health
- Food supply

### Food safety strategy

- Coordinated Food Safety Strategy (MoH and MAFF) of the Republic of Slovenia was prepared in April 2001
- It was forwarded to DG SANCO as a national Food Safety Strategy

### Evidence on nutrition related to health problems is currently being upgraded

- We are observing major differences in mortality rates for CND between west and east Slovenia regions
- A national research on healthy life style, CINDI Health Monitor Survey (dietary habits included) has been performed in spring 2001; data have been analysed and will be finished soon
- Data on micronutrients intake are scarce

### Evidences on food supply

- Analysis of the state of Slovene agriculture and food industry from 1992 to 1999 was prepared by MAFF
- This will be the basis for the future Slovenian food and agricultural policy planning, supporting the necessary reorientation in nutrition policy.

### Article 31

- A Food and Nutrition Council shall be established by the minister responsible for health, and shall operate as an expert advisory body in the area of doctrinal, methodological and expert tasks in connection with the implementation of food policy and health related problems (the framework law: health suitability of foods, materials and articles intended to come into contact with foods act)
- The framework law was adopted in June 2000
- Preparation phase: December to March 2001
- The Food and Nutrition Council was established in April 2001
- It meets approximately once per month
- Working groups more frequently

### Ministries and departments nominated to be part of Council

- Ministry of Health
- Ministry of Agriculture, Forestry and Food
- Ministry of the Environment and Physical Planning
- Ministry of Education, Science and Sport
- Ministry of Labour, Family and Social Affairs
- Ministry of Finance

- Ministry of Economy, Chamber of the Economy of Slovenia
- Office of the Republic of Slovenia for the Consumer Protection

**The professional institutions nominated in the Council are:**

- Public Health Institute
- University of Ljubljana (Medical Faculty, Faculty of food technology, Faculty of Education)
- Slovenian Dietetic Association

**Representatives of different organizations and associations are also included in the Council:**

- Representative of child care service – breastfeeding promotion
- Representative of hospital catering (University Clinical Centre, Ljubljana)
- Representative of consumer organization (Slovenian Consumer Association as NGO organization)

All nominated ministries, departments and working groups have prepared or are preparing lists of their present and future activities.

(present activities, identification of needs, problem definition, priorities statement, improvement proposals, cooperation evidence, legislation, foundation, time schedules)

**Some of the working groups have already identified their tasks**

**1. Working group (WG) for preparation of food composition tables**

Elaboration of national food composition tables

**2. Working Group for nutrition of people with particular nutritional needs - identified tasks**

- Updating and adjustment of the legislation in the field of food intended for particular nutritional use
- Establishment of control over the production and distribution of food for dietetic nutrition for particular medical uses
- Organizing dietary consultation services for people with particular nutritional needs
- Organizing nutrition for people with particular nutritional needs in the living and working environment (in schools, at places of work, in catering and tourism)
- Training of professionals in the field of nutrition of people with particular nutritional needs
- Education of people and raising of public awareness
- Arrangement of nutritional labelling and claims for all food intended for nutrition of people with particular nutritional needs

**3. Working Group for preparation of food-based dietary guidelines (FBDG)**

- Short-term preparation of food-based dietary guidelines
- Acceptance of national recommended reference values for the intake of nutrients
- Long-term preparation of food-based dietary guidelines, their monitoring and adjustment to the developments in this speciality

**4. Working Group for education of various population groups**

- Preparation of educational programmes in relation to needs

## **5. Working Group for nutritional training of professionals**

- Analysis of curricula of professionally oriented secondary schools, colleges, university undergraduate and postgraduate educational programmes dealing with food and nutrition in their contents, and their harmonization with the strategy of food and nutrition policy
- Stimulation and support for the university study programme for public health nutrition
- Incorporation of the nutrition contents into the training programmes for pre-school level (kindergartens), elementary and secondary school training at the Faculty of Education.
- Permanent improvement and refreshment of knowledge for dieticians, and introduction of relevant licences.
- Accreditation of professionals for the training in the field of nutrition outside the school system.

## **6. Working Group for the strategy of encouragement and maintenance of breastfeeding**

- Creation and adoption of health policy on breastfeeding in Slovenia
- Regular monitoring of the prevalence of breast-feeding in Slovenia
- Acceptance of the International code on marketing of infant formulae and control of the implementation of this code (Innocenti Declaration)
- Initiative for baby-friendly hospitals and baby-friendly institutions

### **The decision to establish four additional working groups has been adopted**

- WG for work with industry, commercial networks and public catering establishments
- WG for financial and economic evaluation of nutritional policy measures and actions
- WG for foodstuffs, produced with new technologies (containing or composed of GMOs)
- WG for definition of the competencies and procedures of risk assessment on the national level and definition of the reporting procedures

### **Development, implementation and adoption of the national food and nutrition policy**

- The Slovenian national food and nutrition policy shall be developed, coordinated and formulated, on the base of the evidences and recognized needs/tasks.
- Its implementation will be carried out on the base of urgency and importance order.
- National food and nutrition policy shall be adopted by the parliament of the Republic of Slovenia in the 2002.

## **4.10 The former Yugoslav Republic of Macedonia**

**Presented by Professor Elisaveta Stikova and Dr Lence Kolevska**

### **Geographic characteristics of the former Yugoslav Republic of Macedonia**

- The former Yugoslav Republic of Macedonia covers an area of 25.713 km<sup>2</sup>, thus belonging to the group of relatively small countries in Europe.
- The relief structure of the former Yugoslav Republic of Macedonia is characterized with numerous mountains, rivers, valleys, ravines as well as other orthographic forms.
- In the former Yugoslav Republic of Macedonia there are three major natural lakes and 25 from glaciers.
- 19.1% of the land is plain terrain The Bitolsko-Prilepsko Pole (Field) covers 1206 km<sup>2</sup>, the Skopsko Pole covers 361 km<sup>2</sup> and the Polog Valley covers 332 km<sup>2</sup>.

### **Demographic structure and trends**

- The total resident population in the former Yugoslav Republic of Macedonia is about 2 000 000 inhabitants.
- The resident population is predominantly 66.6% Orthodox Christian, 30% Muslim, 0.6% Roman Catholic, and 2.8% belong to other religious groups.
- During the last thirty years the population of young people has decreased

- The number of elderly people over 65 years of age is increasing.
- The average age of the population is 32.7 years for males and 33.9 for females.
- Some vital events are the following:

## Estimation of nutrition situation

### 1. Nutrition of population

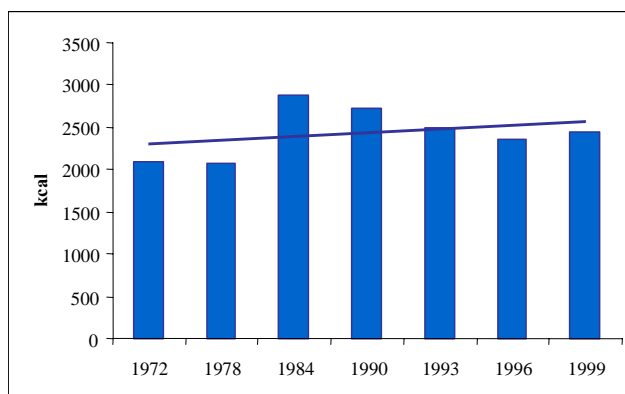
#### *Nutrition intake*

- According to the national monitoring system, the data for the past 30 years has shown a variation among some food product intake in different periods.
- The vegetable intake has shown a slight increasing trend from 152 g per day in 1972 to 216 g per day in 1999.
- Annual fruit consumption per day is 143-177 g
- During this period the total intake, both for fruit and vegetables, has not reached the recommended daily intake of 400 g.
- The cereals intake rose to about 350 g in the seventies to 550 g in the eighties but in the nineties it fell to 400 g.
- Cereal intake composition is mainly white wheat bread, and in the last years the consumption of semi-white and brown bread has increased.
- Milk and dairy consumption is unsatisfactory and varies from 179 g in 1972 to 264 g in 1984 and 222 g in 1999.
- Fish doesn't seem to be characteristic of the Macedonian cuisine.
- The average fat and oil intake increased from 40 g in 1972 to 47 g in 1999. Mostly vegetable oils are consumed, while the use of animal fat is very low.
- There is no major oscillation of the sugar consumption among the population; daily intake was about 35-40 g.
- The consumption of alcoholic drinks, expressed as pure alcohol was about 5 g/day in the the seventies, it increased by double in the eighties, and in the beginning of the nineties it gradually increased to about 5.6 g/day consumed in 1999.

#### *The Nutrition Quality*

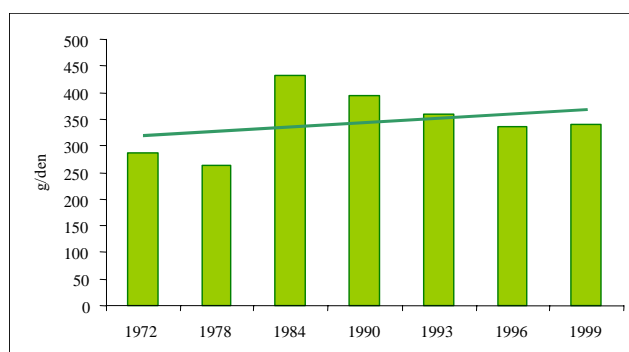
##### *Energy intake*

- According to the energy value intake during the 30 year monitoring period, it was noticed that the value increased from 2090 kcal in 1972 to 2890 in 1984, and at the beginning of 1990 a decreasing trend continued until to 2450 kcal in 1999.



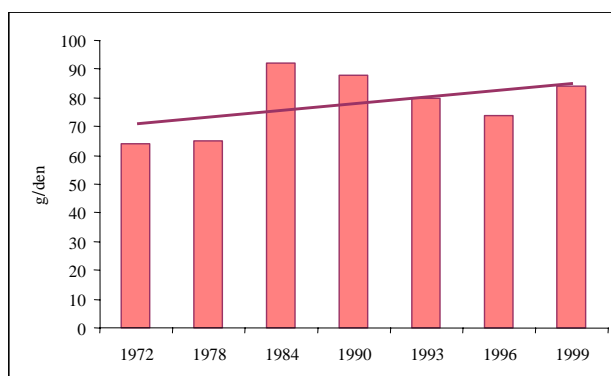
### Carbohydrate intake

- The intake value of carbohydrates, both simple and complex, is lower than the recommended daily intake even though there was an increasing trend for the three decade period.



### Protein intake

- The protein intake from low values in the 1970s of 64 g started to increase to 90 g in the 1990s and has remained at that level. It was noticed that the presence of vegetable proteins in the national diet has increased.



### Fat intake

- The fat intake has not shown significant variations in its monitoring of 30 years with values that range from 75-85 grams per day, with the participation of 30% of the total daily energy intake.

Table 1. Average daily fat intake

	1972	1978	1984	1990	1993	1996	1999
Total fats (g)	74	82	86	86	83	79	83
SFA (g)	21	24	25	22	24	22	24
MUFA (g)	23	26	26	28	25	24	25
PUFA (g)	30	32	34	36	33	33	34
Cholesterol (mg)	161	207	191	162	172	179	225

### Micronutrient intake

The micronutrients analyses in the Macedonian diet in the following period shows:

- The intake of calcium is lower than the recommended value (800 mg).
- The average intake of iron is insufficient, especially among women; approximately 70-80 % of the recommended value.
- The intake of magnesium, zinc and cuprum in the diet has now improved, but it is still only a half of what the population needs, especially among the adults.

Table 2. Intake of calcium, iron, magnesium, zinc and cuprum

	1972	1978	1984	1990	1993	1996	1999
Ca (mg)	502	591	692	498	610	610	667
Fe (mg)	8.4	8	12.3	12.5	10.6	10	12.6
P (mg)	980	1034	1379	1312	1191	1127	1322
Mg (mg)	106	112	208	134	162	179	159
Zn (mg)	2.5	2.7	5.3	2.7	4.1	4.4	4.3
Cu (mg)	0.47	0.47	1.03	0.53	0.77	0.89	0.86

An insufficient intake of vitamin A in the population diet was noticed. The intake of vitamin C is satisfactory.

Table 3. The average intake of certain vitamins

	1972	1978	1984	1990	1993	1996	1999
Vitamin A ( $\mu\text{g}$ )	419	430	347	381	321	348	609
Thiamine (mg)	0.66	0.68	0.97	1.04	0.81	0.8	0.9
Riboflavin (mg)	0.81	0.94	1.03	1.06	0.89	0.87	1
Niacin (mg)	9.5	10	11.4	13.2	10.7	10.3	15.4
Pyridoxine (mg)	0.84	0.87	1.24	1.08	1.01	1.04	1.3
Vitamin C (mg)	56	52	126	109	115	127	138

## 2. Nutrition status

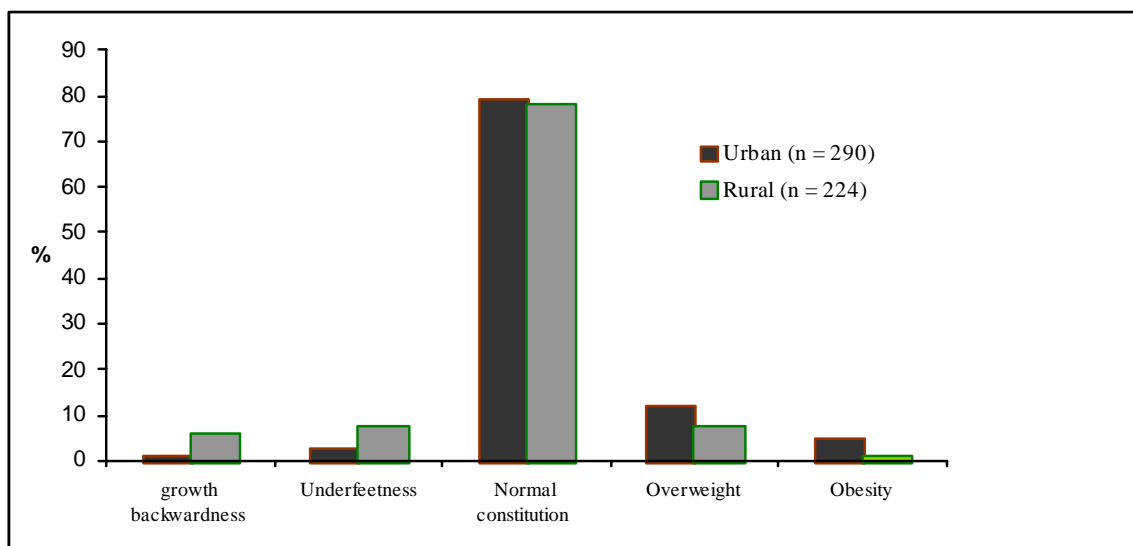
### *Children from 6 to 59 months age*

- Approximately 7% of children aged 6-59 months had height-for-age score below 2 Z.
- A significantly higher proportion (9%) of low height-for-age was observed in rural versus in urban children (6%).
- The prevalence of low weight-for-height was not much greater (3.5%) without appreciable differences between the different strata.
- The prevalence of high weight-for-height (>2 z score), an indicator of being overweight, was 6% with no differences between urban and rural area.

### *Adolescents*

- Among this group a higher prevalence of obesity, according to WHO recommendations, was noticed. About 17% were detected overweight and 4.8% obese. The rural population were 6.6% overweight, and 0.9% were obese. The cholesterol level was normal.

Table 4. Nutritional status of adolescents



**Adults**

- The survey of nutrition status of 265 males and 573 females aged between 20-65 years showed that 48% of the females were overweight (BMI>25-30 kg/m<sup>2</sup>); 19% female and 15% male were obese (BMI>30 kg/m<sup>2</sup>).
- The Multiple Indicator Cluster Survey in the Former Yugoslav Republic of Macedonia measured the micronutrient component of the health and nutritional status of 1749 mothers. A low BMI (<18.5 kg/m<sup>2</sup>) was observed only in about 6% of the mothers and 27% were overweight. Higher degrees of obesity were 10.7%.

Table 5. BMI among adults

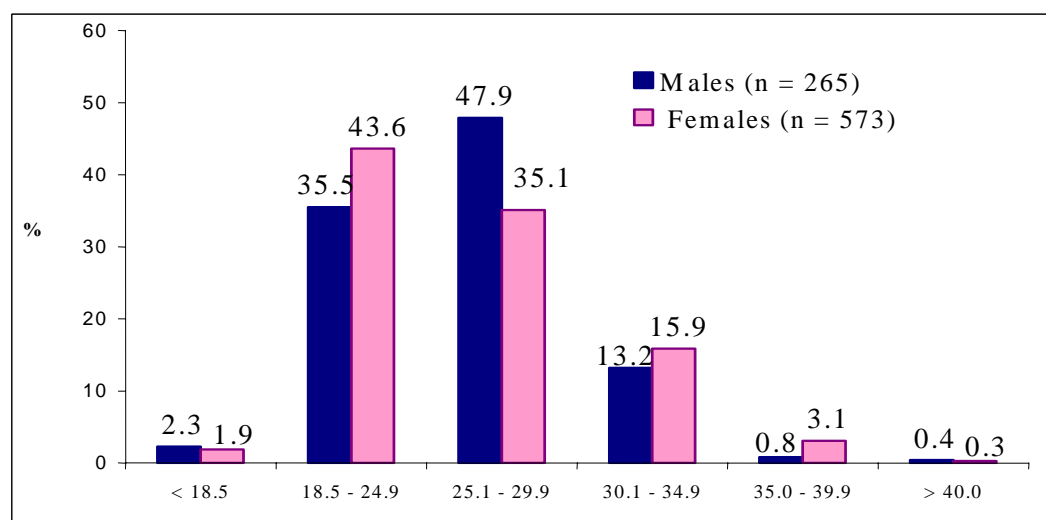
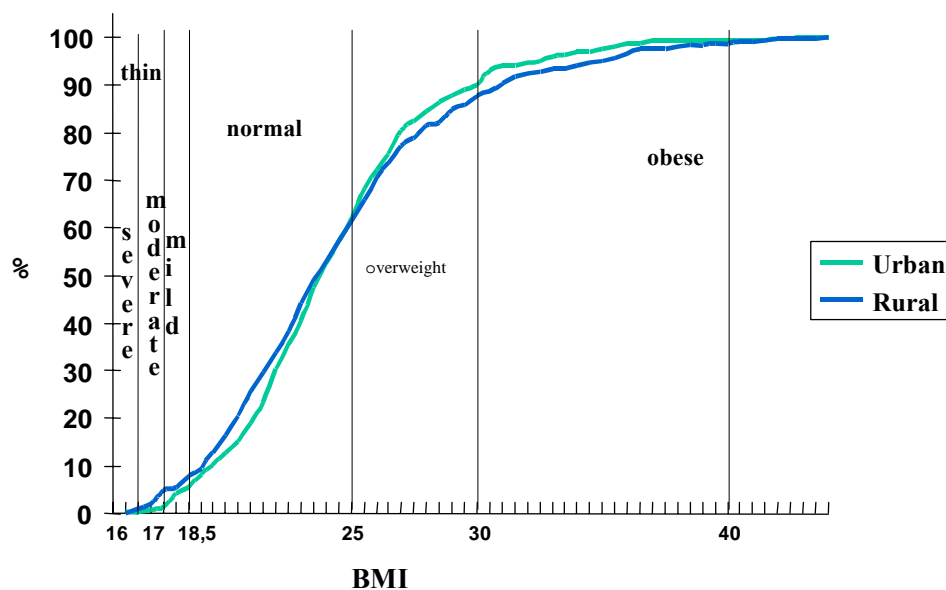


Table 6. Distribution of BMI among mothers aged 25-45 years by strata



### Elderly

- The Multiple Indicator Cluster Survey was carried out in 1999 among 1287 elderly people and showed an average BMI value of 26.9 with a significantly higher index among females (28.4).
- Malnutrition was registered in 2.9%.
- The prevalence for obesity was higher among the females (36.3%) than males (14.3%).
- 36% of the males and 34% of the females were registered overweight.

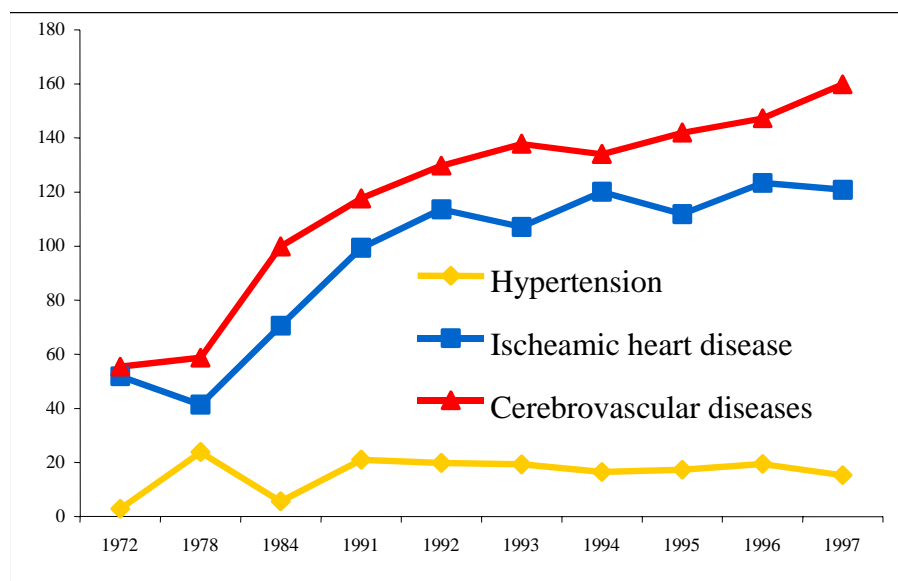
### 3. Nutritional related diseases

#### Noncommunicable diseases

- The last few decades in the former Yugoslav Republic of Macedonia were characterized by an increasing trend of noncommunicable foodborne diseases such as circulatory diseases, malignant neoplasms, and diabetes mellitus.
- Cardiovascular disease remains the most common cause of death for the Macedonian population during the last three decades. In 1972 mortality they accounted for 37% of total mortality, and this percentage has been increasing significantly year after year, up to 55.1%.



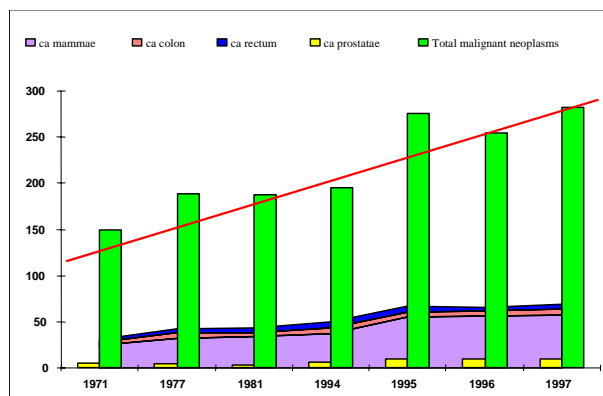
Table 7. Mortality disease from circulatory disease for the period 1972-1999



- Malignant neoplasms are the second most common causes of death. The mortality rate has increased from 87.2/100 000 in 1983, and almost doubled in value in 1998 (147.5/100 000) for all age groups.

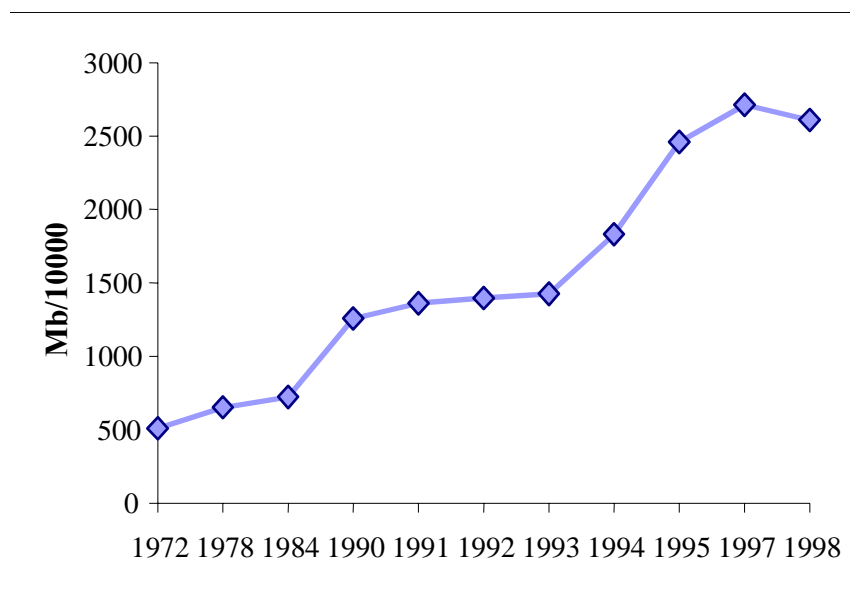
Table 8.

Prevalence rate of malignant neoplasms in the former Yugoslav Republic of Macedonia for period 1971-1997



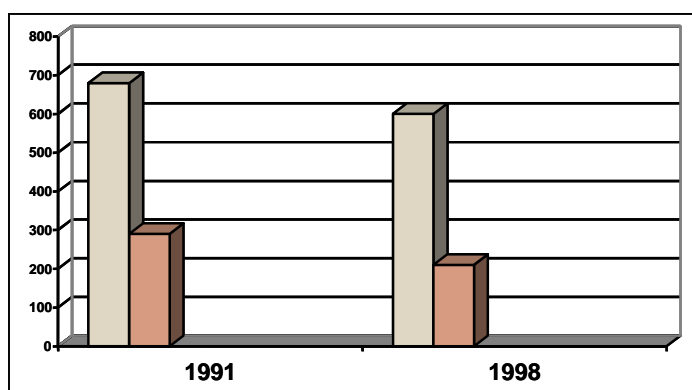
- Type II diabetes has also increased

Table 9. Prevalence rate of type 2 diabetes



- The total morbidity from oral and dental diseases as well the specific morbidity from caries in the former Yugoslav Republic of Macedonia has decreased.

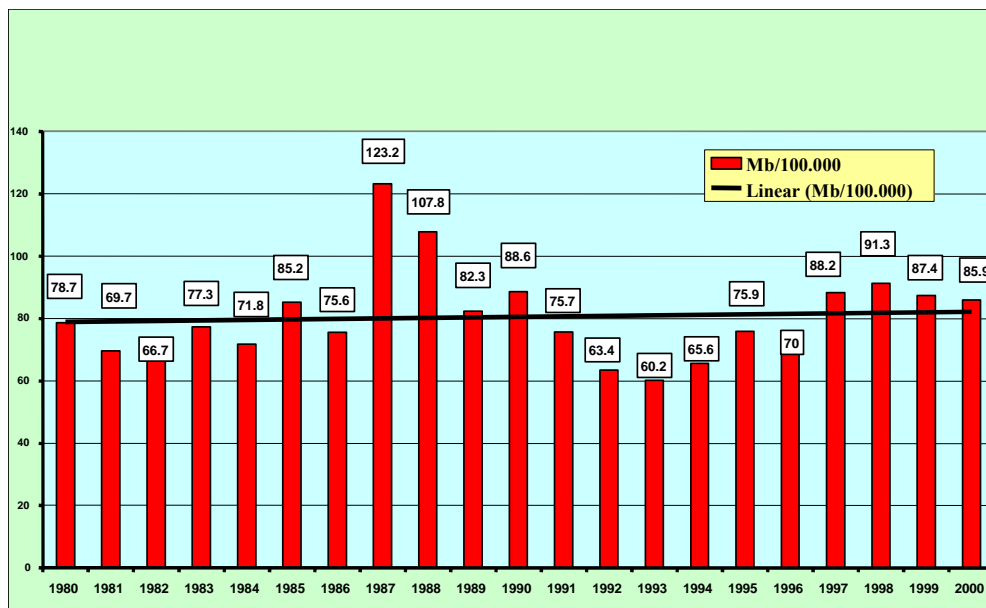
Table 10. Caries morbidity rate and total morbidity from dental diseases in the former Yugoslav Republic of Macedonia for the period 1991-1998



**Communicable diseases related to food**

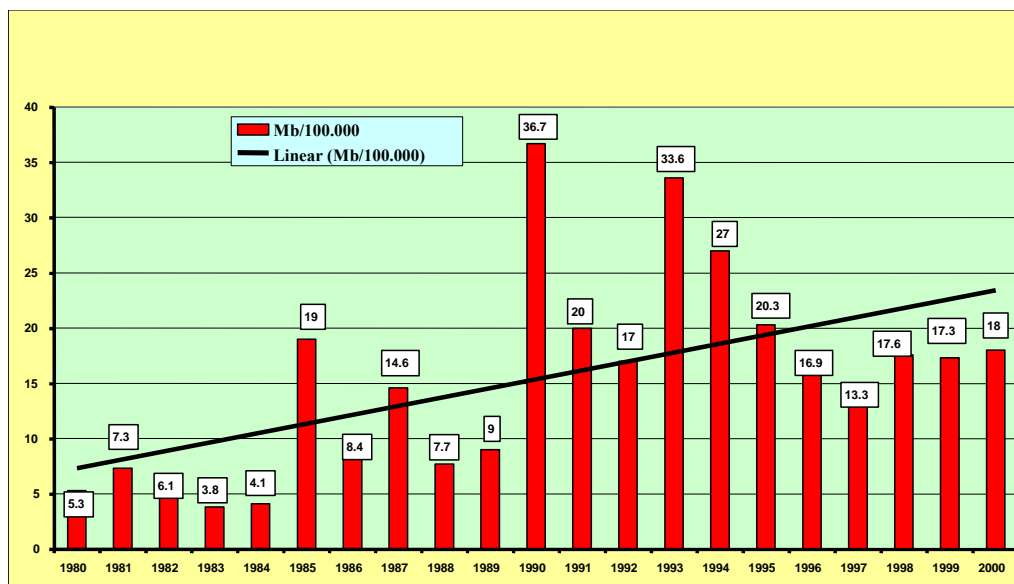
- The former Yugoslav Republic of Macedonia has registered cases of alimentary toxic infections (ATI) from 1980 to 2000. There is a relatively high morbidity rate (80-85/100 000).

Table 11. Alimentary toxic infections in the former Yugoslav Republic of Macedonia and linear trend for the period 1980-2000



- *Salmonellosis*: From 1908-2000 Salmonellosis has been increasing, particularly in the last decade. A relatively constant morbidity was registered: 5-10/100 000.

Table 12. Salmonellosis morbidity rate in the former Yugoslav Republic of Macedonia and linear trend for the period 1980-2000



#### 4. Micronutrient deficiencies

##### Anaemia

The Multiple Indicator Cluster Survey observed mild and moderate anaemia in 26% of the children aged 6-59 months.

Table 13. Prevalence of anaemia among children aged 6-59 months by population strata

	<b>Anaemia</b>				<b>Total</b>
	<b>Severe (Hb &lt;7 g/dL)</b>	<b>Moderate (Hb 7-9.9 g/dL)</b>	<b>Mild (Hb 10-10.9 g/dL)</b>	<b>No Anaemia (Hb ≥11 g/dL)</b>	
<b>Urban</b>	2	45	79	418	544
*Row %	0.4	8.3	14.5	76.8	100.0
*95% C.I.	-0.1-0.9	5.3-11.2	10.7-18.3	71.0-82.7	
<b>Rural</b>	10	67	79	379	535
*Row %	1.9	12.5	14.8	70.8	100.0
*95% C.I.	0.8-3.0	8.8-16.2	11.2-18.3	65.0-76.6	
<b>Total</b>	12	112	158	797	1079
*Row %	1.0	10.1	14.6	74.2	100.0
*95% C.I.	0.5-1.6	7.8-12.4	12.0-17.3	70.1-78.3	
<b>Pearson Chi-square: 11.49, p=0.009; Missing Values=94</b>					

**Adults:** The study of 234 adolescents aged 10 to 15 years showed that 5.4% had anaemia (haemoglobin levels lower than 11 g/dl) in an urban population, with a higher prevalence of 19.7% in rural areas.

**Elderly:** Among the 1287 elderly people, the average concentration of haemoglobin was significantly higher in males (14.3 g/dl) compared to females (13.5 g/dl.). The prevalence of anaemia was 14.8% (males 17.3% and females 12.6%).

##### Vitamin A deficiency

Results of a national survey of children aged 5-59 months showed that the average concentration of serum retinal was significantly higher among children in rural areas. For urban children, the vitamin A deficit was more frequent (31%), and among rural 28%, but a severe case was observed in 2% of rural areas and 1% of urban areas.

##### Iodine deficiency disorders

Table 14. Iodine deficiency disorders

<b>Republic of Macedonia is iodine deficiency area</b>	
West part of the country, Kocani, Berovo	
Goiter up to 90%, 200.000 cases	
<b>1956:</b>	<b>Iodizing of Salt (5-15 mg KJ/kg)</b>
<b>1990:</b>	<b>4.110- checked school population</b> (goiter 20,8-60,8%; iodine urinary excretion < 5µg/dl)
<b>1993:</b>	<b>Iodized Salt (5-25 mg KJ/kg)</b>
<b>1995/96:</b>	<b>11.486 checked school population (goiter 7,829,8% -18.7%</b> <b>Iodine urinary excretion 11,7µg/dl -mild form of iodine deficiency</b>
<b>1998/99:</b>	<b>1.054 checked school population, goiter 8,1%</b> <b>Iodine urinary excretion 10,0 µg/dl</b>
<b>1999:</b>	<b>A new under law for salt quality (20-30 mg J/kg)</b>
<b>2000:</b>	<b>1.200 checked school population</b> <b>Iodine urinary excretion 15,4µg/dl</b>
<b>The elimination of Iodine Deficiency</b>	

## 5. Breastfeeding promotion

- In 1997 the National Breastfeeding Committee was established in the Ministry of Health.
- More than 100 different publications were published in the field of public promotion.
- 800 health workers in hospitals, women care health centres, and maternity hospitals are following national educational programs.
- 19 maternity hospitals (75%) were certificated as baby friendly.
- The percentage of mothers breastfeeding exclusively up to four months has increased from 8% to 42%, and 37% of mothers are breastfeeding exclusively up to six months.
- The Code of Marketing of Breast-milk Substitutes was implemented.
- A public support breastfeeding system with more than 100 groups was established.

## 6. Food safety

To ensure safe food for the entire population of the former Yugoslav Republic of Macedonia the food control system has been established, which consists of: legislation, inspection and laboratory control.

The following elements are controlled:

- Food quality (ingredients, hygienic quality, organoleptic characteristics, declaration)
- Additives
- Pesticides (organochloric and organophosphoric insecticides)
- Heavy metals (Pb, Cd, As, Hg, Mn, Cu, Fe, Co, Ni)
- Mycotoxine (Afla-toxine, B,G,M-toxin, Ochra-toxine, Patuline)
- Antibiotics
- Anabolic
- PCBs
- Radionuclides
- Microbiological contamination

The food safety system follows about 40 000 samples per year, both domestic and imported food products and products from markets. The analysed domestic products data show improper samples among 10-15% of the total number. For imported products the amount is 1-3%.

Table 15. Chemical improper samples distribution by origin in the former Yugoslav Republic of Macedonia

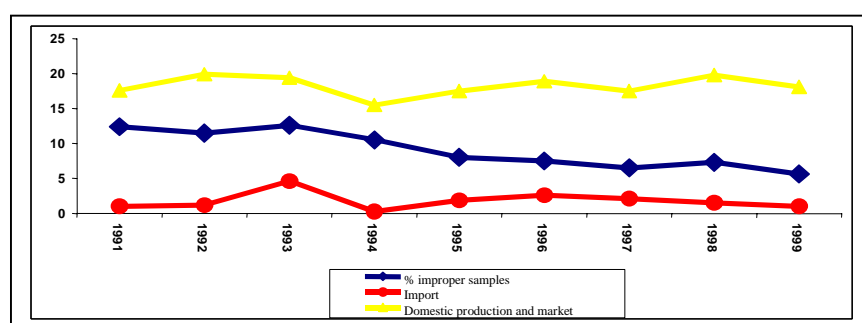
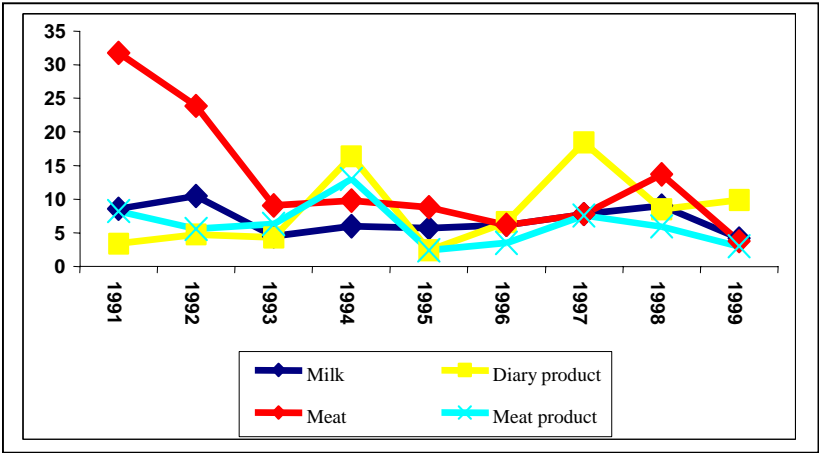


Table 16. Distribution of the percentage of improper analysed samples per year for the microbiological contamination by products



About 25 000 samples are tested annually against microbiological safety; 40% are imported foods and 60% are produced domestically. Microbiological contamination of domestic products in the tested samples was found in 4-6% of the cases with industrial origin, approximately 10% from small enterprises and 8-10% from distribution.

**7. Action plan**

**Nutrition of population**

To improve the quality of the national diet according to WHO recommendations of healthy nutrition

**Nutrition status**

Establishment of a national monitoring system for nutrition status, especially for vulnerable groups

**Nutrition related diseases**

The monitoring of morbidity and mortality rates for nutrition related diseases and conditions

**Micronutritive deficit prevention**

Education on what is a healthy diet plays an important role in the prevention of actual micro deficit: anaemia and vitamin A deficiency.

**Iodine deficiency prevention**

To keep up the elimination of iodine deficiency

**Food supply**

To provide sufficient, quality priced, safe food

**Breastfeeding promotion**

Continuing the activities of the National Committee for Breastfeeding

**Healthy nutrition education**

Health nutrition education should be intensified to ensure good nutrition habits of the population.

**Providing safe, quality food**

- Approximation of the national legislation with relevant international standards and harmonization of Codex Alimentarius standards and EU Directives. Strengthening, rationalization and definition of competencies and responsibilities in the system of food control
- Establishment of proper conditions for safe food production, processing, distribution and consumption
- Development of a concept for monitoring the status of productive land, as a basic means for primary plants production in terms of application of chemicals, taking into consideration production characteristics and traditions in each production region
- Cooperation with nongovernmental organizations and public information media with regard to safe food and nutrition

## 4.11 Yugoslavia

Presented by Dr Ljiljana Trajkovic-Pavlovic, Dr Oliver Petrovic, Dr Dju Rkovic D, Dr Kisin ,  
Dr Gajic Ivanka, Dr Stojiljkovic Djordje

### Food Supply

- Domestic production
- Imported food
- Humanitarian agencies

Table 1: Household Budget Survey:

### Nutrient densities for selected nutrients, inhabitant/day

		1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
Energy value	kcal/day	3099	3160	2843	2434	2545	2887	2817	3009	2705	2411
per 1000 kcal											
Proteins	g	30.0	29.7	29.7	29.5	29.3	29.1	29.8	29.9	28.8	29.6
Fats	g	37.3	37.4	36.7	33.3	34.8	34.6	35.4	32.9	34.8	34.1
Carbohydrates	g	131.7	130.7	132.3	140.1	137.5	135.8	136.7	141.2	139.7	139.9
Calcium	mg	191	188	172	168	174	184	190	181	190	189
Phosphorus	mg	550	547	545	547	541	538	553	520	556	561
Iron	mg	4.5	4.4	4.5	4.2	4.2	4.3	4.4	4.3	4.4	4.5
Zinc	mg	3.78	3.83	3.97	3.53	3.05	3.93	4.19	3.66	3.45	3.10
Vitamin A	iu	1705	1460	1477	1259	1316	1479	1558	1383	1815	1660
Thiamine	mg	0.52	0.49	0.51	0.51	0.51	0.48	0.51	0.50	0.47	0.51
Riboflavin	mg	0.55	0.52	0.49	0.47	0.48	0.52	0.53	0.51	0.56	0.54
Nicotinic acid	mg Eq	5.1	4.9	4.8	4.7	4.8	4.9	4.8	4.8	4.4	4.8
Vitamin C	mg	34.0	32.7	34.8	27.5	29.9	30.2	32.8	30.9	34.8	30.0
<b>Fatty acids:</b>											
Saturated	g	11.75	11.71	11.08	10.19	9.08	12.30	12.53	10.73	8.92	8.97
Oligounsaturated	g	12.88	12.85	12.80	11.05	9.98	13.28	13.64	11.57	9.78	9.62
Polyunsaturated	g	11.97	12.18	12.06	11.50	10.95	13.63	13.89	11.78	10.16	9.91
Cholesterol	mg/day	328.0	320.6	265.8	202.0	216.5	285.9	269.6	269.0	268.7	258.2

\* No data for Kosovo and Metohia for 1999. For the calculation the data for 1998 are used.



**Table 2: Participation of fatty acids in average energy intake  
inhabitant / day**

	Average energy value	Fatty acids:					
		Saturated		Oligoiunsatureted		Polyunsaturated	
		g	% of energy intake	g	% of energy intake	g	% of energy intake
1990	3099	36.4	10.9	39.9	12.0	37.1	11.1
1991	3160	37.0	10.9	40.6	11.9	38.5	11.3
1992	2843	31.5	10.3	36.4	11.9	34.3	11.2
1993	2434	24.8	9.5	26.9	10.3	28.0	10.7
1994	2545	26.2	9.6	28.8	10.5	31.6	11.5
1995	2887	31.3	10.1	33.8	10.9	34.7	11.2
1996	2817	30.5	10.1	33.2	11.0	33.8	11.2
1997	3009	30.5	9.4	32.9	10.2	33.5	10.4
1998	2705	28.2	9.7	30.9	10.6	32.1	11.0
1999	2411	27.8	10.7	29.8	11.5	30.7	11.8

**Table 3: Households Budget Survey: Burden of expenses for nutrition**

%/household/month incomes

	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
%	41.9	36	36.1	48	54.3	50.6	47.7	47.1	44.1	43	45.2

## Food Safety – legislation and enforcement

### Federal Secretariat For Health, Social Policy And Welfare

- Federal Institute of Public Health
- Federal Sanitary, Veterinary and Phytosanitary
- Inspection Service
- Republic Sanitary, Veterinary and Phytosanitary Inspection Services

Legislation is based on Codex Alimentarius Commission standards, guidelines and recommendations

**Table 4: Registered outbreaks of foodborne diseases in Yugoslavia from 1988-1999**

Year	Number of registered outbreaks	Number of registered outbreaks with bacterial laboratory confirmation	% of registered outbreaks with bacterial laboratory confirmation
1988.	76	72	94.74
1989.	85	81	95.29
1990.	97	71	73.20
1991.	107	102	95.33
1992.	127	119	93.70
1993.	119	106	89.08
1994.	152	124	81.58
1995.	349	263	75.36
1996.	234	191	81.62
1997.	257	177	68.87
1998.	256	242	94.53
1999.	246	241	97.97
Total	2,105	1,789	84.99

**Table 5: Registered outbreaks of foodborn diseases in FR Yugoslavia period 1994-1999.**

Region	Number of registered outbreaks						∅
	1994	1995	1996	1997	1998	1999	
FR Yugoslavia	152	349	234	257	256	246	249
Monte Negro	1	72	3	6	2	9	16
Serbia	151	277	231	251	254	237	234
Central Serbia	64	111	89	118	122	-	101
Vojvodina	82	161	129	119	124	-	123
Kosovo and Metohia	5	5	13	14	8	-	9

**Table 6: Number of registered outbreaks according to laboratory confirmed causes in 1999.**

confirmed causes	Number of registered outbreaks	%	Total numbers of diseased
Salmonellae	147	59.76	1060
Trichinella spiralis	46	18.70	686
Alim.bact.intoksications	36	14.63	501
Shigela	7	2.85	104
unknown cause	5	2.03	1432
Bact.intest.infections	3	1.22	18
Cl. botulinum	2	0.81	6
<b>Total</b>	<b>246</b>	<b>100.00</b>	<b>3807</b>

**Table 7: Number of registered outbreaks according to place of occurrence in 1998.**

Place of occurrence	Number of registered outbreaks	Numbers of diseased	%
Households	206	1444	80.47
Hotels, etc	13	112	5.08
Restaurants in factories	12	233	4.69
Preschool institutions, schools	7	373	2.73
Restaurants	5	202	1.95
Candy shops.	5	31	1.95
Unknown	4	755	1.56
Social welfare institutions	2	61	0.78
Hospitals	2	11	0.78
<b>T O T A L :</b>	<b>256</b>	<b>3222</b>	<b>100.00</b>

**Table 8: Number of registered outbreaks caused by salmonellas in 1999.**

salmonella serotypes	number of outbreaks
1. S. enteritidis	135
2. S. typhimurium	2
3. S. infantis	2
4. S. bredneu	1
5. S. unclassified	7
<b>TOTAL:</b>	<b>147</b>

### Micronutrient deficiencies

- Iron Deficiency Anemia
- Rickets
- Iodine Deficiency Disorders

**Table 8a: Goiter prevalence in Yugoslavia**

Year	Survey	Prevalence
1928 -1930	Prof. Sahovic	80% school children 85% school children
1950-1951	Prof. Dr. Sergej Ramzin Prof. Dr Mioljub Kicic Dr Badovinci Dr N.Pazar Dr Gornja Dr Jo Anica	90.1% school children 85.6% school children - 90% school children

**Table 8b. Iron deficiency anaemia prevalence in Yugoslavia**

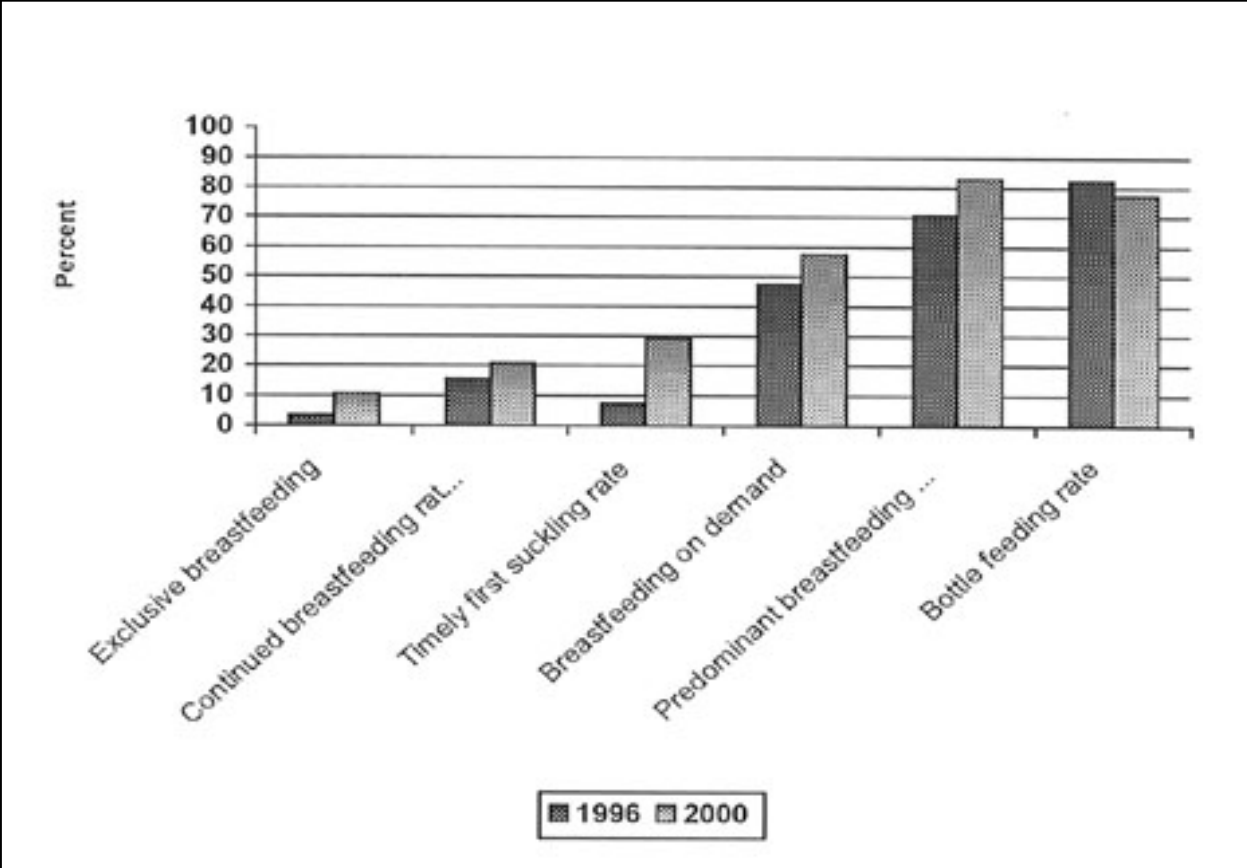
Group	Hb	Sample size number	Prevalence %
Children	< 110 g/l	369	29.5
Women	< 120 g/l	1296	26.7

Source UNICEF, 2000

Indicators	WHO/ICCIDD	Serbia
1997/1998		
• Goitre prevalence	% < 5	2,35
• Households consuming iodized salt	% 95	73,2
• TSH newborns having serum TSH levels > 5mlμ/l	% < 3	1 : 5435
• Children having iodine urine excretion < 100μg/l	% < 5	Several cases

Source: Report on ICCIDD/UNICEF/Yu Program on IDD elimination/2000

Figure: Progress in major breastfeeding indicators since MICS 1996



**Table 9. Hip fracture morbidity rate**

- Per 100 000 -

	Sex	Rate	average hospital daus
1988	all	34.1	30
	male	32.0	27
	female	36.2	32
1989	all	36.7	27
	male	32.6	26
	female	40.8	28
1990	all	40.2	25
	male	37.4	25
	female	42.9	25
1993	all	41.6	27
	male	35.6	25
	female	47.5	29
1994	all	38.5	26
	male	32.1	24
	female	44.8	27
1995	all	51.1	27
	male	40.8	25
	female	61.3	28
1996	all	40.0	25
	male	30.7	23
	female	49.2	25

Figure 1. Age standardized mortality rate due to diabetes mellitus \*

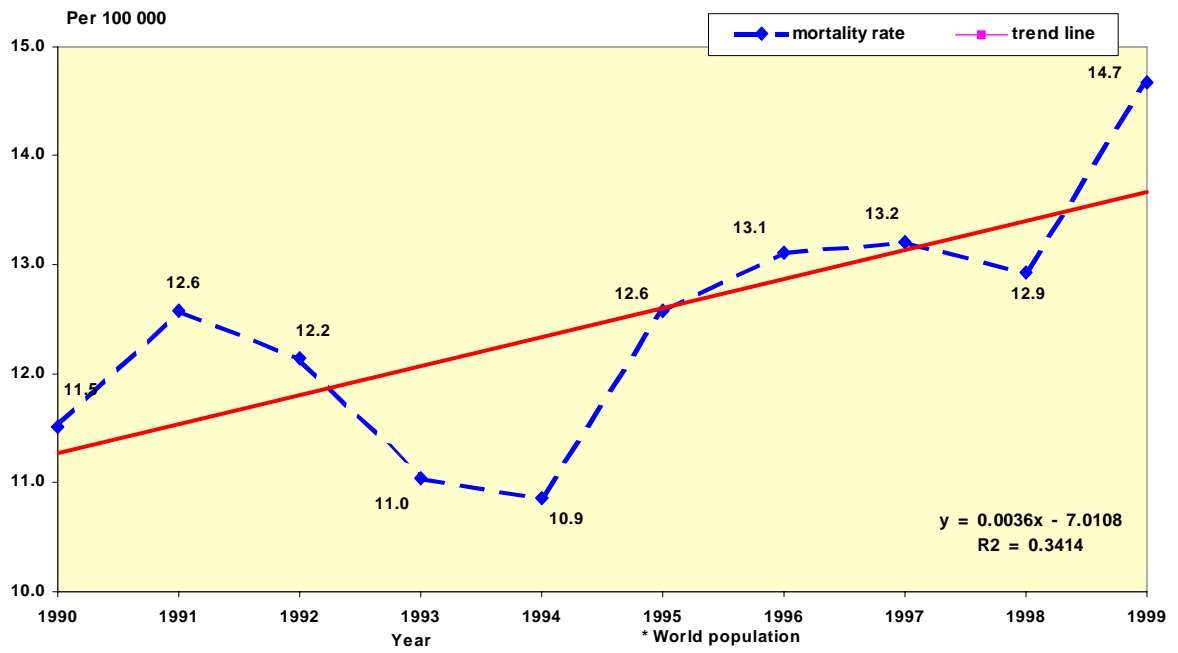


Figure 2. Age standardized mortality rate due to high blood pressure \*

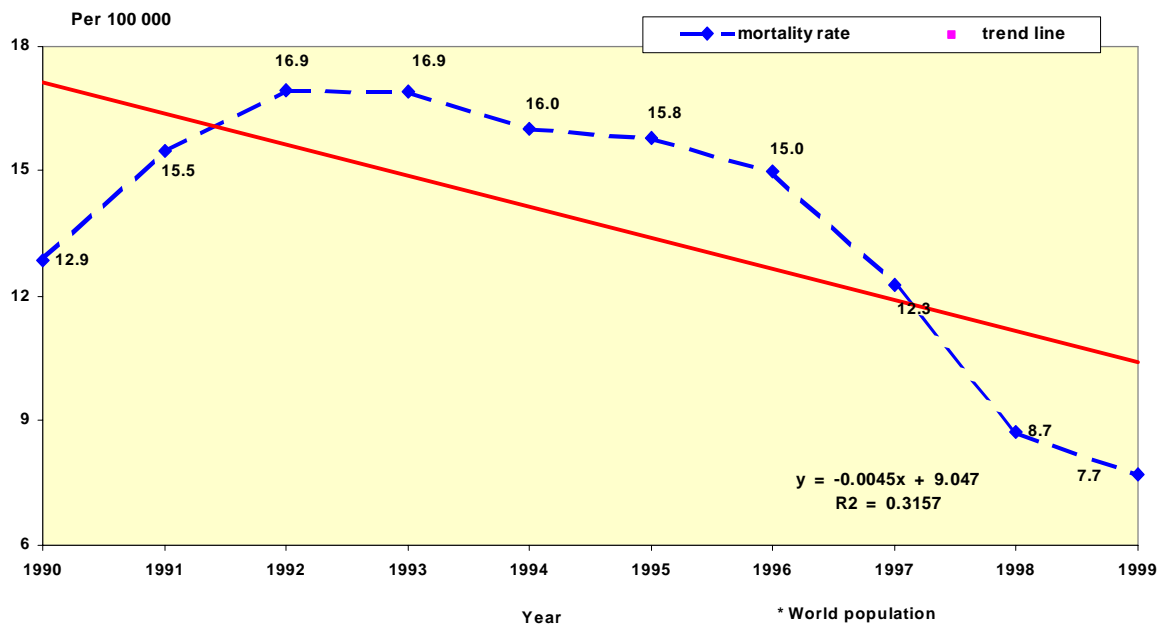


Figure 3. Age standardized mortality rate due to ischemic heart diseases \*

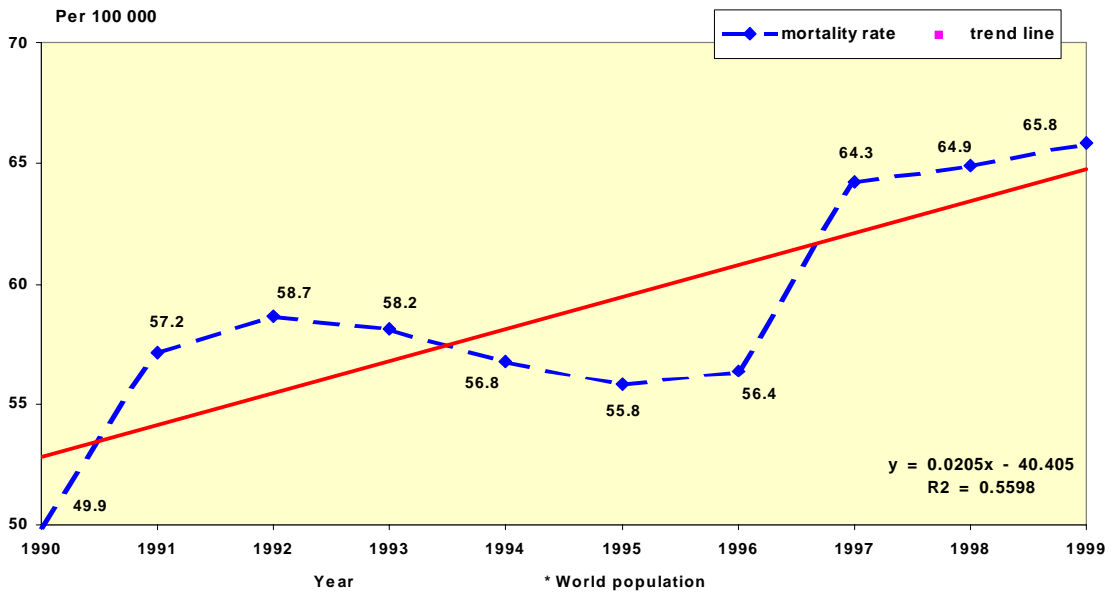


Figure 4. Age standardized mortality rate due to cardiovascular diseases \*

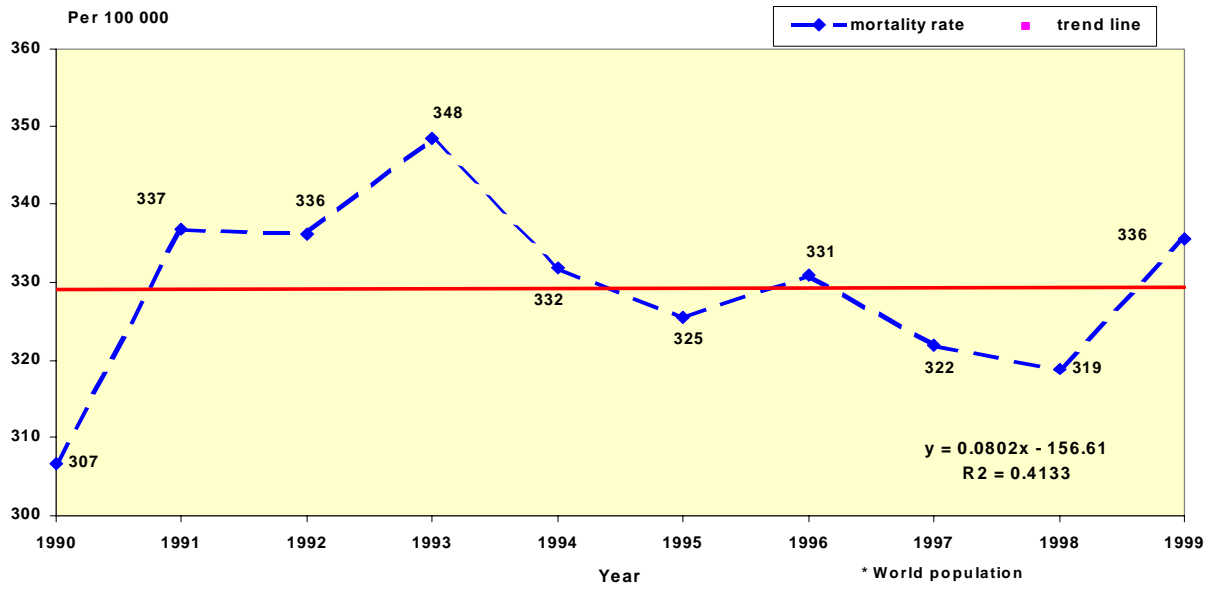




Figure 5 Age standardized mortality rate due to blood vessels diseases \*

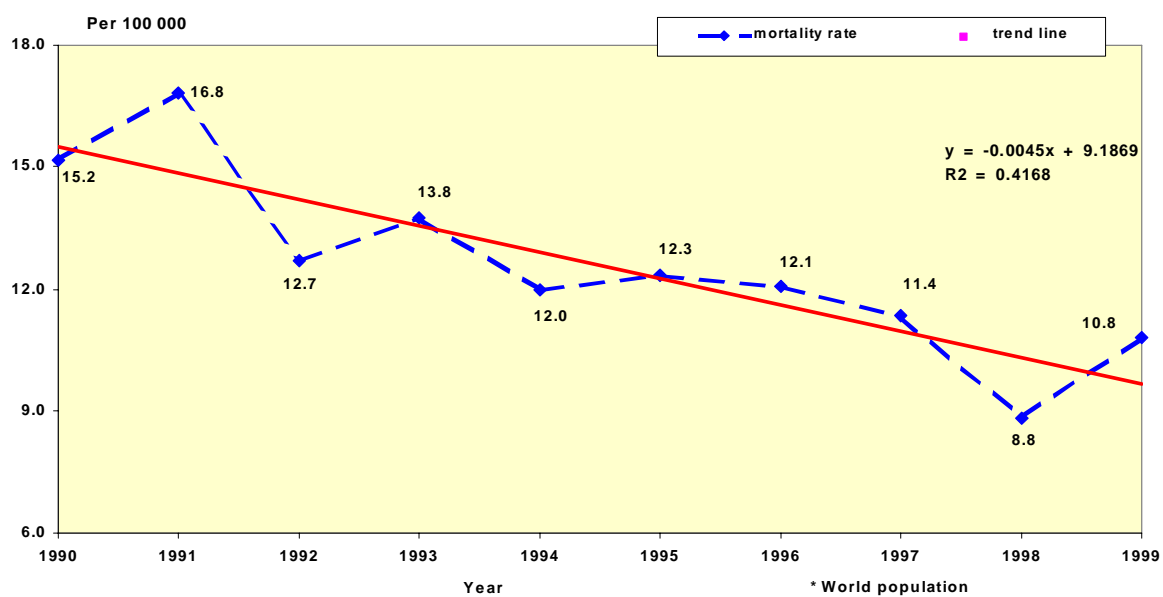


Table 10. Age standardized mortality rate due to colorectal and female breast cancer for prsons aged >35 (per 100 000)\*

Year	Cancer	
	colon **	famele breast ***
1985	24.64	34.94
1986	26.58	35.95
1987	27.35	40.20
1988	28.03	42.59
1989	27.45	43.76
1990	27.92	43.33
1991	28.50	42.83
1992	30.19	46.70
1993	29.56	45.76
1994	29.83	46.08
1995	28.73	46.07
1996	31.06	46.22
1997	31.32	49.94
1998	31.54	49.24
1999	31.56	50.59

\* World population

\*\*colon - whole population

\*\*\*female breast - female population

**Table 11. Age standardized mortality rate due to oesophagus, stomach, corpus uteri, ovarium and prostate cancers for persons aged >35 (per 100 000)\***

	C a n c e r				
	oesophagus**	stomac**	corpus uteri***	ovarium***	prostate****
1985	4.70	24.91	...	...	17.26
1986	3.56	24.49	...	...	16.03
1987	3.81	25.14	...	...	16.52
1988	3.60	26.30	...	10.63	18.35
1989	3.75	25.26	3.63	11.47	17.12
1990	3.94	24.56	4.05	11.77	19.92
1991	3.83	25.09	4.92	10.30	17.56
1992	3.82	23.77	4.13	10.17	21.26
1993	3.74	22.15	3.25	11.27	20.68
1994	3.98	22.29	3.71	11.69	19.72
1995	3.69	20.65	4.60	11.01	18.65
1996	3.92	22.02	4.19	9.49	17.01
1997	3.95	21.36	3.82	10.57	18.73
1998	4.45	21.71	3.83	10.78	19.33
1999	3.30	20.36	...	10.69	20.47

\* World population

\*\* - whole population

\*\*\* - female population

\*\*\*\* male population

## **Conclusions**

- Food supply of the population deteriorated sharply during the last ten years.
- Some modest activities have been carried out on harmonizing food safety legislation with EU regulations.
- The main nutrition deficiency disorders are iron deficiency anemia and rickets.
- IDD has been practically eliminated.
- The Breastfeeding Programme in Yugoslavia has improved the nutrition quality of newborns.
- Morbidity and mortality rates have an increasing tendency to correlate with over-nutrition related diseases.
- There is an urgent need to create a national plan of action in order to strengthen activities of various sectors to improve the nutrition of the population.

## 5. Progress reports

Each country was requested to submit a progress report prior to the meeting.

### 5.1 Albania

#### **Dr Marita Afezoli, Department of Primary Health Care, Ministry of Health**

On June 25, 2000 the Minister of Health signed the Order on “the Preparation of the National Food and Nutrition Action Plan” (FNAP).

The preparation of the Albanian FNAP is organized through the coordination of the work with the Ministry of Agriculture and Food and other interested institutions such as Trade, Tourism, Finance, Environment, Education, Mass media and NGOs.

The implementation of this mission was assigned to the Department of Primary Health Care in the Ministry of Health, in collaboration with the Ministry of Food and Agriculture and WHO.

The working group on the development of the FNAP, comprises specialists from the Department of Primary Health Care in the Ministry of Health, the Institute of Public Health, the Public Health Directorate in Tirana, the Public Health Directorate in Durres and specialists from the other economic sectors in central institutions such as the Ministry of Food and Agriculture, Economic Cooperation and Commerce, Ministry of Tourism, Ministry of Finance, Ministry of Education and Science, Ministry of Work and Social Affairs, National Environmental Agency and nongovernmental organizations.

Up to now we have organized two meetings of the working group chaired by the Director of the Primary Health Care Department in the Ministry of Health. Actually we are in the phase of preparation of the document. The document is available in the Albanian language only.

All the specialists participated in the organized meetings and were invited to assist in the preparation of the document. They agreed to help and each one of them has prepared some specific chapters of the document. After the preparation of the draft, we have planned to forward to all of them for comments.

The draft includes the analysis of nutrition situation in Albania, except the objectives and action plan for the years 2002-2007. The main issues presented are:

#### **1. The Goal and existing political commitments**

#### **2. Social inequalities and the burden of food related ill health**

- Foodborne diseases
- Malnutrition and food insecurity
- Obesity and non-communicable diseases (NCD)

#### **3. Food and nutrition strategy**

- Nutrition strategy
- Food safety strategy
- A sustainable food supply strategy (food security)

#### **4. Approaches**

- Developing a comprehensive approach (bringing the three strategies together)

- Monitoring health information
- Improving knowledge
- Nutrition education, healthy nutrition programs
- Strengthening the partnerships
- Promoting the establishment of national advisory and coordination mechanisms
- The legal framework on food and nutrition

### **National endorsement**

We plan to set up a Ministerial Steering Committee in the near future. After finalization of the document, it will be approved by the Steering Committee and will be introduced to the government for endorsement.

## **5.2 Bosnia and Herzegovina**

**Dr Aida Filipovic Hadziomeragic, Institute of Public Health, Federation of Bosnia & Herzegovina**

### **Time frame**

The process was initiated at the beginning of 1995 by WHO and the Federal Public Health Institute. The working group, later named National Food and Nutrition Committee, consisted of representatives from ministries (Health and Agriculture), academic institutions (Medical Faculty, Veterinary Faculty, Faculty of Agriculture, Faculty of Natural Sciences), the Federal Institute of Public Health and media (BH Television), was formed. The first task of the committee was to develop a situation analysis on the agreed topics (nutritional status of population, diet related health issues, dietary patterns, agriculture, commerce/trade, food quality and safety control, nutrition/health education, food and nutrition policy in Bosnia and Herzegovina before the war).

A few meetings were held and situation analyses on the nutritional status of the population, diet related health issues and dietary patterns have been drafted). Due to the war all the work was interrupted.

At the ICN Follow up Consultation in Warsaw, 1996, constraints in development have been reported.

In 1999 the process was restarted on the entity level, with the agreement of close inter-entity collaboration.

In 2001, a new government of the Federation of Bosnia & Herzegovina came into power and the Federal Ministry of Health formed a new expert group for food and nutrition:

- Dr Aida Filipovic Hadziomeragic - Institute of Public Health of Bosnia and Herzegovina
- Dr Alma Mujanovic - Ministry of Health of Bosnia and Herzegovina
- Dr Fatima Jusupovic - Ministry of Health of the Tuzla Canton
- Dr Nijaz Uzunovic - Federal Sanitary Inspectorate

The group met with representatives of the Ministry of Health and the WHO Liaison Office to discuss further development: the structure of the action plan and collaboration with other sectors. An initial meeting with representatives from the Ministry of Agriculture has also been held.

### **Collaboration**

The expert group from the Federal Ministry of Agriculture:

- Kazimir Ivic - Deputy Minister
- Mervana Hadzimurtezic - Advisor
- Faketa Begovic - Advisor

- Alma Kobaslija - Lawyer

This Group collaborates and liaises with representatives from the food industry, the Ministry of Environment and the Veterinary Faculty, etc. established through other joint activities (development of Integrated Plan of Public Health, development of National Environmental Health Action Plan). The group also works on development of the Food and Nutrition Action Plan.

### **Structure of the action plan**

During the discussions on the structure of the action plan, it was agreed that emphasis should be put on nutrition strategy and food safety strategy as long as draft of the “Strategy of Long Term Development of Agricultural production 2000 – 2010”, written by the Ministry of Agriculture, will be used for addressing sustainable food supply strategy.

It was agreed that written suggestions for the structure of the action plan will be prepared for the next meeting of the group, planned for mid October.

### **National endorsement**

Finalization of the document has been planned for the period of the next 12 months, including comments and approval of all involved sectors. Then it should be presented to the Ministry of Health for final approval. If and when approved, it would be Ministry of Health’s responsibility to present it to parliament and ask for its approval.

## **5.3 Bulgaria**

### **Professor Stefka Petrova, National Centre of Hygiene, Medical Ecology and Nutrition and National consultant on nutrition at Ministry of Health**

The process of developing of the National Food and Nutrition Action Plan started in 2001.

A multisectoral working group including 20 members was established to develop the national action plan. The members of the working group are included in specialized expert groups, together with additional experts, to develop specific programs in the field. Representatives from the following ministries and organizations have participated in the development of Bulgarian Food and Nutrition Action Plan:

- Ministry of Health
- National Centre of Hygiene
- Medical Ecology and Nutrition
- National hygiene and epidemiology inspectorates
- Ministry of Agriculture and Forests
- State Veterinary Sanitary Control
- Ministry of Labour and Social Policy
- Ministry of Education and Science
- Ministry of Economics
- Ministry of Finance
- National Centre for Public Health
- National Centre for Health Information
- Medical University in Sofia
- National Institute of Statistics
- Liaison officers of WHO and UNICEF
- A consultant from FAO
- NGO’s and Health Insurance Fund

The lead institution is the Ministry of Health.

The Bulgarian Action Plan is directed towards three main areas: nutrition, food safety and food security.

### **Nutrition programmes**

Programmes related to nutrition include improvement of nutrition and nutritional status of vulnerable groups: pregnant and lactating women, infants and small children, children in kindergartens and schoolchildren, elderly people and especially towards socially unequal individuals. Other important programs include the reducing risk of diet-related chronic non-communicable diseases, the sustainable elimination of iodine deficiencies, nutrition monitoring, a national information system related to nutrition, nutritional status and diet-related health problems and diseases.

### **Food safety programmes**

Programmes related to food safety include the monitoring of heavy metals, pesticides, mycotoxines and radiation contaminants in foods, improvement of microbiological safety of foods and the establishment of a national information system on food safety.

### **Sustainable food supply**

A special expert group was established to develop a national program for a sustainable supply of sufficient food of good quality for reducing the risk of disease and promoting health.

### **Current and future actions**

The term for the first draft of the Bulgarian Food and Nutrition Action Plan is the end of 2001.

Analyses of current problems related to food safety and nutrition situation were made. A strategy for the improvement of food safety was written, translated in English and sent to the European Commission for comments. Meanwhile, a National Council on Food Safety was established in 2000. According to the existing Food Law, updating of food and nutrition related legislation will be carried out in order to harmonize legislation with EC directives.

In 2002 the first draft of the Bulgarian Food and Nutrition Action Plan as well as specific programs in the field have to be discussed in related sectors and community, have to be revised and edited. The final action plan will be presented to the Bulgarian Council of Ministries to be adopted and financially supported.

## **5.4 Croatia**

### **Dr Antoinette Kaic-Rak, Institute of Public Health of Croatia**

#### **Time frame**

- 1992 International Conference on Nutrition - Rome, Croatia participated and signed the resolution
- 1995 "Food and Nutrition Policy" - Croatian Agriculture at the Crossroads
- 1996 World Food Summit
- 1996 Nutrition Board of the Croatian Academy of Medical Sciences + National Health Council of the Ministry of Health of Croatia initiated preparation of Food and Nutrition policy
- 1996 International Follow up Conference in Warsaw
- 1999 Croatian Food and Nutrition Policy prepared, signed by the Ministry of Health and published

## **Collaboration**

- Participants from food industry, food producers, food safety, education, consumer associations, health/nutrition, environment protection, chamber of commerce
- Zeljko Reiner, Ministry of Health, former minister
- Huber Maver, Croatian Academy of Medical Sciences
- Danko Matasovic, consumer protection/NGO
- Josip Zivkovic, Faculty of Veterinary Medicine
- Inga Koren, representative of food industry
- Milena Mandic, Faculty for Food Technology
- Jasminka Lukac-Havranek, Faculty of Agriculture
- Ferdo Basic, Faculty of Agriculture

Several meetings have been held at the Ministry of Agriculture (preparation of the Food and Nutrition Policy document for the Food Summit), and at the Ministry of Health, National Health Council, two day symposium and round table discussion (open for the public, under the auspices of Ministry of Health, organized by the Croatian Academy of Medical Sciences and Croatian National Institute of Public Health). Consultations have been carried out with representatives from consumer protection NGOs, the food industry, etc.

## **Structure of the Food and Nutrition Policy - main headings:**

- Foreword by the Ministry of Health
- Croatian Strategy for the improvement of food quality and nutrition
- Situation analysis
- Priorities of the National Action Plan for Nutrition
- Goals 2005, specific objectives and targets
- Strategy
- Organizational Structure
- Evaluation

## **National endorsement**

The National Food and Nutrition Policy, endorsed by the Ministry of Health and supported by the Ministry of Agriculture, serves as an umbrella document for joint activities such as :

- Food law - in the process of adoption (September/October 2001)
- Provision concerning the Banning of GMOs
- Establishment of National Food and Nutrition Council ( as a governmental body)

## **5.5 Czech Republic**

### **Dr Zuzana Brázdová, Department of Preventive Medicine, School of Medicine, Masaryk University of Brno**

During 2000 and 2001 the main objectives and priorities of FNAP were set and working groups were established to take a part in the formulation of local FNAPs. The main overall goal is to improve the health status of the population living in the Czech republic and to reduce the incidence of nutrition related handicaps, diseases and death.

The detailed targets for the period 2001-2003:

- Epidemiological survey of prevalence of the diseases related to nutrition at country level, evaluation, action.
- Description of dietary habits and nutritional status of Czech population, including vulnerable groups (children and adolescents, women, elderly people, ethnic groups, refugees). By-product: up-date of food and nutrition tables.



- Model of healthy food production with special support of local sustainable agriculture and food industry.
- Concept of nutrition counseling and systematic education, including a broadly available information system.
- Formal announcement of the official dietary guidelines and recommendations for the population living in the Czech republic.
- Background for monitoring of food quality according to EU standards.
- Background for the detection of early risk factors related to nutritional status.
- Work on the draft of pro-health model of agriculture and food production and marketing policy.

Among the institutions collaborating on development of local action plan there are National Health Institute (Centre for Food Chains, Centre for Health Promotion), National Department of Statistics, Masaryk Cancer Institute, regional hygienic stations, schools of medicine, Czech organization of UNICEF, NGO for BF support IBFAN, NGO for the support of sustainable future STUZ, Czech Nutrition society and professionals from other institutions.

In the National Health Plan defined for the period 1999-2002 the following priorities were set: the equity in access to healthy food, breastfeeding support, prevention of CVD and cancer, prevention of caries, obesity and NIDDM and a solution for iodine deficit. These priorities are already covered by several national programs:

- Program of breastfeeding support
- CINDI and cholesterol programme
- Cancer prevention programme
- Programme for dental health support in school children
- Obesity programme
- Programme for prevention of alcohol problems
- ID prevention programme in school children

The working group (Ruprich J, Hainer V, Poledne R, Schneidrová D, Brázdová Z) is preparing the background material for the estimation of the health, social, economic and political effects of the FNAP in the Czech Republic.

In 2002 the collaboration on local FNAPs, now started from the side of Ministry of Health, will be extended to the groups based at the Ministry of Agriculture, the Ministry of Environment and the Ministry of Industry and Marketing. In June 2002, the elections to the parliament are planned in the Czech Republic and then the draft of the Czech FNAP will be given to the new government. Before the elections, almost all Czech big political parties and their representatives will be contacted by the working group and the draft of the local FNAP will be discussed, to enable the implementation to the agenda of future election winner.

## 5.6 Hungary

**Dr Gabor Zajkas, OKK-OETI, Budapest**

### **Time frame**

The process of developing the Action Plan started in February 2001 within the scope of the Hungarian Public Health Programme for the Healthy Nation that is a complex programme for the next 10 years. The Programme has 17 Chapters; one is on food safety and another is on nutrition. There are 18 actions in the nutrition chapter; one of them is for the National Food and Nutrition Policy, and another one for the implementation and operation of this policy. The other elements of the Nutrition Chapter reflect the main points of the Food and Nutrition Action Plan.

## **Collaboration**

The Action Plan, as part of the Nutrition Chapter of the Public Health Programme, will be under the control of the Programme management, and under the supervision of an interdepartmental Public Health Committee. The experts of institutions of the Ministries of Health, Agriculture, Industry, Education, Sport and Youth are equally involved in the elaboration and the realization of the Programme.

## **Structure of the Action Plan**

- Representative Nutrition and Health Survey
- Publication of the New Hungarian Dietary Guidelines (a short and a long version)
- Education for the population on healthy nutrition and food safety
- Identification of vulnerable population groups
- Development and production of foods that can be used in healthy nutrition
- Offering menu plans of healthy diets for the school catering
- Postgraduate education for heads of mass catering
- Improvements in food safety issue

## **National endorsement**

The entire Public Health Programme is endorsed by the Hungarian government, together with the Food and Nutrition Action Plan and Policy in the Nutrition Chapter.

## **5.7 Romania**

### **Dr Daniela Nuta, Institute of Public Health, Bucharest**

Romania proposed to establish a National Action Plan for Food and Nutrition during 1996-1998. It started with the organization of a national commission made from scientists from many institutions and organizations.

Based on the food and nutrition governmental policies, this plan was finished in 1998 and was approved by the Ministry of Health and Family and the Ministry of Agriculture, Food and Forestry.

After 1998 nothing happened.

Some institutions such as the Institute of Public Health (Ministry of Health and Family) and Academia have activities in this action in their plan:

- Legislation: a food law was finished and published in 1999
- Food control and surveillance of food contamination at all stages from farm to fork
- Studies about the nutritional status of people
- Monitoring of foodborne disease

The administrative bodies that contributed to the above-mentioned action plan 1998 were:

- Ministry of Health and Family
- Ministry of Agriculture, Food and Forestry
- Ministry of Education and Research
- Ministry of Work and Social Affairs
- Institute of Food Chemistry
- Academy of Agriculture Sciences
- Institute of Public Health
- Institute of Nutritional Disease

They have not meet during the last two years.

### **Structure of the NFNAP**

- Introduction of the problem
- Nutrition situation in Romania
- Legislation
- Food security
- Food safety
- Education

### **Future actions**

During the next year we must finalize our work starting with:

- Establishing an National Council of Food and Nutrition
- Reviewing the NFNAP: bring it up-to-date and presenting it to the Government

## **5.8 Slovakia**

### **Milan Kovac, Dipl. Ing. PhD. – Director of the Food Research Institute, Bratislava**

Slovakia creates its nutritional policy in accordance with the National Health Support Programme, as adopted in 1992 and updated in 1995 on the governmental level. In 1992, the part of the programme dealing with nutrition was changed to a Programme for Nutrition Improvement of the Slovak Population and adopted by both - the Slovak parliament and the government.

The preparation and evaluation of the Programme for Nutrition Improvement of Slovak Population was arranged by a working group composed of experts of various sectors. The main experts were designated:

- Rovny Ivan – Prime Hygienist of the Slovak Republic and Director of the State Health Institute
- Truskova Iveta – Prime Expert for Nutrition of the Ministry of Health
- Chudikova Katarina – Director of the department of the State Health Institute
- Sabova Eva – Ministry of Economy
- Tokarova Sylvia – Ministry of Education
- Danihel Miroslav – Research Institute for Labour, Social Affairs and Family
- Rosinova Magdalena – Ministry of Agriculture
- Kovac Milan – Food Research Institute

To specify individual issues of the Programme, seven expert meetings have been held. Special experts *ad hoc* of the above mentioned ministries as well as of the Ministry of Finance and Ministry of Defence were invited to take part.

The Programme for Nutrition Improvement of Slovak Population defines targets and ways of their meeting including related recommendations for individual sections of food industry. The specific aims are defined until 2010. Monitoring of the Programme efficiency, survey of nutritional status of inhabitants and financial issues are also considered.

The main purpose of the Programme is to change nutritional habits of most of the Slovak inhabitants and their attitudes to their own health. A special emphasis is devoted to the young generation. The targets are to be reached mainly by:

- broad publication of relevant information using mass-media;
- support to activities of advisory centres being established within state health institutes;

- backing of relevant nongovernmental organizations, communities and bodies;
- support to rational nutrition of children and young people while a special stress is given on school-catering;
- enforcement of newly recommended nutrition allowances regarding individual forms of catering and different types of consumers;
- adjustments of the SR Food Codex regarding maximum limits risk of factors (especially fat, sugar and salt) in foodstuffs;
- involvement of health insurance companies in preventive activities; and
- relevant collaboration with the food industry.

Implementation of the Programme for Nutrition Improvement of Slovak Population is guaranteed by the Government of the Slovak Republic and coordinated by the Ministry of Health. The Government reviews a progress report yearly.

## 5.9 Slovenia

### **Dr Marusa Adamic, Head of the Nutrition Unit, Institute of Public Health of the Republic of Slovenia, Ljubljana**

The framework law “Health and hygiene suitability of foods, and of materials and articles intended to come into contact with foods act” was adopted in June 2000. Together with the “National Health plan” (also adopted in 2000) it gave the legal basis to start with the development of the Slovenian Food and Nutrition Action Plan.

According to the framework law a Food and Nutrition Council was established at the ministry responsible for health, which shall by definition operate as an expert advisory body in the area of doctrinal, methodological and expert tasks in connection with the implementation of food and nutritional policy and health related problems. The Food and Nutrition Council was established in April 2001 after the preparation phase, which lasted from November 2000 to March 2001.

The mentioned framework law is also a legal base for the establishment of a new intersectoral governmental body for Food and Nutrition, responsible for food and nutrition policy, based on risk assessment. This office will act as the coordinator and link between risk assessors, risk managers and risk communicators. The Food and Nutrition Council will be acting as the scientific, doctrinal and advisory body to the Office and Minister of Health in the field of the implementation of food and nutrition policy. The Foodstuffs and Nutrition Committee will take over its role until the establishment of the new Office.

The ministries and departments nominated to the Committee are: Ministry of Health, Ministry of Agriculture, Forestry and Food, Ministry of the Environment and Physical Planning, Ministry of Education and Sport, Ministry of Labour, Family and Social Affairs, Ministry of Finance, Ministry of Economy, Chamber of the Economy of Slovenia and Office of the Republic of Slovenia for the Consumer Protection.

The professional institutions nominated to the Committee are the following: Public Health Institute, University of Ljubljana (Medical Faculty, Faculty of food technology, Faculty of Education), Chamber of Commerce.

Some representatives of different organizations and associations are also included: childcare service, breastfeeding promotion, hospital catering and consumer organization.

In the near future the Committee is foreseen to include representatives of professionals and NGOs involved in genetic technology, food and nutrition economy and national statistics.

All ministries, departments and branches nominated in the Council are currently preparing the overview of the food and nutrition activities that they are responsible for: a food safety strategy, a nutrition strategy and a sustainable food supply (food security) strategy. The overview will be completed by the end of September 2001.

Besides the already mentioned framework law and National Health Plan, the theoretical and legal basis for all activities are First Food and Nutrition Action Plan for Europe (WHO 2000), White Paper on Food Safety (2000), EURODIET (DG SANCO/G/3, 2000) and HEALTH 21 (WHO European Region, 1998).

To achieve the goals, the following working groups were established:

- working group for preparation of food composition tables;
- working group for nutrition of people with specific nutritional needs;
- working group for education of educators in the field of foodstuffs and nutrition;
- working group for preparation of a national FBDG;
- working group for breastfeeding strategy;
- working group for healthy nutrition of children and adolescents; and
- working group for food safety and nutrition education of different population groups.

In the near future additional working groups will be established:

- working group for new technologies;
- working group for communication and cooperation with consumers, food industry, catering services and trade in the field of public health nutrition;
- working group for definition of the competencies and procedures of risk assessment on the national level and definition of the reporting procedures; and
- working group for evaluation of cost benefit, efficiency and utility of the measures of national food and nutrition policy.

The Food and Nutrition Council meets approximately once a month; working groups meet more frequently.

All nominated ministries, departments and working groups are preparing lists of their present and foreseen activities, which should be finished by 20 September (present activities, identification of needs, problem definition, priorities statement, improvement proposals, cooperation evidence, legislation, foundation, time schedules).

From the evidence base and reports of ministries and working groups Slovenia's draft National Food and Nutrition Action Plan will be formulated. The draft is not available yet but it is foreseen to be available in a week before the conference in Sofia.

Based on the noted tasks the new Slovenian National Nutrition Policy will be coordinated and formulated (according to urgency and order of importance/priority). It is foreseen that the National Food and Nutrition Policy will be adopted by the parliament of the Republic of Slovenia in 2002.

## 5.10 The former Yugoslav Republic of Macedonia

### **Professor Elisaveta Stikova, Republic Institute for Health Protection, Skopje, former Yugoslav Republic of Macedonia**

The main overall goal during the process of development of the Macedonian Food and Nutrition Action Plan was to establish an intersectoral body for Food safety and strength of food control, under the control of the Ministry of Health. This was done in 1999.

#### **Collaboration**

According to a decision made by the Minister of Health in 2001, a National Committee for Codex Alimentarius and a National Committee for Food and Nutrition were established as expert advisory bodies in the area of doctrinal and methodological implementation of food and nutrition policy. They consist of experts nominated from the Ministry of Health, the Republic Institute for Health Protection, the Ministry of Agriculture, Forestry and Water, the Ministry of Economy, the Veterinary Institute, the University, the Office for the Consumer Protection, and nongovernmental organizations.

#### **Structure**

The process of developing the Action Plan started in 2000. In April 2001 the first draft of the Macedonian Food and Nutrition Action Plan was translated into English and sent to WHO for comment. Demographic, socioeconomic and food safety and nutrition analyses were done for the entire country in relation to the current situation. The structure of the Action Plan represents nutrition and health surveys as well as identification of some vulnerable population groups related with food as following:

#### **Foreword**

- Geographic characteristics of the former Yugoslav Republic of Macedonia
- Demographic structure and trends
- Vital indicators
- Socioeconomic characteristics

#### **Nutrition assessment**

- Nutrition of the population
- Nutritional intakes
- Nutritional quality
  - Nutritional status (children, females, adults, elderly)
  - Foodborne diseases
- Noncommunicable diseases (circulatory, malignant, diabetes)
- Communicable diseases
- Micronutrients deficit
- Breastfeeding promotion
- Food safety

#### **Other activities related do FNAP**

Simultaneously, Volume I of the Codex Alimentarius, the WHO-CINDI Dietary Guide, WHO-Influence of Food and Nutrition to Public Health and some WHO member states programmes regarding these issues have been translated into Macedonian and distributed to relevant institutions for promotion. The joint activities from both committees included a suggestion for Food Law (in the process of adoption) as well as preparing the overview of the activities in their responsibility related to improving food safety. In the near future working groups will be established for preparation, definition and promotion of various health issues related to food, i.e. legislation, food control and

surveillance of food contamination at all stages. During this period all the programmes adopted by government and will be published in the Official Gazette (monitoring food safety and availability, food intake among different population groups, mortality and morbidity trends in certain food-borne and dietary habit-related diseases).

### **National endorsement**

Through the National Committee Report (Introduction, Document presentation and final Action Plan) and the Ministry of Health, the document will be presented to the government for endorsement. The implementation of the Document will be provided by governmental decision.

## **5.11 Yugoslavia**

### **Dr Ljiljana Trajkovic-Pavlovic, Federal Institute of Public Health, Belgrade**

The following is an extract from a country paper dated October 2001 entitled Food, Nutrition and Nutrition Related Diseases in the Federal Republic of Yugoslavia. Tables are not included.

#### **Introduction**

The final report from the International Conference on Nutrition convened by FAO and WHO in 1992 stressed that proper nutrition is an essential human right and that every government must increase efforts to provide access to safe food and a well balanced diet to its population. The World Declaration and the Plan of Action for Nutrition outlined the importance for all countries to work together to upgrade their systems for food safety control and to make a comprehensive public health approach to reduce burden of nutrition related diseases.

In the last decade the Federal Republic of Yugoslavia experienced political and economic crises, which greatly affected national food supply systems.

Dynamic world food trade exchange makes it hard for every country to keep up with the changes in the world food safety system. Every country has the responsibility to protect its own population from food-related diseases within the country. At the same time every country has the responsibility to participate in the global network to protect human health from foodborne diseases around the world. Recent food scares, such are the crises related to the epidemiological outbreaks of the bovine spongiform encephalopathy in the United Kingdom and related appearance of a new variant of Creutzfeldt-Jakob Disease, the Asian flu crisis with chickens in China, dioxin contamination of chicken meat in Denmark and the appearance of novel foods and novel food ingredients on the world market highlighted the need for the establishment of the global surveillance system.

#### **Food and nutrition in Yugoslavia**

The territory of the Federal Republic of Yugoslavia spreads in the central part of the Balkan peninsula. The area of the country is 103 170 000 km<sup>2</sup>. According to data from the Federal Institute of Statistics the expected number of the total population for 1998 was 10,616,000. The average age of the population for the same year was 37,6 for women and 35,6 for men. Life expectancy was 74.8 for women and 69.8 for men.

#### **Food supply**

The agricultural sector of the country has the capacity to produce basic commodities in quantities which can meet more than the domestic needs. Related to the well-known political and socioeconomic events (including UN sanctions and NATO intervention), the standard of living of

the population deteriorated sharply. The most basic commodities have become increasingly unaffordable, particularly for vulnerable, low income segments of the domestic population and the refugees from Bosnia and Herzegovina, Croatia, Kosovo and Metohija, and recently from the former Yugoslav Republic of Macedonia. During this period, which has not ended yet, many humanitarian agencies have been engaged in providing remarkable quantities of food for these people.

The household budget survey established by the Food and Agriculture Organization has been conducted since 1953. The established methodology is still in practice. According to the data of the Federal Institute of Statistics there are about 2400 households that every year participate in the survey in the Federal Republic of Yugoslavia.

The nutritive value of an average daily meal consumed by an average inhabitant in the course of the last ten years is presented in this paper. The data, which are processed by the Federal Institute of Public Health, indicate that the energy value of the average daily meal has a decreasing tendency, (from 3100 kcal/capita/day in 1990 to 2650 kcal/capita/day in 1999). The comparison of obtained data on the selected nutrients with the referent values of the dietary guidelines which are recommended by the Joint FAO/WHO Consultation on the Preparation and Use of Food-based Dietary Guidelines from 1998 indicates that average protein, vitamin A and vitamin C density was appropriate, but the density of the total carbohydrates, iron, zinc and calcium were below the recommended values during the observed period. At the same time the density of total fats and cholesterol contained in the average daily meal were relatively high but they also showed a decreasing tendency. At the beginning of the last decade total fat density and cholesterol content of average daily meal exceeded the recommended levels, while at the end of the decade they were within the recommended levels. The participation of the saturated fatty acids in average daily energy intake at the beginning and at the end of the observed decade followed the above-mentioned parameters. The participation of polyunsaturated fatty acids in the average daily energy intake was high. At the beginning and at the end of the observed period the participation of polyunsaturated fatty acids in average daily energy intake exceeded recommendation level.

The data revealed by the Household Budget Survey related to the same observed period indicate that the burden of expenses for nutrition of a total household incomes amounts to about 45% and has an increasing tendency.

### **Food safety legislation**

In Yugoslavia the legal framework that ensures food safety is wide and has been based on an internationally recognized scientific approach. The Federal Government, the Federal Secretariat for Health, Social Policy and Welfare, the Federal Ministry for Economics and Trade are responsible for preparation of the legislation on food, drinking water and consumer goods safety. The leading institution responsible for this issue is the Federal Secretariat for Health, Social Policy and Welfare. This Secretariat is responsible for the preparation and enforcement of several laws that cover the food safety issue: the Law on food and consumer goods safety, the Law on population protection from infectious diseases and the Law on population protection from radiation. Those laws and related sub-law regulations incorporate, with the full acceptance of the food standards, the code of hygienic practice, JECFA recommendations of the upper limits of tolerant levels of environmental contaminants, additives and radionuclides adopted by the Codex Alimentarius Commission.

The Federal Ministry of Economics and Internal Trade, Department for agriculture is responsible for preparation of food quality standards, which are also based on the standards of Codex Alimentarius Commission. This ministry is also responsible for the preparation of the law on livestock protection from infectious diseases.



At the federal level (import and export), the Federal trade inspection service and the Federal sanitary, veterinary and phytosanitary inspection service are in charge of enforcement of the claims of the above-mentioned legislation. When the domestic market is in question, the Republican trade and sanitary, veterinary and phytosanitary inspection services are responsible for the enforcement of all those regulations.

### **National food safety risk assessment**

In 1989, due to the initiative of the Federal Institute of Public Health, the annual food safety monitoring program was launched as a part of the Federal Statistical Health Programme. Relating to the established methodology, all laboratories licensed for food safety testing by the Federal Secretariat for Health, Social Policy and Welfare, were engaged to examine the obtained results and to send them to the one of 21 district public health institutes. The data for the whole country were collected in the Federal Institute of Public Health. 22 food items (bread, milk, dairy products, meat, meat products, vegetable, processed vegetables, etc.) were tested for the quality standards as well as for the parameters of food safety which include microbiological (E.coli, Salmonella, Streptococcus aureus, Proteus, etc.) and chemical safety (residues of heavy metals, pesticides, mycotoxines ,etc.) were collected through this statistical system.

In order to obtain the data of the etiologic spectrum of foodborne diseases in the country, the notification system of every case of food poisoning caused by Salmonella, Clostridium botulinum, Clostridium perfringens, Schigella, Streptococcus aureus, B. cereus, Klebsiella, Citrobacter, E. coli and conditionally pathogenic bacteria was established in 1984, based on the Law on population protection from infectious diseases. The data on foodborne disease outbreaks were also collected through this system. This statistical system includes two parallel ways of reporting. The first one is the Reporting System of Foodborne Infections and Intoxication. Every case of a suspected foodborne incident and outbreak must be reported to the public health authorities as well as to the district public health institute. The second one is the Rapid System of Notification on Infectious Diseases, which also includes the notification of the foodborne disease. Through this system, all important and serious causes have to be reported immediately to the regional health authorities, either by phone or fax. All these data are finally collected in the Federal Institute of Public Health Epidemiological Department. This department is in contact with the WHO Surveillance Program for the Control of Foodborne Infectious and Intoxication's Collaborative Centre in Berlin.

### **Risk characterization**

The majority of investigations conducted in Yugoslavia have yielded no proper and accurate results on contaminants and additives consumption. Data obtained through the above-mentioned food safety monitoring system brought evidence that environmental contamination of food is low. Very few studies related to this issue provided the data of complete biomonitoring of certain contaminants. They investigated total exposure of the target groups to the contaminants originated from air, water and food, daily intake, daily excretion, cumulating in the tissues and adverse effects on health. Very few studies, some of them still in progress, are designed to investigate daily intake of heavy metals (lead, cadmium and mercury). Preliminary data show that daily intake of heavy metals is low.

On the basis of the available data on the environmental exposure of the population, as well as the data on environment contamination that indicated that some mountain areas are unpolluted, the Federal Government passed the Law on organic agriculture.

## **Harmonization to the international standards**

The representatives of the country participated and signed all documents adapted by GATT Uruguay Round. Due to the well-known events, further participation of various experts in the relevant international bodies dealing with food safety issue was greatly reduced. Afterwards only modest efforts have been exerted by the Federal Government aimed at harmonization of all relevant regulations of food safety to the WTO SPS Agreement, which regulates food import and export procedures.

In 1996, the Federal Government decided that the food safety legislation of the country should be adjusted to the proposals of the EU White Paper 1995.

The prepared draft law on food safety is based on the Council Directive 43/93 EEC, General Requirements of food Hygiene (HACCP), JECFA recommendations on food additives and contaminants, and ISO-standards and criteria for food safety laboratory investigations.

## **Foodborne diseases in Yugoslavia**

Foodborne diseases, including bacterial alimentary intoxications, represent respectable health problems in every country in the world, especially undeveloped countries. Due to the fact that real incidence rate is much higher than reported, losses are eminent.

Epidemiological surveillance on foodborne diseases gives us the opportunity to take measures according to the law, with an aim to prevent contamination of food and elimination of food as a vector of infections.

An increase of foodborne diseases in the observed period 1988-1999 is obvious.

Out of 246 registered outbreaks in 1999, 241 (97,97%) got bacterial laboratory confirmation.

The greatest responsibility for the occurrence of outbreaks of pork and trichinella spiralis in households, lies with free marketing of unlabeled meat products.

Laboratory-confirmed salmonella serotypes in foodborne outbreaks in 1999 show by order of appearance that *S. enteritidis* is in the leading causative agent.

Our further recommendations are based on observed situations and an increasing number of foodborne outbreaks in households. It is necessary to strengthen the activities of sanitary and veterinary inspections in cooperation with health services, which deal with food production, distribution and marketing. Special attention should be paid to private slaughterhouses and free meat markets, especially in rural areas, in restaurants and in factories.

Considering the epidemiological situation, it is necessary to perform all preventive measures according to the law.

## Nutritional status of children

The main sources of information on nutrition were mid-decade and end-decade Multiple Indicator Cluster Survey (MICS). The mid-decade MICS was conducted in October 1996 on the whole territory of FRY, in order to assess progress towards the World Summit for Children Goals. The survey covered 10,604 households, 2,437 mothers of children aged under five and 3,228 children aged under five. It was conducted with the Republican Ministries of Health and the Institutes of Public Health of Serbia and Montenegro. The results helped in proper programme design and in developing and adjusting the plan of action for children. MICS II (end-decade MICS) was conducted from July-August 2000. The survey was conducted on the territory of FRY, excluding Kosovo and Metohija and it covered a total of 5,822 households, 4,630 women and 1,674 children under five years of age. The results have helped to assess progress over the decade, and will be of future programmatic use. Of particular importance were some of the modules, e.g. breastfeeding and nutritional anthropometry, which for the first time provided information on these subjects.

Children's nutritional status is a reflection of their overall health. When children have access to an adequate food supply, are not exposed to repeated illness and are well cared for, they reach their growth potential and are considered well nourished.

The major nutritional problem facing children under five is obesity, 14.3% of children were moderately or severely overweight. This can be traced to poor nutritional practices. In particular, these children eat too little protein, too many saturated fats and complex carbohydrates, and too few fruits and vegetables. This is partly the result of dietary custom, but it also reflects the fact that high-quality protein, fruits and vegetables are relatively expensive. There are also problems surrounding the introduction of complementary foods, which occurs too early; breastfeeding is not continued long enough.

In 1996, there was little or no malnutrition. The national prevalence of malnutrition (using the three anthropometric indicators) were at levels at or below what one finds in a reference population. The only exception was stunting in Kosovo and Metohija (8.6%).

In 2000, the MICS found that prevalence of malnutrition had increased (although no data could be gathered in Kosovo and Metohija). The prevalence of moderate and severe underweight children had risen from 0.5 to 1.9%. Moderate and severe wasting had risen from 1.7 to 3.7%, stunting from 2.1 to 5.1%. The wasting and stunting were only 1.6-3 percentage points higher than what one finds in the reference population, and on a national level are of concern, particularly if the survey is registering a trend.

The increase in malnutrition may be due to the deteriorated economic and security situation in 2000, as compared to 1996. Poorer households in particular had greater difficulty in ensuring adequate food intake. Further, the health care capacities of households and public services declined in this period. There has also been an influx of children from Kosovo-Metohija, where higher prevalence of malnutrition is common. Malnutrition, and stunting in particular, is of course associated with a host of illnesses, including higher levels of child morbidity and mortality, poor school performance later in life, and reduced energy levels. Further, stunting is difficult to reverse, particularly once the child reaches the age of two. This situation will need to be monitored closely.

The age structure is displayed in people, and shows some evidence that the child is more vulnerable to wasting in the first year of life, when complementary foods are introduced precociously and breastfeeding rates fall rapidly. It is in this year that irrecoverable stunting begins. The prevalence of stunting and wasting decreases as the education level of the child's mother increases. This is as one would expect (and finds in other countries), and may reflect increased income in the household and a

greater knowledge about childcare on the mother's part. There are no significant differences between the urban/rural and male/female prevalence.

## **Recommendations**

Activities already undertaken (promotion of breastfeeding and timely complementary feeding, training of health workers in growth monitoring and proper feeding practice) should continue. In addition, growth monitoring tools should be provided for all primary health centre units, and training provided in their use. The use of IEC campaigns promoting good feeding practices through other media should also be investigated. The nutritional status of children has proven sensitive to external shocks in the past five years. Given current economic circumstances, this makes it all the more important to closely monitor each child's nutritional status, to ensure a prompt and timely reaction on the part of parents and health professionals to restore any child with faltering growth to health. There is also a need from a public health perspective to monitor the nutritional status of the child population as a whole, to ensure that stunting and wasting return to the low levels of the past.

## **Breastfeeding**

Breastfeeding for the first few years of life protects children from infection, provides an ideal source of nutrients, and is economical and safe. The World Summit for Children goal was for children to be exclusively breastfed for four to six months, and that breastfeeding should continue with complementary food, well into the second year of life. Many countries have adopted the recommendation of exclusive breastfeeding for about six months. This has been adopted by the National Committee for Breastfeeding in the FRY.

From 1995-2000 over 2,500 health workers from 96% of maternity units, as well as some non-health professionals were trained in promoting breastfeeding and the BFHI as part of the UNICEF-supported National Breastfeeding Promotion Programme. Currently 32 out of 69 maternities in the FRY have been certified as a Baby-Friendly Hospital (BFH), and 32 others have taken steps to become baby-friendly.

The MICS 2000 results showed that only 10.6 % of children aged less than four months were exclusively breastfed; a low and unsatisfactory level. At age 6-9 months, 31.3% of children were receiving breast-milk and solid or semi-solid foods; this low rate is the result of a high proportion of women ceasing breastfeeding before the age of six months. By age 12-15 months, only 20.8% of children were still being breastfed and by age 20-23 months, just 10.8 percent were still breastfed.

Even at the earliest ages, the majority of children were receiving liquids or foods other than breast-milk. Only 16% of infants aged 0-1 months were exclusively breastfed, and this proportion drops off rapidly until it is close to zero by four months. 4% of mothers introduced mashed foods in the first month.

There are two additional indicators of well-established breastfeeding: the predominant breastfeeding rate (91.3%) and the timely first suckling rate (32.1%).

Water and other liquids are quickly introduced into the infant's diet, and this was reflected in the high bottle-feeding rate (77.4%). As a result, the prevalence of breastfeeding, still high at four months, drops off rapidly in the subsequent months. By the end of the first year, only roughly one third of children are breastfed.

As a result of the UNICEF-supported programme for the promotion of breastfeeding, progress can be reported in the few years since 1996.

The core of the Breastfeeding Programme is exclusive breastfeeding for a period of about six months. The strategy used to increase the level of exclusive breastfeeding is to recommend that mothers begin breastfeeding within an hour after birth, breastfeed the child on demand and not use bottles while feeding children. The indicators suggest good progress has been made – exclusive breastfeeding during the first four months rose from 3.6% to 10.6%, timely first suckling rate rose from 7.9% to 29.1%, breastfeeding on demand from 47.5% to 57.7%, while the bottle feeding rate has decreased from 82.3% to 77.4%. The continued and predominant breastfeeding rates have also improved. The gains break down regionally in a manner that matches the regional distribution of baby-friendly hospitals, all of which have gained this status since 1996.

## **Conclusion**

Exclusive breastfeeding and continued breastfeeding rates in the first and second year of life are low and unsatisfactory compared to other countries that have provided data on exclusive breastfeeding. Semi-solid and solid foods, as well as other liquids, are introduced far too early into the child's diet, while mothers cease breastfeeding too soon. There is room to change these practices, particularly in light of the extended maternity leave available and current workforce participation rates. The breastfeeding promotion programme and the BFHI have already given positive results, particularly in the early introduction of breastfeeding, the extension of exclusive breastfeeding, and the reduction in bottle use. However, the early introduction of water, liquids and other foods in infant diets is a deeply ingrained practice among mothers that all too often continues to be recommended by health professionals.

## **Recommendations**

The MICS indicates the problems to be addressed, such as the early introduction of tea or water, the early introduction of complementary foods, the use of bottles and the lack of exclusive breastfeeding. The opinion poll on breastfeeding, conducted in August 2000, should also be considered in planning future activities and can provide guidelines on groups to be targeted for further interventions, such as the child's father and female grandparents. Given the clear and positive impact of the BFHI, its further expansion is strongly recommended.

## **Nutrition deficiency disorders**

During World War II and a certain period of time after that, the recorded protein-energy malnutrition was of national epidemiological significance. Relatively high numbers of advanced iron deficiency anaemia, pellagra, rickets and endemic goitre were recorded. Following the improvement of nutrition of the whole population, the majority of nutrition deficiency disorders practically disappeared such as scurvy, pellagra and night blindness.

### **Iodine Deficiency Disorders**

Deficiency of iodine in the diet is the world's single greatest cause of preventable mental retardation and can lower the average intelligence quotient (IQ) of a population by as much as thirteen points.

The Balkan Peninsula is a place where the existence of iodine deficiency disorders/IDD/ is historically proven. The frescoes of Orthodox saints in Serbia in the Middle ages vividly shown existence of goitre that was believed to be a common feature for an average person.

In the early 1950s in the FRY, more than 650,000 persons suffered from endemic goitre and up to 3% of the total population from cretinism. It was estimated that about six million of people were at risk of IDD because they lived in iodine deficit areas. Goitre prevalence in few areas was severe. In villages Badovinci, Gornja Josanica and Gusinci (Novi Pazar) the prevalence of goitre among school children exceeded 85%.

The main strategy in the elimination of Iodine Deficiency Disorders (IDD) is iodization of edible salt, as an effective, low-cost way of preventing IDD. Soon as it was recognised as a public health problem in the FRY, universal salt iodization was introduced in 1953. Standards of iodization were raised in 1992, when legal regulations were endorsed requiring iodization amounting to 20 +/-4 mg of potassium iodide per kg of salt for all salt destined for human and animal consumption.

There are three criteria that determine the elimination of IDD: (1) that at least 90% of households consume adequate iodized salt, (2) that the median level of urinary iodine (among a representative sample of children) be between 100-300 mcg/l, with the proportion of children below 50 mcg/l not to exceed 20%; and (3) that the prevalence of goitre in school children be below 5%.

In MICS, interviewers tested household salt for iodine levels by means of a testing kit in order to assess the proportion of households consuming adequately iodized salt. 99.2% of households surveyed had salt that was tested. 73.2% of the test samples had adequately iodized salt. There were significant regional differences. Over 70% of households had adequately iodized salt in Montenegro (70.7%) and Central Serbia (77%), while the coverage was lower in Vojvodina (62.8%). The disparities are no doubt due to the different suppliers in the different regions.

In order to determine the status of iodine nutrition and goitre prevalence, UNICEF supported a 1999 survey on goitre prevalence and urinary iodine level among school children in the Republic of Serbia. The survey covered 4,598 primary school-age children (7–14 years) living in villages and towns of 44 municipalities of central Serbia and Vojvodina. The results showed that only 2.35% of surveyed school children had increased thyroid volumes and that the median iodine concentration in children's urine was 158 mcg/l.

The MICS result shows that both the Republic of Serbia (excl. K&M) and the Republic of Montenegro are roughly 20 percentage points away from respecting the first criterion. However, using the physiological criteria, the Republic of Serbia (excl. K&M) has eliminated IDD. This illustrates the success of the national program based on universal salt iodization (USI). This success was reached due to an early recognition of IDD as an important public health problem, the implementation of legislation on USI, and the constant monitoring of salt iodization and of its biological impact. The achievement is striking in light of the crises the county faced during this decade, and particularly the loss of the country's main supplier of iodized salt in the early 1990s (in Bosnia). Special efforts were required to educate importers and producers who filled the gap about the importance of iodization, and in some cases to provide them with technical assistance and equipment.

## **Recommendations**

In light of the negative experience of some east European countries, which almost reached the goal, but are now faced with an increase of IDD, future efforts in this area will need to shift to

sustaining achievements. There will be a need for adequate regulation of imports and domestic production, some further support to importers and producers in their iodization activities, and a continued monitoring of the iodine content in salt. A survey on goitre among school children in the Republic of Montenegro should be conducted, taking into account the experience and methodology of the survey conducted in the Republic of Serbia, to determine whether IDD have also been eliminated there.

Recently the National IDD Committee was established. The responsibilities of the Committee are to provide adequate legislation and regulation, ensure reliable quality assurance and quality control of edible salt at production level, and establish a reliable monitoring system, including biological monitoring.

### **Iron Deficiency Anaemia**

Anaemia is defined as an abnormally low haemoglobin level due to pathological conditions. Anaemia can have a variety of causes such as infections and hereditary conditions, but it is believed that the most common reason is iron deficiency.

The causes of a high prevalence of IDA are complex and relate to poor eating habits, current living conditions and chronic illnesses. Throughout the country, the disease is addressed mainly from a clinical perspective. There has been inadequate information to address it from a public health perspective. Women and children are the groups most vulnerable to iron deficiency. In MICS 2000 blood samples were taken from women and children in the population sample, to determine the haemoglobin level in blood. The cut-off points used to determine IDA were a haemoglobin level below 12g/100 ml in women aged 15-49 and below 11g/100 ml for children aged 6 to 59 months. Standard equipment for measurements was used. The blood samples were taken at every third household.

Of the 4,630 women included in the survey sample, 1,296 were blood tested. Among those women, approximately 27% had haemoglobin levels below 12 g/100 ml blood. There were some small differences according to area, age and so forth, but they are not statistically significant.

Of the children who were blood tested, 30% had haemoglobin levels below 11g/100 ml blood. The prevalence of anaemia was significantly higher in some regions. For example, the prevalence in Vojvodina (41.3%) was roughly double of that in Montenegro (19.8%). Also, children aged 6-11 (46%) were significantly more likely to be anaemic than children aged over 36 months (16-18%).

These data are in a correlation with the data on dietary iron bioavailability of average daily meal of the population. The data, based on the household budget survey and the WHO methodology for the calculation of the dietary iron bioavailability that was applied, indicated that the bioavailability of the dietary iron was low and intermediate.

### **Conclusion**

Roughly one quarter of women of reproductive age and one third of children aged 6-59 months suffer from iron deficiency anaemia. Unfortunately, it is not possible to determine the prevalence of anaemia among pregnant women, as data on this are not systematically compiled. Nor is it possible to ascertain trends in anaemia, as nation-wide data have not been compiled before. In any case, it is clear that the health status of both these population groups is unsatisfactory.

Dietary practices are important contributing causes of this problem. The worsening of economic conditions in past years may well have led to a decrease in consumption of iron-rich foods. For infants in particular, anaemia reflects poor conditions in utero (resulting from maternal anaemia), poor practices in the introduction of complementary foods (early introduction and large intake large intake of foods/drink that inhibit iron absorption, such as tea and cow's milk), as well perhaps as illnesses that compromise nutrient absorption.

There is no public health programme to address IDA, yet it is clear that special attention needs to be paid to this issue in pregnant and lactating women, in women in general, and in children.

### **Recommendations**

The problem calls for an urgent introduction of a new, integrated programme. The economic costs of anaemia and the cost of interventions necessary to prevent IDA suggest that an IDA programme will have a high benefit/cost ratio. IDA interventions are among the most cost effective in the realm of public health. The programme should include interventions to improve feeding practices in infants and promoting positive dietary changes in women. Also, the possibility of widespread fortification of cereals and weaning foods with iron and the broadened use of oral iron supplementation should be investigated. The main targets groups are pregnant women, women of childbearing age, infants and young children and adolescent girls.

All stakeholders need to be persuaded as to the magnitude of this problem. Action should concentrate on educating and motivating adolescents and mothers on how to improve their diets, on improving medical curricula and educating health professionals. Specific rapid assessments to determine current practices in feeding might be necessary. These interventions should be linked with other public health programmes, such as family planning, breastfeeding promotion, improved maternal health and the Integrated Management of Childhood Illnesses. Extensive promotional campaigns should follow the implementation of the programme.

### **Vitamin D and vitamin A deficiency**

Rickets has not been eliminated in Yugoslavia although vitamin D prophylaxis is conducted. The basic reason for this problem is unknown due to the lack of systematic investigations. Nevertheless, the data obtained through the official statistical system indicate that every year 50-100 children are hospitalized due skeletal deformation as a consequence of rickets.

The same kind of data obtained by the official statistical system indicates that the number of the patients with hip fracture has an increasing tendency. Related to the WHO recommendation that the prevalence of hip fracture is indicator of osteoporosis magnitude among the population, our data show that osteoporosis is a problem of epidemiological significance in Yugoslavia. Osteoporosis has multicausal etiology but insufficient calcium intake in childhood and early adulthood is one of the prominent contributors. Data obtained from the household budget survey showed that calcium intake of average inhabitant was and still is insufficient. These data indicate that insufficient calcium content together with other relevant unfavourable factors such as a sedentary lifestyle and a high prevalence of cigarette smoking could be a contributor of hip fractures among elderly people.

Vitamin A deficiency is not considered a health problem in Yugoslavia.



Rickets and night blindness started withdrawing after the beginning of the national program on newborns and preschool children vitamin A and vitamin D prophylaxis. This program is still in practice.

### **Overnutrition and related diseases**

Obesity and its related diseases are not only a common health problem in affluent societies. Developing countries are also faced with the accumulation of overweight persons of all ages. Excess body weight is a prominent risk factor for the development of noncommunicable diseases, particularly for cardiovascular and some cancer locations. Epidemiological and clinical investigations in the recent decades apparently showed that cardiovascular risk factors coexist in obese persons. Hyperinsulinemia and impaired glucose intolerance, which may be early signs of non-insulin dependent diabetes, are associated with obesity. Abnormalities in blood lipids and raised blood pressure have been often seen in obese persons. Abnormal fat depositions is common associated with an adverse metabolic risk profile and deterioration of endothel functions and increased platelet aggregation.

A diet characterized by high proportions of fat, sugar and alcohol promotes ischemic cardiovascular diseases. The Yugoslav dietary pattern had strong colinearity between energy intake and fat consumption for a long period of time and has, as a consequence, a high morbidity and mortality rate due to cardiovascular diseases and increasing tendency of morbidity and mortality rate due to certain malignant diseases.

Epidemiological investigation conducted in Novi Sad indicated that the prevalence of syndrome X /metabolic syndrome/ is 13,6%. Overnutrition was recorded in 45% males in 32,6% females. Judging by the epidemiological investigations conducted by the Yugoslav League of Hypertension the prevalence of high blood pressure among adult population is between 29% and 39%. The prevalence of overnutrition among outclinic patients suffering from hypertension is 82%.

The burden of cardiovascular diseases in total causes of deaths in Yugoslavia exceeds 55% and still has increasing tendency. The leading causes of death are cerebrovascular diseases.

Both macro and micronutrients and other bioactive components of the diet have been shown to alter cell processes important for proliferation and differentiation. It is now increasingly believed that certain DNA damage can occur as a result of the oxygen radicals. Oxygen radicals are borne from normal metabolic pathways but can be produced by certain environmental factors. Overnutrition increases a cell turnover and appearance of free oxygen radicals. Scientific investigation brought forth a lot of evidence that a "rich" diet and a diet that does not contain sufficient amount of antioxidant compounds supports cancerogenesis. The Yugoslav diet was this way for a long period of time.

Development of some types of cancer such as colorectal, female breast, prostate, corpus uteri, esophagus and stomach is conditioned with inappropriate nutrition for a relatively long period of time.

A statistical analysis of the association between nutrition (data based on household budget survey) and mortality rate due to some cancer locations for a ten years period for the country was performed. Statistically significant association was recorded between total fat intake and colorectal and female breast cancer mortality rate and alcohol intake and stomach and esophagus cancer mortality rate. The analysis also showed that the mortality rate due to above-mentioned cancer sights has increasing tendency except for stomach cancer. The participation of the mortality rate due to cancer locations that could be in connection with inappropriate nutrition in total mortality rate exceeds 25% for male

and 43% for female. The recent analysis of mortality rate due to colorectal and female breast cancer shows that they have increasing tendency.

## 6. FAO and UNICEF Initiatives in the Region

### 6.1 FAO initiatives in Countries of Central Eastern Europe, Michael Canon (Food Standards and Nutrition Officer), FAO Subregional Office for Central and Eastern Europe, Budapest, Hungary

#### Initiatives in the development of National Food and Nutrition Action Plans

##### Differences within the region

- issues, situations and conditions
- national priorities
- approaches to finding solutions
- implementation of National Plans of Action

#### Initiatives in the development of National Food and Nutrition Action Plans

##### International Conference on Nutrition (ICN), 1992

- *World Declaration on Nutrition* recognized poverty, social inequality and lack of education as root causes
- *ICN Plan of action strategies and actions* necessary to achieve goals

##### World Food Summit Declaration

- “. . . the right of everyone to have access to safe and nutritious food . . .”
- *Plan of action* “. . . physical access to sufficient, safe and nutritious foods . . .”

##### Where do we go from here?

- In the past we have discussed processes, identified priorities and set objectives for achieving the goals outlined in national plans of action.
- Our discussions necessarily need to include where we are going and how will we work to get there.
- “to get there” ----- “together”

##### Areas of activities (not comprehensive)

- Improving household food security
- Improving food quality and safety (PEC 2002)
- Promoting breastfeeding
- Controlling micro-nutrient deficiencies
- Promoting healthy lifestyles and diets
- Monitoring nutrition situations
- Action on the part of SEUR will include working in close cooperation with national delegations to identify obstacles and approaches to provide support for achieving national plans of action. All of these efforts will be in close cooperation with WHO, especially colleagues in the European Regional Office AND other international organizations.
- Our focus at national and international level needs to be on implementing these national plans as fully as possible and doing this together.

## 6.2 UNICEF interventions related to nutrition in Albania, Dr Mariana Bukli, UNICEF, Tirana

### UNICEF guiding principles and structure of programme

The framework is to ensure child rights to survival, development, education and protection through an integrated approach or life cycle approach. The child is considered as a whole and so the focus is not only on one issue but UNICEF tried to take several issues into account at the same time i.e. health, education etc. The Early Childhood Development Programme includes three projects.

### Current situation in Albania

The data showing the current situation is based on data from the Mixed Multicluster Indicator Survey and from breastfeeding figures from a survey on monitoring infant feeding practices (1998).

- IMR: 28 per 1,000
- U5MR: 33 per 1,000
- Underweight (under 5): 14%
- Wasting (under 5): 11%
- Stunting (under 5): 17%
- Use of iodized salt: 56% of households
- Exclusive breastfeeding: 93.5% at discharge from maternity, 28% at four months, 11% at 6 months

### Achievements of programmes

#### 1. Introduction and orientation for IMCI

#### 2. Breastfeeding

- Advocacy and research: a survey of BF (1998, 2001)
- Legal framework:
  - ❖ Ministerial order (1998)
  - ❖ Law on marketing of BMS (1999)
  - ❖ Plan of action for implementation (2000)
- Training of health personnel
- Expansion of BFHI network: 2 BFHF maternities, 1 certificate, 3-4 in the pipeline
- IEC and mother support groups

#### 3. Micronutrients

- The social marketing of iodized salt has been the main achievement in relation to micronutrients.
- More should be done in the area of micronutrients especially as there is indication that iodine deficiency and iron deficiency anaemia are problems (almost 40% of pregnant women are iron deficient).

### Constraints of implementing activities

- Lack of political commitment for certain issues
- Intersectoral collaboration is difficult to achieve
- High turnover of counterparts
- Long administrative procedures

## Future Plans

Funds are available some of the planned activities for others funds still need to be raised:

- Assessment of nutritional status of children
- Support to expand BFHI network
- Support for implementation and monitoring off compliance of BF law
- IEC activities
- Support to quality assurance network for iodized salt
- Support to domestic salt iodization
- IMCI
- Integration of growth monitoring and development monitoring activities

## 6.3 UNICEF perspectives in the former Republic of Yugoslavia (FRY), Mr Oliver Petrovic, UNICEF, Belgrade

### Planning process

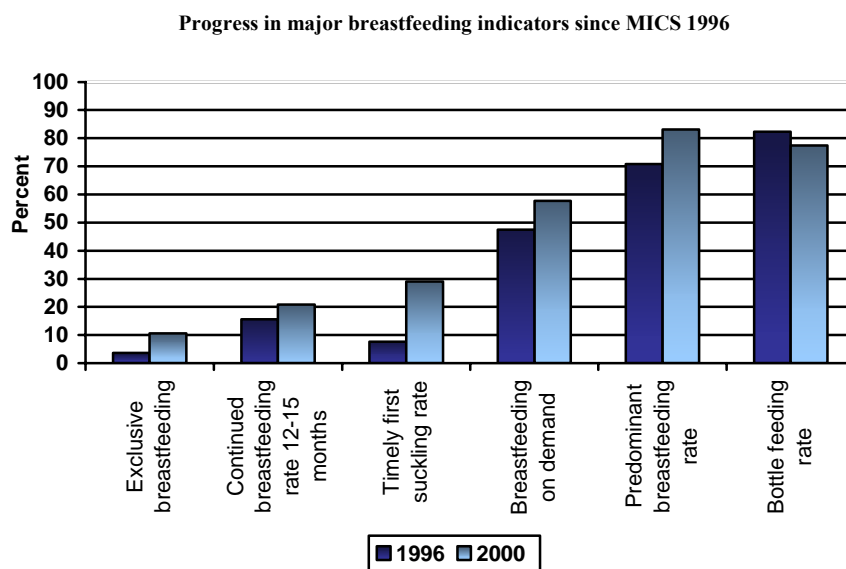
UNICEF has been working in the FRY since 1992. UNICEF is currently preparing the regular country programme cycle for 2002–2005; planning was started with SITAN in 2000. Position papers, strategy papers CPR, and PPOs have been prepared in a participatory process to date. The approach taken by UNICEF is based on the lifecycle approach rather than on a sectoral approach. There are programmes included in the Life cycle approach: ECD, QE (quality education), YPHD (young people health development), CP (child protection). Strategies are based on service delivery, capacity building, advocacy and empowerment.

### BFHI: one of the main priorities

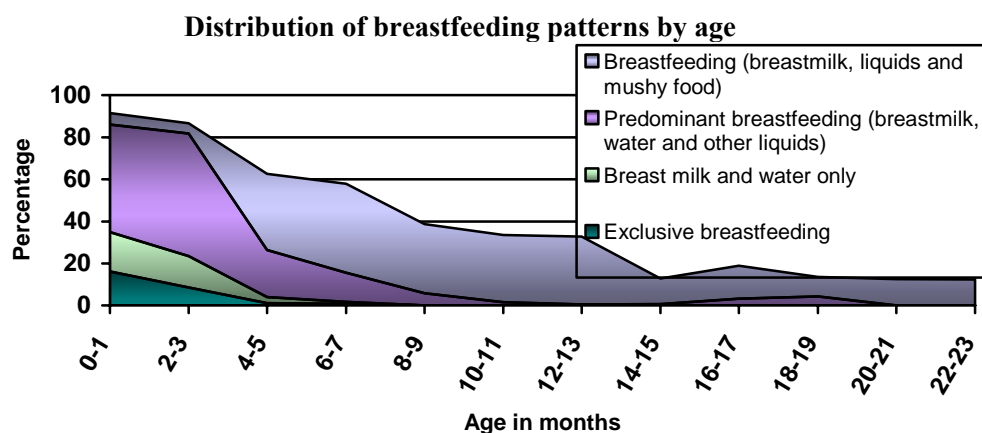
- BFHI Programme began in 1995
- A National Committee has been established
- Over 2,500 health workers and some non-health professionals were trained in promoting BF
- Thirty-two out of 69 maternities in the FRY have been certified as a Baby-Friendly Hospital (BFH)

### Progress made in major breastfeeding indicators since MICS (1996)

Progress is evident but exclusive breastfeeding is still low. Reasons include the introduction of water in the first month upon the advice of paediatricians and the strong decision making role of grandmothers in relation to breastfeeding.



## How did we get there?



### Future activities

- To make all maternities baby-friendly
- To renew the national BF Committee
- To establish network of INGOs and NGOs on BF promotion
- To establish mother support groups
- To set up telephone counseling services

### Iron deficiency anaemia programme (IDA)

IDA is a public health problem in Yugoslavia.

Age	Percentage
0-6	29,5
7-10	24,7
11-14	15,0
15-19	13,4
women 15-49	26,7

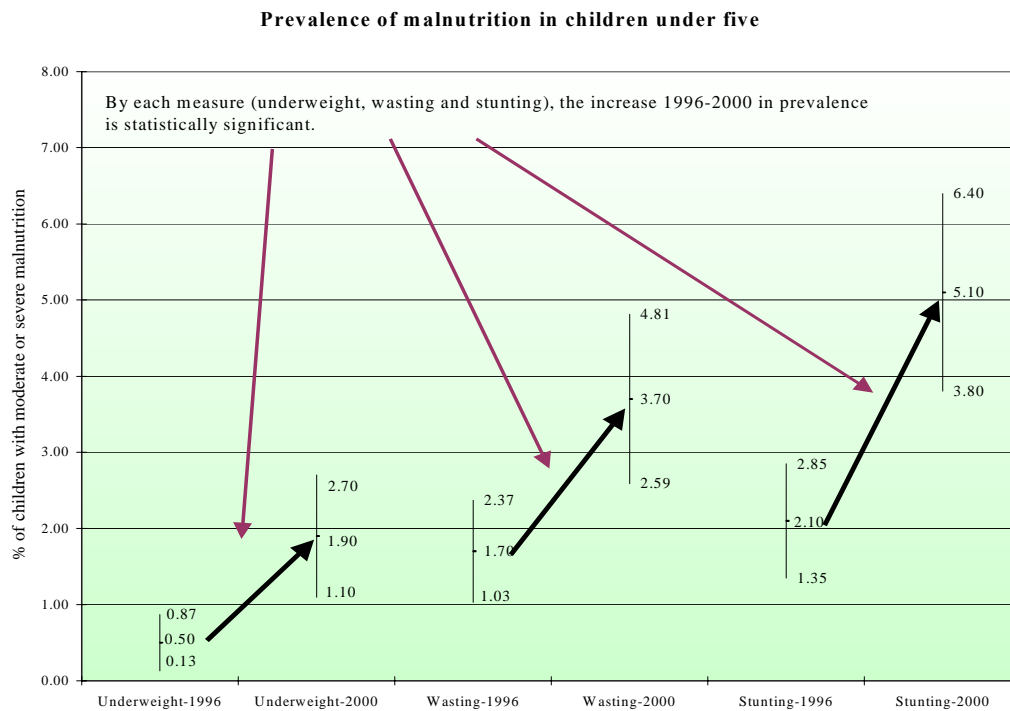
In order to address the problem of IDA UNICEF is working on the following interventions:

- improving complementary feeding of infants
- promoting positive dietary changes
- fortification
- supplementation
- better control of injections
- ongoing programme monitoring

These interventions will be functionally linked with public health programmes such as family planning, breastfeeding promotion, improved maternal health and the IMCI.

## Child nutrition

UNICEF is also monitoring the nutritional status of children.



### Future activities for child nutrition

Future activities include the establishment of mechanisms for early detection, prevention and response to nutritional disorders in all PHC.

### Iodine Deficiency Disorders

- 73,2% of households consume adequate iodized salt
- the median level of urinary iodine is 158 mcg/l
- the prevalence of goiter among school children is 2.35%
- Activities: as proposed by ICCIDD

### Challenge

The challenge is to establish intersectoral policy dialogue between education, health nutrition and social welfare services.

## 7. Discussion on the situation of school meals in each of the countries

### Albania

- The food is provided by the parents
- The tendency to use fast foods has increased
- Parents need to be educated on the increased use of vegetables and fruits
- Private schools are starting to open up, however, only a limited number of children are able to attend these schools

### Bosnia and Herzegovina

- School meals were compulsory before the war. Currently, however, the situation is confusing and there is no organized programme.
- Meals are sometimes provided in public schools for a lower price.
- The quality and quantity recommendations are not always followed
- There are schools that have fast food stations and units, which enable children to purchase food in schools.
- There are private and international schools for which there is no information regarding the meal system.
- A draft integrated plan for public health includes the improvement/provision of school meals.

### Bulgaria

- There are problems in the quality of the meals offered in schools.
- The financial support has not been enough and during last 10 years the situation has become worse, as there is no support from the State. Local municipalities provide limited support.
- Only a few children use canteens. As a result, many of the canteens have been closed and now the majority of children use refreshment bars in schools. The food offered at these bars is mainly “fast food” i.e. soft drinks, sweets and cakes. The choice is limited in variety (no milk) and the healthiest choice offered is sandwiches.
- The MOH developed and published a regulation/governmental degree concerning the improvement of food for school children. The degree has so far not been endorsed and currently there is financial support to implement the degree.
- A new manual on updated recipes is currently being published.

### Croatia

- There is a school-feeding programme consisting of three meals per day.
- Schools provide foods that children like to eat rather than foods based on their nutritious content.
- There are opportunities located close to schools, which enable children to purchase foods.
- Children in lower grades and children from further away consume more frequently the meals provided.
- There are problems with high school children as no meals are provided.
- Meals are paid for socially deprived children. Other children pay only for the food items.
- There is a commission in each school, which is in charge of planning the meals.
- The school standard is being revised.
- The private schools are more interested in providing quality meals.

### Czech Republic

- School canteens and catering are used.
- National standards for energy, etc. have been established.
- The price of the meal is not very high - about ½ dollar.
- Most children use the system.
- 50% of schools are private but current economic situation enables people to use the system.



### **Hungary**

- After a change of system in the country school feeding declined by about 70%.
- In the school meal system either one or three meals are offered.
- Students participating in the system have been shown to be nutritionally better off.
- A law declares that the local government should give lunches free if children are below a certain economic income level.

### **Serbia**

- In Montenegro there are no school meals.
- 10 years ago school meals were organized (3 meals were given) but then everything stopped. This is a problem concerning the nutritional situation of the children.

### **Slovakia**

- Similar to the situation in the Czech Republic.
- The school meal system is partially in private and in state hands.
- 20-25% of 6 to 8 class students use the service.
- A manual of recipes has been prepared based on new recommendations.

### **Slovenia**

- There are special programmes.
- Each elementary school must provide at least one meal for each child. There are 445 elementary school but also 375 branch schools to them.

### **Former Yugoslav Republic of Macedonia**

- Not enough data to be able to provide information.
- There are supplementary meals in elementary schools; about 70% of children use the service in the schools.
- Fast food opportunities have been placed around schools to attract children.
- Parents are required to cover costs.
- The quality of the meals in elementary schools is sufficient in energy content but the quality is not very good.
- In a large number of schools not enough fruit and vegetables and milk are served.
- A cooperation with the biggest bakery has been established for fortifying products and meals with calcium.
- In primary health schools three meals are provided; the quality is sufficient.
- Schools are placed in urban areas and areas where living standards are better.
- There is no data at the moment for secondary schools and other kinds of schools.

### **Romania**

- There are three types of kindergartens and three types of schools. Children in kindergartens with short programmes rely on snacks given by parents; kindergartens are open for up to 12 hours and provide two meals and one snack; weekly kindergartens provide meals from Monday to Friday. Children attending school for a short period are given snacks from home, lunches are provided for longer programmes.
- National programme survey on the composition of food in schools and kindergartens.
- Canteens in High Schools were turned into semi-restaurants so it is not possible to check the nutrition of students.

## 8. Development of funding proposals for implementation of Action Plans

### 8.1 Group work feedback: Obstacles and experiences encountered in preparing/implementing the action plans

The participants were divided randomly into five groups to discuss and debate the obstacles and good experiences encountered in the preparation/implementation of Food and Nutrition Action Plans.

#### Group 1 - presented by Yugoslavia

Obstacles encountered	Good experiences
<ul style="list-style-type: none"> <li>• Lack of political commitment in some countries</li> <li>• Lack of effective organizational framework</li> <li>• Insufficient capacities for laboratory analysis</li> <li>• Insufficient investment in public health sector in the overall health sector reform process</li> <li>• Lack of educational programmes</li> </ul>	<ul style="list-style-type: none"> <li>• International cooperation: documents; seminars and workshops; support of the certain programmes (such as IDD, child care, and humanitarian) by UN agencies (such as UNICEF, WHO, FAO)</li> <li>• Improvement of national cooperations: gathering together various sectors that are in charge for improving food and nutrition</li> <li>• Implementation of some very useful programmes, although not as a part of FNAP</li> </ul>

#### Group 2 - presented by Croatia

Obstacles encountered	Good experiences
<ul style="list-style-type: none"> <li>• Changes of political situation</li> <li>• Emergency situations</li> <li>• Lack of human capacities (especially at implementation stage in some countries)</li> <li>• Lack of legislation</li> <li>• Lack of financial resources and allocations</li> <li>• Timely administrative procedures (things take time)</li> <li>• Weak intersectoral cooperation</li> <li>• Insufficient and unreliable data regarding nutrition situation analysis</li> <li>• Inappropriate undergraduate training</li> </ul>	<ul style="list-style-type: none"> <li>• Political support (with personal commitment)</li> <li>• Good cooperation between MOH and MOA</li> <li>• Commitment from professional</li> <li>• Involvement of the international agencies</li> <li>• “Intersectorality” and networking (different sectors and agencies, NGOs, people on voluntary basis)</li> </ul>

### Group 3 – presented by Bulgaria

Obstacles encountered	Good experiences
<ul style="list-style-type: none"> <li>• Food and nutrition policy and action plans have low priority in responsible ministries and institutions i.e. MOH, MOA</li> <li>• Funding and financial support are insufficient/scarce</li> <li>• Human resources are limited especially at implementation stage</li> <li>• Poor intersectoral collaboration especially in food security area due to rivalries and overlap of responsibilities</li> <li>• High level officials are not fully aware of the importance of food and nutrition policy</li> <li>• Lack of national data on the economic impact of food-related ill-health</li> <li>• Legal framework is not adequate</li> </ul>	<ul style="list-style-type: none"> <li>• Commissions, working groups and councils have been established to deal with food and nutrition policy</li> <li>• Food and Nutrition Action Plans have been established in Slovenia and Croatia (from among the countries represented in group 3)</li> <li>• A lot of programmes, projects, initiatives, have been elaborated/implemented, for example, IDD, CINCI in Slovenia, Yugoslavia and Bulgaria (from among the countries represented in group 3)</li> <li>• Well trained, committed nutrition professionals (core units, enthusiastic) are available but in limited numbers</li> </ul>

### Group 4 - presented by Hungary

Obstacles encountered	Good experiences
<ul style="list-style-type: none"> <li>• Lack of intersectoral communication</li> <li>• Lack of coordination</li> <li>• Weak implementation, although the administrative work was done. Elementary parts of plan have been prepared but due to lack of financial sources the plans have not been implemented.</li> <li>• Suspicious public and political reaction to any new, especially restrictive regulation</li> <li>• Economical environment which often influences implementation of FNAP</li> </ul>	<ul style="list-style-type: none"> <li>• Establishment of the new bodies, for example, nutrition council</li> <li>• Development of food law</li> <li>• Nutrition was recognized being an important issue of public health</li> <li>• Harmonization and standards according to EU</li> <li>• BF support was observed in all countries participating in group 5</li> <li>• Salt iodization by law in some countries</li> </ul>

## Groups 5 - presented by the former Yugoslav Republic of Macedonia

Obstacles encountered	Good experiences
<ul style="list-style-type: none"><li>• Lack of political commitment</li><li>• Lack of intersectoral cooperation</li><li>• Conflict of interests</li><li>• Lack of harmonization of standards (EU, WTO, local)</li></ul>	<ul style="list-style-type: none"><li>• Support form international organizations i.e. WHO, UNICEF, FAO, EU</li><li>• Intercountry cooperation</li><li>• Exchange of experiences</li><li>• Professional cooperation</li></ul>

### 8.2 Stability Pact for Southeast Europe, Dr Aileen Robertson (WHO)

During the Health Ministers Forum in Dubrovnik from 31 August to 2 September 2001, the Ministers of Health of Albania, Bosnia and Herzegovina, Bulgaria, Croatia, the former Yugoslav Republic of Macedonia, and Romania and the Federal Secretary for Labour, Health and Social Welfare of Yugoslavia reached an unprecedented political agreement by signing the Dubrovnik Pledge on Meeting the Health Needs of Vulnerable Populations. Seven top-priority health topics were agreed for collaboration. Seven detailed project proposals were then worked out and forwarded for support from the international community.

The motivation and commitment expressed by all the countries involved in the seven well defined health priority areas mentioned in the Pledge have aroused the interest and support of the international community and not least are recognized within the framework of the Social Cohesion Initiative of the Stability Pact for South East Europe (SEE). Three of these seven health priority areas have been successful in attracting initial political, financial and technical support, and a fourth is under discussion.

To further support the SEE health ministries' action and collaboration in following up the Dubrovnik Pledge, the WHO Regional Office for Europe and the Council of Europe will continuation their joint 2001 activity of the SEE Health Network. The main topic for 2002-2003 will be a multi-country public health initiative entitled "*Health Development Action in South-east Europe*". The objective is to provide a framework for coordinating, guiding and providing technical assistance for health-related initiatives, under the Dubrovnik Pledge. This would include the agreed and funded projects on (i) communicable disease surveillance; (ii) mental health; and (iii) food safety. The multi-country public health initiative will also foster partnerships with relevant donors and partners for regional health efforts in south-eastern Europe.

In order to sustain the above-mentioned initiative during its implementation phase, an appropriate coordination mechanism needs to be set in place, at both political and technical as well as at international and national levels. Each country will therefore be asked to set up a national core team, comprising a focal point for overall national coordination and one expert within each project area to act as the project manager in the country.

### 8.3 Food Safety and nutrition proposals for Stability Pack

The exercise was intended to give an opportunity for the participants to develop a funding proposal in the framework of operationalizing their national action plans.

The groups were asked to consider the following points:

1. To list priorities
2. To identify concrete actions and activities in relation to priorities (budgetary considerations to be included)
3. To consider the source(s) for resources and funding (including government)
4. To consider how resources could be raised. If possible participants should think of already ongoing initiatives (national, regional) on which to “piggy-back”.

Participants were divided into the following groups:

- Albania
- Bulgaria
- Croatia, Bosnia and Herzegovina
- The former Yugoslav Republic of Macedonia
- Slovenia
- Yugoslavia
- Czech Republic, Hungary, Slovakia, Romania

## 8.4 Group presentations

### Albania

There was some discussion among the group on how to proceed and on what issues to cover. It was decided that all three pillars - food safety, nutrition and food security - should be included.

Priorities	Activities
<b>Nutrition</b>	
<ul style="list-style-type: none"> <li>• Micronutrient deficiencies (Fe, I)</li> <li>• Carry out growth monitoring</li> <li>• Nutrition education</li> <li>• Improve legal and administrative framework (cross cutting all fields)</li> <li>• Support breastfeeding and timely complementary feeding</li> </ul>	<ul style="list-style-type: none"> <li>• Assess the nutrition status of the population</li> <li>• Provide supplementation (Fe) to target groups</li> <li>• Capacity building of health personnel</li> <li>• Elaboration of dietary guidelines</li> </ul>
<b>Food Safety</b>	
<ul style="list-style-type: none"> <li>• Control foodborne diseases</li> <li>• Legal framework</li> <li>• Strengthen the role of the national food safety authority</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor foodborne diseases</li> <li>• Revise and improve the food law and the law on sanitary inspection</li> <li>• Advocacy and capacity building</li> </ul>
<b>Food Security</b>	
<ul style="list-style-type: none"> <li>• Achieve a sustainable food supply</li> <li>• Carry out a Situation analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Food consumption survey</li> <li>• Increase domestic production</li> <li>• Establish a fish processing industry</li> </ul>

### Bulgaria: Programme for improving nutrition and the nutritional status of vulnerable groups

#### Background

#### Malnutrition of vulnerable groups – priority problem

- Shortage in consumption of staple foods, food poverty and inadequate micronutrient intakes mainly among:
  - Unemployed
  - Families with many children
  - Households with 5 or more members
  - Young families, socially inactive (students)
  - Disabled persons
  - People aged over 70
- Inadequate micronutrient intakes and high prevalence of anemia among pregnant women, especially economically inactive
- Poor maternal nutrition among socially deprived groups
- Increased rate of low birth weights

- Decreased breastfeeding rate
- Inadequate complimentary feeding of infants in low income families
- Malnutrition of vulnerable groups – priority problem
- Increased prevalence of underweight among risk population groups – infants, children, adolescents, young women and elderly people
- High prevalence of underweight and anemia among institutionalized children
- Inadequate and unbalanced nutrition in kindergartens, school canteens, orphanages, homes for elderly and disabled people

### **Malnutrition through the life cycle – health consequences**

- Birth weight: infant mortality and morbidity; mental development; risk of adult chronic disease
- Inadequate complimentary feeding
- Child and adolescent growth and development
- Nutrition of women in child bearing age
- Nutrition during pregnancy
- Healthy aging

### **Goal**

- To improve health related to nutrition of vulnerable groups of population

### **Objectives**

- To provide adequate and reliable data to assess the problems of micronutrient deficiencies, their magnitude and distribution
- Capacity building of professionals to promote healthy diet in different ages
- To increase the rate of breastfeeding by 10%
- To improve complementary feeding of infants
- To decrease anemia among small children and pregnant women by 10%
- To improve nutrition of children in kindergartens
- To improve nutrition of schoolchildren by mass catering
- To improve nutrition of institutionalized children, adolescents, disabled and elderly people
- To improve the awareness of the population, especially vulnerable groups, concerning healthy foods and nutrition

### **Outputs**

- National systems for information and monitoring on the nutrition situation with special focus on vulnerable groups
- Training manual on nutrition for GPs and other professionals related to health of vulnerable groups
- Education modules on nutrition in primary and secondary schools
- Improved mass catering, especially those directed to the vulnerable groups
- Positive changes in dietary behavior of the population
- Focusing the attention of the community on nutrition problems, especially the vulnerable groups

### **Activities**

- Collection of data on the nutritional status of the vulnerable groups (infants, small children, schoolchildren, pregnant and lactating women, elderly people) with special focus on low income groups from current health information
- Establishment of a national monitoring system on nutrition, introduction to the necessary methods, training of staff
- Conducting of national representative surveys on nutrition of vulnerable groups

- Training of health professionals concerning breastfeeding promotion, healthy diet model and practical aspects of its implementation, prevention of micronutrient deficiencies (curricula in medical schools, courses, seminars, workshops, education materials)
- Establishment of a system for the promotion of breastfeeding and appropriate complementary feeding (BFH, mother support groups etc.)
- Endorsement of requirements for healthy nutrition and control in kindergartens, schools, homes for socially deprived children, homes for disabled and elderly people
- Fortification and supplementation programmes to control iron deficiency anemia and folate deficiency among children and pregnant women
- Development and endorsement of education modules on nutrition in the curricula of primary and secondary schools
- Education campaigns on healthy foods and nutrition directed to the community, with special attention towards vulnerable groups; low income groups and disabled people

### **Budget**

- Limited resources from the state
- Efforts to find other sources

### **Croatia and Bosnia and Herzegovina: Strengthening the food safety assurance system**

Croatia and Bosnia and Herzegovina had a long and interesting discussion on what the priority should be. In the end food safety was chosen as the priority. The proposal focuses on strengthening the food safety assurance system in Croatia and Bosnia and Herzegovina. The project is divided in to seven activities.



Activity	Specific Activities	Cost
<b>1. Approximation and harmonization of food legislation</b>	<ul style="list-style-type: none"> <li>• Situation analysis (harmonigram)</li> <li>• Identification of priority</li> <li>• Translation</li> <li>• Proposal drafting (working groups)</li> <li>• Adoption</li> </ul>	100, 000 US dollars for each country
<b>2. Capacity building</b>	<p><i>a) Reorganization of control laboratories</i></p> <ul style="list-style-type: none"> <li>• Laboratory status and accreditation field</li> <li>• Establish one referral laboratory in one of the two countries</li> <li>• Strengthen laboratories: education and training; equipment; accreditation</li> </ul> <p><i>b) Reorganization and strengthening of enforcement bodies</i></p> <ul style="list-style-type: none"> <li>• Centralization</li> <li>• Education and specialization (curriculum is too broad at the moment)</li> <li>• Equipment for sampling</li> </ul>	<p>a) 500, 000 US dollars for each country</p> <p>b) 50, 000 US dollars for each country</p>
<b>3. Information system</b>	<ul style="list-style-type: none"> <li>• Computerization (of labs, inspections, MOH)</li> <li>• Central alert system</li> <li>• Analytical data exchange</li> <li>• Monitoring purposes</li> </ul>	90, 000 US dollars for each country
<b>4. Improving the monitoring system</b>	<ul style="list-style-type: none"> <li>• Planning</li> <li>• One year execution</li> <li>• Results</li> </ul>	100, 000 US dollars for each country
<b>5. Improvement of public information and consumer complaints solving</b>	<ul style="list-style-type: none"> <li>• World Wide Web site, publications and media</li> <li>• Telephone for complaints</li> <li>• Linking with labs, inspection and experts</li> </ul>	50, 000 US dollars for each country
<b>6. Prepare small premises for introduction of HACCP and hygiene codes</b>	<ul style="list-style-type: none"> <li>• Situation analysis</li> <li>• Education, publications, guidelines</li> </ul>	25, 000 US dollars for each country
<b>7. Establish a National Committee on Food and Nutrition</b>	<ul style="list-style-type: none"> <li>• In Ministry of Health</li> <li>• Responsibilities – EFA</li> <li>• One professional, office</li> </ul>	25, 000 US dollars for each country

**Total cost****890, 000 USD**

⇒ 400, 000 USD in kind from Croatia

⇒ 490, 000 USD fundraising activities

**Possible donors:**

⇒ FAO, WHO, CoE, Donors, NGOs, Government of EU countries (helping candidate countries)

**Former Yugoslav Republic of Macedonia****Priorities**

- To improve the nutrition of the population
- To establish a national monitoring system for nutrition and nutritional status
- To reduce nutrition related diseases
- To prevent micronutrient deficiencies
- To promote breastfeeding
- To provide food quality and safety
- To improve food security

**Activities**

- To upgrade political awareness
- To harmonize legislation with EU standards
- Capacity building
- Fund raising activities

**Funding**

- National budget
- Bilateral partners
- Stability pact initiative
- International organizations (UN)
- NGOs

**Slovenia: Establishment of the National Food and Nutrition Agency****Background**

- Presently we have overlapping competencies between different ministries and parties, which causes uncoordinated activities and unnecessary costs.
- The Food and Nutrition Council (FNC) was established but its role is limited to an advisory and doctrinary function.
- FNC has no formal power for implementing the proposed FNAP.

**Purpose**

Establishment of new independent governmental body in the field of food and nutrition (“Agency”)

**Objectives**

- There is a legal base to establish governmental body in the field of food and nutrition (framework law).
- To assure safe and healthy food to protect and improve human and public health.

- To get national consensus and commitment of all involved sectors and to get support of government of RS.
- To communicate all conflicts of interests between different involved sectors in the field of FN.
- To be a competent partner in the communication with the similar bodies in EU and other countries.

### **Output**

- FNAP preparation
- implementation and funding raising
- communication, inter-sectoral/international cooperation
- monitoring
- evaluation

### **Project activities**

- Preparation of project draft
- Administrative governmental procedure
- Governmental commitment
- Harmonization of the activities of all involved sectors
- Starting of regular functioning (employee)

### **Assumptions**

- Establishment should be sufficiently political supported.
- Operation of the agency shall be without any political influence.
- All strategic decisions shall be supported by the government.
- All doctrinary and scientific decisions, proposed by agency shall be confirmed and accepted by FNC.

### **Assumptions - risks:**

- All involved sectors and other interested parties are not adequately interested.

### **Implementation**

#### ***Staff***

- Director, Assistant Director, financial sector (3), pr, technical and administrative staff (3)
- Official/professional staff:
- Food safety 4, nutrition 2, public health programme 3, agriculture 1, food processing 2, environment 1

#### ***Material investments***

- 350 m2,
- Equipment (21 computers, telephone and mobile phone, fax, copy machine, furniture)
- Car
- Running costs
- Total costs

**Financial plan**

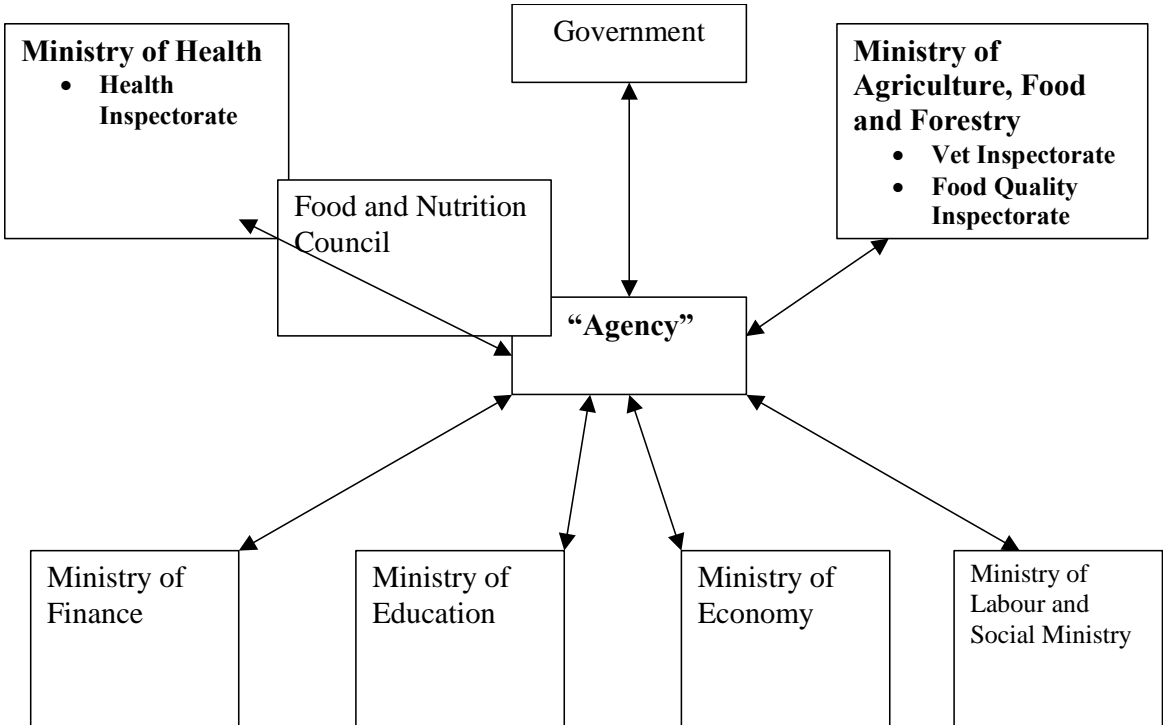
Project output	New budget sources	Reallocation of budget sources	Other sources
Food safety			
Nutrition			
Public health programmes			
Agriculture, food production, Environment			

**Implementation**

*Timetable*

- administrative procedure (beginning 2002)
- approval (first half of 2002)
- establishment (end of the year 2002)
- start of functioning (second half of 2003)

**How the agency is to communicate**



- The Agency is connected with the MOH and the Food and Nutrition Council.
- The Agency communicates with the government as the government should provide the budget for agency.

## Yugoslavia

### Overall objective

To improve the health status of the population.

### Specific objectives

- To decrease morbidity from nutrition-related deficiency diseases (anaemia, IDD, malnutrition)
- To decrease morbidity and mortality from overnutrition-related diseases ( CVD/IHD, diabetes, dyslipidaemia (research shows that children also affected), hypertension and obesity (in some areas 40-50% of people are obese)
- To decrease morbidity and mortality from some malignant diseases (breast, colon, rectal cancers)
- To continue and strengthen the BF programme
- To decrease foodborne diseases
- To decrease the health risk from chemical and radioactive contamination of foods

### Activities/Actions

#### 1) Activities that influence availability of food

- Agricultural policy
- Food industry (to produce products with less salt, fat, etc.)
- Mass catering
- Trade prices and taxes (very difficult issue to influence, however, try to convince politicians to make special arrangements for vulnerable groups)

#### 2) Activities that influence food and nutrition knowledge

- Education of policy decision makers
- Education of educators
- Education of population (using mass media, etc.)
- Important - educational system reform

#### 3) Activities that influence food safety/security

- Legislation
- Improvement of infrastructure (information system, network, etc.)
- Environmental protection (protection of air, water, soil and food)
- Intersectoral collaboration and cooperation

#### 4) Health sector reform

Comprehensive support to improve the public health approach in reducing the burden of food and nutrition-related diseases

#### 5) Establishment of a national food and nutrition committee

This will create and support the national action plan

### Resources

Available in the country are:

- Human resources
- Organizational network
- Governmental organizations (technical bodies such as the Federal Commission on Nutrition, Federal Commission on Child and Mother Health protection, Federal Commission on IDD (established 1956), Federal Commission on infectious disease protection)

- NGOs (Consumer Association (very powerful), Yugoslavian Food and Nutrition Organization, League for Hypertension Control, Yugoslavian Society for Obesity Control, Association for Atherosclerosis Protection)
- Infrastructure (such as laboratories, computers)
- Databases on communicable diseases, NCD and air, water and food pollution

### **Political visibility**

- Improvement of health status of population
- Reduction of the expenses of the treatment of diseases
- Reduction of expenses for invalidity
- Improved quality of life
- Improved life expectancy
- Improved food trade
- Excellent elements for next election campaign

## **Romania, Hungary, Slovakia and Czech Republic: Implementation of national food based dietary guidelines in Romania**

### **Background I.**

Romania needs a principal document, which will serve as a basis for all relevant institutions and for the population to enable the desirable change of population dietary habits.

### **Background II.**

Scientifically sound dietary guidelines could improve the overall nutritional and health status of the population with special respect to nutrition related diseases, handicaps and mortality.

### **Purpose of project**

- To encourage food industry experts to develop and produce foods on healthy basis
- To give the tool to decision makers to follow the principles of FNAP
- To provide mass catering with a relevant informational basis for healthy food

### **Objectives I.**

- To conduct a nutritional survey on the Romanian dietary habits (to assess typical food basket, typical servings of basic food groups, typical frequency of consumption of basic foods)
- To improve the existing database of food composition using modern analytic methods

### **Objectives II.**

To collect data about xenobiotics and food additives (to respect ADI and other norms with dietary guidelines)

### **Activities I.**

- Project organization
- Training of trainers regarding nutritional survey (FFQ, quantitative methods, 24h recall)
- Training of professionals in analytical methods, including AQA
- Training of staff in multicomponent analytical methods

### **Activities II.**

- Providing selected labs with necessary equipment and setting reference labs
- Consultation with international experts on food and nutrition database

- Study tours, workshops

### **Activities III.**

- Creating the expert group incl. international experts to create the national dietary guidelines based on the results of above-mentioned surveys

### **Activities IV.**

- Implementation strategy:
- Food producers
- Retailers
- Catering
- Educators
- Health professionals
- General public

### **Activities V.**

- To make the implementation sustainable
- Monitoring the effect of the project (relevant quantitative criteria)

### **Time schedule 2002 - 2005**

#### ***Year 2002:***

- Project organization
- Training
- Obtaining laboratory equipment
- Start with nutrition survey

#### ***Year 2003***

- Evaluation of the results from the studies
- Draft of Romanian dietary guidelines based on the results

#### ***Year 2004***

- General discussion on the draft of Romanian dietary guidelines among nutrition professionals, scientific bodies, industry, catering, professional NGOs
- Formulation of the official version
- Official recognition and announcement

#### ***Year 2005***

- Implementation (see activities)

### **By-products**

- Printing food composition tables

### **Comment**

- Progress evaluation will be done every 6<sup>th</sup> month

### **Budget**

- As much as possible

### **Comments from participants related to the exercise**

- Fruitful exercise
- Enables us to see how a small part of the NPAN can be developed into specific activities.

- Could be useful to split funding proposals into separate projects especially as donors could be overwhelmed by too many activities, as could be the case with smaller donors.



## 9. Iodine Deficiency Disorders in Southeast Europe, Dr Michael Zimmermann, ICCIDD Deputy Regional Coordinator for Western and Central Europe

### The Spectrum of Iodine Deficiency Disorders (IDD) in Southeast Europe

Estimated IDD severity mid-2001
Albania - moderate-severe IDD
Bosnia - moderate IDD
Croatia - mild IDD
Slovenia - mild IDD
Former Yugoslav Republic of Macedonia - approaching IDD sufficiency
Yugoslavia - approaching IDD sufficiency

#### **Elimination of IDD is one of the most important and most achievable public health goals.**

- IDD during pregnancy and childhood impairs brain development and mental function. This has profound adverse effects on child learning capacity, maternal health, the quality of life of communities and economic productivity.
- The elimination of IDD is a critical development issue and should be given highest priority by governments and international agencies.

#### **The optimal method to combat IDD is Universal Salt Iodization (USI)**

Major components to a sustainable USI program:

- political support
- administrative arrangements
- assessment / monitoring systems

#### **Measuring Progress against IDD**

Selection of appropriate indicators for determining:

- salt iodine content
- impact of USI on the population

#### **Monitoring Salt Iodine Content**

- *Quantitative* titration (thiosulfate) at the production level, verification by external body such as national food standards authority
- *Qualitative* rapid test kits (starch indicator) at the household level

*For information see: Assessment of IDD and Monitoring their Elimination, 2nd Ed. WHO, Geneva, 2001, Annex 1*

## Indicators of USI Impact

**Principal indicator:** median urinary iodine concentration (children or adults)

Median UI (mcg/L)	Iodine intake	Iodine nutrition
<20	Insufficient	Severe IDD
20-49	Insufficient	Moderate IDD
50-99	Insufficient	Mild IDD
100-199	Adequate	Optimal
200-299	More than adequate	Risk of I-induced hyperthyroidism
>300	Excessive	Risk of IIH, autoimmune thyroid disease

### Indicators of USI impact

- Thyroid size/Goiter rate of limited value in monitoring USI programmes
- Palpation (children and pregnant women) versus ultrasound (children)
- Reflects chronic rather than recent iodine status ('lag-time' of months to years in response)
- Useful in baseline assessment of IDD severity
- Sensitivity and specificity of palpation poor with small goiters in mild IDD: not recommended
- Ultrasound measurement of thyroid volume preferable in areas of mild to moderate IDD
- Use of 1997 WHO thyroid volume references *sharply underestimates* true goiter prevalence
- Replace with updated 2001 WHO/ICCIDD reference criteria (IDD Newsletter 2001;1:12)
- Thyroid stimulating hormone (TSH) levels in neonates, have limited applicability due to cost
- However, where a neonatal screening program exists, TSH is a useful impact indicator

### Sustainable elimination of IDD requires that:

- Median UI in the target population is at least 100 mcg/L and no more than 20% are below 50 mcg/L
- At least 90% of households are using salt with an iodine content of 15 ppm or more
- There is evidence of sustainability, as judged by attainment of at least 8 of the 10 specified indicators:
  - an effective multidisciplinary national body responsible to the government for the IDD program
  - political commitment to USI and elimination of IDD
  - an appointed, responsible executive officer for the IDD program
  - legislation or regulations on USI
  - commitment to the monitoring of IDD, with access to accurate iodine laboratories for salt and urine
  - a program of education and social mobilization on the importance of IDD and consumption of iodized salt
  - regular data on salt iodine at the factory, retail and household levels
  - regular data on UI in school-age children, with appropriate sampling for higher risk areas
  - cooperation from the salt industry in quality control

- database of results and monitoring procedures with mandatory public reporting

### **The Example of Yugoslavia - Major progress toward eliminating IDD in Serbia**

Despite significant political/economic barriers and loss of main supplier of iodized salt (Bosnia) in 1990s:

#### **Accomplishments in IDD control:**

- USI with KI at 20 ppm
- Establishment of National IDD Prevention and Control Committee
- Education and awareness campaigns for health workers, salt producers, importers, distributors
- Establishment of iodine laboratory
- Monitoring of salt iodine levels and biological indicators

#### **Indicator Results**

- Target Group for surveillance: schoolchildren
- Goiter rate by ultrasound < 3%
- Median urinary iodine 158 mcg/L with only 3% < 50 mcg/L and 19% < 100 mcg/L
- >70% of households with access to iodized salt

*Source: Country Paper: Food, Nutrition and Related Disease in the Federal Republic of Yugoslavia, Belgrade 2001; Progress against IDD in Serbia. IDD Newsletter, Nov.2000, p.57-58.*

#### **Yugoslavia: Future Considerations**

- Shift emphasis to sustainability
- Consider extension of survey to Republic of Montenegro
- Continue to increase household access to iodized salt
- Consider use of more stable potassium iodate
- Recalculate goiter estimates (2001 WHO/ICCIDD reference criteria for thyroid volume) and consider implications
- Consider including additional target surveillance groups, such as neonatal TSH and/or pregnant women

#### **Working toward Elimination of IDD in southeast Europe**

Virtual elimination of IDD is achievable in southeast Europe through a coalition of national governments and national IDD committees, together with support from UNICEF, WHO and ICCIDD.

## 10. Closing remarks

### 10.1 Next Steps: 2002-2003, Dr Aileen Robertson, WHO Regional Office for Europe, Copenhagen, Denmark

**Opportunities in the coming years to get political commitment include:**

#### 1) Follow-up meeting to Malta

In February 2003 the Greek Ministry will organize a follow-up meeting to the WHO Consultation on “Development of the first Food and Nutrition Action Plan for the WHO European Region”, (held in Malta, 8-10 November, 1999) to assess how the 51 Member States are proceeding. As a result workshop participants attending the follow-up meeting will be able to inform the other Member States of the progress made in the Southeast Europe Region.

#### 2) Ministerial Conference 2005

The resolution endorsing the First Food and Nutrition Action Plan confirms that there will be a WHO Ministerial Conference in 2005. The location of the conference is still to be decided, however, Norway has shown interest in hosting the event.

#### 3) WHO Headquarters activities

**Food Safety:** At the 53rd World Health Assembly in May 2000 a resolution on food safety was endorsed. This resolution has been included in the First European Action Plan for Food and Nutrition

**Health Promotion:** Professor Pekka Puska (formerly of the Public Health Institute in Finland and as of February 2001 Director of the Department of Noncommunicable Disease Prevention and Health) is preparing a paper for the Executive Board (EB) in January 2002 entitled “Towards a global strategy for diet and physical activity in NCD prevention”. If the paper is passed by the EB a resolution will be put forward to the 191 Member States of the WHO at the World Health Assembly in May 2002.

#### Note on Funding

The Biennial Collaborative Agreements (BCA) between the countries and WHO are almost complete and ready to be signed. The WHO Secretariat has until Friday 12 October 2001 to respond to the information provided.

- Albania, Bosnia and Herzegovina, Bulgaria and The FYR of Macedonia have pledged BSC from WHO for food safety.
- Yugoslavia should make use of available opportunities.
- The new WHO Liaison Officer for Croatia should find out more regarding Croatia’s situation.
- Romania needs to find out if minister will or can invest money in the work plan.

### 10.2 Cristina Tirado, GEMS/Food-EURO Coordinator and Food Safety Adviser, WHO, Rome, Italy

Dr Tirado started off by complimenting the countries that have included food safety as a priority in their action plans. She also showed interest in knowing the specific actions related to food safety that countries have included in their action plans.

She went on to emphasize that nutrition should not be separated from food safety and that the sustainable production of food has to involve all concerned ministries especially as ministries such as the ministries of agriculture and environment are in a position to influence the way in which food is produced.

#### **WHO food safety global draft**

She mentioned that the priorities of the WHO food safety global draft will be: surveillance, food contamination monitoring, new technologies and capacity building. The finalized paper will be distributed to the participants.

#### **Better use of resources**

Regarding availability of resources she stressed that it was more economical to access the web pages for information rather than organizing information seminars. She however, stressed that it would be more cost-effective to have specific workshops such as training trainers on HACCP as these have more impact at country level. She advised participants to seek for activities for which a big impact could be anticipated.

#### **Training course in Poland**

She announced that WHO was looking for scientists and people working in laboratories to take part in a food safety course in Poland in April 2002. The following countries are entitled to participate: Albania, Bosnia and Herzegovina, Bulgaria, the Czech Republic, Hungary, Romania, Slovenia, Yugoslavia, Poland and former Yugoslav Republic of Macedonia. Further details can be obtained from Christina Tirado (see participants registration list for contact details).

Finally she thanked all the participants for a wonderful meeting and she hoped to meet them again.

### **10.3 Michael Canon, FAO Subregional Office for Central and Eastern Europe, Budapest, Hungary**

Mr Canon commenced his closing remarks by thanking all the participants for their hard work and the WHO team for putting together the workshop. He further added that his first direct involvement with these kinds of workshops had been extremely pleasurable.

On a more serious note he highlighted the importance of an integrated multisectoral approach in the development and implementation of the national action plans. He went further to say that despite being extremely important it was not always easy to implement this approach and thus it was important, both from a national and international point of view, to be proactive in the promoting of the approach. He also drew attention to its usefulness in the process of putting together funding proposal (as was undertaken as part of the group work exercise). He also noted that at national level there was the possibility to work together as nutrition and food issues go together.

On behalf of FAO and Dr Valeria Menza he thanked the participants for their hard work during the workshop.

### **10.4 Mr Oliver Petrovic, UNICEF, Belgrade, Federal Republic of Yugoslavia**

Speaking on behalf of the regional office of UNICEF he said that he was very happy to note that all the UNICEF priorities had been included in the action plans (such as breastfeeding, iodine deficiency disorders, etc.) and further added that the regional office would be informed about this observation.

On the whole Mr Petrovic was very glad to having been able to meet the participants and to having been part of the workshop.

### **10.5 Dr Snejana Altankova, Director of Department of Health Prophylactics and State Sanitary Control, Ministry of Health, Bulgaria**

She thanked the participants for taking part in this important workshop and even though she herself did not participate, she was sure that it was fruitful for the participants to have been able to share their experiences and information regarding the development of the national action plans.

She thanked WHO, FAO and UNICEF and hoped that there could be similar meetings and on this subject.

### **10.6 Comments and recommendations from participants**

#### **Bosnia and Herzegovina**

- Anticipates having a larger delegation in the coming years
- More examples from western European countries would have been useful
- Not much material from FAO available at workshop

#### **Bulgaria**

- Very fruitful workshop
- Enables us to meet country colleagues and to make new friends
- Meetings make us aware of our problems
- Stability Pact projects need more attention and more precise work for funding
- Funding proposal exercise was useful and should be submitted for further work
- Food security pillar is shaky – more work is needed on that
- The intersectoral approach needs to be stressed more in the future
- There is a need to invite MOA representatives to inform them of how important it is to include nutrition in sustainable agriculture.
- There is a need to organize more specific meetings - we need more technical support

#### **Czech Republic**

- Thanks for all the work before and during the workshop

#### **Croatia**

- The workshop has given us an overview of the situation in the region and reassurance that what we are doing is going in the right direction
- At the next workshop agriculture colleagues should be given the opportunity to see how they can work with us and MOA colleagues should be informed that some topics should be stressed, i.e. food safety and quality. They need to be given more space to give their feedback
- Symposium on “Advantages of Mediterranean diet on health” to be held in Croatia in September 2002. All are welcome to participate.

#### **Hungary**

- Able to exchange experiences and to learn how to solve problems in similar situations
- We need to develop closer collaboration between countries to reach common goals

#### **Romania**

- Learned very much.
- Anticipated that a better situation in Romania could be presented in the future

### **Slovakia**

- Able to gather new knowledge on the preparation process of the NPAN
- In the future more information on concrete types of cooperation among countries would be useful
- Not much spoken about economy on nutrition even though they are strongly linked

### **Slovenia**

- The workshop was excellent and it showed the progress so far achieved in the health sector field. However, more work needs to be undertaken in the area of food security. Maybe the third workshop should focus more on this third pillar. This third workshop could be planned together with the agriculture sector or organized primarily for them
- At international and national level more successful collaboration with agriculture
- Discussion on concrete actions and funding actions for achieving the goals of action plans was not undertaken

### **Former Yugoslav Republic of Macedonia**

- Glad to have been able to participate
- Good opportunity to exchange ideas and to see the progress between first and second workshop
- Suggestion to hold third meeting in former Yugoslav Republic of Macedonia next year
- Important to keep up networking and information sharing

### **Yugoslavia**

- Pleased to be able to participate, as workshops provide good opportunities for information sharing and exchange
- WHO, especially WHO Copenhagen, has given us strong support in the preparation of the NPAN and also the FAO Budapest office is ready to help us in the areas of food legislation
- For the last 10 years there have been no opportunities to participate in any working groups and thus it is extremely nice to be part of these workshops again
- The organization of a seminar in Yugoslavia is very expensive but it would be very useful for politicians as they would be more inclined to participate knowing WHO is ready to help

### **WHO Liaison Officers**

- Thanked organizers for involving the Liaison officers in the process as it enables them to have a much better feel for working and implementing activities in the field.
- Recommended the continuation of involving officers
- Workshops support us and they give us practical and theoretical information and knowledge

## Annex 1: Programme

### Monday 8 October

2000 Welcome Reception

### Tuesday 9 October

**Opening**  
0830-0845 Dr Lubomir Koumanov, Deputy Minister and Chief State Sanitary Inspector,  
Ministry of Health, Bulgaria and Representative from the Ministry of Agriculture  
0845-0900 Aileen Robertson, WHO Regional Office for Europe  
Oliver Petrovic, UNICEF, Belgrade

**Country Presentations**  
0900-1030 Albania  
Bosnia & Herzegovina  
Croatia  
1030-1100 *Coffee break*  
1100-1130 Slovenia  
1130-1200 The Former Yugoslav Republic of Macedonia  
1200-1230 Yugoslavia  
1230-1300 General discussion  
1300-1430 *Lunch*  
14.30-1530 Group work  
1530-1600 *Coffee break*  
1600-1630 Initiatives in Countries of Central Eastern Europe, Michael Cannon, FAO  
1630-1800 General discussion

### Wednesday 10 October

**Development of funding proposals for implementation of Food and Nutrition Action Plans**  
0830-0900 Group work feedback  
0900-1030 Stability Pack for South East Europe, Aileen Robertson  
1030-1100 *Coffee break*  
1100-1230 Continuation of Country Presentations (optional):  
Bulgaria  
Czech Republic  
Hungary  
Romania  
Slovakia  
1230-1400 **Lunch**  
1400-1530 Food Safety and Nutrition proposals for stability pact – group work  
1530-1600 *Coffee break*  
1600-1800 Group work  
1930 Farewell Dinner

### Thursday 11 October

0830-0900 Elimination of Iodine Deficiency Disorders, Dr Michael Zimmermann,  
ICCDD Deputy Regional Coordinator for Europe  
0900-1030 Feedback from working groups  
1030-1100 **Coffee break**  
1100-1200 Next Steps 2002-3, Aileen Robertson  
1200-1215 Closing remarks: Dr Snejana Altankova, Director of Department of Health  
Prophylactics and State Sanitary Control, Ministry of Health, Bulgaria  
1215-1230 Close of the workshop  
1230 Lunch



## **Annex 2: Results of participant evaluation**

### **1. What is the status of your organization in relation to either the development or implementation of the national Food and Nutrition Action Plan?:**

#### **UNICEF: (2)**

- ⇒ No reply (1) from UNICEF Albania
- ⇒ UNICEF Former Yugoslavia has been received an invitation to become involved from the Min. of Health/Agriculture.

#### More information:

- ⇒ UNICEF in Albania is currently involved in the field of nutrition, but there is no official involvement in the food and nutrition action plan so far. Although informal exchange of the information is ongoing
- ⇒ Although the nutrition Action Plan has not been drafted yet in Former Yugoslavia, UNICEF is actively involved in health/nutrition policy development, including participation in Commission

#### **FAO (SEUR, 1):**

- ⇒ Has been officially designated responsibilities in relation to the food and nutrition action plan

#### More information:

- ⇒ In support and cooperation with WHO EURO

#### **Bosnia & Herzegovina: (1)**

Has been officially designated responsibilities in relation to the food and nutrition action plan.(1)

#### More Information:

National counterpart for nutrition was assigned by MOH and is responsible for all activities related to the FNAP. The counterpart is also leader of a group of experts supported by MOH dealing with nutrition and food safety.

#### **Bulgaria: (2)**

- ⇒ Has received an invitation to become involved by the Ministry of Health/Agriculture (1, Ministry of Education and Science)
- ⇒ Has been officially designated responsibilities in relation to the food and nutrition action plan.(1, National Centre of Hygiene)

#### More information:

- ⇒ The Centre of hygiene provide scientific support to policy decisions, carries out applied research on nutrition and food safety and drafts of legislation (1)

#### **Croatia: (5)**

- ⇒ Have been officially designated responsibilities in relation to the food and nutrition action plan.(4, Croatian Inst. of PH (2); Ministry of Agriculture (2))

#### More information:

- ⇒ Croatian Institute of Public Health is closely linked and in capacity of professional support to the MOH (1)
- ⇒ CNIPH is leading institution in Nutritional food safety issues, but still o not have officially designated responsibility for preparing action plan (1)

⇒ In cooperation with MOH (1)

**Czech Republic: (1)**

⇒ Has been officially designated responsibilities in relation to the food and nutrition action plan AND has received an invitation

More Information:

Not provided

**Hungary (1):**

⇒ Has received an invitation to become involved by the Min of Health / Agriculture AND has been officially designated responsibilities in relation to the food.

More Information:

⇒ Responsibility for 13<sup>th</sup> sub-programme of the “The National Programme for a healthy Nation”

**Romania (1):**

⇒ Has not decided whether to become involved

More information

⇒ It is very difficult to begin FNAP implementation, but I hope that we will share a better situation in the future

**Slovakia (1):**

⇒ Has received an invitation to become involved by the Ministry of Agriculture/Health (Food research Institute)

More Information

⇒ We received an invitation through good cooperation between our institute with related organizations under the Ministry of Health

**Slovenia: (7)**

⇒ Have been officially designated responsibilities in relation to the food and nutrition action plan

⇒ Have received an invitation to become involved by the Ministry of Health/Agriculture (1, Min. of Agriculture)

More information:

⇒ IPHOFRS established by the government is an institution for scientific support to MOH in the field of food safety and nutrition (Inst. of PH)

⇒ Ministry of finance is obliged by governmental decision to nominate a member in a food and nutrition council at the Ministry of Health

⇒ I participate in the Food and Nutrition Council (Inst of PH)

⇒ Food and nutrition Council has been established at MOH and it is preparing the food and nutrition action plan for Slovenia

**The Former Yugoslav Republic of Macedonia (3):**

⇒ Have been officially designated responsibilities in relation to the food and nutrition action plan.

More information:

⇒ Republic Inst for Health Protection (former Yugoslav Republic of Macedonia) is the responsible organization for realization of all monitoring activities for food safety and nutrition. RIHP propose all standards, norms and methods. RIPH propose National Dietary Guide.

⇒ Did not provide more information (2)

**Yugoslavia (2):**

- ⇒ Has officially been designated responsibilities in relation to the food and nutrition Action Plan.

**More information:**

- ⇒ Federal Inst of Public Health (FYR) has created an initiative paper to create an intersectoral governmental body, which duty will be to establish a National Food Safety Plan of Action

**2. Please list and describe any positive changes that have been made by your organization to support the Food & Nutrition Action Plan:****UNICEF:**

- ⇒ Inclusion of BF, IDD and IDA in NAP
- ⇒ Support to establish appropriate legal framework in BF
- ⇒ Sharing of survey results in nutrition
- ⇒ Involvement in IDD issues

**FAO:**

- ⇒ No reply

**Bosnia & Herzegovina:**

- ⇒ All other strategic plans in which the development of our institution has been included contain expressed need and recommendations for development of the FNAP and improvements in other fields related to nutrition. Those recommendations were made by experts of our institution. Our institution is involved in all surveys on nutrition and is doing promotional activities.

**Bulgaria:**

- ⇒ The Ministry of Education can support creating of education modules in the primary and secondary schools and by financing *R+D* in the field of agriculture and foods

**Croatia:**

- ⇒ We are preparing food law
- ⇒ Ecology safe production has been adopted from the government
- ⇒ More intensive collaboration on preparation of strategies and regulations concerning food production. Food safety and trade with MAFF and chamber of commerce, also food industry
- ⇒ Preparing and adoption of policy document
- ⇒ Generally through Health Promotion Activities of UPH nutrition is included (booklets, leaflets, mass media)
- ⇒ Better collaboration on preparing strategies and regulations concerning food promotion, food safety with MAFF and food industry

**Czech Republic:**

- ⇒ Establishment of nutrition education at primary and secondary schools and at university level
- ⇒ Setting priorities of "Health Promotion" plan for MOH for 2001-2005

**Hungary:**

- ⇒ Elaboration of basic principles and activities

**Romania:**

- ⇒ Harmonization of legislation in line with the EU directives and regulations
- ⇒ Training of trainers (e.g. HACCP course with international experts)
- ⇒ Promotion of healthy food via organizational structures
- ⇒ Carrying out research on the nutritional state of the Romanian population

**Slovakia:**

- ⇒ We support coordinator of Prague Health Inst. with experts, with software, with results of research and also with results from monitoring programs

**Slovenia:**

- ⇒ National programme for school nutrition in our schools
- ⇒ Education field: food and nutrition in
- ⇒ Preparing data for food processing and production
- ⇒ Ministry of Health is a very strong supporter of FNAP and within health sector progress is rapid and evident. I joined the council in 2001. I prepare the presentation of present tax policy in Slovenia in the subject food and possible use of tax instruments for supporting the goals of food and nutrition strategy and plan, considering the frame of EU legislation
- ⇒ MOH has started to be actively involved and to take over the responsibility for the FNAP development and implementation
- ⇒ For the time being MAFF prepared only data for food producing and production
- ⇒ We (Inst. of PH) are greatly involved in the preparation of FNAP by nomination of 2 experts in the Food and Nutrition Council, one of them is *secretary general* of the Council. Inst of PH is the advisory body of the MOH and has activated a lot in the preparation of the framework legislation, which gives the legal basis to develop FNAP and establish necessary bodies.

**The Former Yugoslav Republic of Macedonia:**

- ⇒ Active participation with education program to progress the action of food and nutrition
- ⇒ Positive support for Ministry of Health
- ⇒ Development of draft of food and nutrition action plan; Active participation and technical support for the work of National Committee for food and nutrition

**Yugoslavia:**

- ⇒ Inst. of PH of Serbia started with some program and activities this year in order to improve nutrition of the population: Manuals, Exhibition, Campaign against risk factors for CVD “Your life is in your hand”, Nutrition education in primary schools
- ⇒ There is strong willing to prepare National Plan of Action of Food Safety

**3. What are the most important difficulties/challenges your facility faces in supporting the Food & Nutrition Action Plan?****UNICEF:**

- ⇒ Intersectoral collaboration
- ⇒ High turnover of counterparts (UNICEF Albania)
- ⇒ Political commitment/instability (conflict of interest and responsibility between federal and republican levels) (UNICEF Former Yugoslavia)

**FAO (SEUR)**

- ⇒ Limited financial resource to support government efforts
- ⇒ Development of technical cooperation projects

**Bosnia & Herzegovina:**

- ⇒ Budget shortage, lack of understanding of policy makers on importance of investing into preventive activities
- ⇒ Political changes were frequent
- ⇒ Org. of MOH on lower level than state
- ⇒ Timely administrative procedures;

**Bulgaria:**

- ⇒ lack of money
- ⇒ Poor interaction with other relevant institutions
- ⇒ Shortage of trained staff at central level of health

**Croatia:**

- ⇒ Lack of human resources within the MAF
- ⇒ Lack of financial resources
- ⇒ Too small number of participants, who participate actively in all working groups
- ⇒ Low position on priority scale for Minister and Ministry
- ⇒ Small number of professionals, especially in (local) county institutes of Public Health; Funds

**Czech Republic:**

- ⇒ Difficulties: intersectoral collaboration, official recognition of FNAP documents
- ⇒ Challenges: Developing material about health, economy and political impact of Czech FNAP in the future

**Hungary:**

- ⇒ Financial sources
- ⇒ International cooperation

**Romania:**

- ⇒ Lack of food and nutrition plan for population education
- ⇒ Policies factors
- ⇒ Lack of the work between all institutions and Ministries who are involved in FNAP
- ⇒ Lack of understanding for food and nutrition issues at the government level
- ⇒ Lack of funds

**Slovakia:**

- ⇒ Coordination in intersectoral level
- ⇒ Lack of money

**Slovenia:**

- ⇒ Lack of intersectoral collaboration (2)
- ⇒ cooperation between Ministry of Health and M. of Agriculture, Forestry and Food
- ⇒ lack of resources and technical capacity
- ⇒ Work on FNAP is still more or less in the circle of health sector without any strong involvement of agriculture
- ⇒ No understanding for this needs or very little by the present tax policy, not only in Slovenia, but in EU, which legislation Slovenia must follow up.
- ⇒ Very little involvement of other sectors, especially agriculture and environment.
- ⇒ Lack of financial sources to develop monitoring system in the field of nutrition, not too much in the field of food safety
- ⇒ Insufficient communication between all involved parties

**The Former Yugoslav Republic of Macedonia:**

- ⇒ Intersectoral cooperation (2)
- ⇒ To harmonise all relevant structures in community

**Yugoslavia:**

- ⇒ There is support that we need from the Federal Secretariat for Health Social Policy and Welfare, After the political changes in 2000, they changed their negative attitude. Now they are ready to help and to support preparation of the food and nutrition action plan.
- ⇒ Lack of political support and of budget

**4. How has this workshop helped in addressing the difficulties/challenges and supporting the development or implementation of the Food & Nutrition Action Plan (FNAP)?****UNICEF:**

- ⇒ Info & experience sharing with other countries (UNICEF Albania)
- ⇒ With some lessons learned and experience exchange with other representatives we gained some skills necessary to start the process

**FAO:**

- ⇒ Much better understanding of the situations within the countries

**Bosnia Herzegovina:**

- ⇒ It initiated several meetings with MOH and Ministry of Agriculture and of working group of nutrition
- ⇒ It was the opportunity to make short situation analysis for both sections
- ⇒ Exchange of ideas was useful for the development of FNAP
- ⇒ Raised hopes, again, that something can be done

**Bulgaria:**

- ⇒ This workshop is useful with shared ideas, opinions and experiences
- ⇒ Overview and knowledge of problems and solutions in individual countries

**Croatia:**

- ⇒ We have a chance to exchange experiences. Suggestion with other countries and see what has been done in other countries.
- ⇒ Gives an overview of situation in other countries of the region
- ⇒ Gives reassurance that our approach is correct and provides us guidance
- ⇒ Exchanging information – lessons learned
- ⇒ Better overview of situations in other countries in region and their experience in field of nutrition

**Czech Republic:**

- ⇒ Information about which activities can be included into national FNAPs
- ⇒ Information about national priorities was very interesting

**Hungary:**

- ⇒ New information
- ⇒ Exchanging experiences
- ⇒ Chances of cooperation

**Romania:**

- ⇒ Workshop was good exercise for me, because I understand that all activities must re-unite in a concrete food and nutrition action plan

**Slovakia:**

- ⇒ New knowledge about movement of creating FNAP are good for strengthening of creation of national coordination body in my county

**Slovenia:**

- ⇒ For me very good. I will do all my best to implement what has been discussed.
- ⇒ Workshop was very useful for me. (discussion with many experts like A. Robertson and the experts from other countries).
- ⇒ Learning from other countries
- ⇒ It proved, that we are in the right track
- ⇒ For me personally this workshop was a very good opportunity to get familiar with wideness of the problems and with possible solutions of which some could be supported also by financial or fiscal instruments
- ⇒ To think about different ways to approach intersectoral collaboration
- ⇒ To find out about and to exercise implementation phase
- ⇒ It is very useful to see the problems and solutions of the other participants and to communicate on different points of view
- ⇒ We discussed our problems from new viewpoints in our delegation and we have found new solutions

**The Former Yugoslav Republic of Macedonian**

- ⇒ Yes it was very useful (3)

**Yugoslavia:**

- ⇒ Workshop was excellent, especially for the Yugoslavian participants
- ⇒ Realising that others have the same problems
- ⇒ To be more aggressive to achieve goals
- ⇒ To expand network between different sectors

**5. Please list other expectations you had of this workshop:**

**UNICEF:**

- ⇒ Workshop meet greatest part of my expectation
- ⇒ Music with dinner

**FAO:**

- ⇒ No reply

**Bosnia Herzegovina:**

- ⇒ Our wider delegation will need again
- ⇒ We would have at least ten observer from Western part of Europe to share their experiences
- ⇒ See “food guide” pyramid with layer of water
- ⇒ See more FAO materials for distribution

**Bulgaria:**

- ⇒ Expected more participation from non health experts

**Croatia:**

- ⇒ Maybe more experiences in fund raising for implementation

**Czech Republic:**

- ⇒ To profit from other countries experience
- ⇒ To compare Czech priorities of FNAP with other countries
- ⇒ To be inspired by SEE countries progress in implementing the FNAP

**Hungary:**

- ⇒ No reply

**Romania:**

- ⇒ No reply

**Slovakia:**

- ⇒ No reply

**Slovenia:**

- ⇒ Start intersectoral cooperation
- ⇒ Maybe WHO should invite other sectors/units of international organizations who are important partners for the successful implementation of FNAP in the whole European region (also EU countries) to see positive examples
- ⇒ I expected more intersectoral discussions between experts from different sectors. First goal of meeting should be setting the goals for action plans and for getting the national support, finances and especially to find right action instruments. You need the awareness of participation of involved sectors.
- ⇒ Once I would like to compare the Slovenian situation to that in Austria, Italy and Switzerland, together with Hungary and the Czech Rep. – I think this would help us to find our position better. But I did not expect that from this workshop.
- ⇒ Closer and more efficient cooperation between WHO and FAO
- ⇒ To put food supply as a main topic on the agenda
- ⇒ That the officials, who cover agricultural matters in their ministries share with us, what their main disagreements and oppositions they have, are

**The Former Yugoslav Republic of Macedonia:**

- ⇒ Very good organization and excellent support for future activities
- ⇒ Contact with the other colleagues

**Yugoslavia:**

- ⇒ No reply (2)

**6. Please list any issues you would like discussed at future workshops:****UNICEF:**

- ⇒ I hope we (FYR) will be able to present draft NAP and I would like to hear lessons learned from implementation from other countries
- ⇒ No reply from UNICEF Albania



**FAO:**

- ⇒ School food catering – teaching healthy nutrition and healthy life styles actively through school feeding programmes

**Bosnia & Herzegovina:**

- ⇒ Bilateral exchange between 2 countries of CFE
- ⇒ Further development of FNAPs
- ⇒ Specify development of, some methodology for carrying out surveys on nutritional status and diet patterns system

**Bulgaria:**

- ⇒ Legislation frame in the different countries and research activities and priorities
- ⇒ Food security seems out of place included in the nutrition policy because it involves much more agriculture environment. There needs to be much more improvement in intersectoral cooperation organize a meeting with top level officials from agriculture (economy) environment to teach them the importance of including nutritional considerations in sustainable agriculture planning and strategies

**Croatia:**

- ⇒ Nutritional standards and dietary guidelines
- ⇒ Implementation of food and nutrition action plans
- ⇒ More about the responsibility of MAF in field of food safety and quality, link between MAFF and MOH
- ⇒ Implementations steps of stability pact project
- ⇒ Implementation problems

**Czech Republic:**

- ⇒ Detailed steps of drafting and discussing new legislation related to FNAP

**Hungary:**

- ⇒ How to develop common work, network & programmes for east European countries
- ⇒ School food catering – teaching healthy nutrition and healthy life styles actively through school feeding programmes

**Romania:**

- ⇒ Suggest solutions for implementing the plan

**Slovakia:**

- ⇒ one proposal: in the next meeting it would be better to divide topics – Food Safety and Nutrition
- ⇒ I hope it will be reasonable to discuss about economy of nutrition (main problem of this region)

**Slovenia:**

- ⇒ School nutrition (curricula and system of organized school nutrition in other countries)
- ⇒ Consultation with country which managed to implement Nutrition Action Plan.
- ⇒ The first pillar –food security/supply has been practically omitted. I propose to dedicate the next workshop to the pro health agricultural policies in SEE countries – the presentation should be prepared and presented by agricultural people.(2)
- ⇒ So far future workshops could maybe focus on ways of solving problems, possibilities of funding including international support.

- ⇒ How to get to greater political agreement between all involved departments. I would like to learn more about the organizational solutions from different EU countries

**The Former Yugoslav Republic of Macedonia:**

- ⇒ To evaluate the national food and nutrition plans
- ⇒ How every country implements that plan in its condition
- ⇒ Harmonization of regulations (EU, WTO Codex, National)

**Yugoslavia:**

- ⇒ HACCP
- ⇒ BSE
- ⇒ Undergraduate and postgraduate studies in nutrition
- ⇒ Experiences from other countries
- ⇒ Nutritional status of children and elderly
- ⇒ Sanitary inspection problems related to food
- ⇒ Labelling of food
- ⇒ Food industry
- ⇒ Agricultural collaboration

**7. Do you think it useful to establish a Nordic-Baltic Nutrition Network for nutrition experts working in both the Nordic and Baltic countries?**

- ⇒ 22 participants said **YES**
- ⇒ 5 participants are **Not sure** (Croatia):

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