Development of a WHO global strategy on diet, physical activity and health: European regional consultation

Report on the Consultation
Copenhagen, 2-4 April 2003
ABSTRACT

The European consultation with Member States on the WHO global strategy on diet, physical activity and health was held in Copenhagen from 2 to 4 April 2003. The goal of the consultation was to put forth recommendations for the development of the global strategy. The consultation was attended by intersectoral delegations of high-level technical government authorities from 15 invited Member States, as well as a representative of the European Commission, technical advisers and members of the WHO secretariat. Participants represented a range of sectors including food and nutrition, physical activity, sport, transport, agriculture, health promotion, environment and education.

The consultation reviewed the prevalence of noncommunicable diseases at the global and regional level and highlighted the importance of developing sound and sustainable diet and physical activity policies to help reduce noncommunicable diseases. Most Member State delegations made presentations and/or submitted case studies on local and national initiatives to promote healthy nutrition and increased physical activity in their respective countries. Four parallel working groups addressing important elements of the policy-making process (evidence collection, policy development, policy implementation and monitoring and evaluation) were held to generate European recommendations which have been submitted to WHO headquarters for incorporation into the global strategy. It is expected that these recommendations will also help define the European Region’s needs and directions for further work to promote healthy diet and physical activity.

Keywords

NUTRITION
EXERCISE
LIFE STYLE
HEALTH PROMOTION
HEALTH PLANNING
STRATEGIC PLANNING

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**Introduction**

Chronic diseases dominate the burden of disease in developed countries and now increasingly affect low- and middle-income countries. Concern about these trends led the Fifty-third World Health Assembly in May 2000 to adopt a resolution emphasizing the need to prevent and control noncommunicable diseases and requested WHO to maintain this area as high priority (WHA53.17). In May 2002, the Fifty-fifth World Health Assembly also requested the Director-General to develop a global strategy on diet, physical activity and health in consultation with Member States and the United Nations system (WHA55.23).

In response to these resolutions and in keeping with the seriousness of the public health problem, WHO has engaged in a process involving a broad and inclusive consultation, which will lead to the global strategy on diet, physical activity and health. The overall goal of the strategy is to improve public health through healthy eating and physical activity (cf. Process document1). Consultations with Member States, as well as parallel consultations with United Nations organizations, civil society organizations and the private sector, were carried out during the first half of 2003. As part of this process, the WHO Regional Office for Europe organized a European consultation with Member States on the WHO global strategy on diet, physical activity and health in Copenhagen from 2 to 4 April 2003. It was attended by intersectoral delegations of high-level technical government authorities from 15 invited Member States, as well as a representative of the European Commission, technical advisers and members of the WHO secretariat (see Annex 3). Participants represented a range of sectors including food and nutrition, physical activity, sport, agriculture, health promotion, environment and education.

The goal of the European consultation was to put forth recommendations for the development of the global strategy on diet, physical activity and health. Specifically, this consultation aimed to serve as a technical forum to provide and assess information on the extent of health problems associated with diet, physical activity and chronic diseases in the region; to review prevention strategies appropriate for individual countries; to discuss global, regional and national interventions while taking social, cultural and economic realities into consideration; to explore the role played by sectors other than health and their policies (such as those related to transport, environment and agriculture) in providing opportunities for physical activity and healthy diets; to look at interventions that take place at the local (and not only national) level; and, to reflect upon regional differences, common concerns and global consensus.

**The European consultation**

A task force was convened to coordinate the technical aspects of the European consultation. The task force included: Dr Haik Nikogosian (Promoting Health in Lifestyle, Environment and Development), Coordinator of the Task Force; Dr Mikael Ostergren (Child and Adolescent Health and Development); Ms Francesca Racioppi (Accidents, Transport and Health); Ms Vivian Rasmussen (Promotion of Young People’s Health); Mr David Rivett (Promotion of Young People’s Health); Dr Aileen Robertson (Nutrition and Food Security); Dr Aushra Shatchkute (Noncommunicable Disease Prevention); Dr Maria Cristina Tirado (Food Safety); Ms Wendy Tse Yared (Regions for Health Network); Dr Agis Tsouros (Healthy Cities and Urban Governance); and Dr Erio Ziglio (Health Promotion). Ms Cecile Knai, Technical Officer, served as focal point for day-to-day preparations and drafting of the European background paper.

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1 [http://www.who.int/hpr/NPH/docs/GlobalStrategy.pdf](http://www.who.int/hpr/NPH/docs/GlobalStrategy.pdf)
Overall coordination of the process for the global strategy in the Regional Office was undertaken by Dr Roberto Bertollini, Director, Division of Technical Support, Health Determinants in cooperation with Dr Gudjón Magnússon, Director, Division of Technical Support, Reducing Disease Burden. The task force met on two separate occasions to select the countries to be invited, to contribute to the European background paper (Annex 5), and to help decide upon the themes and organization of the working groups.

The selection of the 15 invited countries was based, in part, on geographic balance but also on the basis of criteria such as active involvement (policy development and implementation) in the fields of diet and/or physical activity, recent focus at the political level on diet and/or physical activity, health promotion tradition and whether the country is a member of relevant networks. The final list of participating countries was: Denmark, Finland, France, Hungary, Ireland, Israel, Kazakhstan, Latvia, Netherlands, Norway, Russian Federation, Slovenia, Switzerland, The Former Yugoslav Republic of Macedonia and the United Kingdom.

Once country delegations were confirmed, participants were sent information, including the European background paper and key reference documents, to prepare for the consultation. An inventory of global and regional reference documents was compiled during the months leading up to the consultation (Annex 8).

**Procedures of the consultation**

**Introductory statements**

Dr Roberto Bertollini (WHO Regional Office) welcomed the participants and said that as in the other WHO Regions, diet and physical activity were of major importance in relation to the current rapid rise in noncommunicable diseases (NCD) in the European Region. He said there was a need to consolidate the European Region’s activities in relation to physical activity and to strengthen the existing actions relating to nutrition. As part of its response, the WHO Regional Office for Europe had established a task force on the global strategy on diet, physical activity and health comprising representatives of all relevant regional programmes. The Regional Office had also prepared a background document, which provides an overview of the evidence and actions to address NCD. The meeting of nutrition counterparts in the WHO European Region held in Athens in March 2003 had provided a useful opportunity to discuss the process for the global strategy, in particular with regard to nutritional factors.

Dr Gudjón Magnússon (WHO Regional Office) said that while NCDs predominate in many countries in the Region, there was a double burden in eastern Europe where NCDs were increasing while the level of communicable diseases remained high. He said one of the greatest challenges in combating NCD was to find better ways of communicating so as to convince populations to recognize the situation and adjust their lifestyles accordingly. Dr Magnússon believed the consultation should provide useful insights in that regard. Translating the available evidence into effective action would also require new partnerships. He looked forward to increased collaboration between the WHO Regional Office, WHO headquarters and Member States as work on the European strategy on NCD developed over the coming years.

Ms Arnhild Haga Rimestad (Norway) and Dr Jožica Maučec-Zakotnik (Slovenia) were elected as Co-Chairpersons and Mr Brian Brogan (Ireland) as Rapporteur.
Keynote presentations

The Global Strategy – an overview
Dr Pekka Puska, Director, Noncommunicable Disease Prevention and Health Promotion, WHO headquarters

Dr Pekka Puska presented an overview of the rationale for, and the process of, the development of a global strategy on diet, physical activity and health. He said that the world’s health was undergoing an unprecedented transition on several fronts: epidemiological, nutritional and demographic. The result, felt keenly at country level and substantiated unequivocally by scientific evidence, was a broad shift in disease burden. The majority of deaths (59%) are from NCD (Fig. 1).

Fig. 1. Death by broad cause group 2000

![Death by broad cause group 2000](image)

In the European, American and Western Pacific Regions, NCD are in an overwhelming majority. The South-East Asia and Eastern Mediterranean Regions are in transition, with NCD now a more significant public health problem than infectious diseases (Fig. 2).

Fig. 2. Global burden of disease 1999-2020 by disease group in developed countries

![Global burden of disease 1999-2020 by disease group in developed countries](image)
The African Region is also in transition and, while in many countries in the region communicable diseases still predominate, the incidence of NCD is rising rapidly. A wealth of medical research shows the risk factors responsible for this growing pandemic and clearly points out the strategies needed to reduce their impact. The data gathered for *The World Health Report 2002* show high blood pressure to be the major contributing factor to all deaths in the world (Fig. 3). Of the ten leading risk factors, six relate to nutrition, diet and physical activity. Progress in these two areas, combined with reductions in tobacco and alcohol use, will have enormous importance for the prevention of NCD and will lead to major health gains that are cost-effective.

**Fig. 3. World deaths in 2002 attributable to selected leading risk factors**

![Diagram showing number of deaths attributable to various risk factors]

Source: *World Health Report 2002*

The figures also make clear the important role played by undernutrition. This must not be forgotten in the concern to address obesity. In many countries, overnutrition and undernutrition coexist, in addition to unbalanced nutrition, emphasizing the essential role a balanced diet must play in improving population health. Childhood obesity too is a growing problem across the world, with physical inactivity a major factor.

Data from the Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme show that, in most European countries, more than half the population have elevated blood cholesterol levels and hypertension, and are overweight. Obesity is rising and physical activity is declining, especially in children. Moreover, smokers form a high proportion in European populations. Close to 80% of the NCD burden is now found in the developing world, moving to lower and lower socioeconomic groups and contributing strongly to inequities in health. The determinants of these changes are urbanization, changes in occupation and many global influences. The transition concerns adults and children alike.

NCDs are, to a great extent, preventable diseases. While genetic susceptibility to NCD may be a factor, appropriate preventive action can alter environments, protect against risk factors and change life expectations. On a population scale, relatively modest behavioural changes affecting several of the risk factors simultaneously, can make swift, affordable and dramatic changes in population health.
Diet is a powerful instrument in this regard. In Finland, the North Karelia project, through community-based activity encouraging a healthier diet, reduced annual CHD mortality by 73% over 25 years; in Japan, reduction of salt intake resulted in lower blood pressure levels and greatly reduced stroke mortality; in Mauritius, changing cooking oil from palm to soybean oil resulted in a 15% decrease in serum cholesterol in the population; and in Poland, a change in dietary fats resulted in a 20% decline in heart disease mortality.

There are many obstacles to implementing prevention activities, but they can be overcome. They include: outdated concepts such as seeing NCD as “diseases of affluence”; a lack of understanding about the speed with which prevention activities can make an impact on morbidity; low public visibility for success stories in comparison with the needs of sick patients; powerful commercial interests that block policies and generate conflicting messages; traditional training of health personnel that emphasizes curative care; and inertia among institutions, financing bodies, and services.

Food consumption and physical activity patterns are a key to tackling NCD. However, these behaviours are embedded in the environment, the community, and in national policies on industry and agriculture. It will be essential to work with all these sectors as partners, and to look carefully at what factors influence consumption patterns, in dialogue with those partners. The problems are complex, and cannot be solved by any one entity on its own. The consultation process for the global strategy will draw all those partners into debate, with the specific intention of working positively towards change. WHO is confident that, given this background and through broad consultation, such a partnership will succeed in developing and implementing a global strategy, leading to major health gains in Member States and globally.

**Physical activity and health**

Dr Mikael Fogelholm, Director, UKK Institute for Health Promotion Research, Finland

There are clear associations between physical activity and health and between diet and health and the two relationships are often linked through obesity (Figure 4). So while obesity, an unhealthy diet and physical inactivity are independent risk factors, they are often found together as common risk factors for type 2 diabetes (already being seen in obese children), hypertension, stroke, cardiovascular diseases (CVDs), metabolic and endocrine diseases, and cancer, all of which are increasing across the world.

**Fig. 4. Physical activity and obesity in the European Union**

In some countries, such as Finland, the number of people engaging in regular leisure-time exercise is increasing. But, changes in lifestyle, with more sedentary jobs, commuting to work using transport, and sedentary leisure activities such as regular television-watching have reduced everyday exercise in many societies. It has been known for some time that vigorous activity can be beneficial for health. More recent studies indicate that, even with moderate exercise, the risks of NCD can be reduced, although a combination of moderate and vigorous activity produces greater benefits. Even in those who are not fit or who do not exercise sufficiently to increase fitness, physical activity is beneficial. Regular moderate activity of 30 minutes daily is recommended, although it appears that two sessions of 15 minutes also bring benefits, which might suit more people on a day-to-day basis. In a European context, it would be useful to encourage a switch to walking or cycling as a substitute for short car journeys.

The risk for CVDs is highest in those who are generally inactive and do not either walk or run. Increases in either moderate or vigorous activity reduce the risk. Studies of the effects of increased exercise during treatment of obesity have shown a dose response but only in the short term, and this does not appear to be a solution for weight reduction. Nevertheless, those who remain active after weight reduction show better weight maintenance. Type 2 diabetes is associated with obesity, so preventing weight gain can prevent this type of diabetes. Exercise is more effective than dieting in reducing fasting insulin levels, and epidemiological data indicate a clear dose response for diabetes risk. The greatest changes are seen in those who were previously inactive, so it would seem important to target this group. The studies on stroke and physical activity are ambiguous: some have shown a positive dose response but others show that while moderate exercise is beneficial, vigorous activity may not be appropriate. The International Agency for Research on Cancer recently reviewed studies related to weight control, physical activity and cancer. The biological links are not yet well understood. However, cohort studies show a significantly lower risk for colon cancer in those who are physically active. For breast cancer, the association of physical activity with reduction of risk is also strong, particularly in premenopausal women, while that of weight control appears to be stronger in postmenopausal women. Bone density, important for preventing osteoporosis, improves with weight-bearing exercise. Bone appears to be particularly responsive to exercise before puberty, which is therefore a critical period for healthy bone development. There is some evidence to suggest that physical activity is also beneficial for mental health, but more research is needed in this area.

Lifestyle choices are changing patterns of physical activity, often to the detriment of health. While these choices are affected by individual predisposing factors, they are also influenced by the physical and the social environment, and there are many opportunities for appropriate health promotion activities to counter current trends.

**Diet and health**

*Imogen Sharp, Head, CVD and Cancer Prevention, Department of Health, UK*

Diet-related disease has become a major burden in terms of health impact and cost to the European economy, and tackling diet is therefore a key priority. Prevalence of CVDs is rising across the region and these diseases are the leading cause of death in men in most countries, especially in eastern Europe, followed by cancer. In women, there are high rates of stroke, again especially in eastern Europe, and stroke is a leading cause of morbidity and loss of quality of life. Obesity (Figure 5) and type 2 diabetes are rising too. For example, Britain has seen a threefold increase in obesity in 20 years. There is some evidence of a social gradient in this trend, with higher socioeconomic groups less likely to be obese.
Dietary patterns still vary across the region, although there is a general convergence of diet and lifestyles. Intakes of total fat and saturated fat are high, particularly in northern and western Europe. Eating patterns are changing, with a tendency to eat frequent snacks rather than regular meals, and there has also been a rapid rise in eating outside the home. The percentage of fat in such food is often higher than in home meals. Fruit and vegetable intakes are quite high in the south but low in eastern and northern Europe. Evidence indicates that a rise by one portion of fruit and vegetables is associated with a 20% reduction in all-cause mortality, so that even small changes in diet can make big differences in health. Fruit and vegetables, linoleic acid in oily fish and fish oils, high intake of potassium, and low-to-moderate alcohol intake decrease the risk of CVDs, while myristic and palmitic acids, trans fatty acids, high sodium intake, overweight, obesity and high alcohol intake increase the risk.

There is also some evidence to suggest that alpha-linoleic acid, non-starch polysaccharides, oleic acid, wholegrain cereals, plant sterols and stanols, and folate decrease the risk while dietary cholesterol and unfiltered boiled coffee increase it. There is convincing evidence that fruit and vegetables decrease the risk of oral cavity, oesophageal, stomach and colorectal cancers. Overweight, obesity, alcohol, aflatoxin-preserved meat, salt-preserved foods, salt, and high-temperature drinks and foods all contribute to the risk of various forms of cancer. Voluntary weight loss in overweight and obese people and increased fibre intake decrease the risk of diabetes. Overweight and obesity, abdominal obesity, maternal diabetes, high saturated fat intake and intrauterine growth retardation all increase risk of diabetes. High fibre, healthy school and work environments and breastfeeding all reduce risk of obesity, while high intake of energy-dense foods, high consumption of sweetened drinks and adverse social and economic conditions increase risk of obesity.

No Member State in the region has yet achieved the dietary goals recommended in The World Health Report 2002, although Greece, Portugal and Spain come close to the goals for fat intake. However, there have been some improvements in response to health education and promotion, including reductions in total fat intake, and switches to semi-skimmed rather than full fat milk, to wholemeal rather than white bread and to grilling rather than frying of food. Campaigns to encourage people to eat more fruit and vegetables are under way in some countries. In England, for example, a “5-a-day” programme has been introduced, and a national fruit scheme offering
free fruit in school to children aged 4-6 years is proving successful. Supplies of fruit and vegetables across Europe are not currently sufficient to meet the increased requirements for achieving a net 400 g per person per day, and producers will need to be encouraged to increase supplies.

The impact of the European Union (EU) Common Agricultural Policy (CAP) on food supplies has been considerable, and health professionals should seek to influence the policy in the interests of health (cf. Public health aspects of the European Union Common Agricultural Policy). The proposed WHO global strategy on diet, physical activity and health should emphasize that policy actions should be comprehensive and should define what is best done at the various levels – international, national and local. While governments have a central steering and stewardship role (with a crucial contribution from health ministries), they clearly cannot act alone; the convergence of diets demands global responses. Strategies should take a life-course perspective, address imbalances in nutrition, be age and gender sensitive and have an impact on the poorest communities. It will be important to interact with the food industry to influence attitudes and to encourage appropriate changes and the development of alternative, healthier products.

**Country presentations**

Leading up to the consultation, country delegations were given the option to prepare presentations on their respective country’s work on diet and physical activity. Presentations were to be delivered by one member of the multisectoral delegation and were to be representative of the delegation. Twelve countries opted to give a presentation. These are summarised here in chronological order.

**France**

With high political commitment, a public debate was initiated in 1998 involving government, scientists and civil society. This action took account of WHO and European initiatives and culminated in an official instruction from the Prime Minister to the Ministry of Health in December 2000 for the preparation of a national programme on nutrition and health. The activities of the comprehensive five-year programme (2001–2005) are identified by a common policy logo. The primary objective is to improve the state of health of the whole population by acting on one of its major determinants – nutrition. The programme, which is linked to other public health programmes, e.g. programmes on CVDs and cancer, has nine quantified priority objectives, nine specific objectives (not quantified) some general principles for intervention, six strategic directions, actions for each strategy and a clear schedule for the five-year period.

The objectives are to modify food consumption, e.g. reduce the number of low consumers of fruit and vegetables by at least 25%, to increase by 25% the number of people doing the equivalent of 30 minutes of fast walking per day, to reduce by 20% the prevalence of overweight and obesity in adults (from 10% to 8%), and to halt the increase in prevalence of obesity in children. The programme is coordinated by a multisectoral committee involving representatives of seven ministries and government agencies, the food industry, consumer
associations, local authorities and scientific experts. A major requirement set by the population was consistency in actions and messages.

There have been national promotion campaigns to increase fruit and vegetable intake and there will be a campaign to promote physical activity in 2004. National food guides have been developed, using innovative designs and positive messages, for use in the general population and among health professionals. Guides for special population groups are planned. The guides recognize differences among consumers and provide non-judgemental advice on how to make changes that benefit health. Tools for clinical practice have also been developed. Monitoring and evaluation of the programme have been planned from the outset and will be undertaken by a special unit.

**Norway**

The Directorate of Health and Social Affairs coordinates the actions of the separate Ministries of Health and Social Affairs, and responsibility for policies on physical activity rests with its Division for Public Health and Social Welfare. An independent council of experts from a range of backgrounds facilitates the development of evidence-based policies and has been instrumental in raising awareness among decision-makers of the impact of inactivity on health.

A Year 2000 report on physical activity and health made specific recommendations on physical activity in children and youth, a national cycling strategy, and possible primary health care interventions. These included informing children and youth of the benefits of physical activity, encouraging them to undertake one hour of physical activity daily and exploring possibilities for safe walking and cycling to school. The national cycling strategy – the responsibility of the Ministry of Transport and Communications – aims to make it safer and more attractive to choose cycling as a means of transport and will be incorporated in the national transport plan (2006–2015). Strategies at the primary health care level include increasing the knowledge of general practitioners about the benefits of physical activity, developing a computer-based manual for general practitioners giving recommendations on physical activity, encouraging general practitioners to give lifestyle advice and prescribe physical activity and developing partnerships with organizations that can follow up on this advice and offer physical activity classes. The aim is to make healthy choices the easy choices.

A white paper “Prescription for a healthier Norway” (2003) reviewed the current situation and sets goals and strategies that will form the basis of work for the coming decade. The paper focuses on lifestyle factors, including physical activity, and it is hoped that it will elicit increased budget funding for physical activity interventions.

The main objective of the Physical Activity Department is to improve health through increased physical activity in various population groups (children and youth, adults, older people, physically disabled people). The Department will provide expert advice and recommendations in the form of guidelines to public authorities, research institutions, health and social services, schools, employers, nongovernmental organizations and the media. It will also monitor physical activity and fitness levels; the validation of tools has been completed and monitoring will start in 2004. The department is working at central, regional and local level with many different partners to bring about changes aimed at improving health and reducing the burden of NCD.

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**Prescription for healthier living -primary health care in Norway**

- Increasing GP’s knowledge of the effects of physical activity
- Develop a computer based manual with general lines for PA
- Introduce a lifestyle rate that might increase the time and effort GP’s spend in lifestyle advising
- Implement a lifestyle prescription for treatment with PA as an alternative or a supplement to ordinary medical treatment
Finland

Social and health problems are expensive for local communities, so cost-effective preventive measures are attractive. The city of Turku, population 170 000, has participated in the WHO healthy cities movement since 1987, and is the location for the WHO Collaborating Centre for Healthy cities and Urban Health in the Baltic Region. It boasts a strong sports tradition and a sports research centre. The city took six steps to increase physical activity among its population: evidence-gathering to convince individuals and decision-makers of the benefits to health; formulation of policy focusing on a healthy environment, quality of life through well-being, and children; situation analysis emphasizing innovative intersectoral ways of working; strategy development, strategy implementation; and monitoring and evaluation.

The outcome was the Move 2000 project (1994–2000), funded by the city authorities in collaboration with Turku University. The project aimed to increase physical, psychological and social well-being across the life span by providing facilities and information, reaching out to break barriers and involve previously inactive people, and involving regular follow-up by questionnaire and a high level of media publicity. The project succeeded in raising awareness of the benefits of exercise for health and raising regular activity levels in both adults and children, and is being continued. Current challenges include improving integration of health promotion in health care services and intersectoral working, giving greater attention to reduction of tobacco and alcohol use, and increasing individual responsibility for health.

Hungary

The main objective of the national public health programme (2001) is to increase life expectancy at birth by three years. The programme, which attracts considerable political commitment, focuses on promoting physical activity, healthy nutrition and food safety, developing a healthy physical environment, and reducing smoking, alcohol and drug abuse.

A Year 2000 survey showed declining levels of physical activity, especially among children. New approaches are being adopted to counter this trend with the aim of improving and expanding sports facilities, encouraging physical activity in the workplace, and promoting daily physical education and activity in schools. A multisectoral approach to interventions for children draws in health professionals and medical staff, physical education teachers and parent associations, as well as relevant ministries and regional health institutions.

Activities include supporting specific schools with legislation on levels of activity to be provided (initially set at a mandatory five, but reduced on teacher demand to three classes per week, with other physical activity on the other two days, for children aged 6–10 years from 2003; 2.5 sessions of physical education per week for higher age groups). A primary prevention programme for cervical and lumbar discopathy, through physical education, is also being conducted in schools.

<table>
<thead>
<tr>
<th>City support to physical activities</th>
<th>16 M € = 100 € / inhabitant</th>
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<tbody>
<tr>
<td>children and youth</td>
<td>43%</td>
</tr>
<tr>
<td>leisure and fitness</td>
<td>28%</td>
</tr>
<tr>
<td>competitive sports</td>
<td>11%</td>
</tr>
<tr>
<td>school and student</td>
<td>8%</td>
</tr>
<tr>
<td>special</td>
<td>2%</td>
</tr>
<tr>
<td>non-specified</td>
<td>8%</td>
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participates in the health-promoting schools initiative and legislation requires that health promotion activities, financed through the national budget, are undertaken in schools.

For activities aimed at adults, partners include all those working in health promotion settings, nongovernmental organizations, older people, physical education teachers and physiotherapists. Programmes for women, for the workplace and to promote cycling, are being planned and implemented.

**Ireland**

Epidemiological data indicate that the principal causes of death in 2000 were CVDs (approx. 45%) and cancers (24%). For men, CVD death rates are falling, but remain among the highest in Europe.

Government policies include the health strategy, “Quality and fairness 2002”, which aims to improve the population’s health and lies at the centre of all health planning and health and social care delivery. The second health promotion strategy (2000–2005) has targets and goals across lifestyles, including diet and physical activity. National cardiovascular health and national cancer strategies are also being implemented.

Activities are aimed at particular settings, population groups and topics, and focus on the determinants of health through national and regional structures, with growing emphasis on intersectoral working and partnerships, including collaboration with colleagues in Northern Ireland and dialogue with the food industry. Evidence is drawn from a national lifestyle survey conducted every four years, which is proving a valuable tool for mapping progress and evaluating the impact of individual campaigns.

Data indicate that while 42% of the population engage in some form of physical activity, 60% are not active enough for health. Duration of television viewing is high and there is a marked decline in activity with age. Activities to counter this trend include the “get a life, get active” campaign, recruitment of physical activity coordinators at regional level, development of national promotion materials, marked walking routes, exercise referral to leisure facilities by general practitioners and, in collaboration with the leisure industry, a variety of regional developments. Research indicates that the message is getting across: 50% of the population recall the campaign, and there is a 10% self-reported increase in activity since 2001 and a 25% increase in awareness of the benefits of physical activity for cardiovascular health.

Overweight and obesity are increasing across all age categories. Initiatives include publicizing the food pyramid as a learning tool, developing healthy eating guidelines adapted for various target groups, and initiating an annual national healthy eating week. Schools, workplaces and supermarkets are being targeted. In addition, more dieticians are being trained and fruit and vegetable cooperatives are being set up. Evaluation has shown that 60% of the population are aware of the campaign, and 30% have modified eating habits – 70% eat four or more portions of fruit of vegetables (excluding potatoes) daily.

During its presidency of the European Union in the first half of 2004, Ireland will take cardiovascular health as its health theme, with a sub-theme of obesity, and hopes to stimulate new initiatives, enhance political commitment and ensure that greater priority is given to that area.
Latvia

Latvia has high death rates from NCD. Some 30% of the population are overweight and 8% of males and 15% of females are obese. Leisure-time physical activity levels are relatively low, although there has been a slight increase in recent years. Dietary habits have shown some improvement, with reductions in salt, sugar and fat intakes, changes in the type of fat consumed and increased use of vegetables.

Latvia has developed a public health strategy (2002–2010) aimed at improving health status (indicators currently place Latvia well below others in Europe). The goals are to increase life expectancy to 95% of the European average and improve healthy eating and other lifestyle habits. A national food and nutrition action plan (2003–2013) is being formulated. The 11 targets include development of a plan of action to educate the general public about healthy nutrition, establishment of a nutrition council, development of a unified information system and suitable indicators, strengthening of the implementation of food safety strategies, and establishment of normative acts for sustainable environment and sustainable and healthy agriculture. Food-based guidelines have been developed for adults and draft guidelines for other groups are under development.

Legislation on sports (2002) is aimed at promoting physical activity and sports, especially in educational institutions, and healthy leisure-time activities. Local governments are required to designate a sports institution responsible for promotion, build and maintain appropriate facilities, including cycle-tracks and pathways, promote formation of clubs, and support further education of sports teachers and workers. Employers are required to support employees in taking exercise.

Implementation of policies is intersectoral: the Ministries of Health, Agriculture, Education and Science, Environment, Transport, the food safety agency, local authorities, nongovernmental organizations and the mass media are all involved.

United Kingdom

The United Kingdom followed the key dietary recommendations set by the Committee on Medical Aspects of Food Policy for prevention of CVDs (1994) and cancer (1998), which are to maintain a healthy body weight, reduce intakes of fat, saturated fat, salt and added sugars, increase intakes of fruit and vegetables and dietary fibre, and undertake 30 minutes of moderate activity per day (60 minutes for children). The Food Standards Agency has responsibility for protecting health and the interests of consumers, food safety and standardization, food labelling and advice to the public on food safety, diet and nutrition. It has a strategic nutrition framework established by a board on which a wide range of interests are represented. The Agency also plays a strong role in encouraging nutrition research programmes for example on food acceptability and choice, and has developed an interactive CD-ROM on healthy eating for teenagers. The four countries in the United Kingdom have separate policies in the area of diet and physical activity, but all emphasize intersectoral collaboration at national and local level, include elements on capacity-building, education and training, monitoring and evaluation, and focus on effective...
local delivery, with quantified targets, in various settings. Their aim is to strengthen the evidence base, make better use of resources, improve access and use innovative ways of reaching priority groups.

In Wales, the “Well-being in Wales” strategy comprises integrated multisectoral policies and programmes and includes programmes on nutrition and healthy and active lifestyles. Objectives include increasing public knowledge, reducing health inequalities, creating supportive environments, reducing barriers and increasing opportunities.

In Scotland the approach contains health improvement plans that include strategies on physical activity, diet and communication. The underlying principles are to stimulate demand across the life span for healthy eating and physical activity and to strengthen the opportunities to meet that demand. All programmes are identified by a “healthy living” emblem.

Northern Ireland has a similar approach, with a strategic document for public health (2002–2010). The main goals are to improve the health of the population and reduce inequalities in health. Specific targets include halting the increase in obesity so that by 2010 the proportion of men and women that are obese is less than 17% and less than 20%, respectively.

In England, national Department of Health policies include the physical activity component of the national health service plan, national service frameworks for service delivery and prevention, and the cancer plan, which have specific targets for physical activity and nutrition. In the area of physical activity, the Departments of Health, and of Culture, Media and Sport have plans with specific targets. For example, to ensure that by 2006, 75% of 5–16-year-olds have a minimum of two hours per week of high quality physical education and sport, and that by 2020, the proportion of people undertaking physical activity for at least 30 minutes on five days per week rises to 70%. A sustainable farming and food strategy (2002) is committed to the development of a comprehensive multisectoral food and health action plan.

**Denmark**

Among other activities related to diet, physical activity and health, Denmark has developed a national action plan against obesity, issued a handbook for doctors on prevention of NCD through physical activity, undertaken a study of funding for physical activity initiatives, instituted a “6-a-day” campaign to encourage increased consumption of fruit and vegetables and implemented an information campaign on 30 minutes of physical activity a day. However, 20–30% of the population are inactive, mechanical transportation is widespread and many jobs are now sedentary. As elsewhere in the region, diets include high intakes of energy from fat and sugars and low intake of fruit and vegetables. Moreover, there is often a clustering of unhealthy behaviours.

Activities to promote physical activity and a healthy diet involve a wide range of stakeholders, including national and regional authorities, local communities, education institutions and the

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**Key Dietary Recommendations**

Committee on Medical Aspects of Food Policy, 1994 (CVD) and 1998 (Cancer)

- **Maintain a healthy body weight** (BMI 20-25kg/m2)
- **REDUCE:**
  - fat intake to 35% energy 38 – 39%
  - saturated fat to 10% energy 16 - 17%
  - salt intake to 6g / day 9g / day
  - added sugars to < 10% energy 16%
- **INCREASE:**
  - fruit and vegetables to at least 5 portions per day
  - dietary fibre intakes from a variety of sources

In Denmark, activities related to diet, physical activity and health involve a wide range of stakeholders, including national and regional authorities, local communities, education institutions and the
private sector, with a particularly strong contribution from voluntary sports organizations. The national health policy (2002) sets out the responsibilities of individuals and families, communities, government and partnerships. Health targets include preventing obesity, promoting healthy diets and encouraging physical activity using pooled resources.

The Danish national action plan against obesity (2003), focuses on obesity as a health problem, the need for lasting lifestyle changes and the avoidance of discrimination and stigmatisation. It is not about ideals of appearance or slimming diets, but about finding appropriate balances in respect of weight stability and physical fitness, energy intake and expenditure, and individual and public responsibility. The plan focuses on various target groups, covering availability and accessibility, structural conditions, normative conditions, and education and information. The keys to success will be cross-collaboration, adequate training of professionals, encouraging changes in attitude and increased research.

Netherlands

Policies on physical activity and nutrition are linked, in particular in the area of overweight. There are three main goals for physical activity by 2010: to increase the number of people undertaking healthy exercise from 40% to 50%, to reduce inactivity from 12% to 8% and to improve knowledge about healthy exercise to 75%. Interventions include a physical activity campaign (2003–2005), mainly targeting adults, a sports participation policy, which focuses mainly on youth, and programmes for special target groups, e.g. people with chronic diseases and employees in the workplace. A cycling-to-work project aims, over the next two years, to encourage 5 000 inactive people to cycle to work. In addition to an annual national survey of physical activity, 7 000 people will be given a national fitness test (questionnaire and stress test) over one week and provided with fitness recommendations, in cooperation with commercial fitness centres. The test will be widely publicized and the results will be published. During 2003, 10 pilot community-based interventions will be implemented, targeting groups with low socioeconomic status.

The goals of the 1998 nutrition policy action plan are to increase fruit and vegetable intake by two pieces per day, reduce fat intake, and promote breastfeeding through baby-friendly hospitals. A pilot scheme to provide free fruit in primary schools together with an education programme scheme in seven cities is underway in collaboration with the agricultural sector, which it is hoped will influence parents to give more fruit. Government is in dialogue with the food industry to encourage lower levels of saturated and trans fatty acids in food products, and to influence portion size and marketing techniques for the benefit of health.
Some 40% of the adult population are currently overweight, 10% are obese and obesity is increasing in young people. Following an awareness campaign in 2002, the Health Council plans to provide further advice, and a multisectoral meeting in May 2003 will discuss cooperation with additional partners, with a view to formulating an action plan to counter this trend.

**Slovenia**

The Ministry of Health is highly committed to the concept of linking diet, physical activity and health in policies that receive regular budget funding so that activities can be sustained.

Standardized mortality rates and risk factors vary in the east and west of the country, mirroring patterns in eastern and western Europe. Evidence indicates that risk factors are also similar to those elsewhere in Europe, with high intakes of energy-dense foods, fats, saturated fats and sugars, low intakes of fruit and vegetables and low levels of physical activity. Some 15% of the adult population are obese and 38% overweight, and there is a high prevalence of hypertension and elevated serum cholesterol.

Slovenia takes a multisectoral approach to action in this area. The health care and health insurance law (1992) requires the institution of economic, ecological and social policy measures that will facilitate health promotion and health care, and coordination of activities across all sectors to achieve optimal health. A government-level health council has been established. A law that covers health and hygiene safety of foods and of materials and articles intended to come into contact with foods (2000) established a food and nutrition council, a national programme of health protection and promotion (2000) and a food safety strategy (2001). A national food and nutrition action plan (FNAP) (2003-2008) and a health-enhancing physical activity strategy are also under preparation. The FNAP requires intersectoral coordination of activities, education and awareness-raising in the population and among professionals, the drawing up of new nutritional guidelines and the adaptation of food production and processing to these guidelines. Priorities have been set for implementation. Slovenia has conducted a health impact assessment of food, agriculture and nutrition policies, and recommendations are currently being finalized focusing on practical measures to improve public health. Efforts are also being made to encourage increased local production of fruits and vegetables.

The main goals of the physical activity strategy are to lower the proportion of the population that is physically inactive, enhance the level and intensity of all kinds of physical activity in all age groups, ensure accessibility to physical activity programmes and establish the environmental and legislative basis for a physically active lifestyle. The strategy includes components related to transport, leisure-time physical activity and workplace promotion, and focuses on four main target groups: children and adolescents, families and women, older people and people with special needs. The transport strategy will increase attention on the provision pathways for walking and cycling and more accessible public transport choices. Collaboration in the field of
nutrition and physical activity between health sector and education, labor and tourism sectors has also been established.

**Switzerland**

Switzerland has a national environmental health action plan (1997), which covers nutrition and food production, mobility and housing, and policies on sports (2000), nutrition (2001) and human-powered mobility (2003). A pyramid of recommendations for physical activity, similar to the food pyramid, has also been developed. Logos from the various agencies involved are all used in publicizing the policies. The objectives are to halt the decline in physical activity and to increase the proportion of physically active individuals by 1% per year.

The nutrition policy seeks to promote a healthy body weight, to increase consumption of fruit and vegetables, to improve knowledge of healthy and sustainable eating habits in schoolchildren, and to promote breastfeeding. The human-powered mobility policy aims to raise the number of people who walk, cycle, roller skate and use public transport. A priority programme on physical activity, nutrition and relaxation (1998) promotes projects and networks on movement, nutrition and relaxation, ensures coordination of implementation, and evaluates the results of interventions. A further programme, Suisse Balance, aims to achieve a significant increase in the percentage of the population with a healthy body weight by 2010. Interventions will include public information campaigns to raise awareness at the community level, in children and youth and at the workplace, with emphasis on reaching high-risk groups.

**Russian Federation**

The government gives priority to promoting healthy, active and creative lives for its people, emphasizing family wellbeing, professional longevity and a comfortable old age. It recognizes the importance of health as a factor in national security, public stability and welfare. NCD trends are similar to those elsewhere in Europe, but with particularly high premature male mortality and an increase in neurological diseases. The government is aware of the cost-benefits of disease prevention programmes and is therefore moving from a culture of treatment to one of health promotion and disease prevention, encouraging people to take responsibility for their own health. A complex of measures, across government, is needed to provide an enabling environment for these changes.

In the first instance, it is important to monitor functional status in healthy people and to intervene early in those with lower functional reserves, before disease develops, to maintain health. Systems for assessing levels of functionality (e.g. of the cardiovascular system) have been developed, but there is no consensus as yet on methodology and there is a lack of sufficient resources to make such assessments on a large scale. Nevertheless, some programmes have shown successes (e.g. physical exercise programmes for pregnant women have improved pregnancy outcome; and a combination of physiotherapy and other non-drug methods has succeeded in lowering respiratory disease rate in frequently sick children).

A programme for preserving the health of the healthy (2003–2010) has been approved by the Ministry of Health. It seeks to develop further the concept of preserving health throughout life, and to modernize health care practices to ensure rapid diagnosis and prompt and effective treatment for those who require it. It also aims to improve the quality of life of people living with chronic disease or disability. The programme promotes interdepartmental and multilevel approaches, and accessibility of services. Together with the Ministry of Education, the Ministry of Health is also implementing a programme to establish health centres for students and teachers in various towns and cities, and is also undertaking monitoring and evaluation. Regional ministries of health across the country are taking similar approaches.
Presentations on region-wide developments

The second day of the consultation was opened by a presentation on the Common Agricultural Policy by one of the invited technical experts, Associate Professor L. Schäfer Elinder. This was followed by an overview of the food and nutrition action plans in the European Region by Dr Aileen Robertson, Regional Adviser for Nutrition from the WHO Regional Office for Europe.

Public health aspects of the European Union Common Agricultural Policy (CAP)
Associate Professor Liselotte Schäfer Elinder, Research Manager, National Institute of Public Health, Sweden

The public health aspects of CAP, focusing on four areas, fruit and vegetables, dairy, wine and tobacco, are examined in a recent report published by the Swedish National Institute of Public Health—-a follow-up to a 1996 report on the same topic. The six leading risk factors for NCD in the European Region, tobacco, high blood pressure, alcohol, high blood lipids, overweight and low intake of fruit and vegetables, are influenced by agricultural products from the four sectors surveyed.

Agricultural policy, as opposed to a free market in agricultural products, should provide added value to society, to justify subsidies paid for by taxpayers. Agricultural policy should be in the interests of the common good, including public health, welfare and a clean environment. The main objectives of CAP, established in 1962, were to ensure food security, a public health goal, by increasing agricultural productivity and ensuring a fair standard of living for the agricultural community. Those objectives were achieved in less than 10 years and food surpluses began to build up. Despite a call in 1999 for public health to be considered in all EU policies, there has been no review of the CAP objectives, and public health has not been mentioned as a policy determinant in the Agenda 2000 reform or the recent mid-term review of CAP.

CAP costs some €43 billion per year, 45% of the total European Union (EU) budget, and has two main pillars: market support, which accounts for 90% of expenditure; and rural development, 10%. The policy regulates the production, trade, price and processing of agricultural products. Each commodity is regulated separately and according to different principles that relate to historical factors rather than public health or societal concerns. In terms of the total monetary value of support given to farmers as a percentage of gross farm receipts (producer support estimate), the EU provides some 35% of farmers’ incomes compared with 1% in New Zealand, 4% in Australia, 67% in Norway, and 69% in Switzerland. Some 40% of dairy farmers’ income comes from policy measures, compared to 80% for tobacco and 91% for beef. EU subsidies also threaten the agricultural sector in developing countries through dumping of food surpluses at prices lower than the production costs in these nations.

Some current CAP regulations are clearly detrimental to public health, including subsidies: for withdrawal and destruction of good quality fruit and vegetables (€117 million per year) to maintain prices; consumption aid for butter (€460 million per year); for consumption aid for high-fat milk products in schools (about €50 million per year); for distillation of surplus wine (€650 million per year); to promote sales of high-fat milk products and wine (€10 million per two years); and to support tobacco farming (€950 million per year). Moreover, the rules concerning alcohol make it difficult for countries to encourage reduction in alcohol consumption by increasing taxes. Some EU food promotion messages are also not in the best interests of public health. A step forward is that these messages will have to be screened by public health specialists before being released in the future.
Changes in CAP that could promote public health include phasing out of subsidies to increase consumption of high-fat dairy products; limiting support to schools to low-fat content milk products (a switch from high to low-fat milk in schools would reduce fat consumption by 1.5 kg per child per year); introducing similar school support for fruit and vegetable consumption; redistributing agricultural support in favour of fruit and vegetable production; and improving support for farmers who wish to cease wine and tobacco production. The health sector should provide sound evidence and encourage discussions at national and European level to ensure that CAP objectives are reformed in a healthier direction. It is hoped that the Swedish report will stimulate further analysis of the influence of agricultural policy and health.

Regional food and nutrition action plans
Dr Aileen Robertson, Regional Adviser for Nutrition, WHO Regional Office for Europe

Governments across the region are taking steps to ensure an adequate supply of healthy safe food for their populations. As mass production of food in the region increases, mechanisms are being sought to deal with new food safety challenges that include an alarming rise in food-poisoning and other serious problems, such as bovine spongiform encephalopathy and dioxin contamination. Governments have instituted food safety legislation and regulations and responsible elements of the food industry are keen to avoid incidents that damage consumer confidence. However, it is difficult to monitor all food outlets adequately. Nutrition is also high on national agendas. Nutrition-related problems in the region include iodine and iron deficiencies as well as the major NCDs, CVDs, cancer and diabetes.

At the fiftieth session of the Regional Committee in September 2000, the Member States of the WHO European Region endorsed a five-year regional food and nutrition action plan (FNAP), which integrates strategies on food safety, nutrition and a sustainable food supply. Implementation at the Regional Office level has included various activities, including the publication of the “CINDI dietary guide: 12-steps to healthy eating”. The guide includes the advice to “Increase physical activity” (step 4), since it is clear that this should be part of the guidance given with nutrition messages. A further report, “Food and health in Europe: a basis for action”, sets out the scientific evidence on which food and nutrition action plans should be based and also includes some aspects of physical activity. The Regional Office has also been working with countries to support development of national FNAPs, inter alia, through a series of workshops across the region, establishment of a public health nutrition network for the Baltic/Nordic countries, work on a similar network for southern, central and eastern Europe, and collaboration with the European Commission. Information on all these activities is available through the Regional Office website and a monthly electronic news service.

These activities were discussed at the meeting of nutrition counterparts in the WHO European Region, held in Athens in March 2003, and there was unanimous agreement by the 42 countries present that a second regional FNAP should be developed for the period 2006–2010, which would give greater emphasis to increasing physical activity and address obesity. During 2004-2005, the Regional Office will continue to build on the progress already achieved in the lead up to a Ministerial Conference in 2006.

Working group sessions
Four parallel working group sessions were designed to help bring about recommendations to the global strategy. Participants were informed in advance about the working groups and were asked to prepare for them, in part, by considering the discussion points and information presented in

2 http://www.euro.who.int/cprise/main/WHO/Props/NUT/Home
the European background paper. Rather than focusing on the subject areas at hand (diet and physical activity), attention was given to the steps to developing and implementing integrated strategies to meet the physical activity and diet needs. The participants therefore worked in groups on the second and third (last) day to examine the following topics in detail: a) evidence: data on health implications of diet and physical activity; b) policy-making: turning evidence into policy; c) implementation: translating policies into action; and d) monitoring and evaluation: measuring impact and effectiveness of policies. On the basis of the discussions in these groups, the participants formulated a set of recommendations to be taken into consideration during development of the WHO global strategy on diet, physical activity and health at WHO headquarters.

Each working group had a rapporteur and a chair (Table 1), each from either nutrition or physical activity to maintain a balance in technical expertise. There were approximately 10-15 people in each working group and each group was as much as possible balanced to include all represented geographic regions, government sectors, technical skills and subject area (e.g. diet, physical activity).

Working group sessions were followed by a plenary session in which working groups reported back and a list of recommendations was compiled. Working groups worked further in the morning of the third day to refine the recommendations and formulate them in a way that would reflect the working group discussions and participants’ contributions. The plenary session then put forth the recommendations to the global strategy. Participants requested that the WHO secretariat finalise the editing and send the recommendations around by email to all participants for another round of reviews. This was done, suggested changes were made and the final recommendations sent to participants and WHO headquarters as agreed.

Table 1. Chairs and rapporteurs for working groups

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<tr>
<th>Evidence group</th>
<th>Development group</th>
<th>Implementation group</th>
<th>Evaluation/monitoring group</th>
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<tbody>
<tr>
<td>Jaap Seidell (Netherlands), Chair</td>
<td>Vladimir Kendrovski, (FYR Macedonia), Chair</td>
<td>Chris Fitzgerald (Ireland), Chair</td>
<td>Sigmund Anderssen (Norway), Chair</td>
</tr>
<tr>
<td>Mary Allison (UK), Rapporteur</td>
<td>Ulla Hollund (Denmark), Rapporteur</td>
<td>Dorit N Kaluski (Israel), Rapporteur</td>
<td>Gábor Zajkás (Hungary), Rapporteur</td>
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**Closing**

The last round of comments before closing the meeting reflected a general satisfaction with the process and with the effort at taking a cross-disciplinary approach to addressing noncommunicable disease prevention. Many delegations said that they had welcomed the opportunity to share the work done at national and local levels in diet and physical activity, and to brainstorm on lessons learned and the directions for the future. There was also interest in applying some of the findings of this process in the European Region to continue work in food and nutrition policy, to strengthen the focus on promoting physical activity and to put more energy into solving the shortcomings of policy implementation (for example, finding solutions for funding inadequacies).

The Regional Director, Dr Marc Danzon, said that he looked forward to learning what Member States were seeking in the area of diet, physical activity and health and how he could take their recommendations forward in the region’s work and, in collaboration with headquarters, at the global level. For some years, efforts have been made in the public health field to regroup
activities that are connected either because of their origin or their solution, for example NCD prevention and control, and health promotion. However, it is difficult to prescribe what such groupings should be, and Member States should decide for themselves how best to tackle these issues in accordance with their situations. Work is under way to expand the Regional Food and Nutrition Action Plan (FNAP) to better promote physical activity. But it will be important to find integrated approaches and Dr Danzon hoped to present to the Regional Committee in 2004 a regional strategy for NCD linking activities relating to NCD, the FNAP and physical activity, alcohol and tobacco, although managerially that would not be an easy task. In due course, a component on mental health might be added. He hoped that over the next few years there would be real progress in developing such integrated programmes in Member States. Dr Danzon thanked the Member State delegations for their active interest and contribution to the global strategy process and particularly to the regional consultation.

Dr Pekka Puska said that although the process was not an easy one due to its very broad focus and its heterogeneous nature, important public health gains were at stake, warranting continued efforts to improve intersectoral collaboration. He suggested that at the regional level there be continued work to collect evidence of best practice and to systematically analyse the impact of diet and physical activity policies. Finally, he made some comments about the next steps towards a global strategy and said that the draft strategy would be shared with Member States before being presented at the Executive Board. Once approved and endorsed, the strategy would be an essential tool for implementation of policies at country level and better management of trade and advertising at the global level.

Dr Haik Nikogosian closed the meeting and thanked governments for their commitment to this issue and participants for their contributions and efforts both before and during the consultation.
European recommendations to the global strategy

The European regional consultation on the global strategy on diet, physical activity and health was held in Copenhagen from 2 to 4 April 2003 with participants from 15 Member States, a representative of the European Commission, technical advisers and members of the WHO secretariat. Participants represented a range of sectors including food and nutrition, physical activity, sport, agriculture, health promotion, environment and education. The consultation put forth the following recommendations to be taken into consideration when developing the global strategy.

General conclusions

1. There is strong evidence of the benefits of a healthy diet and physical activity for the prevention of noncommunicable diseases (NCD). Therefore, governments need to act without delay. Policies on nutrition and physical activity should be linked and should be developed and implemented in close collaboration with all relevant sectors - including concerned ministries, governmental agencies, nongovernmental organisations (NGOs) - and communities.

2. Core messages across sectors should be consistent, positive and non-judgemental.

3. Policies should be tailored to specific groups and settings.

4. Diet and physical activity should be promoted through appropriate economic and regulatory instruments (e.g. taxation and legislation).

5. Diet and physical activity policies should take into consideration the fact that food and physical activity should be enjoyed with confidence.

6. Accessibility, availability and affordability should be taken into consideration when developing diet and physical activity policies. Less privileged groups should have access to healthy choices. Equity between and within countries should be pursued.

7. In order to reduce inequalities in health, food production should ensure the availability of healthy, safe foods at affordable prices, and supplies of such foods should be sustainable. Food and nutrition policy should cover food safety, sustainable food supply and nutrition.

8. Agricultural, transport, leisure facilities and community planning policies need to take into account public health goals.

9. The media has an important role to play in promoting diet and physical activity.

10. Health impact assessments should be undertaken across all sectors.

11. Qualitative and quantitative measures should be employed so that both WHO and Member States can assess their progress in fulfilling the global strategy.

12. The global strategy should acknowledge the different stages of nutrition and physical activity policies between and within the WHO Regions to ensure that those regions which have already done considerable work in this field - such as the European Region - can further benefit from the tools and mechanisms provided by the global strategy. This implies documenting progress, building on the existing regional action plans and policy frameworks, systematically analysing these policies to identify needs and gaps, and formulating appropriate strategies in regions.
Recommendations

Evidence

1. The process of gathering evidence should be a multisectoral process. In order to prioritise action on nutrition and physical activity and strengthen the case for action, ministries of health should take the leading role. They should be responsible for collaboration across governments and with other partners to collect and collate reliable data (e.g. through national surveys) to assess:

   a. mortality and morbidity - to demonstrate health outcomes;
   b. risk factors and behaviour - to demonstrate the magnitude of the problem;
   c. determinants - to identify the reasons for physical inactivity and poor diet (barriers to successful policy implementation); and
   d. quality of life and process indicators - to describe intermediate benefits.

2. To help build data globally and provide inter-country comparisons, countries should have a minimum set of indicators relevant to nutrition and physical activity (e.g. height, weight, life expectancy). Successful networks at local, national and/or international level such as CINDI and Healthy Cities should be built upon, and benefited from, in the gathering of evidence and the design and implementation of policies.

3. Governments should appoint advisory boards, which should have transparent selection procedures, clear terms of reference and transparent ways of working. Scientific advisory boards should exclusively include independent experts/researchers in the fields of nutrition, physical activity and related topics. Policy advisory boards should be multisectoral and include technical experts and representatives of government agencies (including local authorities) and have an independent chair in order to ensure that scientific evidence is interpreted without any conflicts of interest. Scientific advisory boards should assess evidence and policy advisory boards should advise on necessary actions.

   a. Governments should consider establishing an NCD advisory board to coordinate advice and prioritise action on multiple morbidities and behaviours.
   b. Where multiple scientific boards operate, recommendations should be crosschecked for consistent messages.
   c. Ministries of health should collaborate with other bodies (e.g. other ministries, scientific institutions, local actors, NGOs, etc.) to ensure that scientific evidence is presented consistently and effectively to government and to the general public.
   d. WHO should support countries to strengthen government capacity in this area.

4. Governments or their scientific advisory boards should use attainable short-term goals and markers (such as quality of life indicators) that represent stepping stones to longer-term health goals. Examples include short-term measures of health and quality of life indices at school, in the workplace, and at home, such as reduction in short journeys made by cars, higher productivity and reduced absenteeism. Comprehensive health promoting schools programme should contain elements concerning nutrition and physical activity. Governments should also adopt a staged approach to establishing standards.

Policy development

1. The use of evidence should be improved to inform the decision-making process, including the promotion of health impact assessment, cost-benefit analysis, national burden of disease studies, evidence-based models, scientific advice and dissemination of good practice.
2. Achievement of public health benefits should be a stated objective of key sectoral policies and shared responsibility so that sectors other than health can take them into consideration (targeted advocacy). Ministries of health should take the leading role in providing information on how nutrition and physical activity are influenced by other sectors in the society.

3. The opportunities for other sectors to achieve their goals, while at the same time contributing to achieve health objectives, should be acknowledged and valued. This could also allow the identification of new sources of funding for action and build on opportunities offered by other sectors (e.g. national cycling and walking policies developed by the transport sector can become opportunities for physical activity).

4. Cooperation with the private sector should be improved on items such as precautionary principles, fortification, labelling, health and nutritional claims. At the international level, relevant intergovernmental organisations such as the OECD, Codex Alimentarius, WTO and others should assist in this cooperation. Win-win strategies should be identified for and by the public health sector and the private industry (e.g. food industry, employers, public transport providers, fitness centres) with attention to inequalities.

5. EU and national policies concerning subsidies and tax regulations should optimally support healthy habits both nutritionally and in physical activity.

6. Opportunities provided by different settings (e.g. school and work places) should be better taken advantage of, for example walking or cycling to school and to work. Physical education should be part of the curriculum and should be promoted through education legislation and other relevant legislation.

7. National plans for nutrition and physical activity should be consistent and should reinforce each other. Health promotion strategies and communication should build on and make links between nutrition and physical activity for greater added value.

   a. At the national level:
      * Promotion of cross-sectoral collaboration, starting from the national level and allocating resources for application at sub-national/local levels. This includes facilitating the exchange of experiences and creating databases of good practices, and addressing the challenge posed by possible competition between different sectors of the administration/government.
      * Promotion and support of capacity-building on formulating public health policies for physical activity and nutrition (e.g. by supporting development of post-graduate curricula for health professionals and other relevant professionals).
      * Increased awareness and understanding of health implications by other sectors (e.g. education, urban planning, transport, food production, agriculture, economy, media).
      * Establishment of a framework for initiating collaborations and partnerships with the private sector and NGOs.

   b. At the intermediate level, the government should play an important role and ensure two-way links between national and local levels.

   c. At the local level, authorities can develop local action plans for health, which tailor action to fit the specific needs of the community. Local authorities can also develop win-win strategies to support local economies (e.g. tourism, local food production) while at the same time contributing to achieve health goals. For example, health aspects should be incorporated into Agenda 21 activities at the local level.
8. The public health sector should work with the media to build awareness of the need to use reliable sources of information, for example by emphasising the need to use credible experts.

9. There should be a platform for developing consistent, simple and clear messages to be given by government experts, NGOs and industry (e.g. the food pyramid, fruit and vegetable promotion messages such as 5-a-day messages, and physical activity messages such as 30 minutes physical activity/day).

10. Countries with extensive experience in policy development should collaborate bilaterally and/or multilaterally with countries with limited experience.

**Policy implementation**

1. Political commitment (by consensus or legislation), including the allocation of adequate funds, is essential at the implementation stage.

2. Effective implementation requires an assessment of the existing evidence and of needs and preferences of the target population as well as an understanding of cultural and gender sensitivity. Appropriate marketing tools should also be assessed.

3. Strong political support is needed through consensus and/or legislation involving a wide range of key partners on issues including action planning, labelling, and promoting health impact assessment.

4. Ministries of health should have the leading role in coordinating national and local partnerships with governmental and nongovernmental organisations, communities, and the private sector for investment in capacity building and preventative measures.

5. The role of local authorities in translating national strategies and policies into action relevant to individual communities is vital at the implementation stage.

**Monitoring and evaluation**

1. Member States should be encouraged to collect physical activity and nutritional data as part of health behaviour monitoring. This should occur at regular intervals (to enable trend analysis), at national level and where appropriate, at local level.

2. Member States should be encouraged to periodically monitor and report on progress in the implementation of policies.

3. A standardized approach to data collection should be adopted to enable national and international comparison.

4. In addition to health behavioural data, other sources of data should be used, for example, data from health services (primary and secondary), transport, industry and other sectors. Monitoring and evaluation is needed at behavioural, policy and environmental levels.

5. Member States are encouraged to invest further in capacity building (education, training, resources and structures), expertise in NCD and monitoring and evaluation of policies and interventions, including dissemination and research.
6. At the planning stage of policies and interventions, it is recommended that a sufficient proportion of the budget be allocated so that the monitoring and evaluation methodologies adopted are the most appropriate to the interventions building on existing good practice. Process, outputs and outcomes should be measured.

The above recommendations were presented to WHO headquarters for consideration in drafting a global strategy on diet, physical activity and health.
Annex 1: Towards a WHO global strategy on diet, physical activity and health

Background

1979 The Global Strategy for Health for All by the year 2000 underlined the growing importance of chronic noncommunicable diseases (NCD) for developed and developing countries alike.

1985 The Thirty-eighth World Health Assembly called for increased efforts to assess the importance of NCD and to coordinate long-term NCD prevention and control programmes (resolution WHA38.30).

1989 The Forty-second World Health Assembly urged the promotion of intersectoral and integrated approaches for the prevention and control of NCD, especially at the community level in developing countries (resolution WHA42.45).

1990 In its report \textit{Diet, nutrition and prevention of noncommunicable diseases}, a WHO Study Group made recommendations to help prevent chronic diseases and reduce their impact (WHO Technical Report Series, No. 797).

1997 \textit{The World Health Report 1997. Conquering suffering, enriching humanity} described the high rates of mortality, morbidity and disability from the major NCD and proposed the development of a global strategy for NCD prevention and control.

1998 Recognizing the burden on public health services resulting from the growth in NCD, the Fifty-first World Health Assembly requested the Director-General to formulate a global strategy for NCD prevention and control (resolution WHA51.18).

2000 The Fifty-third World Health Assembly endorsed the WHO global strategy for NCD prevention and control and urged Member States and WHO to increase efforts to combat NCD (resolution 53.17).


2002 Macroeconomics and health: investing in health for economic development, the final report of the Commission on Macroeconomics and Health, noted that many NCD can be effectively addressed by relatively low-cost interventions, especially prevention activities related to diet and lifestyle.

2002 Having considered a report on diet, physical activity and health, the Fifty-fifth World Health Assembly requested WHO to develop a global strategy on diet, physical activity and health (resolution WHA55.23).

2002 “Move for health” was the theme for World Health Day, 7 April 2002. “Move for Health” has become a continuing initiative across the world.

2002 \textit{The World Health Report 2002. Reducing risks, promoting healthy life} described how a few major risk factors account for a significant proportion of all deaths and diseases in most countries. For chronic NCD, the most important include tobacco, overweight and obesity, physical inactivity, lack of fruits and vegetables, alcohol and intermediate outcomes such as hypertension and raised serum cholesterol and glucose levels.


2003 The Framework Convention on Tobacco Control was adopted by the Fifty-sixth World Health Assembly in May 2003.

Development of the global strategy

2003 \textbf{Phase I} \\

\textbf{Phase II} \\

\textbf{Phase III} \\
Reference Group, a group of internationally recognized experts, to advise WHO on the preparation of a draft global strategy. Completion of the draft strategy (October 2003).

2004 Submission of the draft strategy to the Executive Board at its 113th session (January 2004). Revision of the draft strategy to take into account the Board’s comments. Discussion of the revised draft strategy at the Fifty-seventh World Health Assembly (May 2004).
**Annex 2: Programme**

**Wednesday, 2 April 2003**

<table>
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<th>Time</th>
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<tbody>
<tr>
<td>08.30–09.30</td>
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| 09.30–10.30 | **Plenary session 1**  
|           | 09.30–09.45  | Opening and election of meeting officers                                |
|           | 09.45–10.15  | The Global strategy on diet, Physical Activity and Health – an overview  |
|           | 10.15–10.30  | (Dr Pekka Puska, WHO headquarters)                                      |
| 10.30–11.00 | **Coffee break**                                                       |
| 11.00–12.30 | **Plenary session 2**  
|           | 11.00–11.20  | Physical activity and health (Dr Mikael Fogelholm, Finland)              |
|           | 11.20–11.40  | Diet and health (Ms Imogen Sharp, United Kingdom)                       |
|           | 11.40–12.00  | Questions and answers, interventions by participants                    |
|           | 12.00–12.30  | Country presentations: France, Norway                                    |
| 12.30–14.00 | **Lunch break**                                                        |
| 14.00–15.30 | **Plenary session 3**  
|           | 14.00–15.15  | Country presentations                                                   |
|           | 15.15–15.30  | Questions and answers, interventions by participants                    |
| 15.30–16.00 | **Coffee break**                                                       |
| 16.00–17.30 | **Plenary session 4**  
|           | 16.00–17.00  | Denmark, The Netherlands, Slovenia, Switzerland, Russia                  |
|           | 17.00–17.30  | Questions and answers, interventions by participants                    |
| 17.30–18.30 | **Welcome reception in the lobby**                                     |

**Thursday, 3 April 2003**

<table>
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<tr>
<th>Time</th>
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| 09.00–10.00 | **Plenary session 5**  
|           | 09.00-09.15  | Presentations                                                           |
|           | 09.15-09.30  | Public health aspects of the Common Agricultural Policy                  |
|           | 09.30-09.45  | (Prof Liselotte Schäfer Elinder, Sweden)                                 |
|           | 09.45-10.00  | Questions and answers, interventions by participants                    |
| 10.00-10.30 | **Coffee break**                                                       |
| 10.30-12.30 | **Parallel working groups**  
|           | Formulation of recommendations to the Global strategy                   |
| 12.30-14.00 | **Lunch break**                                                        |
| 14.00-15.30 | **Parallel working groups**  
|           | Formulation of recommendations to the Global strategy                   |
| 15.30-16.00 | **Coffee break**                                                       |
| 16.00-17.30 | **Plenary session 6**  
|           | Working groups report back and general discussion                       |
| 17.30-18.30 | **Meeting of a drafting group to collate draft recommendations**       |
Friday, 4 April 2003

09.00-10.30  **Working groups**  
Formulation of recommendations to the Global strategy

10.30-11.00  **Coffee break**

11.00-12.30  **Plenary session 7**  
Discussion and agreement on European recommendations to the Global Strategy on Diet, Physical Activity and Health

12.30-13.30  **Lunch break**

13.30-15.00  **Plenary session 9**  
Conclusions and next steps  
Closure
Annex 3  List of participants

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**Annex 4: Country case studies**

In preparation for the consultation, case studies were gathered as part of the background material, and to get a better idea of initiatives in different countries. The case studies presented here are examples of how countries (or regions within a country) have tried to reduce NCDs and generally improve population health through physical activity and food and nutrition policies.

<table>
<thead>
<tr>
<th>Denmark</th>
<th>Finland</th>
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<tbody>
<tr>
<td>1. '6 a Day' in Denmark</td>
<td>5. Co-operation to promote Finnish (heart) health and prevent overweight</td>
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**Other country experiences**
1. ‘6 a Day’ in Denmark

The recommendation
In 1997-1998 the Danish Veterinary and Food Administration established a working group with the aim of scrutinizing the scientific literature to arrive at a consensus for establishing the association between disease risk and intake of fruits and vegetables. Based on that work, in September 1998 the Danish Veterinary and Food Administration along with the Danish Cancer Society, the Danish Heart Association, the Danish National Board of Health, and CO-OP Denmark agreed on the following recommendation:

6 a Day - eat more fruit and vegetables
  e.g. 3 fruits and 3 vegetables (each weighing ca. 100g)- a total of 600g every day

This recommendation is aimed at the general population above 10 years of age. The need of variation is also emphasized. The Danish '6 a Day' has two exceptions: 1) Potatoes are not included 2) Fruit juices only count as 'one a day'.

The literature suggests a dose-response relationship between lowered risk of cancer and coronary heart disease and the amount of fruits and vegetables consumed up to about 600 grams a day. It is likely that a higher daily intake will confer decreased risk - calculations have shown that intakes up to 900 g/day may still be of benefit and will not adversely affect the nutrient and energy content of the food.

In order for the recommendation to be attainable, '6 a Day' was chosen, and not - as in many other countries - 5 a Day.

In 2002 the literature following the report of 1998 was reviewed. All prospective trials of the association between intake of fruits and vegetables and disease since the report in 1998 show that the then recommended daily intake of 600 g or more is still valid. Overall, the studies reviewed showed that while the inverse association with the risk of cardiovascular has been strengthened, the association between intake and several cancer diseases has been weakened somewhat.

The 1998 report recommended that the daily intake of fruits and vegetables for children 4 to 10 years of age should be 25% lower than the adult recommendations. The lower intake was motivated by a lower energy requirement and consequently a lower intake of food for this age group. A closer view of intake in relation to energy requirements for 4-10 year old children in 2002 has resulted in a recommended daily intake of 300-500 g of fruits and vegetables for this age group.

The research project
In 1999, a research project with several participating health and produce organizations was launched to develop new methods to increase the intake of fruits and vegetables in Denmark. The project focuses on the effect of improved accessibility of fruit and vegetables, and includes a school fruit pilot project (subscription), workplace fruit, education/upgrading of retail fruit and vegetable workers, interventions in workplace canteens, etc. The project will be completed at the end of 2003.

The school fruit pilot project conducted an intervention trial in four schools. Forty-five per cent of 6-10 year old children subscribed and the intake of fruit and vegetables was measured by 24-hour recall before intervention and again after five weeks. The study showed that the intake of fruit increased by 0.4 pieces per day for subscribers and 0.3 pieces per day for non-subscribers.
The project succeeded in ensuring sustainability and a commercial school fruit program has been launched in a joint marketing project to many schools, parents and pupils in Denmark.

The workplace fruit project is not yet completed, however, the effect on intake of fruit and vegetables has been investigated in 12 workplaces (283 employees) using two dietary interviews, before and then after three months of having workplace fruit at six of the workplaces. At these workplaces, the intake of fruit increased by 0.7 pieces per day and among men the intake of fruit decreased by 22 g per day. Ninety-six per cent of participants said they made use of the free fruit daily or almost daily and 83% were of the opinion that they now ate more fruit.

In the workplace canteen project interventions in five different workplace canteens were conducted. The interventions involved the entire kitchen staff, which repeatedly measured the weight of all fruit and vegetables eaten in the canteen. The staff made their own goals for how to increase consumption. In the canteens the mean daily consumption increased from 113 grams per customer before the intervention to 183 grams at the end, about six months later. A further follow-up six months later showed that the intake had increased even more, up to 208 grams per customer.

'6 a Day' campaign
In the years 1998-2001 the public was informed about the '6 a Day' message through the distribution of leaflets. In May 2001, a campaign was launched under the heading "'6 a Day' – eat more fruit and vegetables". Now some of the organizations and producers have decided to cooperate and coordinate their activities on promoting fruit and vegetables. The campaign encourages children from the age of 11 and adults to eat 600 grams of fruit and vegetables every day. Children below the age of 11 are recommended to eat 400 grams a day. The campaign also advocates for the accessibility changes, which have been proven effective in the research project.

The intake of fruit and vegetables
In 1995, a survey of food habits showed that Danes aged 11-75 consumed a daily average of 279 grams of fruit and vegetables. However, after the launch of the 6-a-day message in 1998, Danes have started eating more fruit and vegetables. New surveys show a significant rise in the consumption of fruit and vegetables. Thus, in 2002 every Dane above the age of 11 consumed 379 grams of fruit and vegetables, which is an increase of 100 grams a day. In particular, Danes seem to have developed an appetite for fruit, their favorites being apples, pears and bananas.

2. Model project on Children, Food and Activity - a Health Promotion Project in Funen County, Denmark
By Morten Kromann Nielsen, project coordinator

The model project Children, Food and Activity is a 2½ year cooperation project between 10 municipalities on the island of Funen - the Danish Ministry of the Interiors and Health, the Danish National Board of Health, the Aarhus School of Architecture, the Athletic History Workshop/Gerlev Play Park, the Educational Centre in the County of Funen and the County of Funen. The model project is based in the Department for Prevention and Health, County of Funen. The project is evaluated by the National Institute of Public Health.

The main goal is to enhance well-being and health and prevent illness among children through a number of precise and measurable goals:
- To develop food and activity policies
- To develop knowledge and competence of the professionals
To develop the competency of children so that they can act to promote healthy practices in relation to food and activity
To create environments for food, meals and activity
To involve parents and families in the project
That children are more physically active
That the diet of the children fulfil the official recommendations

The target area is the institutional context in which the children spend a big part of their day. The target groups are: children between 3 and 10 years; pedagogues; teachers; leaders; health visitors; paediatricians; and dentists. The involvement of parents and families is also a main concern in the project.

The participating municipalities have chosen one local area, each embracing a kindergarten, a public school and a recreation centre (SFO). In each area there has been established a 12-member local development group consisting of professionals from each institution as well as local health workers and officials from the municipality.

The core activity in the project is an educational programme on food and activity directed at these groups of professionals. The elements in the programme discuss new ways of dealing with food and physical activity with a focus on the institutional framework of activity cultures. Any additional activity is considered a good activity. Participants are directed to locate the possibilities and resources to encourage the children to increase their level of activity through new patterns, new hours and new practices. This focus is supported through cooperation with the Athletic History Workshop/Gerlev Play Park. Introduced to the old athletic plays ‘reinvented’ at this institution the participants can make experiences from initiating and activities that to a higher degree include the whole group of children, rather than the traditional sport and exercise activities that often have at tendency to do.

The new ways of dealing with food issues include the recognition of food as an integrating factor in social life and the role of meals in the making of community; in other words the social, cultural and aesthetic as well as the pedagogical and nutritive dimensions of cooking and eating.

In the cooperation with the Aarhus School of Architecture a number of students and teachers are working with the themes of the project in connection with the physical frames of the schools and institutions. Their work falls into two parts; in one department, the students are making suggestions for changes in existing physical settings. In another department, the work is to produce suggestions on how new institutions and schools can look if the maximum possibilities to improve the food and activity culture of the children are taken into account. The architectural contribution will be presented at the final conference, planned to take place in the autumn of 2004.

The anchoring of the project at the political level is emphasized through assistance in formulating local food and activity policies. Partnerships and dialogue between professionals and families on the common interest in the intervention are also emphasized, reflecting the intention of making a positive long term impact on the role of food and activity in institutions as well as in families.

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3. Physical activity. Handbook on prevention and treatment, Denmark

**Aim:** Create an evidence-based platform on physical activity.

**Objectives:** 1) qualify health professionals (especially General Practitioners) on prevention and treatment on physical activity; 2) inform health professionals on the existing evidence; and 3) encourage professionals to encounter the importance and possibilities of physical activity that lies in getting patients more active.

**Target population:** General practitioners, physiotherapist, nurses, etc.

**Policy/Initiative:** The National Board of Health in Denmark is focused on getting the healthcare system more prepared to include physical activity in prevention and treatment. The Board considered that there was a lack of knowledge and materials on this topic.

The National Board of Health asked two of the best scientists in this field, Professor Bente Klarlund Pedersen and Professor Bengt Saltin, to cooperate and create the new material. Pedersen and Saltin consulted the databases MEDLINE and Cochrane Library, where they looked for all research on physical activity. The handbook is therefore solely based on the latest research in the field. The handbook, which is made as a binder, will be updated every 6 months on the internet. The handbook consists of three parts:

- Part one: The elements of work physiology
- Part two: Physical activity and prevention
- Part three: Physical activity as therapy

The turning point in the book is part three. The authors have collected information and evidence on 27 noncommunicable diseases that GPs are very frequently confronted with in their daily life with patients e.g. overweight, hypertension, back pain, different kinds of cancers, etc. For each disease there is: (THIS IS NEW AND NOT SEEN BEFORE!!)

- listed the evidence that physical activity has on the particular disease
- background information about the disease
- mechanism
- physical activity ordination
- contraindications

With this handbook, doctors can prescribe precisely what kind of physical activity can be used to prevent and treat a number of widespread diseases. The handbook will be an active tool in the health sector and at the same time function as a dialogue tool in the co-operation between doctors, physiotherapists, sporting associations etc. – to promote public health as the ultimate goal.

**Distribution:** Physical activity. Handbook on prevention and treatment was launched at a conference for health care professionals on physical activity in February 2003. The handbook has been distributed to all GPs in Denmark, all hospitals and a widespread range of people working with healthcare. The handbook was distributed in February 2003, and has been very well received. The book has not yet been translated into English. The National Board of Health is considering this action.

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4. The Danish national dietary survey 2000-2002

Summary from the report “Danskernes kostvaner 2000-2001”

The aim of the national dietary survey is to describe dietary habits in the Danish population. The method used is a seven-day estimated record combined with a personal interview. This method was also used in the Danish nationwide dietary survey conducted in 1995.

Data collection started in June 2000 and continued until December 2002. In total, 4,000 participants 4-75 years of age participated. The results described in this report comprise the results from the first year of the survey, from June 2000 to June 2001. During this period 207 children aged 4-14 years and 869 adults aged 15-75 years have participated in the survey. The results are compared with the results from the former dietary survey. The number of participants in the survey 2000/01 is relatively small and data only represents a minor part of the whole survey. Therefore, interpretations are done cautiously.

The results show an increase in the intake of fruits and vegetables and a reduction in the intake of fat for both children and adults. For the other foods, only minor changes have occurred. The intake of beverages has risen due to an increase of soft drinks (children); water and fruit juice (both age groups) and wine (adults).

The fat content of the diet has decreased as the proportion of energy derived from fat has decreased from 37% in 1995 to 33% in 2000/2001. For children the amount of added sugar is too high, contributing 14% of the energy.

The overall energy intake has decreased for both children and adults, but apparently not enough to take into account a rising sedentary lifestyle. Analyses show that the proportion of low energy reporters has increased from 1995 to 2000-2001.

5. Cooperation to promote Finnish (heart) health and prevent overweight

Heart health in Finland has improved remarkably during the last 20-30 years. During that time cardiovascular disease mortality of the working age population has been reduced by over 60%. Despite this remarkably positive development, cardiovascular disease incidence and mortality are still too high. For instance, working age men's coronary heart disease mortality rate exceeds the Southern European level by 2-2,5 times. Due to this, the Ministry for Social Affairs and Health and the Finnish Heart Association (FHA) organised a consensus meeting in November 1997 that approved the Action Plan for Promoting Finnish Heart Health. The Action Plan aims at reducing the working age population's cardiovascular disease mortality by half from levels in the late 1990s. The Action Plan, which targets the whole population, consists of more than 100 recommendations for nutrition, physical activity, smoking cessation, decreasing psychological and social risk factors and promoting the health of children and young people.

Among 5 million Finns there are 180,000 people with diabetes and their number is estimated to rise to 300,000 by the year 2010. The majority of them (nearly 90%) suffer from type 2 diabetes. In type 2 diabetes, activation of genetic predisposition requires the effects of certain lifestyle factors. These lifestyle factors, overweight and physical inactivity, have lately increased radically and thus type 2 diabetes is a rapidly expanding public health problem. To improve the situation, the Finnish Diabetes Association (FDA) with its partners (among these FHA) has launched the Development Program for the Prevention and Care of Diabetes in Finland 2000 -
2010. The main goal of this program is systematic prevention of type 2 diabetes. The program also aims at developing diabetes care.

The above-mentioned two big national programs were a natural basis for the cooperation between FHA and FDA. This cooperation has enabled them to launch "A small decision a day"-project in 2001 and, prior to that, the Heart Symbol System in 2000.

**A small decision a day-project:** A small decision a day-project is a practical tool for promoting Finnish heart health and for preventing type 2 diabetes. The main target group of the program is the working age population. An important background factor is the growing overweight problem in Finland. Due to recent research, more than half of the Finns have a BMI of over 25. The project consists of two functional units:

a) Losing weight and weight control -group activity model for health care professionals. In this activity the Research and Development Centre of The Social Insurance Institution of Finland is our official cooperation partner. During 2001-2002 FHA and FDA organised 12 training courses for group instructors (3+2 days) and eight more are planned for this year. The latest knowledge of metabolic syndrome prevention, obesity treatment, modification of eating and physical activity habits and group guidance is utilized in the training and related material.

b) SELF-HELP (ITE) -activity. The goal is to develop a peer group working method based on the previous experiences of FHA. The starting point is to support lifestyle changes (everyone helps him/herself to reach the goal with the help of a peer group). The first new ITE-instructors' training course was organized in autumn 2001. Twelve similar training courses were organised in 2002 and at least ten more are planned for the year 2003. FHA and FDA tried to create a working method which could be used not only by local societies belonging to FHA and FDA, but also by other organizations and actors.

FDA and FHA not only organize the training, but also produce material for instructors and clients. Part of this supporting material is produced as a www-service. Education packages and related material will be finalised during this spring.

An essential part of the "A small decision a day" -project is a population-level information campaign that started in October 2002. The objective of the campaign is that every adult will stop at least for a moment to consider matters important to his or her own health and well being. It is also planned to give people small every day choices they can make for the benefit of their own health. Key issues of the campaign are nutrition, physical activity and non-smoking. The media used includes national TV, radio channels, the biggest magazines etc. Part of the media campaign is an information package of the importance and possibilities of health promotion for municipal decision-makers. A seminar "Healthy Media" will also be organized next year. Chiefs in charge of editorial and news policies in media and leading specialists of health organizations will be invited to discuss the power and responsibility of the media regarding health related information.

KKI (Fit for Life) -program, Finnish Sport for All Association, Finnish Rheumatism Association and The Cancer Society of Finland work together with FHA and FDA in the information campaign. This kind of cooperation increases public attention and the impact of the themes. The service net of the coalition helps Finns to locate physical activities etc. in their own surroundings to support their decisions. The campaign is planned in such a way as to support the local activities of the organizations involved. At its best, the campaign might contain elements of marketing of these local activities.
6. Contribution from the Finnish Heart Association to the interim report of EHHI III
(European Heart Health Initiative)
(Reporting period July 2002- December 2002)
Grant Agreement SPC.2002243

a) Update on the Finnish Heart Association’s national alliances

As a part of on-going heart health promotion and primary prevention of CVD in Finland, FHA
and Ministry of Social Affairs and Health have published a consensus statement 'Action Plan for
The role of the FHA has been to build and foster alliances between other organisations and
partners which share its goals in heart health promotion and CVD prevention and coordinating
the implementation of the proposals and the recommendations made by the alliances. FHA set
the first priorities for future national heart health promotion and CVD prevention by selecting
the set of recommendations and establishing the alliances. The main focus of the interest was first in
nutrition and physical activity. During the last two years special attention has also been paid to
health promotion among children and young people and to planning prevention strategies in
tackling psycho - social risk factors.

Leading experts from different areas of heart health promotion were asked to participate in the
work of the alliances. The list of the alliance members that has been attached to the previous
report is still up-to-date. The following alliances have been active during the reporting period.

Heart Symbol - to establish a system by which a heart symbol awarded to foods can support the
realisation of nutrition recommendations. FHA and the Finnish Diabetes Association launched
the Heart Symbol system at the beginning of the year 2000. The right to use the symbol is
granted (on application) to a packed product that fulfils the granting principles for the product
group in fat quantity and quality, salt and cholesterol. For bread and cereal products, fibre
content is also taken into account. Products that are not important as sources of fat and salt intake
(e.g. vegetables and fruit) have been left outside of this system. At the beginning of the year
2003 131 products (19 companies) have the right to use the symbol.
In December 2002 FHA conducted a survey (Finnish Gallup Ltd) to find out whether consumers
recognise the symbol and whether it has an effect on their purchase intent. According to the
survey, both the recognition of the Heart Symbol and its influence on purchase intent have
increased. More than 42 % of over 15-year-old Finns know the Heart Symbol. Approximately
one in four and 38 % of those who recognise the Heart Symbol said that it has influenced their
purchases either frequently or every now and then. Women recognise the Heart Symbol more
often than men do and it also influences their purchases more often.

Canteen Catering - to improve public health through well-planned and well-accomplished
canteen catering. Meals prepared outside home have a high impact on Finnish nutrition: every
third Finn eats at least one meal prepared outside home every day.

The purpose of the alliance is to make heart healthy dietary recommendations effective in
canteen catering. Healthy, tasty choices, as well as variety, should be emphasised in canteen
food. In particular, attention should be paid to fat, sodium (salt) and fibre contents. Customers
ought to be informed about the healthiness and nutritional value of the meals and encouraged to
make healthier choices.
The group supported the production of a report on 'Canteen Catering and Proposal to arrange a System to follow-up Canteen Catering' (FHA's publication 2002:1), in which canteen catering is examined from the viewpoint of public health, i.e. to ensure the realisation of dietary recommendations. The aim is to speed up the Catering Audit System and evaluation of the quality of canteen catering. The National Institute of Public Health has been creating a system for monitoring consumers' eating habits. FHA’s responsibility, together with Ministry of Health and Social Affairs, is to take care of the Catering Audit System. The expert groups of the alliance have met five times.

The training of catering staff, nine events during the fall, has been carried out together with the Finnish Horticultural Products Society. The events had approximately 1000 participants. A new recipe booklet 'Lighten up a meeting' was a part of the course material. The idea was to give fresh alternatives to traditional servings e.g. coffee and Danish pastry. (Annex 2).

Health-Enhancing Physical Activity (HEPA) - to promote exercise or other sufficient and regular physical activity to become a stable lifestyle among as many Finns as possible. FHA's nationwide physical activity recommendations targeted at professionals are being drafted by the expert group (one meeting). Recommendations of nutrition and physical activity will be released as one document to emphasise their importance both together and separately according to the European model.

Children's Health Forum - to increase the wellbeing of children and young people. The primary objective was to give support to parents, professional educators, those involved in health work and others being in touch with children not forgetting the main target: children and young people. The Forum also targets the decision-makers and other authorities to ensure that they are well informed about key factors and activities. The most valuable outcome of the Forum so far has been to offer a platform for open conversation and development of collaboration. The Children's Health Forum has produced an information pack on the alliance members (activities, materials and calendar of events). At the end of the year 2002 there were 11 alliance members. The annual workshop 'Listen adult' took place in September 2002.

'A Small Decision per Day' with Finnish Diabetes Association - to promote heart health and prevent type 2 diabetes and metabolic syndrome. Obesity and overweight increase the risk of CVD and non-insulin-dependent diabetes mellitus. Already high levels of overweight and obesity in Finland are increasing rapidly. In response, in 2001 FHA and Finnish Diabetes Association launched a joint campaign, 'A Small decision per day', to prevent heart disease and type 2 diabetes. As part of the campaign, a weight control model is being produced for health care providers. The weight control programme includes supporting material connected to the model and instructor training. The material is especially targeted at people who are overweight, but have BMI, however, less than 35 or have metabolic syndrome or type 2 diabetes. Planning and pre-testing of the programme and training started in 2001 with the final programme planned for 2003. During the fall of 2002, six training courses were organised (about 130 participants). The results of the evaluation (training and education and the weight control programme) have been very encouraging.

Self-help groups are an efficient, flexible and helpful way to promote heart health: with one’s own effort and with the backing of the group one can get towards a healthier way of life and prevent CVD, metabolic syndrome and type 2 diabetes. The goal is to develop a peer group working method based on the previous experiences of FHA. FHA’s self-help (ITE) groups have ready-made materials designed for instructors and group members. During the year 2002, 12 training courses were organised for the new ITE instructors.
An essential part of the project is a nation wide media campaign that started in October 2002. The campaign is targeted at the whole adult population. The idea of the campaign is that everyone will stop for a while and consider matters important to their own health and well-being. The campaign also gives easy hints of small every day choices, which are possible to make for the benefit of one's own health on website, television, radio and newspapers. The partners that take part in the campaign are the Finnish Rheumatic Association, the Finnish Cancer Association, FHA, the Finnish Diabetes Association, Fit for Life programme and the Finnish Sport for All Association. According to a survey (Finnish Gallup Ltd) conducted five weeks after the campaign started, about 25 % of the population had noticed the campaign in some way and about 20 % had made some changes in their lifestyle as inspired by the campaign.

**Mental Well Being and Heart Health** with the Finnish Mental Health Association - to promote individual mental well-being and encourage workplaces to provide an environment which supports people to maintain their fitness for work. Psychosocial factors are very important, but a difficult subject, when heart health is in question. The Action Plan has been produced:

- to educate those active in health promotion on mental well-being and heart health;
- to promote mental health at work; and
- to organise local cooperation in mental health promotion

Funding for the implementation is still missing.

**EHHII Management Committee** - to advocate and support national organisations and partners in promotion of heart health and urge national decision-makers and the European Commission to give CVD prevention a high priority in planning future health policies. The committee has not had meetings during this reporting period. A new concept for the work of the Committee is under consideration. The new concept could be 1 - 2 high level seminars per year, targeted at special accurate topics and a monthly Newsletter (European wide health highlights).

**b) Update on the Finnish Heart Association FHA's activities:**

**FHA’s nutrition recommendation** - FHA's first nutrition recommendation has now come out. It has been worked out by FHA's expert group in nutrition and based on international (American Heart Association (AHA), European Heart Network (EHN) etc.) and national recommendations. The recommendation is aimed primarily at health care personnel. Population goals are:

- to promote healthy nutrition;
- to decrease excessive intake of energy and increase energy expenditure to decrease overweight and obesity;
- to decrease the intake of hard fats;
- to increase the proportion of soft fat in total fat;
- to decrease the intake of salt;
- to increase the intake of fibre;
- to increase the consumption of vegetables, fruit and berries.

The recommendation includes detailed objectives of the most crucial factors affecting heart health. (Annex 3).

'Life in colours - health from vegetables'- campaign - The campaign carried out by the Finnish Horticultural Products Society, the Finnish Heart Association and the Finnish Cancer Association, 'Life in colours - health from vegetables' started in mid-August and continued till the end of October. The campaign targets 7th grade schoolchildren. The campaign aims at
increasing consumption of vegetables, fruit and berries to meet the recommendation of half a kilo per day. Included are the following components:

- The cookery book "Racking hunger", meant for 7th graders, is full of youthful, easy to prepare recipes. The foods contain abundant amounts of vegetables; the ingredients are low fat and low salt materials. Used in home economics classes, it is also a good aid in home cooking. Schools receive the book free of cost. The web site www.raastavanalka.info included an internet version of the cookery book, party hints, party recipes, a food glossary, and hints for beginners in cooking, a vegetable test and information on eating vegetables. The book and the web sites were publicised in a poster sent to schools.

- In co-operation with the Centre for Countrywomen and Homemakers, about 100 vegetable events were arranged at primary schools. More than 22 000 schoolchildren became acquainted with vegetables through exhibitions and vegetable tasting. Vegetable crossword puzzles reinforced knowledge in a fun way. Many schools also offered food connected with the theme in their school canteens. Only a fifth of schoolchildren eat at least three portions of vegetables, fruit and berries daily. The purpose of the school events is to remind children of the good effects and qualities of vegetables.

- TV spots that join physical activity and the health promoting effects of vegetables support the campaign. In badminton and sambic, success came with the help of vegetables.

**Woman's Heart - Programme (2002 - 2004)** - The purpose of the programme is to spread the word that heart disease is a women's issue. One out of every four women in Finland dies of heart diseases. According to a survey commissioned by the FHA, only one out of four women recognises that CVD is the main cause of death among women. (Annex 5).

The target groups to start with are:

- women over 40 years old;
- women with CVD;
- health care personnel;
- political decision-makers.

The workshop took place in October 2002. The aims of the workshop were:

- to highlight current scientific advances, gaps in knowledge and research opportunities for CVD in women from prevention through diagnosis, treatment and rehabilitation in the context of the individual, community and policy level;
- to crystallise the evidence regarding women and CVD;
- to make more detailed plans for action.

**World Heart Day 2002 in Finland** - World Heart Day 2002 and traditional FHA's sporty Heart Trip were combined into cheerful autumn events. The aim was to inspire Finns to walk for the benefit of their health and to promote health enhancing regular physical activity. The Heart Trip was an event for the whole family. About one hundred heart associations arranged local Heart Trips. During the events, material and leaflets on heart health promotion were distributed to the public. Good media coverage enhanced the effects of the events, in which approximately 7 000 people participated.

A public event under the theme 'A heart for life' was carried out in collaboration with the Finnish Society of Cardiology. The event included, among other things, presentations on women's coronary heart disease, hormone replacement treatment and the possibility to prevent CVD with drugs. There were cholesterol and blood pressure screenings, ECG examinations for the public
and a possibility to consult a cardiologist. Approximately 500 people participated in the event. (Annex 6, 47 press clippings). The event was also noticed by radio and TV.

FHA, together with the Finnish Society of Cardiology, organised a press conference before the Heart Day (23 September) targeted to medical journalists. The main topics were 'European Heart Plan' and 'Hormone Replacement Treatment'. Unilever Best Foods distributed six press releases between 20 to 29 September. Three out of the six press releases were based on interviews of FHA's experts (nutrition, physical activity and CVD). The physical activity theme in the issue of ‘Heart - Sydän' supported the events. The World Heart Day was welcomed and promoted in the national and local media. Commissioner Byrne's statement was available on FHA's website.

Promoting physical activity among children and young people - The paper 'Children and Young People - the Importance of Physical Activity', published in the context of the European Heart Health Initiative, has been under discussion in HEPA expert group. The implementation of the recommendations has been considered in the context of the Finnish National Recommendation for the Local Promotion of Health Enhancing Physical Activity and the Committee Report 'Nation Wide Recommendations for Promotion of Health Enhancing Physical Activity'. The committee emphasises the importance of adequate physical activity for whole life. Physical activity ought to be a part of daily life for everyone, and families should be encouraged to be physically active together. As far as children and young people are concerned, the target of health-enhancing physical activity is the promotion of daily activity - especially targeted at sedentary inactive children. Physical activity must be a part of day care, the school day and organised after-school activities.

FHA, together with Mannerheim League for Child Welfare, is producing basic health education materials for families to be used in healthy baby/child clinics. The starting points are the basal factors of daily life in families with children: nutrition, physical activity, rest and joy. Three publications ‘ABCs of Care’ targeted at children under 1 year, 1 - 3 years and 4 - 6 years of age are being drafted.

Media coverage for activities - The main media forum for activities has been FHA's paper Sydän - Heart and FHA’s website (www.sydanliitto.fi). Heart Matters V has been translated into Finnish and distributed as hard copies and/or through the website.

c) Publications

“Principles for granting the Heart Symbol”, according to product groups, revised in 2002
“Lighten up a meeting” (Kevennä Kokousta), Recipe booklet, published in 2002
“FHA's Nutrition Recommendation”, published in 2002
“Racking hunger” (Raastava nälkä), Recipe book, published in 2002
“Woman's Heart” (Naisen Sydän), leaflet, published in 2002

d) Policy developments

Tobacco policies in Finland - The recent debates on tobacco issues have been interesting. The main topics are to decrease or to increase the tobacco tax, and the possible consequences (young people, smuggling etc.) and the rights of the hospitals to set a limit and/or to forbid smoking during working hours.
7. Heart Symbol - a better choice, Finland

The Finnish Heart Association and Finnish Diabetes Association launched at the beginning of
year 2000 the HEART SYMBOL, which tells the consumer at a glance that the product marked
with this symbol is a better choice in its product group regarding fat and sodium.

The primary goal of the Heart Symbol system is to promote public health. For food industry it is
an effective means of marketing products that have been given the right to use this symbol.

Many consumers find it difficult in practise to put together a healthy diet. The Heart Symbol
makes it easier. It is an easy-to-notice addition to the nutritional information on the food
packages and helps the consumer to pick out a better choice regarding the quality and quantity of
fat and sodium.

At this point, the right to use the Heart Symbol can be given in six different product groups: milk
and milk (dairy) products and other similar products; edible fats; meat products; bread and
cereals and cereal products; convenience foods; and seasonings and seasoning sauces.

The products, where sodium and fat are not a problem, have been left outside this system (such
as vegetables and fruit) as well as unpacked food. The criteria for granting the symbol are: the
quantity and quality of fat, sodium (also from raw-materials and additives), cholesterol (in some
product groups), fibre (in products rich in fibres belonging to the bread and cereals group can be
used Heart Symbol + fibre - symbol). These are also the main nutrition-related problems known
currently in Finland.

A group of professionals nominated by the organisations, which are in charge of this system,
grants the rights by applications of the manufacturers. The right is granted for a given period.
The right to use this symbol is subject to a charge, but the system is not designed to bring profits.
The fees collected are used to keep up this system. At the moment (24.3.2003) altogether 149
products (20 companies) have the right to use the symbol.

The responsible organisations invest heavily in making the Heart Symbol known by the public.
Brochures have been printed for different target groups such as consumers, health sector and
market personnel. The system has its own homepage www.sydanmerkki.fi where additional and
updated information is available. A consumer campaign was launched in autumn 2000. After
that, Heart Symbol has been made known to consumers with advertisements in TV, radio and
magazines (including the retail sector's own magazines), shopping trolleys and Heart Symbol -
stands during fairs and other events. In November 2002 FHA conducted research (Finnish
Gallup) to find out whether consumers recognise the Symbol and whether it has an effect on
purchase intent. According to the research, 42% of the adult population recognise the Symbol
and every fourth person said that the Symbol has, at least now and then, influenced their
purchases.

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8. Physical education school program to prevent degenerative spine diseases, Hungary

The prevention program of the Hungarian Spine Society started in 1995 and, financed by the Ministry of Health, has became part of the Johan Béla National Public Health Program, and also of the Bone and Joint Decade of WHO.

**Background:** In many countries 60-80-90 % of school children have poor posture, which is a predisposing factor for early discopathy of the cervical and lumbar spine. Degenerative spine diseases are one of the leading causes for sick-leave, especially for workers between 25-40 years. Primary prevention needs to start at school.

**Goal:** 1) every day physical activity for school children; and 2) special exercises as part of regular physical education, for all children, for several years.

**Rationale:** 1) Posture is an automatism, which can be modified by habits. Correct posture needs correct balance (correct strength and flexibility) of postural muscles; 2) Sitting too much: muscle balance disappears, postural muscles get shortened and/or week, the use of spine gets biomechanically incorrect.

**Solution:** 1) Stretching and strengthening of postural muscles regularly for several years, for all school children; and 2) Special posture correcting exercises to be taught to teachers of physical education.

**Result:** 1) Correct balance of postural muscles, correct posture as an automatism; 2) Biomechanically correct use of spine; 3) One element for preventing discopathy.

**Working method of the prevention program of the Hungarian Spine Society:** The prevention program is teaching the teachers of physical education, how they should build into physical education of all school children special posture correcting exercise material. Up to March 2003, 5 178 teachers of physical education and kindergartners from 3 093 schools and kindergartens have learnt the preventing exercise material, they all got the material in book and video cassettes. 975 teachers have sent to the centre of prevention program 49 113 muscle tests made of 31 705 children. Results of these muscle tests show, that only 12 % of tested children have correct muscle balance, all other have shortened and/or week postural muscles. The Ministry of Health, Social and Family Affairs, the Ministry of Children, Youth and Sport and the Ministry of Education have been supporting this prevention program since 1995.

**Evidence on health impact:** A controlled prospective study was made in Békéscsaba (Hungary) in 2001/2002, with 200 index and 213 control school children aged 6-14 years. In the index group very significant improvement of postural muscles was found, whereas postural muscles of the control group did not change or worsened very significantly. Evaluation was made using Students t-tests and non-parameter tests.)

**Links:**
- [www.gerinces.hu](http://www.gerinces.hu) (in Hungarian): website of the prevention program of HSS
- Johan Béla National Public Health Program: [www.eszcsm.hu](http://www.eszcsm.hu) (website of the Ministry of Health, Social and Family Affairs
- [physioth@axelero.hu](mailto:physioth@axelero.hu): e-mail address of the Hungarian Association of Physiotherapist – here one can get information on courses of the preventing material for physical education.
9. CD-ROM “Dish it Up!” in secondary schools, N. Ireland, UK

Aim: The aim of the project was to design, develop and evaluate an interactive CD-ROM based on effective, positive and personally relevant models of behaviour change in relation to dietary intake in 12-year-old children across the United Kingdom.

Methods: Development and evaluating the CD-ROM was done in five phases: collection of background material; development and testing of storyboards and design ideas; pilot testing of the prototype CD-ROM; modification of the CD-ROM based on feedback from the pilot testing, and finally, evaluation of the effectiveness of the CD-ROM in the school setting. Each phase was carried out in close collaboration with school principals, teachers and pupils using focus group discussions (pupils), structured interviews (principals and teachers) and questionnaires (pupils and parents). In total, 27 different schools throughout the UK participated in one or more phases of the research. The schools represented the range of demographic (urban/rural), socio-economic, ethnic backgrounds and academic ability.

Dish it Up! is an interactive tool that links to the UK national curriculum providing young people with a range of nutrition and food related information. It covers a range of issues including body image and provides an avenue for young people to assess a virtual diet (i.e. food choices made during the course of the interactive programme) as well as an actual food diary using a ‘balance-a-tron’ based on the Balance of Good Health (a pictorial representation of the recommended proportions of foods in the diet).

Policy / Initiative: Existing evidence indicates that:

- Eating behaviours established in childhood are difficult to change.
- A focus on behaviour, rather than knowledge, is a key determinant in the likely success of nutrition education programmes.
- Interactive multi-media offer enormous potential as a medium to deliver nutrition education interventions.

The primary goal of school based nutrition education should be to help pupils adopt eating behaviours that will promote health and reduce the risk of diet-related diseases in adulthood. Adolescence is a time of particular nutritional vulnerability. In the short term, the characteristic dietary patterns of adolescents may result in low levels of essential nutrients and high intakes of fat, sugar and salt. In the long term, some of the physiological processes that lead to diet-related chronic diseases in adulthood have their antecedents in childhood diet.

CD-ROM Format: The CD-ROM contains games and quizzes designed to interest and motivate young people towards healthier eating. The central concept of Dish it Up! is a “virtual” school day
in the life of a 12-year-old child. The “virtual” day is designed to provide personally relevant situations, environments and dilemmas that face 12-year-olds with respect to food and provides information on food-related issues.

The main theme of Dish it Up! is one of achieving a healthy balanced diet: it covers a range of issues and themes. The issues are discrete sections within the typical school day and include those of breakfast, snack foods, school lunchtime and “fast” food in a social setting. Opportunities are also provided for children to self-monitor and analyse their food intake, and set goals for themselves.

The themes run throughout Dish it Up! and include the importance of enjoying food/eating; balance and variety; self-esteem; body image; peer pressure; media pressure; physical activity; motivations for eating well; addressing barriers to choosing a balanced diet and misconceptions about food or particular diets. The “virtual” day is itself divided up into six episodes. As the user moves through each episode, he/she visits a number of locations that are based around a typical school day. Each location contains a number of interactive elements.

Evaluation: The effectiveness of Dish it Up! for bringing about measurable changes in the target group’s nutrition knowledge, attitudes and behaviour towards nutrition was evaluated pre- and post-intervention in 11 schools across the UK. Within each school, two classes of 12 year olds were selected. One class acted as an intervention group and the second class acted as the control group (i.e. they were not exposed to Dish it Up)! over three weeks, for approximately 1hr per week. The intervention group used Dish it Up! according to the comprehensive lesson plans provided for teachers and pupils.

Analysis of pre- and post-intervention questionnaires showed a significant improvement in nutrition knowledge, but no change in nutrition attitudes, for the intervention compared with the control groups. There was some indication that the intervention group had changed their behaviour with respect to sweets and crisps (decreased intake) and fruit (increased intake). However, based on this short-term evaluation, no definitive conclusions about the overall effectiveness of Dish it Up! are merited. Regular evaluation studies will be important to fully document the longer-term impact and success of this educational tool.

Teachers of Key Stage 3 (in Scotland P7-S2) will find this tool useful across a range of curricular areas such as food technology, home economics, personal, social and health education, science and information technology. The Agency has provided three free copies of the CD-ROM to all secondary schools across the UK. Since the Food Standards Agency is making Dish it Up! freely copiable by teachers, it can also be used by young people in their home environment and would be ideal for use in after-school clubs.

A summary is available on the Agency’s Website at: http://www.food.gov.uk/science/research/NutritionResearch/n09programme/n09projectlist/n09012/

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10. Fit to Succeed, Exeter, England, UK

Background - Aims and objectives, target population: The pilot project came about in response to teachers’ concerns about motivating lethargic pupils to reach their academic potential and
growing evidence of children’s ‘couch potato’ lifestyle. The project aims to promote physical activity and academic achievement in schools. The Project is coordinated and monitored by The Schools Health Education Unit.

Following a £33,000 award, which has now finished, from the Barnardos/Glaxo SmithKline ‘Right Fit’ programme, the project was extended to all state middle and high schools in Exeter. Involving over 10,000 pupils between the ages of 8 and 15. A mentoring project has now been established in the neighbouring town of Tiverton.

Description of initiative including process, methods, partners & sectors involved: The pilot project involved the following elements:

**Pupil’s access to free sessions:** Pupils are offered five free sessions at clubs or facilities of their choice. Parents and teachers are included by getting reduced rates for facilities.

**Record card to count towards certificate:** As part of the pack, children were given information about where they could get their five free sessions at leisure facilities and sports clubs in the Exeter area. Paid and free sessions were recorded in a "Fitness record card". After the children attended twenty recorded activity sessions, they were presented with a certificate of activity achievement.

**Class Materials:** Each participating class was given a set of materials, including an information pack for each pupil regarding the benefits of regular exercise. Each teacher decided how best to present the information to their class.

**Monitoring questionnaire:** A questionnaire was designed to collect baseline information regarding current levels of participation in physical activity. It also collected data about pupil’s perceptions of their own levels of fitness and their enjoyment of PE within school, their perceptions of how much significant adults (like their father or their teacher) enjoyed being physically active. Pupils were invited to say which activities they would like to do more of if they had the chance, so we could identify some of the current barriers to exercise of children and how we can best help them to become more active.

The pilot project in seven schools started with a survey of 1,400 pupils in Years 5 to 7 (age 8 to 12). The questionnaire was then re-administered 6 and 12 months later to act as a monitoring tool. The monitoring questionnaire is now used as an online tool to inform the Devon School Sport Co-ordinators, working in 77 primary schools in the county.

**Newsletter and Toolkit:** Schools have been provided with newsletters keeping them informed about the project, key contacts, new facilities, survey results, and new ideas for getting pupils moving. In addition a toolkit is also being produced which is to be posted on the SHEU website towards the end of April.

**Participants in the project:** Participants in the project are Exeter schools, Exeter Academic Council, Exeter City Council, Devon Curriculum Services, The Schools Health Education Unit, DC leisure management. Additional funding was provided by and Barnardo’s and Glaxo SmithKline through their Right Fit programme, which has now finished.

The benefits of the scheme to the partners involved included: teachers motivation to get children into clubs and activities; schools are keen to investigate a possible link between active bodies and active minds; children demonstrating an interest in a variety of activities; DC Leisure having the facilities and involving more children; Devon and Exeter Councils have the contacts with schools to bring partners together; the scheme met the objective of the Right Fit Awards.
programme of improving health among young people.

**Evaluation:** The Schools Health Education Unit has monitored the effectiveness of the project using a monitoring questionnaire including items about: physical activity; attitudes to exercise and fitness; participation in clubs; attitudes of family members. SHEU have also been using their wider data banks, established from their Health Related Behaviour Questionnaire (HRBQ), for the questions that are identical to see how the Exeter data compares to a broader picture. The analysis also takes into account the new project starting in Tiverton. Findings of the project have been presented at the Right Fit conferences in December 2001 and the local projects own dissemination conference in February 2003.

At the recent conference it was explained how vital the data collection exercise had been in informing the Exeter County Council’s Sports Development team in planning and delivery of support to youngsters across the city. The introduction of Baseball to the city was identified by children in the questionnaires as a sport which had previously lacked provision. The Exeter team that emerged from this initiative have now been National Champions for two years in a row.

**Is there evidence for impact on health and, if so, what?** Results from the pilot project have shown evidence of increased participation in physical activity in project schools compared with control schools. In addition, there is strong evidence to suggest that a project can have a positive effect on young people’s participation in physical activity and that there is a correlation between young people’s participation in physical activity and academic achievement.

A new question on water has been included into the latest version of the questionnaire in response to schools reporting that they have seen a difference in the concentration levels in pupils since having more access to water in school. The findings need to be explored in more detail but early indications suggest that there is an association with drinking water and the enjoyment of physical activity.

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Fit to Succeed full report: www.sheu.org.uk/fts/report2a.htm
[Similar findings of California State Study: www.cde.ca.gov/news/releases2002/rel37.asp]


Wright Robinson Sports College (WRSC) has funded the Millennium Research Project (MRP) since 1998 and has now been extended until 2005, in collaboration with Manchester Metropolitan University. The project is designed to support the College’s strategic aim of raising standards and increasing participation in PE and Sport, within WRSC Family of Schools.

**Aim:** The project’s initial objective was designed to increase participation in physical activity in Year 7 (350 pupils). Aiming to increase physical activity levels among female adolescents.

**Methods:** Baseline data was collected on self-esteem, body mass index, and physical activity profiles. The evidence was gathered using pupil questionnaires, focus group interviews with project officer and staff registers/statistics.

**Description:** The data highlighted several factors that influenced female activity levels. These included inappropriate PE kit, traditional team games and lack of physical competence. The
The college has now changed the girls PE kits in response to this and a variety of non-competitive activities have been offered. In addition, the college has introduced a Transition Curriculum.

The Transition Curriculum was developed to increase inclusion and provide students with a positive first experience in PE from September to January for all incoming Year 7 cohorts. Inclusion incorporated participation, attendance, and curriculum accessibility for all students. That is, accessibility in terms of equipping students with basic generic skills (with an emphasis on movement competence) that are transferable across a wide variety of activities.

In 2001-02 the college continued to deploy the fundamental principles upon which the Transition Curriculum is based. This includes, mixed gender teaching groups; grouping students with primary peers; staff consistently teaching the same group across a range of activities (where possible this member of staff should have worked with the group at Key Stages 1 and 2).

A specific teaching style is adopted with staff trained through the Manchester Education Partnership Scheme. Lessons follow similar formats with the emphasis strongly based on enabling students to acquire basic generic skills. Assessment is made against core tasks developed from National Curriculum Guidelines, however it is widely accepted that the purpose of the Transition Curriculum is not to raise student attainment over a five-month period but to promote inclusion through raised self-esteem, attendance and participation. It is also agreed that the Transition Curriculum may facilitate an improvement in attainment to be realised over a longer period of time i.e., across the Key Stage.

The project has now been cascaded into East Manchester Primary Schools, through Networked Learning Communities. The proposal is to raise standards in Primary Schools through raising self-esteem and improving attendance, to increase parental involvement in their child’s education and to instil in pupils the confidence to invest in their own education.

Evaluation: The evidence of the success of the Transition Curriculum innovation on raising standards has been presented to the DfES, DCMS, Performance Innovation Unit, Youth Sports Trust, and Technology Colleges Trust and appears on the QCA website www.qca.org.uk/ca/subjects/pe highlighting a definite link between:

- physical activity participation and academic attainment;
- the impact of an active healthy lifestyle on a young person’s academic and physical development;
- increased physical activity helps to maximise learning potential

Evidence for impact on health: The project has already begun to inform the college and the profession about the pupils as they move into, and through, adolescence. So far, the evidence suggests that participation in physical activity enables young people to significantly improve their physical competence, confidence and self-esteem. Generally pupils who are physically active tend to feel better about themselves and achieve higher academic attainment. For example, girls achieve an emphatic one level higher across all Key Stage 3 SATS and boys half a level higher.

The Transition Curriculum has raised the Year 7 physical activity participation levels from 50% to over 78% (for girls) in three years and, in addition, there is evidence that the most physically active youngsters have greater self-esteem, healthy BMI and attain higher English, Maths and Science SAT scores at Year 9.
12. Physical Activity and the Elderly, Eastern Health Board Area, N. Ireland, UK

The Eastern Physical Activity Co-ordination Group is a multi-agency group within the EHSSB area whose main aim is to increase levels of health-related physical activity, particularly among those who exercise least. This Group consists of members with representatives from the Eastern Health and Social Services Board, the Belfast and South Eastern Education and Library Boards, councils, five physical activity groups/forums, the Eastern Area Health Promotion Forum, the Department for Regional Development, Playboard, Chest Heart & Stroke Association and the local Health and Social Services Trusts. The Sports Council for Northern Ireland is a corresponding member.

This group carried out an audit in December 2000 on Physical Activity Provision within Health & Social Services Facilities, Residential and Nursing Homes within the Eastern Health & Social Services Board Area. It was identified, in order to increase the number of people participating in daily physical activity programmes, training of staff and development of resources and initiatives to support them will be of major importance.

To initiate a process to address these needs, the Eastern Physical Activity Co-ordination Group agreed to focus on a workshop for the elderly in Residential/Nursing Homes and Fold Accommodation. A workshop was held, in October 2001, and presented evidence of how physical activity benefits older people.

The workshop raised awareness, explored the needs within a care setting and provided "hands on" experience with practical physical activity programmes. A new training schedule was developed to support the workshop, which included:

**Activate**: The Activate 50+ physical activity module is designed for the averagely fit, reasonably healthy '50-plus' age group. It is not designed for the frail elderly. The aim of the module is to provide sufficient information and experience to enable every course participant to make changes to their established way of living, which will lead to a much greater ability to appreciate and enjoy life.

**Mobility Training**: This training programme, "Moving to Music" attempts to provide participants with the knowledge and skills to deliver safe and effective exercises in their workplaces. The content includes 1) basic mechanical approach to anatomy and movement; 2) safe stretching exercises; 3) how to improve circulation and stimulate those that are chair-bound with limited mobility.

**Walking for Health**: Walking supports community based schemes targeting urban and rural areas across the EHSSB area. It makes a direct and positive contribution to the lives of the people in these communities by offering significant, yet largely untapped health benefits through walking programmes for the elderly. Each local scheme provides programmes of short led walks, self-help information to encourage independent walking, opportunities for volunteering and connections to other services and support networks concerning better health.

An evaluation is being undertaken in the coming year to assess the efficacy of the above training programme, but it was clearly evident that further work was necessary around Falls Prevention.
A Falls Prevention Action Plan was developed, which the Eastern Board Area strive to implement. This initiative is a partnership between Down & Lisburn Physical Activity Group and East Down Institute and it will provide a four-day course with a built in mentoring programme for care workers with experience of caring for frailer elderly people—*Exercise for the Prevention & Management of Falls*. This training course has initially been piloted and identified the need for two levels, NVQ level 2 that will concentrate on practical activities around chair based exercises and NVQ level 3 which will be a more dynamic exercise programme. Each unit will contain five major areas: 1) Strength and Mobility; 2) Visual Screening; 3) Foot care and Footwear; 4) Medicine Management; 5) Environmental Changes.

This training course will be offered by the East Down Institute and supported by local Physiotherapists. The final package will be written and accredited in May 2003 with training commencing in September 2003.

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**Aim:** To provide schools with the information needed for them to plan and mark their own playgrounds.

**Objectives:** To explore and develop a resource & training programme to: 1) Promote children's active enjoyment and use of the school playground; 2) Stimulate children to use their environment creatively; 3) Increase participation in active games and play at break times; 4) Stimulate positive social behaviour, interaction and co-operation between children; 5) Reduce Bullying; 6) Provide relevant activities and opportunities appropriate to the primary age group for individuals and groups; 7) Influence the future behaviour of young people so that they adopt a lifelong habit of physical activity.

**Target Group:** The non-specialist who wishes to give children at key stages one and two some enjoyable physical activities.

**Description of project:** The project was developed by the Eastern Area Physical Activity Strategy Co-ordinator along with Alison Vance, Assistant Advisory Officer for PE/Health Education, SEELB to make the best use of the opportunities provided by the school playground.

The multi-agency Eastern Physical Activity Co-ordination Group (EPACG) provided essential support mechanism for the co-ordinator and also provided the funding for the publication.

The following organisations were represented on the EPACG: Ards Borough Council, Belfast City Council, Belfast Education & Library Board, Castlereagh Borough Council, Chest Heart & Stroke Association, Down Lisburn Trust, Down District Council, Eastern Health & Social Services Board, Lisburn Borough Council, North & West Belfast Trust, South & East Belfast Trust, South Eastern Education & Library Board, and the Ulster Community & Hospital Trust.

**Main conclusion of project:** This project introduces children to new ideas and a variety of different activities and games for playground markings at school break times to provide them with the stimulus and equipment to be physically active. As a result it will give the children the freedom to be themselves and to 'truly' play with minimal adult supervision, enabling them to be
active at home in their own time which will lead to optimising physical fitness, current health and wellbeing.

In order to be truly effective, playground games and activities must be a whole school issue. Commitment and leadership needs to come from the principal, Senior Management Team, all teachers, supervisory assistants and pupils.

**Future Action**: SEELB and BELB have identified two schools in each of the ELB board areas to run pilot projects to monitor and evaluate the use of playground markings. Active School Training for Primary School Teachers and Supervisory Staff will begin in May 2003. The training will help teachers and supervisory staff make best use of all existing resources e.g. playground markings and games, jump rope for heart, tops programme.

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### 14. Breakfast Club in School Scheme, Belfast, N. Ireland, UK

**Aim**: To promote healthier eating by the development of Breakfast Clubs in seven pilot schools in Belfast Health Action Zone.

**Objectives**: 1) to support and develop service in schools to make breakfast available at pilot schools; 2) to enhance the development and well-being of pupils participating in the Communities in Schools initiative; 3) to promote a multi agency approach based on a proactive integrated service to enhance the quality of school life; 4) to enhance and foster working relationships which brings synergy to the work of schools in a holistic way; and 5) to develop along with direct catering services of the Belfast Education and Library board a template, which can serve as a model of best practice to benefit the wider school community.

**Target population**: Post-primary children in schools situated in the most socially disadvantaged wards of North and West Belfast.

**Description of project**: Belfast Education and Library Board provided a breakfast in school consisting of fruit juice, healthy cereal, scrambled egg, beans, tea and toast. The menu was devised in collaboration with dieticians and the dental department. The cost to children of 30 pence per day was subsidised by Belfast Regeneration Organisation.

**Evaluation**: Pupils attending the breakfast club completed a self-administered questionnaire. Teachers and catering staff also completed a similar questionnaire. The Department of Social Development's Policy and Research Unit facilitated data compilation. An evaluation is ongoing to obtain some insight the perspective of a sample of children in the participating schools. The Northern Ireland Statistics and Research Agency is conducting this evaluation using computer-assisted interviews.

**Main findings from initial scheme after first year:**

- 68% of those using Breakfast Club would not otherwise have breakfast on schooldays
- 60% reported that they snack less after having breakfast
- 97% reported that they felt better after having breakfast
Many benefits have emerged, including a sense of inclusion and community within the schools. Teachers supervising the breakfast clubs use the opportunity to improve their working relationship with the children. The individuals involved have demonstrated outstanding commitment.

Making healthy options more attractive has many challenges when faced with media advertising. Belfast Education and Library Board Direct Catering Service has worked with North and West Belfast Health & Social Services Trust towards meeting this challenge. With the support of the teaching staff, the Catering Service has achieved considerable success in some of the schools. The current project has contributed towards informing joint understanding of the issues involved and in developing a future implementation strategy.

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Further information

a) North and West Belfast Health and Social Services Trust School Screening data. Eastern Health and Social Services Board, Belfast.

b) Mid term review of Northern Ireland Oral Health Strategy www.dhsspin.gov.uk/pgroups/dental


15. Women in Sport and Physical Activity, Belfast, N. Ireland, UK

**Introduction:** Following the Greater Shankill Health Profile (1994) a health sub group was established to address the wide range of health issues identified in the research. Subsequently, in 1997 a group of community and statutory representatives from the Greater Shankill came together to form Women in Sport and Physical Activity (W.I.S.P.A). As an interagency community based group, it was set up to address women’s health issues within the Greater Shankill area. W.I.S.P.A seeks to assist women to be well informed and able to access physical activity of their choice.

Through several surveys carried out by W.I.S.P.A., it was found that women felt there were barriers which prevented them from participating in sport and physical activity i.e. child care, transport, cost and apathy. W.I.S.P.A decided to try and remove these barriers.

Over the last couple of years W.I.S.P.A. has run many activity programmes in various centres in the Greater Shankill such as an annual 5-a-side ladies football tournament, aerobic classes, swimming classes and tai chi. W.I.S.P.A has also strived to educate, encourage and empower women to lead a healthier lifestyle.

**Aims and Objectives:** W.I.S.P.A aims to encourage women from the Greater Shankill and surrounding areas to participate in sport and to improve their health and well being. This pro-
active group is developing a variety of opportunities for women to have a voice and participate in sport and recreational pursuits at a level that suits them. W.I.S.P.A.’s target population is women who work and/or live in the Shankill. The users and beneficiaries are women in the Greater Shankill area with a particular focus on young women, mothers and unemployed women.

- W.I.S.P.A. seeks to assist women to be well informed and able to access physical activity of their choice.
- W.I.S.P.A. to have significant roles influencing local policy regarding physical activity/health benefits, (ref. Health Action Zone Council, Belfast City Council etc.).
- To increase the number of female coaches/instructors in North & West Belfast.
- To increase the participation of young women in physical activity by supporting a wider choice of physical activity programmes in and out of school
- To support women from North & West Belfast to be involved in physical activity once a week.

How the evidence was gathered: The Shankill Health Profile carried out in 1994 highlighted a range of issues in relation to women’s health. In particular, it expressed concern at the levels of smoking and drinking, lack of exercise, mental health problems, excessive weight and low self-esteem. Since it has been developed, W.I.S.P.A. has gathered information to establish needs of women in the area, particularly by interviews and questionnaires at events promoted by W.I.S.P.A. from 1997 to date. The identified needs include:

- Accessible information about a wide range of Health issues;
- Range of levels of physical activity to engage a broad range of women;
- Group support to participate;
- Child-care and subsidy to support initial participation.

Description of the policy/initiative (including the processes - methods used - partners and sectors involved): W.I.S.P.A. complements National Health Strategies by targeting vulnerable individuals and groups through a community empowerment approach, designed to enable people to increase control over their own health and well being. As a result of Healthy Living Centre (HLC) funding Health Promotion, physical activity and peer education programmes will provide opportunities for health related learning through information, empowerment and support. The provision of training and skills will improve education and training outcomes leading to skills enhancement and better employability and active citizenship.

W.I.S.P.A. is also complimentary to:

- NI Physical Activity Strategy 1997-2002 DHSSPS
- Mainstreaming Community Development in the Health and Personal Social Services Report 1999 - Vision into Practice
- New Targeting Social Needs Policy 1999
- Priorities for Action 2003 - 2004 DHSSPS

All of these above strategies are informed by National Health Policies. W.I.S.P.A. directly links with a number of priorities in the EHSSB commissioning intentions for Health and Personal Services 2001 - 2004 e.g. the physical activity, nutrition and mental health promotion. The community development approach adopted also meets the Board’s requirements of delivering Health Promotion services on an inter-sectoral basis. The Board’s strategy direction for Health Promotion services follows the regional strategy for Health and Social Well Being 1997-2002 and well into 2000 by reaffirming its aim to “promote Health in its widest sense including Social
Well Being”. W.I.S.P.A.’s work links with these aims. W.I.S.P.A. is facilitated by the Greater Shankill Partnership. As a local committee it is made up of representatives from the community, voluntary and statutory sectors.

How was the policy/initiative implemented: W.I.S.P.A. has been operating on a limited budget from 1997-2002. However a successful funding application has been made to the New Opportunities Fund and money has been received through the Healthy Living Centre funding stream. The work will thus continue and develop through a multisectoral approach which will be implemented through planned events and training programmes which will have implicit Health Promotion inputs and work with women of all ages in a range of settings. Overall the partnership approach will facilitate mutual support, complementary working and regular up-dating.

Was the policy/initiative evaluated, and if so how: Initial impact evaluation was used for each planned activity to date. However, it is only within the last few months that funding has been secured through a HLC bid in which a W.I.S.P.A. Development Worker has been employed. As a result evaluation will be incorporated into W.I.S.P.A. over the next five years.

Is there any evidence to date of the impact of the initiative on Health?
If yes what is the evidence: To date there are increased numbers participating in events and courses therefore, by inference, there is an increase in Health gain. In addition increase in health gain is reflected in the increase number of trained coaches who will deliver health related physical activity projects and programmes.

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16. ‘5 A DAY’ Programme, England, UK

Background: Cancer and coronary heart disease account for 60% of all early deaths in England. Therefore a key feature of the Government's prevention strategy to reduce early deaths from cancer and coronary heart disease is action to improve diet and nutrition. The National Health Service Plan (2000)1 and other key policy documents2, 3 all highlight diet and nutrition as a key area for action. One of the main approaches to improve diet and nutrition in England is action to increase consumption of fruit and vegetables, particularly in disadvantaged groups.

Current recommendations are that everyone should eat at least 5 portions of a variety of fruit and vegetables each day, to reduce the risks of cancer and coronary heart disease and many other chronic diseases (WHO, 19906; UK COMA 1994 & 19984,5). Yet average fruit and vegetable consumption among the population in England is less than 3 portions a day. Consumption tends to be lower among children and people on low incomes.

The main barriers to eating more fruit and vegetables in England are:

- access and availability – whether people have access to good quality, affordable fruit and vegetables locally
- attitudes and awareness – awareness of the 5 A DAY message, and people’s knowledge, attitudes, motivation and skills concerning buying, preparing and eating fruit and vegetables.

Aim: The 5 A DAY programme offers targeted action to improve access to, and increase consumption of fruit and vegetables among people with the lowest intakes. There are five main strands with monitoring and evaluation underpinning the whole programme:
1. **National School Fruit Scheme (NSFS)**
   Entitles every child aged 4-6 (around 2.5 million children) to a free piece of fruit each school day, by 2004. The Scheme has already been piloted with excellent evaluation results:
   - Consumption of fruit was high;
   - School staff regarded the scheme as a way of improving children’s health (99%) and a supplement to children’s diets (99%);
   - 97% of schools regarded the NSFS as a support to teaching and learning about healthy eating.

   Following these successful pilots, expansion is now taking place on a region-by-region basis, supported by £42m from the New Opportunities Fund. The first whole regions to benefit from the scheme in 2002 were the West Midlands and London, in Summer and Autumn Terms respectively. North West and East Midlands followed in Spring and Summer of 2003. These four regions will mean around 1 million children will be receiving free fruit. We are now looking to expand the range of produce, including vegetables, following favourable evaluation results of piloting carrots and tomatoes.

2. **Local 5 A DAY initiatives**

   Aims to increase access to and availability of fruit and vegetables within disadvantaged communities. Following successful piloting, the New Opportunities Fund has made £10m available to support the establishment of 66 initiatives, led by Primary Care Trusts. A 5 A DAY handbook has been developed following evaluation of the pilots and will help staff in Primary Care Trusts and other organisations to establish community-wide evidence based approaches to increasing fruit and vegetable consumption.

   The pilot initiatives which targeted over 1 million people suggested that community initiatives can produce important changes in people's knowledge, access and intake of fruit and vegetables. Key findings are that:
   - Overall, the intervention was found to have had a positive effect in people with the lowest intakes - this is important for addressing inequalities in health. Those who ate less than five a day at baseline increased their intakes by 1 portion over the course of the study.
   - Frequency of intake was found to be an important determinant of total fruit and vegetable consumption. Low consumers should be advised to eat fruit and vegetables more often.
   - Average fruit and vegetable portion sizes, measured in the control group, were similar to the amount commonly assumed to represent one portion (80g).

3. **Work with food industry**

   The Department of Health recognises that in order to achieve the long-term goals of the 5 A DAY programme that it must, on the Government’s behalf, forge powerful relationships with the British food, retail and leisure sectors and all supporting services. We know that the industry are consumer focused and we are looking for all sectors to lead the changes in demand, shaping what consumers are asking for at the till and in stores.

4. **National and local partners and cross government**

   The success of the 5 A DAY programme also depends on partnership working with – national and local – government, health, consumer and education organisations.

5. **A communications programme**
The 5 A DAY communications programme will provide clear and consistent messages about 5 A DAY including the amount that constitutes a portion and the benefits of eating at least five portions of a variety of fruit and vegetables a day.

The key parts to the 5 A DAY message are:

- Eat at least five portions of a variety of fruit and vegetables each day.
- Fresh, canned, frozen, dried and 100% juice products can all contribute towards 5 A DAY.
- The 5 A DAY message should be placed in the context of a healthy, balanced diet.

A 5 A DAY logo has been developed in consultation with other government departments, the food industry, health, education and consumer organisations. A series of focus groups were carried out to test consumer reaction to the logo. Resources bearing the 5 A DAY logo that explain the 5 A DAY message and suggest ways of increasing fruit and vegetable intake are being distributed through primary care settings. The 5 A DAY logo can be also used on foods - designed to be a trusted symbol that aims to provide a consistent 5 A DAY message and help consumers to meet the target.

Evaluation and monitoring: A framework is being developed, to assess the impact of the 5 A DAY programme on consumption, attitudes and awareness. As part of the evaluation of the local 5 A DAY pilot projects, a validated questionnaire has been developed. The short questionnaire provides a simple, practical tool for assessing change in population intakes and can be used to evaluate the effectiveness of other population interventions. The Department has also funded the development of validated tools to assess the impact of the National School Fruit Scheme on children’s diets and wider. The Health Survey for England aids the monitoring of population trends in BMI, physical activity and fruit and vegetable consumption.

Contact: For more information on the 5 A DAY programme, please email fiveaday@doh.gsi.gov.uk or visit our website at www.doh.gov.uk/fiveaday.

References


17. Community Food Initiative, Wales, UK

Aim: The aim of the scheme is to increase healthy eating, especially in disadvantaged areas, by assisting the development of community food initiatives. Examples of initiatives which are eligible for funding include: cooking classes, breakfast clubs, fruit tuck-shops, community cafes, food co-operatives, fruit and vegetable box schemes and food growing projects.

Policy / Initiative: While dietary intake in adults in Wales had improved over the ten years prior to the launch of the scheme, social class differentials in food intake had generally remained
constant, with those from socially disadvantaged groups consuming less of recommended foods such as fruit and vegetables, wholemeal bread, low-fat milk and oily fish. Social class differentials are also evident for coronary heart disease, overweight and obesity in Wales. (Sources of evidence include Lifestyles Changes in Wales: results from the Health in Wales Survey 1985 – 1986; 1998 Welsh Health Survey; Health Behaviour of Schools aged Children in Wales surveys, 1996, 2000). There was a need to develop innovative ways of tackling inequalities in dietary intake. Community initiatives involving a variety of partnerships have a key role to play in this area, through activities such as food co-operatives and community cafes which address the identified barriers to healthy eating in low-income communities, namely the lack of availability and high cost of healthy food items. (Sources of evidence include The Scottish Community Diet Project (funded by Scottish Executive) and Sustain)

Description: The Community Food initiative was launched in 2000. It provides small grants of up to £5,000 to fund local activities that improve healthy eating. The initiative is specifically targeted at disadvantaged groups and areas. The initiative aims to support the Welsh Assembly Government’s work to tackle social exclusion by addressing issues of inequality, improving basic cooking and budgeting skills and addressing issues such as the cost and availability of healthy foods. Projects are advised to focus their activities around the nutritional guidelines outlined in line with national nutritional recommendations. The initiative is open to any non-profit making group as long as they have a constitution and can demonstrate proper control of their financial and general affairs. Project bids are assessed against the following criteria:

- aim to improve healthy eating at the local level, by increasing access, addressing cost or improving skills;
- address inequality issues;
- evaluate effectiveness;
- demonstrate sustainability beyond the funding period.

Twelve projects, receiving between £443 and £4,976 each, were funded in the first round of the scheme (2000 & 2001). A further twenty projects, receiving between £400 and £5000 each, are being funded through the second round (2002 & 2003). Projects funded to date include:

- Fourteen projects funding cooking skills / nutrition / budgeting skills courses for vulnerable and disadvantaged groups across a wide range of settings including low income families, homeless, teenage mothers, people with mental health difficulties etc.;
- Four projects funding daily breakfast clubs for children;
- Three projects funding fruit tuck shop in schools;
- Four growing projects for people on low incomes, people with disabilities or learning difficulties;
- Three projects aimed at increasing access to fruit and vegetables for ethnic minority groups, patients referred to exercise referral schemes and young children and parents from low income families;
- A ‘nutrition and food safety’ workbook for young homeless people;
- A pictorial healthy eating recipe book for school pupils with learning difficulties.

Partners and Sectors involved: A wide range of partners and sectors are involved. These include voluntary organisations, local government, schools, National Health Service, workplaces, social services, food producers, retailers.

Evaluation: As part of the criteria for funding, the projects are required to evaluate their impact. From the reports provided by projects at the end of the first round of funding it became clear that the evaluation advice given in the format of a one-day seminar for all projects was insufficient.
Therefore for the second round of funding a consultant was commissioned to provide advice to individual projects for the first year to enable them to set up appropriate monitoring measures and evaluation processes. An overarching evaluation of the scheme was carried out during the latter half of 2002. The evaluation acknowledges that the Community Food Initiative, through the funding of a wide range of projects, has engaged with target groups at high risk of nutritional imbalance and preliminary results suggest that activities have had a beneficial effect on many of the barriers to adopting healthy food choices. Key recommendations are that the current work should be developed to embrace a wider number of projects, identify key/demonstrative projects for long term funding, and assist development, implementation and evaluation procedures by the establishment of a centralised, co-ordinated, networking agency. An enhanced scheme reflecting these recommendations is due to be launched in Autumn 2003.

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Background - the context of the school: Abbey Park Middle School is situated close to the centre of Pershore, a small Worcestershire town between Worcester and Evesham. It caters for 215 pupils aged nine to twelve. It is a friendly and welcoming school with three classes in each of the three year groups. The catchment area of the school provides an interesting socio-economic mix, serving families from the large council estates either side of the A44, recent modern housing as well as some settled traveller families. It has become an increasingly popular choice of school for pupils experiencing both behavioural and learning difficulties, and many successes have been celebrated. As there is no schools’ meals service in the county, the free school meal figure does not reflect accurately the number of children that are eligible for free school meals.

One of the many strengths of the school is that it spans two key stages of the national curriculum, giving the unique advantage of being able to build on the work of the first school, act positively on assessment procedures at 11 and build the foundation of key stage 3. Overall attainment on entry is broadly average. The school takes pupils from a number of local first schools. It also links with the local high school to which the majority of pupils go when they leave school. Attendance has traditionally been good in the school although the unauthorised absences figure does remain high. Attendance is recorded on SIMS, where patterns can be easily noted.

The school’s main aim is to provide a well ordered and caring environment for pupils where they can enjoy learning and reach their full potential, thus preparing them for the next phase of education. In addition, the school aims to develop strong partnerships with parents and the community in order that they can work together to achieve success for all pupils; and support the maturing child during the formative middle years of education and ensure that they are well prepared both academically and socially for the next stage of their education.

What the school did: As part of the healthy schools programme, the school has a strong emphasis on healthy living including eating and exercising. They have put into place three elements to ensure the focus on health is as strong as possible:

1. a lunchtime programme called ‘Huff and Puff’ for a few years. It was decided to put more into the scheme by employing a supervisor, Amy, to take responsibility for promoting and developing physical activity at break times and lunchtimes. She was paid for out of the school budget.
2. transformed the school tuck shop. The PE subject leader approached a local supplier, who agreed to supply the school with a variety of fruit and vegetables for a trial period. If pupils
buy ‘unhealthy’ options from the tuck shop, they must also buy 5p’s worth of fruit. Parents have supported this and pupils now eat fruit on a regular basis at break times and lunchtimes.

3. appointed a school nurse to run drop-in sessions. She is kept fully informed of out-of-hours school sport activities and counsels and encourages children to join.

Within the Huff and Puff programme, Amy’s main tasks are to plan what goes on at break times and lunchtimes and to oversee Year 7 pupils who run the ‘loan shop’. Pupils buy a key-ring which they can then use as a deposit for equipment they borrow from the loan shop. This gives them more control over what they do. Amy has completely reorganised what goes on in the playground and joins in with games and activities. In particular, she has reorganised the football so that pupils can deal better with competitive aspects that led to arguments in the past. Her work in the playground is supported by circle time developed through the behaviour support services, including a ‘life skills’ project led by a member of staff. One of the main features of Amy’s work is to reward pupils who reach set activity targets by giving them play equipment. This has been bought through sponsorship from local businesses. The PE adviser, who provided training for her midday supervisor colleagues, has supported Amy’s work. The training focused on how to organise and develop purposeful play. It included: communication and organisation skills, a range of ideas that could be used how to organise and use space.

What difference did it make? Pupils who did not take part in out-of-hours school sport in the past have started to attend. This includes a number of children who are overweight. Pupils are eating more fruit and now see it as ‘cool’. Pupils are noticeably more tolerant of each other. This has led to less disruption in lessons and during the changeover between lessons. Teachers have noticed greater co-operation between pupils. Midday supervisory staff are more confident and take a positive part in developing and improving lunch times. Behaviour in the playground has improved. Since Amy started work, the number of serious misbehaviour incidents has more than halved. This has saved considerable time for senior staff.

Why did it work? Providing opportunities and support for positive play has been very important. Amy provides structure, purpose and rewards, and has been central in changing the way pupils play. The support in school through circle time reinforces what the school expects. This gives Amy the support she needs and ensures that break times and lunchtimes are seen as part of the learning that takes place each day. Working closely with parents and pupils has helped to change attitudes. Using the health support staff has reinforced our messages effectively. The most important factor has been to get pupils to see the link between eating well, physical activity and feeling good about themselves.

How was the information collected? Behaviour incidents sheets were monitored, teacher interviews with a sample of key pupils were conducted and pupils kept diaries.

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19. Local Exercise Action Pilots (LEAP), England, UK

**Background:** There is substantial evidence to support the role of physical activity in promoting good health. Regular physical activity decreases the risk of coronary heart disease, stroke and diabetes, and the associated risk factors such as hypertension and obesity. Currently, six out of ten men and seven out of ten women are not meeting the recommended half an hour of moderate intensity physical activity on five or more days a week. There is a similar picture for children with four out of ten boys and six out of ten girls not meeting the recommended hour a day physical activity.
However, there is limited evidence within the UK of the effectiveness of community approaches to increasing physical activity within target groups. The LEAP programme will test out such approaches through Primary Care Trusts (PCTs) by running nine regional community pilots, based on the concept of the successful *Five a day* pilots, details of which can be found on www.doh.gov.uk/fiveaday. The ongoing results will inform and lead action on physical activity across all PCTs.

The LEAP programme will test out different evidence based community approaches to increasing the numbers of adults and children in deprived, priority groups who take regular, moderate intensity physical activity and to reducing the numbers of sedentary adults and children. The programme is funded in partnership with the Countryside Agency, Sport England and the Department for Health.

**Objectives:**
1) to fund one community physical activity pilot within each of the nine government office regions over three years, with activities aimed at increasing opportunities, focusing on high risk and disadvantaged groups; 2) to develop strong national and local strategic partnerships between health/sport/leisure/education/countryside/environment local authority and other organisations that will facilitate the development of effective community exercise programmes; and 3) to evaluate the effectiveness of PCT led, community approaches to increasing physical activity; and 4) to test ways of delivering the objectives and milestones of the National Service Frameworks for CHD, diabetes, older peoples, mental health and the Cancer Plan that are related to physical activity and relevant targets within the NHS Planning and Priorities Framework (PPF).

**Methods:** During the autumn of 2002, each of the nine government regions selected up to four Primary Care Trusts to work up full applications to apply to be part of the LEAP programme. The closing date for applications was 10 January 2003, and selection of the final nine pilot sites has now been completed. There will be a six-month start up phase and pilot activity will begin in September 2003 and will continue for two years. A further six months will then be dedicated to completing the evaluation and final report. An interim report will be produced in December 2004. Individual pilots will aim to reach a minimum of 50 000 people, covering target groups of around 1 000 people. Each pilot site will receive up to £200,000 funding over two years to develop interventions. Each pilot will be led by a PCT and all nine will be based in a neighbourhood renewal fund areas. They will be based in a range of urban, rural, market town and Sport Action Zone settings.

Pilot interventions will be directed at one or more of the following specific target groups: pre-school children, young people, older people, black and minority ethnic groups, people at high risk of illness such as diabetes and heart disease, and people recovering from CHD or stroke. Each pilot will target the above groups but will not be expected to cover all these locations and target groups.

**Case Study 1: Aim and target audience**

To develop a preventative pilot programme targeting 5-14 year olds. Also a specific programme to give young people 11-14 who are identified as sedentary, from deprived and disadvantaged market town areas, the knowledge and skills necessary to become physically active and become change agents within their peer groups. The pilot will centre delivery on partnership working creating strong links between physical activity and health whilst contributing to the evidence base and ensuring equal opportunities and access for all.
Interventions

1. A preventative programme delivered in schools which aims to develop knowledge, skills and understanding of both children and teachers in relation to health related fitness, and link skill related fitness components of physical education and sport.
2. A series of three one-week camps over the summer months for a total of 150 young people aged 11-14 who have been identified as sedentary or at risk of exclusion. These will aim to encourage the adoption of a healthier lifestyle for the future as well as improve their self-esteem and confidence.
3. A young people’s forum to give a structured platform for young people to articulate their views, ideas and suggestion around physical activity in their schools and communities.

Case Study 2: Aim and target audience

To increase the number of adults aged 50 years and older who take regular moderate physical activity by 5% and reduce the number of sedentary adults in the age group by 10% within the most deprived areas of Nottingham PCT.

Interventions
1. Audit of local opportunities and barriers to physical activity for older people within target areas of the city.
2. Community-wide multi-component campaign to promote physical activity by increasing public awareness of the benefits of active living and how to live an active life locally by creating a network of older people’s activities.
3. Involving older people in developing activities to overcome the extrinsic barriers to activity participation.
4. Physical activity peer mentoring by developing a training programme to empower motivated older people who are involved in group activities to be physical activity peer mentors.
5. A client-centred, individually adapted behaviour change programme and training of PCT staff.

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Other country experiences

Many countries reported₃ participating in and initiating many programmes and networks to reduce NCD and to promote healthy lifestyles, including healthy diets and physical activity. Several of these are listed here. This is not an exhaustive list.

- The National Healthy Eating Campaign in Ireland targets the whole population with special focus on low-income groups. Media, NGOs and the private sector are all involved. One of the main success criteria is the raised awareness of the Healthy Eating Guidelines.
- Happy Heart at Work in Ireland is a workplace programme which includes healthy eating, physical activity, smoke-free environment and stress reduction. The Department of Health and the Irish Heart Foundation are involved. One of the success criteria is behaviour change motivated in changes in food supplies i.e. less fat, more fruit and vegetables, less salt and sugar.
- The Public Health Education Programme in Turkey is designed for health workers and the community and aims to promote adequate, balanced and healthy nutrition in the community. It is done through educational materials, training of trainers and education in the community. The programme has an evaluation mechanism built in.
- The Martignacco Project in the Italian municipality of Martignacco aims to improve diet and lifestyle. The success criteria are decreased blood cholesterol levels and decreased CVD morbidity.
- In Spain, the Ministry of Health, the Ministry of Education and Sports and parent-student associations collaborate to promote healthy nutrition and physical activity at school. Activities include speeches, films, and competitions.
- A weight reduction programme in Malta is aimed at adults through education, empowerment and support. Also in Malta is a cancer prevention programme aimed at the whole population through information and increased awareness of risk factors.
- A breastfeeding promotion programme, such as in Bosnia and Herzegovina, is aimed at health professionals and mothers through training of health workers and breastfeeding counsellors. Health and education centres work together. Success criteria include knowledge on breastfeeding and the number of Baby Friendly Hospitals.
- The First Croatian Health Project targets 18-65 year-olds through the education of public health specialists in health promotion. Milestones and indicators defined for evaluating success are the prevalence of obesity, hypercholesterolaemia, prevalence of hyperlipidaemia, knowledge, attitudes and practices in food consumption and physical activity.
- In Estonia, the Heart health project (Heart week, Heart day) (1996-ongoing) is designed for the whole population through activities and materials using media, organizations, schools, kindergartens etc.
- The Health Promoting Physical Activity in Finland targets the whole population through the joint work of members from sports, health, education, health promotion and research.
- Heart and Nutrition programme (1997- ongoing) in Finland, is aimed at the whole population. The programme was planned by a Heart Health Committee having members of all sectors of the society. The Committee Report has over 100 recommendations for different sectors. Bi-annual Nutrition Report summarizes the main findings in development of nutrition and so does the Public Health Report on health issues. The programme is evaluated at regular intervals.

₃ Working groups on the Global strategy for diet, physical activity and health, WHO Nutrition counterparts meeting, Athens, 26/02-02/03 2003
• DEHKO-Prevention of type 2 diabetes in Finland, aimed at the whole population but specifically at diabetes high-risk groups and patients with newly diagnosed DM. The main activities include:
  o Health promotion in municipal action and budgeting plans
  o Training in nutrition expertise among primary health care workers
  o Development of postgraduate training for care, nutrition and education personnel in nutrition, weight control, physical activity and prevention of NCD
  o National guidelines on screening for adult population
  o Low threshold model in health promotion to reach groups outside normal services
  o Focus on welfare of children, young people and families
  o Risk test form in use in primary health care and early guidance and care for newly diagnosed persons
  o Effective implementation of the proposals of the Committee on Health Promoting Physical Activity
  o Effective implementation of the recommendations of the National Nutrition Action Plan
  o Health Media-project to support media publicity in implementation of DEHKO

• “A small decision a day” in Finland is a programme on prevention of obesity and on promotion of physical activity; organised by the Finnish Heart Association, Cancer Association, Sport for All Association and Diabetes Association and others (2000-2003); activities include:
  o Group model in weight loss and weight control for the use of health care professionals and training of group leaders
  o Peer group activities in health behaviour changes
  o Material for the professionals and the clients
  o The material and training programme contains information on weight loss, on changing of eating and activity habits and on group training and leading

• The North Karelia project, Finland, started in 1972 and was one of the first WHO cooperative programme on CVD community-based prevention, launched in 1974. The name of the programme was "Comprehensive cardiovascular community control programmes in Europe". Finland (North Karelia), the German Democratic Republic, the Federal Republic of Germany, Hungary, Italy, Norway, Switzerland, USSR, Yugoslavia all participated in the programme. The programme was focused on a healthy lifestyle and countries reported numerous activities in the field of diet. The CINDI programme evolved from this programme. The North Karelia (Finland) programme was formulated, launched, further developed and evaluated in close cooperation with WHO\(^4\).

• In Denmark fat intake has gone down, but not based on just one intervention. Denmark has a new national policy on obesity control (available in English Spring 2003).

• Slovenia has been developing an action plan on nutrition and physical activity. An example of this would be the Radenci Declaration formulated last year with active CINDI participation.

• In Norway the rate of heart disease deaths has gone down, but not in association with one particular intervention, and in both Norway and Sweden there has been some increase in vegetable and fruit intake through the influence of varying factors.

\(^4\) e.g. WHO REGIONAL OFFICE FOR EUROPE publish (ISBN 92 890 1006 1) the results of the 1972-1977 evaluation of the North Karelia programme
• the CINDI programme in many countries and its impact on reducing serum cholesterol;
• the Baby friendly Hospital Initiative and its positive impact on increasing rates of exclusive breastfeeding (e.g. Spain).
• the development and implementation of National Food and Nutrition action plans in many countries of the region.
• Health Promoting Schools.
• the 5-a-day programme to increase fruit and vegetable consumption (although it was noted that this initiative needed more focus since at the moment it was not considered sustainable due to a lack of long term results).
• mass media or local interventions on healthy diet that have been measured as being successful (e.g. the Netherlands).
• Physical activity promotion programmes (e.g. “Slovenia on the move”, where physical activity is promoted intersectorally and is planned for every municipality. It includes a 2 km walking test to measure fitness test.
• health promotion in rural populations (e.g. Slovenia);
• healthy eating awareness campaign for low income groups (e.g. in Ireland, where such a programme was evaluated and the group did change their consumption);
• Salt iodisation programmes (e.g. in Switzerland where iodisation of salt started 8 years ago and now 90% of salt is iodised, similar programmes in Turkey, Italy);
• Wide dissemination of dietary guidelines (e.g. in Italy, distributed to 8 million families and an improvement of 5-6% in dietary patterns was measured.
• exclusive breastfeeding increased through BF programmes (e.g. Israel)
• programme on reducing salt intake (e.g. in Portugal where blood pressure decreased in community studied);
• community-based programmes to increase the intake of fruit and vegetables (e.g. in the UK where a 1-portion increase was measured in the low consumers).
• Active living in the city is a priority for the cities of the WHO Healthy Cities Network. For this purpose the Multi-City Action Plan on Active Living was established. Belfast, Dublin, Mechelen, Rotterdam and Turku are the lead cities of this group. They have produced guidelines and excellent case studies for promoting active living for all citizens in cities.

5 Countries participating in the CINDI Programme: CINDI Austria, Belarus, Bulgaria, Croatia, Cyprus, The Czech Republic, Estonia, Finland, Germany, Hungary, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Malta, Poland, Portugal, Republic of Moldova, Romania, Russian Federation, Slovakia, Slovenia, Spain (Catalonia), Turkmenistan, Ukraine, United Kingdom (Northern Ireland)
Annex 5: The European background paper

The process for the global strategy on diet, physical activity and health

Introduction
The reduction of noncommunicable diseases (NCD) through the promotion of healthy, affordable and accessible food and physical activity demands a global response. There are limits to what individual countries can do to promote optimal diets and healthy living on their own. Such a global strategy should be multisectoral and have a long-term perspective addressing all major risks for chronic diseases.

The strategy should be designed to focus on having a positive impact on low-income communities. The strategy should also be age-sensitive and have a life-course perspective to NCD prevention and control. This starts with maternal, infant and child/adolescent health services, includes school and workplace structures as well as home-based care for older people and disabled people. Furthermore, the strategy should be gender-sensitive as women often make the decisions about food in the household, and patterns of physical activity differ by gender and age.

The purpose of this paper is to provide a background to the European Consultation; provide a European perspective to the global strategy; ensure that the global strategy will be relevant to the specific challenges encountered by the European Region; highlight the policies and programmes in the WHO European Region that are aimed at the prevention and control of NCD; illustrate European innovative practices and strategies for possible use in other Regions; continue to be a part of a global effort to reduce NCD through comprehensive approaches; and provide an overview of WHO Regional Office for Europe's work in this field.

The evidence in the European Region

Noncommunicable diseases in the European Region
The European Region suffers the greatest proportion of deaths from noncommunicable diseases (NCD) in the world (Figure 1). NCD cardiovascular diseases (CVD) and cancers dominate as causes of premature death in the WHO European Region (Figure 2). CVD, for example, cause over 4 million deaths per year in Europe. Coronary heart disease (CHD) is the most common cause of premature death, accounting for 16% of all premature deaths in men and 12% in women. Moreover, in the countries of central and eastern Europe and the newly independent states, CHD mortality is almost double that in the European Union (EU) and is still rising in many countries. The picture for stroke is the same. In western Europe, deaths from CVD are declining, but prevalence appears to be increasing. The risk of CVD increases with age, and improved survival rates mean that, with an ageing population, a greater number of Europeans live with impaired cardiovascular health.
Fig. 1  Putting Europe in global context

Deaths, by broad cause group and WHO Region, 2000


Fig. 2  Main causes of death in WHO European Region

Source: WHO Health for All database 2001

* EU=European Union, NC=Nordic countries, CCEE= Countries of Central and Eastern Europe, NIS and CAR= Newly Independent States and central Asian republics.

Approximately 20-30% of adults in the European Region are obese 6, and obesity shows escalating rates in children, increasing their future risk of CVD (ASTRUP 2001). The prevalence of overweight and obesity among children is rising significantly in eastern and western Europe as clearly shown by trend data on overweight and obesity in 10 year olds (International Obesity

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6 Obesity is defined as a body mass index (BMI) of 30 or more; BMI is determined by dividing one’s weight in kg by one’s height in m².
For example, in the Czech Republic the percentage of overweight and obese children increased from 10 to 13% from 1991 to 2000 respectively, and from 8 to 18% from 1994 to 2000 respectively in Poland. In France data is available from the early 1960s and shows an increase from 3% childhood overweight and obesity in 1963 to 16% in 2000. In 1999 Hungary reported that 20% of children aged 11 to 14 years are obese, and that 6% of these obese children suffer from hypertension (WHO Regional Office for Europe nutrition programme unpublished survey material). The major problem associated with childhood and adolescent obesity is its persistence into adult life and its association with increasing cardiovascular disease and diabetes risk in later life and with premature death (e.g. Nicklas et al. 2002; Maffeis, & Tato 2001).

Preliminary analyses suggest that poor nutrition accounts for 4.6% of the total disability-adjusted life-years lost in the EU, with obesity and physical inactivity accounting for an additional 3.7% and 1.4%, respectively.

Diet

Detailed analyses have shown that at least 75% of CHD could be prevented if smoking was eliminated and diets and levels of physical inactivity were to be improved dramatically (Stamler J et al., 1999, Magnus et al., in press). It is increasingly recognised that dietary factors are involved in explaining a large proportion of the differences in cardiovascular diseases seen in Europe. The update of the Global Burden of Disease prepared by WHO includes an estimate of the quantitative contribution of dietary risk factors in the European Region. Hypertension, high serum cholesterol levels, obesity and low intake of vegetables and fruit, along with smoking, contribute to the top 5 most important risk factors (Figure 3).

Fig. 3 Deaths in 2000 in Europe attributable to selected leading risk factors

Diets rich in a variety of vegetables and fruit are protective against CHD and stroke: the more vegetables and fruit consumed, the stronger the protection (e.g. Klerk et al 1998; and Veer van’t et al 2000). Estimates show that a mean increase in vegetable and fruit intake of 150g/day could reduce the risk of CHD mortality by 20-40%, stroke by up to 25% and CVD mortality by 6% to
22%, with the lowest estimates accounting for the impact of smoking and/or heavy drinking on CVD (Klerk et al 1998).

The population nutrient intake goals for consideration by national and regional bodies establishing dietary recommendations for the prevention of NCD are presented in Figure 4.

Fig. 4 Ranges of population dietary intake goals

<table>
<thead>
<tr>
<th>Dietary factor</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total fat</td>
<td>15-30% energy</td>
</tr>
<tr>
<td>Saturated fatty acids</td>
<td>&lt; 10% energy</td>
</tr>
<tr>
<td>Polyunsaturated fatty acids (PUFAs)</td>
<td>6-10% energy</td>
</tr>
<tr>
<td>n-6 Polyunsaturated fatty acids (PUFAs)</td>
<td>5-8% energy</td>
</tr>
<tr>
<td>n-3 Polyunsaturated fatty acids (PUFAs)</td>
<td>1-2% energy</td>
</tr>
<tr>
<td>Trans fatty acids</td>
<td>&lt; 1% energy</td>
</tr>
<tr>
<td>Monounsaturated fatty acids (MUFAs)</td>
<td>By difference (^1)</td>
</tr>
<tr>
<td>Total carbohydrate (^1)</td>
<td>55-75% energy</td>
</tr>
<tr>
<td>Free sugars (^1)</td>
<td>&lt; 10% energy</td>
</tr>
<tr>
<td>Protein (^1)</td>
<td>10-15% energy</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>&lt; 300 mg/day</td>
</tr>
<tr>
<td>Sodium chloride (sodium) (^1)</td>
<td>&lt; 5 g/day (&lt; 2 g/day)</td>
</tr>
<tr>
<td>Fruits and vegetables</td>
<td>&gt; 400 g/day</td>
</tr>
</tbody>
</table>


Part of the political commitment needed to promote healthy diets should include the translation of these nutrient population goals into food-based dietary guidelines (FBDG) at a national level. Ministries of health should endorse FBDG that are consistent and easily understood. Specific recommendations will vary from country to country based on the availability and cultural acceptance of foods. To make their implementation feasible and effective, FBDG must take account of dietary patterns and the prevalence of both deficiency disorders, especially iodine and iron, and NCD prevalence in each country. Health professionals should review the premature mortality rates, morbidity data and the available data on dietary intake and nutritional status before developing national FBDG. This will ensure that the recommendations are tailored to correspond with national conditions. In addition, FBDG should be in accord with public policies that promote exclusive breastfeeding for 6 months, food safety, a healthy environment and a robust local food economy.

A comparative analysis of food-based dietary guidelines in WHO European Member States reported that of the 48 countries participating in a WHO survey on FBDG, 25 reported having national, government-endorsed food-based dietary guidelines (*Food-based dietary guidelines in WHO European Member States*. WHO, 2003). However, during the Athens nutrition counterpart meeting (28 Feb-2 March 2003) most European Member States reported poor eating habits in all age groups (Working groups, WHO Nutrition counterparts meeting, Athens 2003). For example, Nordic and Baltic countries reported that their populations have a high intake of saturated fat (> recommended 10% of energy intake\(^7\)), a high intake of salt (> 5 g/day), a low intake of vegetables and fruit (< recommended 400 g/day), high blood pressure (> recommended 140/90 mmHg), high serum cholesterol (> recommended 5.2 mmol/l). Many countries also reported a high intake of sugar (> recommended 10% of energy intake). Children and young people have the highest sugar intake of all age groups. Combined with smoking, it was agreed that if tackled

successfully reduction in these risk factors could help reduce prevalence of obesity and noncommunicable diseases (NCD) significantly.

**Physical activity**

The latest WHO burden of diseases study indicates (Figure 3) that lack of physical activity is among the top leading risk factors to which diseases burden in Europe is attributed. Regular physical activity has considerable health benefits, such as reducing the risk of coronary heart disease, cerebrovascular disease, diabetes, and osteoporosis (Vuori, 2001). Physical activity also plays a role in overweight and obesity: people with low levels of physical activity have higher body fat and abdominal fat and are more likely to gain body fat than those with high levels of physical activity (Prentice & Jebb 1995). Physical activity contributes to maintaining lower blood pressure throughout life and to lowering the ratio of LDL to HDL cholesterol in the blood. It is also associated with reductions in the risk of colon cancer, and with maintaining physical functionality in older people (i.e. reducing the risk of osteoporosis), as well as alleviating the symptoms of depression.

In the most sedentary people, health benefits can be obtained with as little as 30 minutes per day of moderate physical activity. This is important when trying to identify strategies that are cost effective and feasible. Thirty minutes of walking or cycling per day (in 2 episodes) is equivalent to the distances that are covered by 50% of urban trips presently done by car. If this message can be clearly conveyed, synergies with the transport and urban planning sectors can be identified as feasible and effective in increasing levels of physical activity. These arguments can be used to advocate more physical activity through, for example, commuting to school and to work (e.g. in combination with public transport) (A physically active life through everyday transport WHO 2002).

The World Health Report 2002 illustrates the differences in physical inactivity levels within the European Region. Specifically, the “EURO C” (low child mortality, high adult mortality) countries8 are estimated to have the highest prevalence of physical inactivity throughout the world (24 % among over 15 year olds) and an attributable fraction of mortality from physical inactivity in the range of 8 – 10 %. This is higher than in western European countries and some CCEE (“EURO A” (very low child and adult mortality) and “EURO B” (low child, low adult mortality) according to the WHR 2002.

The physical activity levels of children have been assessed (Currie et al 2000). As they grow older children do progressively less exercise. The proportion of 15-year-olds who report taking part in sports outside school at least twice a week varies, in girls, between 37% (Greenland) and 66% (Czech Republic), and in boys between 60% (Greenland) and 90% (Northern Ireland) (Currie et al 2000).

In school children, associations between physical activity and eating patterns have been observed in some countries. For example in the German survey (Müller et al 1999), involving 3,400 children aged 5 to 7 years, lower physical activity was associated with unhealthy eating patterns. The survey found that the consumption of confectionery and ‘fast’ foods was significantly greater among children watching more than one hour of television per day, compared with children watching less television (Müller et al 1999).

The data on levels of physical inactivity in European adults are inadequate. However one survey (only EU Member States) shows that physical inactivity levels in EU countries are high, with on average 32% of adults not carrying out any leisure-time physical activity in a typical week. In

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8 Belarus, Estonia, Hungary, Kazakhstan, Latvia, Lithuania, Republic of Moldova, Russian Federation, Ukraine
general, adults in Southern EU countries appear to have lower levels of physical activity than Northern and Western countries (Institute of European Food Studies, 1999).

Most European Member States reported (Working groups, WHO Nutrition counterparts meeting, Athens 2003) physical inactivity is a problem in all age groups. The prevalence of inactive lifestyles is reportedly a problem in many countries. It is also indicated that physical activity and healthy diet are often neglected as topics and practices in workplaces and in schools.

**Issues to consider when formulating European recommendations**

These issues are meant to:

- generate thought in preparation for the European consultation on the Global Strategy on Diet, Physical Activity and Health 2-4 April in Copenhagen;
- generate discussion during the European consultation;
- help formulate European recommendations to the Global Strategy; and
- help formulate recommendations for further action in the European Region.

**Evidence: data on health implications of diet and physical activity**

<table>
<thead>
<tr>
<th>Discussion points</th>
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<tbody>
<tr>
<td>Should one sector take the lead on data gathering or should it be collaborative effort?</td>
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<tr>
<td>How can health professionals make a convincing case to governments address diet and physical activity?</td>
</tr>
<tr>
<td>How can governments (at all levels) prioritise intersectoral policies to improve diet and increase levels of physical activity? (E.g. carry out a national burden of disease study which would help show the relative importance of risk factors in each country.)</td>
</tr>
<tr>
<td>How can obstacles to political commitment regarding obesity and NCD reduction be overcome?</td>
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<tr>
<td>How are scientific advisory boards created, and how can they be improved?</td>
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<tr>
<td>How can “short-term” political goals be rationalised with “long-term” benefits of investing in prevention of obesity and NCD?</td>
</tr>
<tr>
<td>What are effective ways to ascertain the levels and trends of major risk factors for chronic disease?</td>
</tr>
<tr>
<td>How can data collection best be harmonized for comparison within a country and internationally?</td>
</tr>
<tr>
<td>What are the barriers to establishing standards and norms for diet and physical activity and how can these be overcome?</td>
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</table>

**Prioritising noncommunicable disease prevention**

When asked about the process of gaining political commitment on implementing strategies to reduce levels of chronic diseases and obesity, some countries (Working groups, WHO Nutrition counterparts meeting, Athens 2003) cited obstacles, such as:

- Obesity is not always considered a disease by policy makers;
- Even if government states its commitment to reduce obesity and NCD, the appropriate funding is not always allocated;
- Other relevant sectors (transport, education) may not be as committed and knowledgeable about obesity and NCD prevention.
Governments may want a simple solution, but the issue of obesity and NCD prevention is complex and requires a multifaceted approach; and

Reforms such as tax increases and restricted marketing are often unpopular.

It would be appropriate for ministries to refer to the global burden of diseases analysis (Murray & Lopez, Global burden of diseases study, WHO 2002) and consider establishing systems for estimating the relative contribution of different national risk factors. The burden of disease is currently assessed in terms of "disability adjusted life years" (DALYs). These incorporate an assessment of the years of life lost (YLL) before the age of 82.5 for females and 80 for males from different diseases and the years spent in a disabled state (YLD). Non-fatal health states are assigned values (disability weights) for estimating YLD based on surveys. Years lost (severity adjusted) to disability are then added to years lost to premature mortality (YLL) to yield an integrated unit of health, the DALY (disability adjusted life year), where one DALY represents the loss of one year of healthy life.

There are positive economic consequences to reducing NCD, and if this argument can be conveyed beyond health circles, there could be better chances to gain broad support and identify win-win opportunities by establishing partnerships with other sectors. In the early 1990s, the German Ministry of Health did an estimate of costs related to diseases and found that among the diet-dependent diseases, the highest costs were generated by cardiovascular diseases – approximately DM33 billion (12% of the total national health care costs) (Kohlmeier et al 1993). In the United Kingdom, Liu et al. (2002) estimated that CHD cost £1.65 billion to the health care system, £2.42 billion in informal care and £4.02 billion in productivity loss. The total annual cost of CHD was £8.08 billion, the highest category of disease in the UK for which comparable analyses have been done.

In the United States, the overall estimate of the costs of illnesses associated with dietary factors and physical activity patterns\(^9\) reportedly amounts to US$137 billion (Kenkel & Manning 1999; Wolf and Colditz 1998). The estimates are based on the assumption that dietary factors and sedentary lifestyles contribute 60% of diabetes, 35% of breast, colon, and prostate cancers, 30% of gall bladder disease, 25% of arthritis and 20% of heart disease and stroke.

In Europe, an estimated 2-7% of health care costs are directly attributable to obesity (Obesity - ... Report of a WHO Consultation 1998). Direct costs of obesity to the health budget have been estimated in the Netherlands (Seidell and Deerenberg 1994), France (e.g. Levy et al 1995; Detournay et al, 2000), Germany (Kurscheid and Lauterbach 1998) and Sweden (Sjöstrum et al 1995). The indirect health care costs attributable to obesity are also estimated to be substantial, for example, 3-4% in Germany (Kurscheid and Lauterbach 1998). The avoidance of childhood diseases through breastfeeding has also been estimated to reduce the economic costs to society (E.g. Kaiser Permanente Study, 1997; Holtermann et al 1998).

A study in Switzerland (Incidence économique...Office Fédéral du Sport, 2001) estimated that insufficient levels of physical activity cause 1.4 million cases of disease and 2000 deaths and cost about Sw.fr. 2.4 billion per year. In England, the estimated annual direct and indirect costs of obesity in 1998 amounted to £2.6 billion, and if present trends continue these costs may increase by a further £1 billion per year by 2010 (Tackling obesity in England, 2001).

An increased consumption of fruit and vegetables – proven to help reduce the risk of some cancers - is much more cost beneficial than treating cancer as shown in Norwegian and Danish

\(^9\) Heart disease, diabetes, stroke, osteoporosis, gall bladder disease, breast cancer, colon cancer, and prostate cancer
studies (Cost-effective evaluations … 1998; and Gundgaard et al 2002). The Norwegian group calculated the cost of treating each patient with cancer as 250,000 NKK. They estimated that potentially NKK 3 million could be saved if cancer cases were prevented and NKK 1.5 million if the cases were delayed for 10 years, using prices at 1997. The Danish researchers estimated that if the Danish population doubled their intake from 250g to 500g, life expectancy would increase by 0.9 years and 22% of all cancer incidence could be prevented.

Optimal diets and minimum thresholds for physical activity levels

Thus far, research provides information on optimal diets and minimum thresholds for physical activity levels. Diet and physical activity recommendations include:

- increase consumption of fruit and vegetables, as well as legumes, whole grains and nuts to >400g/day;
- substantially increase levels of physical activity across the life span, aiming at least 30 minutes per day of moderate physical activity;
- shift consumption from saturated fats and trans-fatty acids towards unsaturated fats and, in some settings, reduce levels of total fat intake;
- encourage fish, lean meats and low-fat dairy products when consuming animal-based foods;
- reduce the intake of “free” sugars;
- reduce salt consumption from all sources and ensure salt is iodised;
- provide appropriate food information to consumers to allow them to make “healthy choices”;
- reduce heavy marketing of foods high in fat, salt and/or sugar to children; and
- support exclusive breastfeeding for 6 months and healthy infant and child feeding practices, combined with breastfeeding, up to 2 years.

However, studies on the success of diet and physical activity interventions are scarce. The number of these studies should be increased and more support invested into interventions that are effective. More research is needed to identify the most successful public health interventions (both individual and population-based). The translation of recommendations (together with effective tobacco control) into supportive national and local policies and actions require the collaboration of many stakeholders.

Policy-making: Turning evidence into policy

Discussion points

- What are the best ways to promote intersectoral collaboration?
- How can scientific findings best be fed into the policy-making process?
- What is the role of and how could we effectively engage the private sector?
- How to proceed with developing national physical activity policies?
- How to build on the success of the national food and nutrition action plans?
- What is the role of national, regional and municipal governments in developing policies for physical activity and diet?
- What should be the role of different actors including the media, NGOs, private sector, academic groups, and intergovernmental bodies?

Multisectoral collaboration

Governments cannot act alone. The combined energy, resources and expertise of the private industry (including, but not limited to, the food, beverage, sports goods, sport organizations,
retail, advertising, vehicles and gear manufacturers, insurance and media sectors), health professional bodies and consumer groups, academics and the research community are all essential to sustained progress.

An essential step towards multisectoral collaboration is to understand what is important for the other sectors involved - can they use health arguments to achieve their own goals? For example, promoting walking and cycling for health reasons is seen as a good way of moving towards sustainable development - a win-win strategy. This approach helps to identify effective strategies with better chances of attracting political and financial support. Also important is carrying out a analysis to understand the perspective of each stakeholder.

Member States reported that many sectors are involved directly or indirectly in developing strategies related to diet and increased physical activity, including: Ministries of Health, Agriculture and Fisheries, Education, Sports and Youth, Economic Development, Labour and Social Welfare (protection), Social Community and Family Affairs, Ministry of Finance and Justice to get support for financial backing and to put forth adequate fiscal policies, and Environment. Also mentioned are trade, Academy of Medical Sciences, NGOs, private sectors – fitness and sport, food industry, transport sector, urban planning, communication and advertising consumer associations, and health promotion groups.

Health ministries have a crucial role along with other ministries such as ministries with responsibility for food and agriculture policy; youth, sports policies; education policies; commerce, industry and finance policies; transportation policies; environmental/sustainability planning as well as local authorities and those responsible for urban development.

Local governments have a very important role for the following reasons:

- by and large, issues relating to sport, physical activity, urban infrastructure supportive to active living, as well as nutrition in educational and social institutions, fall within the domain of local governments;
- local governments have a greater proximity to community groups and citizens in general. Very often the success of policies and plans depends on the active involvement of civic society;
- intersectoral collaboration and partnership building can be easier at the local level; and
- local governments have the ability to mobilise local resources and to energise local communities to become active and enthusiastic participants in campaigns and efforts aimed at healthier lifestyles, for example, introducing health fairs, cycling and dancing days, etc. There is a wealth of innovative initiatives at international or national levels whose success ultimately will depend on local mobilisation.10

Member States were asked (Working groups, WHO nutrition counterparts meeting, Athens 2003) to comment on existing strategies to promote intersectoral collaboration regarding a healthy diet and increased physical activity. Examples include:

- policies and action plans for both diet and physical activity (e.g. Switzerland, Turkey, Ireland);
- nutrition and physical activity in schools (e.g. Italy, Malta);
- dietary guidelines in which there is a chapter on the daily need for physical activity (e.g. Greece);

• mass media campaigns (the Netherlands, Italy, Switzerland);
• legislation for food safety (e.g. Spain, Ireland, Turkey, Israel).

Collaboration with nongovernmental organisations and/or the private sector to promote health diet and increased physical activity was also reported in many countries. Collaboration with industry was reported in countries, for example to:

• reduce fatty dairy, to reduce size of portions and to influence marketing (e.g. the Netherlands);
• increase consumption of dairy products to reduce osteoporosis (e.g. Spain);
• increase fish consumption through collaboration with the fish board and other non-branded industries (Ireland);
• improve food quality through collaboration with restaurants and catering services (e.g. Italy);
• support Five-A-Day with the help of the fruit and vegetable industry (e.g. Switzerland, UK, Malta);
• support physical activity through collaboration with the sporting goods industry (e.g. Austria);
• bring about salt reduction in processed foods (e.g. UK); and
• promote physical activity with the fitness industry (e.g. UK: pilot initiatives in nine regions to promote physical activity with private and NGO collaboration).

Collaboration with NGOs occurs in the development of health education campaigns (e.g. the Netherlands); collaboration with national heart foundations (e.g. Ireland, Norway); collaboration with cancer societies (e.g. Switzerland, Norway); and with consumers associations (e.g. Austria, UK).

Evidence-based policy making
Scientists have the skills necessary for generating testable theories, developing methods for measuring and evaluating and for showing statistical relationships. Policy-makers have the skills for negotiating between conflicting interests, drafting and enacting legislation and ensuring that it is put into practice. But between the two fields of expertise lies an area of difficulty concerning how scientific findings are fed into the policy process.

Scientific advisory committees provide the key role, interpreting the current scientific evidence and giving opinions for policy purposes. Increasingly, scientific committees at national and international level are becoming more transparent in their activities and non-scientific members, such as consumer representatives, are being invited to participate. Furthermore, the methods for evaluating the scientific evidence are becoming clearer and more tightly structured. Evaluating scientific evidence is itself becoming a well-developed science. The sensitivity of theories and models can be assessed by checking on the importance of the various assumptions and the robustness of the predictions. Evidence can be ranked in importance according to agreed criteria such as the methods used in the research, the size of the sample and the replication of the findings.

Many countries report (Working groups, WHO nutrition counterparts meeting, Athens 2003) having such scientific bodies, specifically an intersectoral working group or a national council on diet, physical activity and lifestyle (e.g. Italy, Spain, Switzerland, Croatia, Norway).

Physical activity policies
The need to promote physical activity as an essential part of health and well being is strongly backed by findings of the World Health Report 2002 on “Reducing Risks, Promoting Healthy Living”, which lists physical inactivity among the main risks contributing to noncommunicable
disease (NCD) global morbidity and mortality. Globally, physical inactivity is estimated to cause 1.9 million deaths (in 2000) and 19 million disability adjusted life year (DALY) losses annually, and about 15-20% of cases of ischaemic heart disease, diabetes and some cancers (The World Health Report 2002). Physical inactivity influences the global burden of disease either directly or through its impact on other major risks, in particular high blood pressure, high cholesterol, and obesity. Tobacco use and poor diet, along with physical inactivity, are also major risk factors for chronic disease.

Opportunities for people to be physically active exist at work (especially if the job involves manual labour); in transport (for example, walking or cycling to work); in domestic work (housework or gathering fuel such as chopping wood); and in leisure time (participating in sports and recreational activities) (The World Health Report 2002).

Policies to promote physical activity should take into consideration urban planning policies (cycle lanes, walking routes), transport policies, and facilities at work. This can be done through health and environment impact assessments and cost-benefit analyses that, when including expected health benefits of increased physical activity, may show, for example, that providing infrastructures for cyclists and pedestrians can have high benefit/costs ratios (Saelensminde 2002). In addition, comparing costs of different transport infrastructures can be of help highlighting the affordability of investments in cycling and walking facilities. For example, estimates from the Netherlands indicate that while the cost of 1 km of motorway is in the order of €9 million and that of 1 km of national road €4.5 million, the cost of building a 1 km high quality cycle lane would be at least one order of magnitude lower, and cost something in the range of €0.45 million (CROW Faster by bike. Policy guideline for cycle-friendly infrastructure).

Physical activity-promoting policies are the responsibility of many sectors: urban planners can develop policies to make walking, cycling and other forms of exercising easy and safe; schools can ensure that children receive daily physical activity; workplace policies can support physical activity breaks; and sport and recreation facilities should be involved in improving access to 'Sport for All' concepts and principles. The combined impact could be a major increase in activity levels across the life-course.

Transport and land use policies are very important determinants for physical activity. Transport volumes and the number of motor vehicles in Europe have been growing steadily over the past 30 years. In the European Union, passenger and freight transport have more than doubled over the past 25 years and car ownership is approaching the figure of one car for every two inhabitants. Private passenger cars now account for more than 80% of traffic volumes in western European countries, and similar trends are appearing also in countries in transition. Public and rail transport, which used to play an important role in central and eastern Europe, are quickly losing ground to private road transport, in part due to a lack of investment and maintenance of their infrastructure and fleets (UNECE – WHO Regional Office for Europe 2001).

The uncontrolled growth of private motorization and of urban sprawling, in combination with concerns over road safety has had profound implications on increasing sedentary lifestyles and discouraging walking and cycling.

For example, in the UK there was an overall 20 % decrease in average kilometres walked per person per year between 1972/74 and 1992/92. Among children, the decrease reached 28 % (Department of Transport, National Travel Survey: 1992/94. London: HMSO, 1995). The same trend applies to cycling: in the European Union cycling now accounts on average for merely 5 % of trips, and only in the Netherlands (27%), Denmark (18 %) and Sweden (12.6 %) exceeds the threshold of 10 % of total modal share (EU Transport in Figures – Statistical Pocket Book 2000).
In addition, while overweight and obesity among children are increasing, the levels of cycling and walking (e.g. to and from school) are declining. In the mid-1980s, two thirds of British children aged between 5 and 10 years walked, and more than 6% of 11-16 year-olds cycled to school. By the late 1990s, this had fallen to just over half of children (5-10 years) walking to school, and less than 2% of pupils (11-16 years) cycling (Noble 1999). From 1984 to 1994, overweight increased from 5.4% to 9.0% in English boys and from 9.3% to 13.5% in girls. The prevalence of obesity increased correspondingly, reaching 1.7% (boys), and 2.6% (girls) (Chinn and Rona 2001).

There is now broad consensus that halting and reverting these trends requires intersectoral action. Health needs should be fully integrated into transport and land-use policies. However national and local authority for policy developments in urban mobility have not been facilitated by the development of strong (i.e. legally binding) actions at the international level. In addition, very little attention, if any, has been placed on investing in safe infrastructures for cyclists and pedestrians. Only in recent years has there been an acknowledgement of the importance of walking and cycling as part of urban sustainable mobility, and some policy directions have been given at the international level. For example, in the European Union the Green paper “The citizen's network - fulfilling the potential of public passenger transport in Europe” suggests a number of ways in which the use and development of public transport, bicycles and walking might be encouraged in urban and wider urban areas. In addition, the White Paper “European transport policy for 2010: time to decide”, which sets the common transport policy framework for the EU, is placing emphasis on improving the safety of cyclists and pedestrians. This should contribute to addressing the single most important barrier to increase walking and cycling. These policy directions are in line with both the “Charter on Transport, Environment and Health” and the “Transport, Health and Environment Pan European Programme” (THE PEP), that are both advocating for (re-)creating the conditions for safe walking and cycling.

Many Member States reported (Working groups, WHO nutrition counterparts meeting, Athens 2003) national promotion of sport but not physical activity. However, some countries are active in promoting physical activity, for example:

- Action plan to support physical activity through the development of recreational spaces in all educational institutions (e.g. Bosnia and Herzegovina)
- The European Network for the promotion of health-enhancing physical activity (HEPA)\textsuperscript{11}
- Health Promoting Schools (www.who.dk/eprise/main/WHO/Progs/ENHPS/Home);
- enabling children to walk to school in a safe environment (e.g. Israel)
- walking programmes for older people (e.g. local government in Udine, Italy)
- walking and cycling strategies strategy in collaboration with the Ministries of Transport, and Environment (Slovenia);
- collaboration with the Ministry of Tourism – (e.g. Slovenia “healthy tourism” where cycling and waking routes are being built to promote physical activity; this is considered not only in transport strategy but also tourism strategy)
- shifting responsibility for physical activity from national to regional (e.g. Slovakia, where concrete policies have been developed by local authorities at regional level e.g. cycling routes, and where special centres for sports are the responsibility of Government);
- creation of cycling lanes through Healthy Cities projects (e.g. Czech Republic);
- national strategy for cycling (e.g. Norway)

\textsuperscript{11} chaired by the Finnish UKK institute and consisting of policy development, Europe on the Move! information network and the promotion of walking as a simple and safe method of health-enhancing physical activity. Members of HEPA are Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden, United Kingdom, Estonia, Iceland, Israel, Norway, Slovenia and Switzerland.
It should be noted that the above activities have been reported mostly by respondents from the health sector. However, there are also other initiatives carried out by other sectors (e.g. local transport authorities, community NGOs) which, though not having as a main or openly stated goal (promotion of physical activity for health reasons) do, in fact, contribute to achieve this objective (e.g. the activities undertaken by non-health NGOs, such as Sustrans, that in the UK is leading the “Safe routes to school” programme www.saferoutestoschools.org.uk/). Synergies with this kind of initiatives should be actively sought, as they can be very important for pooling know-how, reach-out capacity and resources.

Health impact assessment (HIA) should be included in all sectors and programmes and policies. HIA is a process that identifies both positive and negative health impacts of policies and includes recommendations to improve policies to maximise the health benefit to the population (e.g. Breeze, C. H. & Lock, K (eds). 2001.; and: Health Impact Assessment: Gothenburg consensus paper. WHO 1999). HIA is a proactive way to improve health, to promote equity in health, and to increase transparency of decision-making. HIA has the potential to prevent future harm and maximise future benefit. HIA can be done prospectively on a proposal, and includes recommendations to adjust policies in order to enhance health gain.

**Food & nutrition policies**

Many European Member States are building on the WHO European Food & Nutrition Action Plan (FNAP) endorsed in 2000. Over half of the 51 Member States of the European Region have, or are developing, their national food & nutrition action plans. These provide a foundation upon which to build more comprehensive policies for obesity and NCD control and prevention. For example, to include strategies on physical activity.

Food and agricultural policy (Food Security pillar of FNAP) could provide incentives and support for production and marketing of healthier food, for example: production of fruit, vegetables and legumes and other healthy produce in agriculture; low fat/salt foods; distribution and export of these products. Ways to stimulate this process include: development of national food and nutrition action plans; government support to public catering and food welfare programmes, as well as by developing contracts with national food growers so that they are ensured a market.

Given that the EU will almost double its number of Member States, its agriculture policies will affect most countries in central and eastern Europe. The directives relating to food labelling, criteria for establishing food safety, demands for specific agriculture and slaughter practices and taxation systems all affect the nature of the food supply and ultimately the health of people.

This is illustrated by a new analysis by the Swedish Institute of Public Health “Public Health aspects of the Common Agricultural Policy (CAP)” within the EU. This analysis concludes that the regulations and systems involved in CAP have probably led to effects on consumption which can have detrimental effects on health. Slovenia is going through a similar process to analyse the potential impact of agriculture policy after EU Accession.

Member States reported (Working groups, WHO nutrition counterparts meeting, Athens 2003) that the agriculture sector affects diet, nutrition and health in a variety of ways. Generally, there are few agriculture policies in countries to promote production of healthy foods (e.g. subsidising low fat dairy products and fish production in Israel (Working groups, WHO nutrition counterparts meeting, Athens 2003), and agriculture policy is not often influenced by nutrition guidelines. Some countries have programmes to promote vegetable and fruit consumption in schools (Norway, UK). Some countries (e.g. Nordic, Baltic, Ireland, Portugal) reported having
programmes to subsidize milk allowances in schools and in some countries this includes reduced-fat dairy products. Finland in particular has worked with the EU to include reduced-fat milk in their school milk programme. In EU countries, though, agriculture policies tend to promote high fat dairy and meat production, while making vegetables and fruit less available and more expensive.

Health impact assessment (HIA) should be included in all sectors and programmes and policies (e.g. Breeze, C. H. & Lock, K (eds). 2001.; and: Health Impact Assessment Gothenburg consensus paper, WHO 1999). HIA is a proactive way to improve health, to promote equity in health, and to increase transparency of decision making. HIA has the potential to prevent future harm and maximise future benefit of agriculture policies.

Many countries of the European Region suggested (Working groups, WHO nutrition counterparts meeting, Athens 2003) that Codex Alimentarius should take on board the issues of healthy diet in an explicit way. The Codex Alimentarius is reported as having an important role for food standardisation, food safety / quality control of agriculture but has not been much used for healthy eating.

Implementation: Translating policies into action

<table>
<thead>
<tr>
<th>Discussion points</th>
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<tbody>
<tr>
<td>• What are the key issues in developing and ensuring successful implementation of action plans for diet and PA?</td>
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<tr>
<td>• What are appropriate targets for strategic and operational planning?</td>
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<tr>
<td>• What should be the role of different actors including the media, NGOs, private sector, academic groups, and intergovernmental bodies?</td>
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<tr>
<td>• What is the required capacity at national and local levels (including need for training and need for tailor-made information materials)?</td>
</tr>
<tr>
<td>• What are the most effective economic instruments (e.g. subsidies and taxes) and how can they best be used to improve diet and increase physical activity?</td>
</tr>
<tr>
<td>• What are the most effective regulatory instruments and how can they best be enforced (e.g. marketing) to improve diet and physical activity?</td>
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The process of implementing policies should be based on systematic needs assessments (to identify technical and financial considerations, for example) as well as solid evidence. Existing structures that already address many aspects of diet and physical activity could be built upon. For example, in many countries, national food and nutrition action plans have been developed that could be used as the basis for addressing obesity and chronic disease control.

The production of certain foods can be promoted through subsidy systems or increased/decreased taxation of food products. Public funds and subsidies can also be used to promote access in poor communities to recreational and sporting facilities. Each country may consider a review of whether financial measures could lead to improved diets among their populations. Involvement of the Ministry of Finance in such reviews, and the development of economic analyses of the impact of obesity and chronic diseases on national finances may prove to be decisive in getting long-term supportive fiscal policies.

It is recognized that transport, agriculture and other non-health sectors have prime responsibility for their own areas. Contradictory opinions may be held by the various parties involved: food producers and consumers; ministers of the economy and those responsible for social matters;
representatives of domestic consumption and export markets; and those advocating increased public transport, cycling and walking versus car manufacturers. To be effective, public health policy will need to harmonize these diverse opinions as far as possible. Evidence, which illustrates the impact on public health, is one way of stimulating harmonization and consensus.

Finding a consensus among potentially conflicting interests is a challenge. Strengthening partnerships between sectors is one way forward (see Fig. 5).

**Fig. 5 Collaboration of sectors in developing and implementing policies for healthy diet and physical activity**

Member States reported (Working groups, WHO nutrition counterparts meeting, Athens 2003) that policy-makers in the health sector in many countries of the European Region are generally interested in health and nutrition, but not all are committed to solving the problems. For example, budgetary resources available to the health sector are not always invested into programmes to reduce levels of NCD even though reduction of NCD is stated as a priority. Furthermore, some European countries reported (Working groups, WHO nutrition counterparts meeting, Athens 2003) that neither the population nor policy-makers consider obesity a disease, and that there is a general lack of understanding about what is meant by prevention. Also, opportunities offered by interventions led by other sectors (e.g. transport, for the provision of infrastructures for cycling and walking) seem to be still largely untapped, or not recognised.

**Information, education and communication**

**Training**

Education on healthy diet and physical activity should be systematically included in the curriculum of undergraduate and postgraduate health professionals. However, most countries reported a lack of material offered or time spent on healthy diet and physical activity in undergraduate education for health professionals. In postgraduate education, health profession students can choose classes on healthy diet and physical activity, but these classes are often optional. One of the consequences of this is seen in the clinical setting where it is not routine for health professionals to advise clients on healthy diet or physical activity.
In addition, the importance of physical activity, and especially walking and cycling, its health benefits, and the necessary conditions for people to engage in these activities, should be considered for the curricula of non-health professionals, such as transport and urban planners and engineers. This could be a pre-requisite for professionals from other sectors to be more receptive and prepared to consider opportunities for physical exercise as part of their work.

**Research**

Investment in applied research, especially in community-based demonstration projects combined with increased involvement of scientists in research related to diet and physical activity will lead to better-informed policies and policy-makers and ensure that a cadre of expertise is created at national and local levels.

**Advertising and the role of industry**

The food industry has a critical role to play in providing healthy and affordable food. Their initiatives to reduce the amount of salt, sugar and fats and to review current marketing practices could accelerate health gains worldwide. Working with industry, governments could review how best to stimulate industry and retailers to increase their investment in the development of “healthy messages” and in new product development.

One of the ways to effectively promoting healthy lifestyles is to understand how the food (and other) industry influences policy and consumer behaviour. As countries east of the European Union open their markets, they represent new opportunities for the food, tobacco and other industry (Euromonitor. *Quick—Service Restaurants in eastern Europe*. Euromonitor, August 2000). The rate of multinational entry varies significantly between countries, from 13.9% in Russia to 38.9% in Hungary (*Globalization, diets and noncommunicable diseases*. Geneva, World Health Organization, 2002). There may be a discrepancy between the rate of new advertising and the advertisement regulations in new markets, creating an opportunity for marketing of products such as fast foods, sugary cereals, and cigarettes, before regulatory mechanisms to protect consumers come into action. It was reported by Member States (Working groups, WHO nutrition counterparts meeting, Athens 2003) that heavy marketing and availability of foods high in saturated fat, sugar and salt have an impact on the nutrition status of populations and more effort should be put into understanding the breadth and depth of that impact.

**Media**

Media can also be a very positive way to promote healthy diet and increased physical activity. Some examples of this were reported by Member States e.g. in Baltic and Nordic countries, when there is an event, campaign, or scientific result that is newsworthy, the media is contacted and made aware of the matter itself and of the public health significance of such a finding. Awareness among the general public, though, varies depending on education and socio-economic levels. Still, even among those who understand that healthy diet and physical activity can improve health, many do not know how to act on this knowledge to improve their own health, and many simply do not have access to healthy choices. Countries reported that health messages are promoted on local and national television, internet, radio, and newspapers. Further investigation into how to use media in a positive way (e.g. through social marketing) and allocation of adequate resources for such positive marketing, are needed.

When asked whether the general public is aware of how important a healthy diet and physical activity are (e.g. similar awareness as smoking), most countries reported that in general, women are more aware than men, and adults are more aware than children, and that overall the awareness about diet and physical activity was not as high as the dangers of smoking tobacco.
Health services and role of health professionals

Health professionals can provide practical advice to patients and families on the benefits of optimal diets and increased levels of physical activity. When Member States were asked (Working groups, WHO nutrition counterparts meeting, Athens 2003) whether health services routinely provide patients with advice on healthy diet and increased physical activity, some reported that no formal advice is given (e.g. Malta, the Netherlands) and others reported a sophisticated system, including a computerised global risk assessment of health whereby standard questions on NCD risk behaviour are asked of patients and recorded (e.g. Israel, Ireland). Some countries reported that obesity and CVD were not routinely addressed in hospitals but in special centres (e.g. Italy, Greece). The UK reported a system whereby primary practitioners can give a prescription for exercise. In some countries dieticians are starting to work with physicians (e.g. Turkey). But most countries reported that advice on diet and physical activity from the health services is ad hoc.

Economic instruments for example subsidies and taxes, regulatory instruments and how to best enforce them (e.g. marketing), health claims and labelling, all need to be evaluated to assess their effectiveness.

Surveillance and evaluation: measuring impact and effectiveness of policies

<table>
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<tr>
<th>Discussion points</th>
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<tbody>
<tr>
<td>How can interventions to promote physical activity and improve diet best be measured?</td>
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<tr>
<td>How can successful interventions best be evaluated to achieve desired changes?</td>
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<tr>
<td>How can definitions of indicators be harmonised to allow for better monitoring and international comparisons?</td>
</tr>
<tr>
<td>What are the attributes of an effective surveillance system and how can it better include NCD prevention and report on NCD risk factors?</td>
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<tr>
<td>How can health services be better organised to systematically gather data on NCD?</td>
</tr>
<tr>
<td>What are other mechanisms to gather evidence on NCD prevalence and risk factors?</td>
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</table>

Investment in surveillance systems to monitor major risk factors and their responsiveness to changes in polices and strategies, is critical. These could build on systems already in place to some degree in some countries. Emphasis should be given to levels of physical activity, selected dietary components, as well as levels of blood pressure, serum cholesterol and blood glucose, and tobacco use. Several European countries assess population physical activity levels (Working groups, WHO nutrition counterparts meeting, Athens 2003). These include:

- national surveillance systems which regularly report on eating and physical activity patterns of the population (such as reported by all Baltic and Nordic, Switzerland, Italy, UK); and
- health behaviour surveys for school children and adults (e.g. HBSC\(^{12}\));

Only a handful of countries collect transport statistics on walking and cycling, as these are often not considered as “real” transport means. The lack of reliable information makes it difficult to monitor progress on the amount of walking and cycling undertaken, and on the effectiveness of interventions and investments in this area\(^{13}\). Further research is therefore needed to harmonize the definitions of indicators and to improve or start their collection to allow for better international comparisons and monitoring.

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\(^{12}\) Currie et al 2000

\(^{13}\) Safety of Vulnerable Road Users, OECD 1998
Surveillance systems can measure whether an intervention produces the desired changes in mortality or morbidity but results are achieved only several years after policy implementation. In contrast, process evaluation monitors how a policy or intervention is implemented. The process evaluation of a health initiative is an assessment of how this initiative achieves its effects, including evaluation of the amount of resource inputs used, and a description of activities implemented and outputs (intermediate outcomes, proximal impacts) of this initiative. For any given project or initiative, the process evaluation scheme is driven by a number of considerations, namely:

- the project’s overall goal, as well as specific objectives, strategies and target populations;
- the scope and level of the evaluation (national, regional or local); and
- the cost and practicality of gathering various types of data.

Fig. 6 is taken from the CINDI handbook for process evaluation of NCD and shows how process evaluation fits within the broader context of an evaluation framework. Inputs are converted into outputs via implementation strategies, and this process is facilitated by a feedback mechanism among the various processes, inputs and outputs.

### Fig. 6 A framework for process evaluation

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Implementation Strategies</th>
<th>Outputs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
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<tr>
<td>In-kind</td>
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Another useful tool for policy-makers is the WHO publication on Health Promotion Evaluation (Health Promotion Evaluation: Recommendations to policy makers, WHO 1998) which summarises the core features of approaches appropriate for the evaluation of health promotion initiatives, namely participation, multiple methods, capacity building and appropriateness (Table 1).

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14 Handbook for process evaluation ... WHO 1999.
### Table 1 Health promotion evaluation: conclusions and recommendations to policy makers

<table>
<thead>
<tr>
<th>Conclusions</th>
<th>Recommendations</th>
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<tbody>
<tr>
<td>Those who have direct interest in a health promotion initiative should have the opportunity to participate in all stages of its planning and evaluation.</td>
<td>Encourage the adoption of participatory approaches to evaluation that provide meaningful opportunities for involvement by all of those with a direct interest in health promotion initiatives.</td>
</tr>
<tr>
<td>Adequate resources should be devoted to the evaluation of health promotion initiatives.</td>
<td>Require that a minimum of 10% of the total financial resources for a health promotion initiative be allocated to evaluation.</td>
</tr>
<tr>
<td>Health promotion initiatives should be evaluated in terms of their processes as well as their outcomes.</td>
<td>Ensure that a mixture of process and outcome information is used to evaluate all health promotion initiatives.</td>
</tr>
<tr>
<td>The use of randomised control trials to evaluate health promotion initiatives is, in most cases, inappropriate, misleading and unnecessarily expensive.</td>
<td>Support the use of multiple methods to evaluate health promotion initiatives. Support further research into the development of appropriate approaches to evaluating health promotion initiatives.</td>
</tr>
<tr>
<td>Expertise in the evaluation of health promotion initiatives needs to be developed and sustained.</td>
<td>Support the establishment of a training and education infrastructure to develop expertise in the evaluation of health promotion initiatives. Create and support opportunities for sharing information on evaluation methods used in health promotion through conferences, workshops, networks and other means.</td>
</tr>
</tbody>
</table>

*Source: Health Promotion Evaluation: Recommendations to policy makers. WHO 1998.*
Annex 6. Existing political commitments for diet and physical activity

There have been a number of public health commitments, endorsed at global and/or European level, which have overlapping areas concerning reducing noncommunicable diseases, and are helping to pave the way to a global strategy on diet, physical activity and health.

Resolution WHA53.17 on Prevention and control of noncommunicable diseases
The Fifty-third World Health Assembly (WHA), May 2000, adopted a resolution endorsing the World Health Organization (WHO) Director-General's global strategy for prevention and control of noncommunicable diseases. The strategy emphasized integrated prevention by targeting three main risk factors: tobacco, unhealthy diet and physical inactivity.

Resolution WHA55.23 on Diet, physical activity and health
The Fifty-fifth World Health Assembly, May 2002, discussed a report by the secretariat and recognized the importance of the framework for action on diet and physical activity within the integrated approach to prevention and control of noncommunicable diseases. The resolution approved by the Assembly requested the Director-General to develop a global strategy on diet, physical activity and health.

The organization by WHO Member States of an “Annual Move for Health Day” was recommended by Resolution WHA55/23 on Diet, Physical Activity and Health of the Fifty-fifth World Health Assembly (May 2002), following the successful World Health Day 2002 on Move For Health (7 April 2002).

Resolutions WHA 54.2 (2001) and WHA 55.25 (2002) on infant and young child nutrition
These resolutions urged Member States to encourage breastfeeding through, for example, parent- and baby-friendly hospital environments, and to strengthen their controls on the marketing of breast-milk substitutes, with the support of WHO. (In 2002, WHO issued a global strategy for infant and young child feeding that outlines the action necessary to promote the youngest children’s health.)

Sustainable development was defined in 1992 as development that meets the needs of the present without compromising the ability of future generations to meet their own needs. Many health promotion policies can be incorporated into Agenda 21 activities in Member States.

International Conference on Nutrition (ICN), 1992
The World Declaration and Plan of Action for Nutrition were adopted at the ICN in 1992 and subsequently endorsed in their entirety at the Forty-Sixth World Health Assembly in 1993 (resolution WHA46.7). The ICN aimed to serve as a mechanism to create a momentum for increasing the focus of nutrition-related activities throughout the world.

Innocenti Declaration on Protection, Promotion and Support of Breastfeeding (1990)
The Innocenti Declaration sets a number of goals for achieving optimal health for infants and mothers in Member States, including supporting articles of the International Code of Marketing of Breast-milk Substitutes and subsequent relevant World Health Assembly resolutions in their entirety.
**Codex Alimentarius**

Several aspects of the strategy may be strengthened by using existing international norms and standards, such as **Codex Alimentarius**, and by addressing, for example, trans-national aspects of harmful and beneficial marketing of foods to children and increasing access to fruit and vegetables. Global surveillance of major risk factors and consumption trends as well as international research into the causes, and course of, nutrition transition and physical inactivity would also benefit all countries.

**WHO Food and Nutrition Action Plan 2000-2005**

In September 2000, the 51 Member States of the European Region of the World Health Organisation endorsed a resolution (EUR/RC50/R8) to implement the Region’s First Action Plan for Food and Nutrition Policy. This Action Plan makes the case for combining nutrition, food safety and food security and sustainable development into an overarching, intersectoral policy, and offers support to governments to develop, implement and evaluate such policies. The Action Plan stresses the need to develop food and nutrition policies, which protect and promote health and reduce the burden of food-related disease, while contributing to socio-economic development and a sustainable environment. It insists on the complementary roles played by different sectors in the formulation and implementation of such policies.

**Third Ministerial Conference on Environment and Health, London, 1999**

Ministers of health and the environment jointly reaffirmed their commitment to improving public access to information, securing the role of the public in decision-making, and providing access to social justice for health and environment issues. The adoption of the **Charter on Transport, Environment and Health** by representatives of ministries of transport, health and environment has provided the policy framework for linking the public health need for more physical activity to opportunities offered by walking and cycling in the context of transportation.

The objectives of the Charter are now being pursued through the **pan-European programme on transport, health and environment (THE PEP)**, adopted at the second high level meeting on transport, environment and health (2002). THE PEP streamlines and consolidates WHO and UN ECE activities on transport, the environment and health and establishes a new intergovernmental body in which these three sectors are equally represented. This will result in the more effective use of resources and better coordination of efforts at the international and national levels.

**Aarhus Convention, 1998**

The signatories of the Aarhus Convention, adopted at the Fourth Ministerial Conference “Environment in Europe”, organized by the United Nations Economic Commission for Europe, agreed to improve public access to information, public participation in decision-making and access to justice on environmental matters.

**Council of Health Ministers – two resolutions**


Annex 7: Relevant WHO Regional Office for Europe programmes

There are several WHO Regional Office for Europe programmes working, either directly or indirectly, to help support Member States in reducing the burden of noncommunicable disease.

Nutrition and food security (NFS)
http://www.euro.who.int/eprise/main/WHO/Progs/NUT/Home

The nutrition and food security (NFS) programme encourages the development of national food and nutrition action plans, which are needed to improve diet and reduce noncommunicable diseases. Action plans include food-based dietary guidelines and infant and young child feeding strategies and are an integral part of national health policies. To assist Member States in developing and implementing national food and nutrition action plans, WHO has developed a 3-day training module on Intersectoral food and nutrition policy development. NFS supports the development of nutrition information systems that highlight the relationship between food, nutrition and health, such as micronutrient deficiencies (iodine and iron deficiencies) and noncommunicable diseases (cardiovascular disease, cancer, obesity and diabetes). WHO publications, documents and workshops support the development of nutrition intervention strategies to improve health and reduce infant mortality through healthy food and nutrition.

Countrywide integrated noncommunicable diseases intervention (CINDI) programme
http://www.euro.who.int/eprise/main/WHO/Progs/CINDI/Home

The countrywide integrated noncommunicable diseases intervention (CINDI) programme works to improve health and the quality of life in communities by reducing premature death, disease and disability from major noncommunicable diseases, including cardiovascular diseases, cancer, chronic respiratory diseases, accidents, diabetes and mental disorders. Its objectives are to enable Member States to develop measures for integrated disease prevention and health promotion as part of their primary health care systems in order to reduce morbidity by reducing common risk factors and to establish effective collaborative mechanisms and methodologies to implement these measures. CINDI provides participating countries with an integrated approach to activities to prevent and control risk factors (such as smoking, high blood pressure, high blood cholesterol, obesity and excessive alcohol consumption) and to address their social and environmental determinants. CINDI puts existing knowledge in participating countries to use – first in demonstration projects in small areas and then countrywide. In addition, its member countries form a network in which they can share their experience in developing their national programmes.

Accidents, transport and health
http://www.euro.who.int/eprise/main/WHO/Progs/TRT/Home

European countries face the conflicting needs of transport policies. While transport has a key role in the economy, concern is increasing about the harm to health and the environment of current transport policies and about their social sustainability. Promoting healthy and sustainable transport alternatives prevents the negative effects of transport patterns on human health. To do this, intersectoral cooperation and high-level political commitment should ensure that health issues are considered when transport policies are formulated. As mandated by the Third Ministerial Conference on Environment and Health (1999), where the London “Charter on Transport, Environment and Health” was adopted, the transport programme facilitates a shift in the current strategies towards full consideration of transport policies' implications for development, the environment and health, focusing on developing methods and tools for health impact assessment (HIA) to support Member States in the definition and management of
mobility policies beneficial to health; developing policies for transport sustainable for health and the environment; and promoting healthy transport modes. The programme places a special emphasis on enhancing opportunities for increasing physical activity through safe walking and cycling. Since the second high level meeting on Transport, Environment and Health (2002), the programme is working jointly with the UNECE to implement the Transport, Health and Environment Pan European Programme (THE PEP). THE PEP provides the policy framework to carry out specific work addressing the priority areas identified for joint action on transport, environment and health under the rationalized framework of the Vienna Declaration and London Charter follow-up processes.

**Healthy cities and urban governance**


Action at the local level is an essential component of any national or sub-national strategy or programme for health and sustainable development. Healthy Cities provides national and local governments with an effective means of dealing with health-related issues such as poverty and social exclusion, pollution and sustainable development, lifestyles and living conditions, care and social support, urban planning and transport, and the special needs of vulnerable groups. Via the WHO European Centre for Urban Health, WHO works directly with local governments through a network of committed cities and national networks, promoting commitment and change through strong leadership, strategic guidance, capacity building and networking, to implement the goals of its Healthy Cities and Urban Governance Programme. 1300 cities are involved in the 31 national and regional healthy cities networks in Europe. There is a wealth of city initiatives in the field of nutrition/diet and physical activity/active living.

**The European Network of Health Promoting Schools**


Many thousands of schools throughout Europe are now linked to the European Network of Health Promoting Schools (ENHPS) through national or regional programmes. The programme’s primary objective is to establish a systematic process of health promoting school development. This is achieved by building capacity within the health and education sectors in order for schools to be supported in improving and protecting the welfare of pupils, teachers, non-teaching staff and the wider community. Health promoting schools commit themselves to promoting health by creating safe and health-enhancing social and physical living and learning environments. At the heart of the model is the young person, who is viewed as a whole individual within a dynamic environment. Such an approach creates a highly positive and supportive school climate which can have a powerful influence on young people. Schools, in adopting health promoting school approaches, can develop pupils’ values and attitudes about themselves and their health, in its widest sense and thus influence decision they might make concerning their health. Healthy, well educated young people can help to reduce inequities in society, thus contributing to the health and wealth of the population at large.

**Child and adolescent health and development**


The programme assists European Member States to take appropriate measures to pursue the full implementation of the health-related articles of the United Nations Convention on the Rights of the Child. The programme focuses on three main topics, namely promoting effective perinatal care (PEPC), an initiative developed to promote appropriate technology for birth and neonatal care and breastfeeding; the integrated management of childhood illness (IMCI), a strategy developed by WHO and UNICEF that provides guidelines for care for the most common
childhood illnesses, as well as preventive measures and improved family and community practices; and child protection, which supports preventive and protective strategies with particular attention to the psychosocial determinants of health. The programme works through country and intercountry interventions, pilot approaches and the provision of essential packages for training, monitoring and impact evaluation.

**Children's health and environment (CHE)**
http://www.euro.who.int/eprise/main/WHO/Progs/CHE/Home

The children's health and environment (CHE) programme advocates the rights of children to live and grow in an environment that allows them to reach their highest attainable level of health. The programme pursues this goal by: coordinating activities in the European Region; taking part in the global community; and working for the implementation of the recommendations from the Third Ministerial Conference on Environment and Health (1999). Increasing hazards where children live are raising concern about the effects of the deterioration of the environment on their health. Children have a special vulnerability to environmental pollution, and their specific exposure patterns make them subject to higher exposures. Although children’s health in the WHO European Region is currently satisfactory on the whole, warning signals are emerging. They include the return of diseases previously under control (e.g., diphtheria and tuberculosis), the increase of chronic diseases (e.g., asthma and allergies), and the new morbidity from substance abuse, injuries and mental disorders. Adverse effects on children's health also result from increasing socio-economic inequalities across the Region, the consequences of armed conflict, child labour and the sexual exploitation of minors.

**Healthy ageing**
http://www.euro.who.int/eprise/main/WHO/Progs/HEA/Home

Active ageing is the process of optimising opportunities for health, participation and security in order to embrace quality of life as people age. WHO/Europe is highlighting the issues associated with active ageing, i.e. fostering policy advocacy, promoting healthy lifestyles, reducing health risks and increasing quality of life, because ageing will put increased economic and social demands on all countries of WHO European Region. At the same time, older people provide a precious, often ignored resource that makes an important contribution to the socio-economic fabric of our lives. WHO Regional Office for Europe is helping policy-makers address relevant issues including how to help older people remain independent and active; how to best balance the role of the family and the state when it comes to caring for older people who need assistance; how to improve the quality of life in old age. An intersectoral approach is warranted. For example, city governments can offer well-lit streets for safe walking and appropriate transport systems, and recreation services can offer exercise programmes that help older people maintain or recover their mobility.

**Food safety**
http://www.euro.who.int/eprise/main/WHO/Progs/FOS/Home

The food safety programme ensures that information on food safety is properly collected and circulated to provide the basis for policy and monitoring; health guidelines are constantly updated to provide assistance to countries with state-of-the-art knowledge; and an international independent body plays a public health advocacy role in countering the strong economic forces within the areas of food production, retailing and global marketing. In the European Region food contamination is very common, even in the most developed countries, and foodborne diseases have reached epidemic proportions in several Member States. Emerging problems, such as bovine spongiform encephalopathy, enterohaemorrhagic *Escherichia coli*,...
multidrug-resistant strains and genetically modified organisms are creating additional concerns among both the public and decision-makers.

Health Care Delivery
http://www.euro.who.int/eprise/main/WHO/Progs/HCD/Home

To facilitate informed decision-making, the programme on health care delivery produces evidence on strategies for and the management of the reform of health care services. The programme tries to identify how services can be improved and how human resources can be planned in a better way. The programme runs projects on integrated care, primary care, hospital management, health promoting hospitals, emergency medical services and telemedicine.

The Gender Mainstreaming Programme (GEM)

The ultimate goal of the GEM programme is to achieve greater gender equity. Women have the advantage of disease resistant biology but also the disadvantage of a lower social status and less access to wealth. Thus men and women have, to a degree, different patterns of ill health. This is due to their different biology, to women’s reproductive function and to the fact that their life styles and risk factors differ because their gender role, their socio-economic status and their access to resources are different. The GEM programme seeks to develop the capacity of Member States to identify and address gender inequities in the planning, implementation and evaluation of health policies and programmes. The programme has been set up as a cross-cutting initiative within the WHO Regional Office for Europe. The programme is undertaking gender analysis in HIV and AIDS, tuberculosis, vaccines, child abuse and neglect and mental health. This will give policymakers, health managers and health professionals the evidence they need on gender inequities in different health contexts, to help them to integrate a gender perspective into their work. Furthermore, together with Member States, GEM is in the process of identifying success factors integrating gender into selected existing health policies. GEM seeks to advise countries in the process of planning and implementing gender sensitive policy. GEM is also developing guidelines for gender mainstreaming in health programmes at the country level. GEM addresses inequities with particular focus on women’s health, migrant women, gender-based violence, and trafficking of women.

Regions for Health Network
http://www.euro.who.int/eprise/main/WHO/Progs/RHN/Home

The Regions for Health Network (RHN) is one of a number of networks organized through the WHO Regional Office for Europe. Complementing the work at the national level, RHN supports the development of policies and strategies to improve health at the level immediately below the national level. Members of the RHN advocate through pan-European networks and observation; support regions in accession states; cooperate on regional health systems and information development; support existing members requesting help; and promote linkages between regions in areas of common programmatic interest. RHN members promote excellence and effectiveness in their regions by sharing resources and good practice. To this end, we agree to exchange ideas and experiences concerning the structures, processes and skills essential for working across sectors to build new alliances for health, and to openly discuss some of the obstacles and threats to this approach. In a spirit of solidarity, appropriate members work together on specific projects to bring changes for health gain at the regional and local level.
Reproductive health/pregnancy
http://www.euro.who.int/eprise/main/WHO/Progs/RHP/Home

The programme works to reduce maternal and infant mortality and morbidity and to protect the health of women, children and young people by: strengthening the use of evidence-based interventions in reproductive health within primary health care; applying strategies to promote reproductive health in policies and settings outside the health sector; and advocating the implementation of the health-related sections of United Nations conventions in health policies and health care. The programme assists Member States in developing policies and strategies, and offers technical interventions and specific packages for infrastructure development and capacity building.
Annex 8: Inventory of global and regional reference documents

GLOBAL

English: http://www.who.int/hpr/physactiv/docs/concept_paper_english.pdf;
French: http://www.who.int/hpr/physactiv/docs/concept_paper_french.pdf;
Russian: http://www.who.int/hpr/physactiv/docs/concept_paper_russian.pdf


Consultation document to guide the development of a WHO global strategy on diet, physical activity and health.
English: http://www.who.int/hpr/NPH/docs/consultationdocument.pdf;
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