WORLD HEALTH ORGANIZATION
Regional Office for Europe
Programme for Nutrition Policy, Infant Feeding and Food Security
Lifestyles and Health Unit

Comparative Analysis of Nutrition Policies in WHO European Member States

A comparative analysis of the situation regarding nutrition policies and plans of action in WHO European Member States made on the basis of country summary reports submitted at a Consultation held in Warsaw, Poland, 2–4 September 1996

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TARGET 16

HEALTHY LIVING

By the year 2000, there should be continuous efforts in all Member States to actively promote and support healthy patterns of living through balanced nutrition, appropriate physical activity, healthy sexuality, good stress management and other aspects of positive health behaviour.

ABSTRACT

The aim of the International Conference on Nutrition (ICN) held in 1992 was to create a momentum for increasing the focus on nutrition-related activities throughout the world. Nutritional status is one of the best indicators of the welfare of individuals and, in turn, of societies. The ICN brought together all sectors involved in nutrition and was intended to be one event in the whole process of alleviating nutritional problems worldwide. The World Declaration and Plan of Action for Nutrition adopted at the ICN were subsequently endorsed in their entirety at the Forty-Sixth World Health Assembly in 1993 (resolution WHA46.7). Since then, the action-oriented strategies delineated in the Declaration and Plan of Action have served as a platform for technical support to Member States provided by the WHO Global and Regional Programme of Nutrition. These strategies provide a framework and a guide for countries to develop food and nutrition policies and strengthen their national plans of action for promoting nutritional wellbeing. Since the ICN in 1992, several regional and sub-regional meetings have taken place in order to measure progress towards the development and implementation of national nutrition policies and plans of action. An ICN Follow-up Consultation for the WHO European Region was held in Poland in 1996 and this document is based on the 35 country reports received. This document aims to provide a comparative analysis of the situation in 1996 as well as a base-line analysis to assess future developments in national policies and plans of action. Conclusions and recommendations are also included. For the purposes of this report, Member States have been grouped into 8 geographic regions: Balkan, Baltic, Central Asia Republics (CAR), countries of central and eastern Europe (CCEE), western Europe, southern Europe, Commonwealth of Independent States (CIS) and Nordic countries. Data are presented in tables under the headings of the nine action-oriented strategies of the Plan of Action for Nutrition adopted at the ICN.

Keywords

COMPARATIVE STUDY
NUTRITION POLICY
HEALTH PLANNING
EUROPE
EUROPE, EASTERN
ASIA, CENTRAL
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COMMONWEALTH OF INDEPENDENT STATES

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Foreword

The fundamental aim of the International Conference on Nutrition (ICN) held in 1992 was to serve as a mechanism to create a momentum for increasing the focus of nutrition-related activities throughout the world. Nutritional status is one of the best indicators of the welfare of individuals and, in turn, of societies. The ICN brought together all sectors involved in the issue of development in order to address nutritional problems in a comprehensive manner and to promote the inclusion of nutritional wellbeing as an objective of development plans. For this reason, the ICN was not the end itself, but rather it was one event in the whole process of alleviating nutritional problems worldwide.

The ICN was the first global intergovernmental conference on the subject, and as such provided a unique opportunity to focus the world's attention on the multifaceted and often changing nature of nutritional problems, and to address them in a comprehensive manner. In recognition of the vast differences in nutritional problems around the world, attention was given not only to the problem of undernutrition, but also the increasing problems of obesity and diet-related noncommunicable diseases, such as cardiovascular disease, hypertension and stroke, (non-insulin-dependent) diabetes mellitus and various forms of cancer.

The World Declaration and Plan of Action for Nutrition adopted at the ICN were subsequently endorsed in their entirety at the Forty-Sixth World Health Assembly in 1993 (resolution WHA46.7). Since then, the action-oriented strategies delineated in the Declaration and Plan of Action have served both as a platform for technical support to Member States provided by the WHO Global and Regional Programme of Nutrition and to reinforce the Programme's ongoing normative scientific output.

In addition to providing support to individual countries, WHO Regional Offices have organized from 1994 to 1996, in collaboration with FAO, and UNICEF in some regions, regional or sub-regional ICN follow-up workshops and meetings. These meetings were held to stimulate and review country progress towards the development and implementation of national policies and plans of action for nutrition, to share information and experience, and to provide assistance to those countries needing help in finalizing their national plans of action. The consultation held in Warsaw, Poland, 2–4 September 1996, on which the analyses of this report is based, was the European Regional ICN follow-up meeting.

Great efforts have been made over the past six years in implementing the World Declaration and Plan of Action for Nutrition at all levels. Let us build on these efforts and resources invested at national, regional and international levels, and accelerate the translation of national plans and policies into action.

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SUMMARY

The country data in this report are presented in tables under the headings of 8 of the action oriented strategies of the Plan of Action for Nutrition adopted at the ICN:

1. **Developing nutrition/food policy**
2. **Assessing nutrition situations**
3. **Improving food security**
4. **Protecting health through food safety and quality**
5. **Promoting breastfeeding**
6. **Caring for the deprived and vulnerable**
7. **Micronutrient deficiencies**
8. **Appropriate diets and lifestyles**

1. Developing Nutrition/Food Policy

A cross-section of experiences is represented in the country reports, from countries in the process of developing plans to those actively involved in implementing them. Out of the 35 responding Member States, 27 declare that they have initiated, are currently planning or have already implemented activities on nutrition policy and/or NPAN development. Three countries indicated the need and the intention of formulating and setting up nutrition policy (Greece, Luxembourg, the Federal Republic of Yugoslavia (Serbia and Montenegro)).

Their aims and objectives also vary, reflecting the different needs in different countries. Different approaches were particularly apparent between countries in a state of economic transition and those with experience of the market economy. However there were common concerns which were shared by all, especially the concerns associated with the link between noncommunicable diseases and diet.

2. Assessing nutrition situations

Nutrition-related information is essential for formulating, implementing, monitoring and evaluating effective polices and programmes to improve nutritional wellbeing. Member States are aware of this and several countries have indicated the need for data on food consumption and nutritional status to facilitate the formulation of nutrition policy (Bosnia and Herzegovina, Luxembourg, Slovakia, Ukraine).

In a number of Member States surveys on nutritional status and food consumption data are being collected (Albania, Azerbaijan, the Baltics, Croatia, Kazakstan) and in others it has been incorporated in the plan of action (Czech Republic, Romania, Slovakia). There is a lack of nationally representative data on dietary habits and nutritional status in Poland, only estimates based on household budget surveys are available. Turkey has stated the need for nutrition, health and food consumption data for comparison with the previous national survey data. Ireland has indicated need for a comprehensive food consumption survey and in Luxembourg nutritional surveys are needed. Only some Nordic countries and the United Kingdom appear to have

developed comprehensive nutrition information systems which incorporate regular monitoring of dietary habits and nutritional status.

Luxembourg addressed the issue of improving and harmonizing food and nutrition data and emphasized the importance of having a unified European approach to the collection of food intake and anthropometric data throughout Europe This would allow comparison of national nutritional data on a European wide basis without a substantial increase of work or cost.

3. Improving food security

In countries in economic transition national plans were more likely to address the issue of food security. Strategies and actions focus on ensuring a sufficient food supply both at the national level and at the household level. In Albania, Croatia, Romania and Armenia an increase in total agricultural production is a priority whereas in Turkey and the Federal Republic of Yugloslavia (Serbia and Montenegro) there is a demand to increase production of specific products such as milk and meat.

In Armenia, Azerbaijan, Hungary, Poland and Romania, household food security is an increasing problem particularly among socially and economically vulnerable groups. The most food insecure groups are the elderly, families with many children, the unemployed and rural families. In the Republic of Moldova specific programmes for developing food products for children were adopted due to the risk of nutritional deficiency.

Food insecurity did not appear to be a priority in the western and southern European countries since none of the reports mentioned it. In fact, concern about overproduction was expressed by France and Norway especially where agricultural polices encourage the destruction of food. Norway stressed the importance of ecologically sound and sustainable food production and that food policies should include the protection of animals, plants and genetic and environmental resources.

4. Protecting health through food safety and quality

The importance of protecting consumers through improved food quality and safety by strengthening food control systems, promoting food manufacturing practices and educating food sellers and consumers about appropriate food handling are recognized by many Member States (60% of the 35 Member States included information on this issue). Legislation and regulations to cover the control of food quality and safety have been or will be implemented in several countries (Albania, Austria, Croatia, Estonia, Hungary, Latvia, Slovakia, Turkey, the Federal Republic of Yugloslavia (Serbia and Montenegro),).

Member States are aware that in order to have access to the export market it is necessary to adopt Codex standards and to harmonize with EU Directives to ensure fair trade of food (Albania, Armenia, Belarus, Croatia, Estonia, Hungary, Lithuania, Poland, Turkey, Slovakia, the Federal Republic of Yugloslavia (Serbia and Montenegro)). This is particularly relevant for countries of CAR and CIS where food safety is still enforced through a vertical system by the issue of hygienic certificates attesting to the quality of food products.

In countries with established market economies, legislation regulates the composition of processed foods and tries to prevent foodborne diseases especially epidemics from salmonella

infections (Denmark, Germany, Hungary, Lithuania, Norway). In the Federal Republic of Yugloslavia (Serbia and Montenegro), foodborne diseases are the leading cause of epidemiological outbreaks and since 1991 this trend has been increasing. Control strategies against zoonotic diseases (diseases capable of being transmitted from animals to humans) include additional regulations, specific plans of actions, education of food producers and handlers and the development of a coordinated control programme through the Centre for Zoonoses (Denmark).

Member States emphasized the need to:

- improve food control system
- establish sufficiently-equipped laboratory facilities capable of carrying out analysis in line with international standards
- improve analytical methods for controlling food quality and safety
- improve system for monitoring radiological safety of food products
- introduce techniques that help reduce use of agrochemicals
- develop and improve monitoring and warning systems for foodborne diseases
- develop training programmes for food safety personnel
- update legislation on labelling including "use by" and "best before"
- control claims on food labelling, i.e. products advertised as "slimming products"

A few countries specifically mentioned using HACCP[1] to identify and manage hazards in foods. With the HACCP system, food safety control is integrated into the design of the process rather than the ineffective system of end-product testing. Use of HACCP for the processing of certain foods has been recommended by the EU[2] and the Codex Alimentarius Commission endorsed the system as the most cost-effective approach devised to date for ensuring the safety of food.

5. Promoting breastfeeding

In western and southern European countries (Austria, Germany, Ireland, Italy, Malta and Norway) main activities include: policy implementation, legislation formulation, adoption of WHO Code of breastmilk substitutes, marketing issues, and the distribution and content of information on infant feeding.

In all countries the aim is to promote breastfeeding. However in some countries there were plans to increase the production of new breastmilk substitutes. Care will be needed to ensure that this does not jeopardize an increase in the levels of breastfeeding. In the Republic of Moldova a resolution was adopted on the need to develop various food products for infants and children. However simultaneous actions also need to be taken to promote, protect and support breastfeeding.

According to UNICEF the central European countries have made good progress in implementing the BFHI. The Czech Republic, Hungary and Poland are three of the six countries that have accepted the challenge to expand the BFHI. Hungary was the first country in Europe to designate a hospital as "baby-friendly" and in the Czech Republic, Poland, Romania and Slovakia 5, 11, 10 and 2 hospitals respectively were awarded the baby-friendly status by 1995. Turkey has a total number of 56 baby-friendly hospitals. In the western European countries only 10 baby-friendly hospitals are registered and there is only 1 baby-friendly hospital in the vast

Russian Federation. In Norway, Denmark and Sweden, 29, 1 and 56 baby-friendly hospitals had been awarded certificates by 1995. There were no baby-friendly hospitals in the Balkans, Baltic and southern European regions in 1995 according to the UNICEF report[3].

6. Caring for the deprived and vulnerable

In the ICN Report the socioeconomically deprived and nutritionally vulnerable groups include: infants, young children, pregnant and nursing women, elderly and disabled, individuals within poor households, refugees and displaced persons, the landless, the unemployed immigrants, and orphans. Individuals most at risk of under-nutrition are those who are both physically vulnerable and socioeconomically deprived.

There is a general recognition that different population groups have different needs and that specific approaches are required to solve different nutrition problems. Countries stated the need to establish, through surveys, the nutritional status of socially and or economically deprived citizens before developing and implementing strategies (Denmark, Germany, Lithuania and Switzerland).

Objectives and priorities for caring for the deprived and vulnerable have been mentioned by nearly half of the Member States: Albania (infants, women, PEM); Armenia (elderly, different age groups); Azerbaijan (children in institutions, aged and disabled in homes, refugees); France, Ireland (women and children); Croatia, the Federal Republic of Yugloslavia (Serbia and Montenegro) (children, elderly, women, refugees, expels); Turkey (women), Poland (schoolchildren and other groups); Slovakia (pregnant women, infants, children, and other groups); United Kingdom (low income, ethnic, elderly), Malta (elderly, adolescent, pregnant women), the Republic of Moldova (children); Denmark (elderly, children, women, immigrants), Sweden (unemployed, low income, children, adolescent, elderly and disabled).

Actions to improve care for nutritionally vulnerable individuals focused foremost on children and women. The need to ensure a well-balanced and safe diet for young children through implementing school feeding programmes and the production of specific "child foods" was reported by several Member States. The promotion of good weaning practices including timely introduction of complementary foods of optimum quality and quantity was mentioned in only two reports (Albania and Italy).

The health problems of the elderly was recognized as a rapidly growing concern. It is estimated that by the year 2000, 16% of the world's population will be over 65 years of age[4]. The nutritional status of elderly people has received attention through the SENECA (Survey in European Nutrition and the Elderly: a Concerted Action) study which was started in 1988 within an EU programme. The study across 19 towns in 12 countries has contributed to improving the understanding of the dietary standards for elderly people in view of physiological, lifestyle and environmental factors. Similar initiatives will be required in the future in order to address the problems of our aging European population.

7. Micronutrient deficiencies

The importance of reducing micronutrient deficiencies was highlighted by several Member States. Strategies and activities such as information campaigns, fortification and supplementation

programme have been formulated and in some cases implemented to tackle specific micronutrient deficiencies.

Iodine deficiency is one of the two major nutrient deficiencies that exist in the region. Areas of endemic goitre included Albania, Armenia, the Republic of Moldova and Tajikistan. A common strategy planned or already in practice for eliminating IDD is iodization of table salt (Armenia, Italy and Poland), and several countries are considering the use or are using iodized salt in food manufacturing and preparation of meals in mass catering (Germany, Italy).

Iron deficiency is the other main deficiency in the region and exists in Albania (pregnant women), Croatia (children and pregnant women); the Federal Republic of Yugloslavia (Serbia and Montenegro), Hungary, Kazakstan, Turkey (children and young women); Romania (infants and children); Armenia and the Republic of Moldova. The problem is primarily confined to women of reproductive age and children.

Other micronutrient deficiencies mentioned by Member States include: vitamin A deficiency (Albania, Armenia, Hungary, the Republic of Moldova, Romania, Turkey). Vitamin C (Hungary), Vitamin D deficiency (Romania) and calcium deficiency (Czech Republic, Hungary, Poland, Slovak Republic, Turkey), riboflavin (Turkey, Hungary), vitamin B_6 (Turkey), thiamine (Hungary). The need for supplementation of folic acid for pregnant women was reported by Denmark, Poland and the United Kingdom.

8. Appropriate diets and lifestyles

The countries with established food and nutrition polices focused mainly on the reduction and prevention of nutrition-related diseases such as cardiovascular disease, certain cancers, and risk factors such as obesity. In countries undergoing economic transition, diet-related disease such as cardiovascular disease, cancers and diseases related to overnutrition are as great a problem, if indeed not greater, as the much highlighted micronutrient deficiencies. No information on noncommunicable disease was provided by Albania, Israel, Kazakstan, Latvia, the Republic of Moldova, Romania, Slovakia, Ukraine and Uzbekistan. Member States that have mentioned the link between NCDs and diet in their report include: Armenia, Azerbaijan, Belarus, Croatia, the Czech Republic, Estonia, Germany, Greece, Hungary, Iceland, Ireland, Luxembourg, Norway, Poland, Sweden Switzerland, Turkey, the United Kingdom and the Federal Republic of Yugloslavia (Serbia and Montenegro). NCDs most frequently mentioned are coronary heart diseases, cancers, hypertension, diabetes mellitus and obesity. Osteoporosis and tooth decay were mentioned by 4 and 5 Member States respectively.

Although there is a general recognition of the link between diet and disease, it is not clear what actions have been taken and how much priority is placed on preventing them.

Strategies included:

- Nutrition education for the public; training of health professionals, strengthening the teaching of nutrition in universities, medical and agricultural faculties and other educational institutions;

- Updating recommended nutrient reference values and dietary guidelines.

- Improving nutritional standards in mass catering was reported by Austria, Denmark, Germany, Iceland, Sweden and the United Kingdom.

- Promotion of active living was highlighted by Armenia, Estonia, Malta, Poland, Sweden, the United Kingdom.

- In several Member States (Azerbaijan, Uzbekistan) attention is given to education in dietology. Dietology (or dietetics) is the practice of treating different disorders with different therapeutic diets (metabolic, gluten-free, etc.). However, many therapeutic diets have not been scientifically proven to be of value, and countries such as Hungary have now changed their approach so that the teaching of dietitians is geared to public health nutrition rather than therapeutic dietetics.

Cooperation and collaboration

The need for cooperation and collaboration both on a national and international level and a greater mobilization and cooperation in the health sector was emphasized by several Member States. Countries report that there is insufficient awareness and understanding of nutrition problems among policy-makers and planners. This results in inadequate resource allocation to:

- food and nutrition information systems;
- strengthening national capacity;
- strengthening intersectoral coordination.

Several Member States indicated the need for establishing a committee for coordinating the food and nutrition issues of different Ministries. Additionally there is a need to improve the collaboration between governments and organizations involved or interested in nutrition and health problems.

Bilateral cooperation between western and eastern Europe (Baltic, Nordic, the United Kingdom) has already started in the fields of food legislation and food control and it would be good to see similar initiatives started in the area of nutrition.

INTRODUCTION

In December 1992, after more than two years of preparatory work by the Member States and the joint efforts of the World Health Organization (WHO) and the Food and Agriculture Organization (FAO), the International Conference on Nutrition (ICN) was convened in Rome to:

- **increase public awareness of the extent and seriousness of nutrition- and diet-related problems worldwide**
- **promote effective strategies and actions to address these problems**
- **encourage the political commitment necessary to do so.**

The agenda was defined by hundreds of papers and meetings at the local, national, regional and international level. Countries examined social, political and economic factors that needed to be considered when shaping national and regional strategies, and national seminars brought together the many sectors that share responsibility for nutrition. A WHO preparatory meeting for the ICN was held in Copenhagen, Denmark, in April 1992 with participants from 21 European countries. While drawing together all the national and regional studies, papers and meetings, the Preparatory Committee in Geneva decided the issues for debate at the ICN in Rome.

When the Member Governments of FAO and WHO met in Rome in December 1992, each of the 159 participating countries and the EC re-affirmed their determination to ensure sustained nutritional wellbeing for all people and committed themselves to achieve this goal by unanimously adopting the ***World Declaration and Plan of Action for Nutrition***[5]**.** The nine action-oriented strategies of the World Declaration and the Plan of Action for Nutrition are summarized in Table 1.

Table 1: The Nine Action-Oriented Strategies of the Plan of Action for Nutrition

1. Incorporating nutritional objectives, considerations and components into development policies and programmes.
2. Improving household food security.
3. Protecting consumers through improved food quality and safety.
4. Promoting breastfeeding.
5. Caring for the socioeconomically deprived and nutritionally vulnerable.
6. Preventing and controlling specific micronutrient deficiencies.
7. Promoting appropriate diets and healthy lifestyles.
8. Assessing, analysing and monitoring nutrition situations.
9. Preventing and managing infectious diseases (N.B. not included in this analysis since not mentioned in any country reports).

These provide a framework and help to guide countries develop food and nutrition policies and strengthen their national plans of action for promoting nutritional wellbeing.

Since the ICN, the Nutrition programme of the WHO Regional Office for Europe has been monitoring progress. In 1993, the World Health Assembly adopted Resolution WHA 46/7 entitled "***The International Conference on Nutrition: Follow-up Action",*** where Member States requested the WHO Director-General, ***"to report by 1995 on progress regarding implementation of the World Declaration and Plan of Action for Nutrition".***

In June 1994, the Nutrition unit of the WHO Regional Office for Europe sent a questionnaire to all 49 Member States, requesting information on implementation and a progress report was prepared in 1995[6] on the basis of responses from 33 Member States. Some of this information was incorporated into the global report[7] presented to the World Health Assembly in May 1995.

In 1996 a follow-up to ICN was held in the European Region through a FAO/WHO consultation in Warsaw, Poland. Its aim was to assess implementation of the World Declaration. Representatives from European Member States and Canada, USA, the European Commission and the Holy See attended the meeting along with representatives from UNDP, UNICEF, NGOs and the private sector.

AIM OF THIS REPORT

Member States were requested to prepare a summary report of their progress for the 1996 follow-up meeting in Poland. Based on the 35 reports received (response rate of 70%) the WHO Nutrition unit has compiled an overview of the situation in 1996. This document aims to:

- **provide a comparative analysis of the situation in 1996;**
- **provide a base-line analysis to assess future developments in national policies and plans of action;**
- **develop some conclusions and recommendations.**

METHOD

Table 2: Member States at the ICN follow-up consultation, Poland, September 1996

Total no. of FAO/WHO Member States invited	Total no. of countries present	Total no. of representatives	Percent of health and agriculture representatives from European Region	Total no. of reports submitted (European Region)
57	40	62	66% health 27% agriculture 7% others	35

Member States were grouped into 8 geographic regions: Balkan, Baltic, central Asia republics (CAR), countries of central and eastern European (CCEE), western Europe, southern Europe, Commonwealth of Independent States (CIS) and Nordic countries. (Please refer to the map at the front of this document). It was difficult to decide on the optimum grouping structure, especially where to place Turkey and Israel, and so the main aim is to facilitate comparative analysis and interpretation and assist in drawing conclusions and recommendations.

Table 3: Member States of the WHO European Region, 1996

BALKAN	BALTIC	CAR and TURKEY	CCEE	WESTERN EUROPE	SOUTHERN EUROPE	CIS	NORDIC
Albania Bosnia and Herzegovina Croatia Slovenia* The Former Yugoslav Republic of Macedonia* Federal Republic of Yugoslavia (Serbia and Montenegro)	Estonia Latvia Lithuania	Kazakstan Kyrgyzstan* Tajikistan* Turkmenistan* Uzbekistan Turkey	Bulgaria* Czech Rep. Hungary Poland Romania Slovakia	Austria Belgium* France Germany Ireland Luxembourg Netherlands* Switzerland UK	Greece Israel Italy Malta Monaco* Portugal* San Marino* Spain*	Azerbaijan Armenia Belarus Georgia* Republic of Moldova Russian Federation* Ukraine	Denmark Finland* Iceland Norway Sweden

* no report submitted

The country data are presented in tables under the headings of the nine action-oriented strategies of the Plan of Action for Nutrition adopted at the ICN. Information on preventing and managing infectious disease was not mentioned in any of the reports submitted by Member States, therefore this category has been omitted.

Table 4: Information on Member States participating at the ICN follow-up consultation, Poland, September 1996

	Attended meeting	No. of representatives	Field of competence of Representative	Report submitted
BALKAN				
Albania	x	2	health and agriculture	x
Bosnia and Herzegovina	x	1	health	x
Croatia	x	1	health/agriculture	x
Slovenia	no	none	-	no
The Former Yugoslav Republic of Macedonia	no	none	-	no
Federal Republic of Yugoslavia (Serbia and Montenegro)	x	2	health and embassy	x
BALTIC				
Estonia	x	1	health/agriculture	x
Latvia	x	2	health and agriculture	x
Lithuania	x	1	health	x
CAR AND TURKEY				
Kazakstan	x	1	health	x
Kyrgyzstan	x	1	health	no
Tajikistan	no	none	-	no
Turkey	x	4	3 health and agriculture	x
Turkmenistan	no	none	-	no
Uzbekistan	x	1	health	x
CCEE				
Bulgaria	x	1	agriculture	no
Czech Rep.	no	none	-	x
Hungary	x	2	health and agriculture	x
Poland	x	2	health and agriculture	x
Romania	x	1	agriculture	x
Slovakia	x	2	health and agriculture	x
WESTERN EUROPE				
Austria	x	1	health	x
Belgium	x	1	health	no
France	no	none	-	x
Germany	x	2	2 health	x
Ireland	x	1	health	x
Luxembourg	x	1	health	x
Netherlands	no	none	-	no
Switzerland	x	2	health and agriculture	x
UK	x	2	health and agriculture	x
SOUTHERN EUROPE				
Greece	x	1	health	x
Israel	x	1	health	x
Italy	x	2	health and agriculture	x
Malta	no	none	-	x
Monaco	no	none	-	no
Portugal	no	none	-	no
San Marino	no	none	-	no
Spain	no	none	-	no
CIS				
Azerbaijan	x	1	health	x
Armenia	x	2	health and agriculture	x
Belarus	x	1	health	x
Georgia	x	2	health and embassy	no
Republic of Moldova	x	2	health and agriculture	x
Russian Federation.	x	1	health	no

Ukraine	x	1	health	x

	Attended meeting	No. of representatives	Field of competence of Representative	Report submitted
NORDIC				
Denmark	x	3	2 health and embassy	x
Finland	x	2	health and agriculture	no
Iceland	x	1	health	x
Norway	x	1	health	x
Sweden	x	1	health	x

SUMMARY OF REGIONS BY ICN STRATEGIES

BALKAN REGION

No reports were submitted by Slovenia and The Former Yugoslav Republic of Macedonia.

1. Albania, Bosnia and Herzegovina and Croatia have initiated activities on nutrition policy and/or NPAN development. A background document in preparation in Bosnia and Herzegovina should provide a basis for policy development. The Federal Republic of Yugoslavia (Serbia and Montenegro) stated the need to formulate nutrition policy in order to prevent noncommunicable diet-related diseases and that it should be developed by a multi-sector team of experts.

2. Both Croatia and Bosnia and Herzegovina have indicated need for data on dietary intake and nutritional status. In Bosnia and Herzegovina there was no regular data collection on national dietary patterns even before the war. No recent data is available in Albania but a national nutrition survey is being carried out during 1996/97. In the Federal Republic of Yugloslavia (Serbia and Montenegro) surveys are needed to formulate nutrition policy and so help overcome nutrition-related problems.

3. Albania, Croatia and the Federal Republic of Yugoslavia (Serbia and Montenegro) indicated the importance of improving food security by increasing local agricultural production. In Albania a programme by FAO aims to strengthen institutional policy in the agricultural sector, develop the agricultural and agroindustrial sector, support private farmers and improve legislation. In the Federal Republic of Yugoslavia (Serbia and Montenegro) lack of healthy food poses particular difficulties for the elderly and households with many children.

4. Albania, Croatia and the Federal Republic of Yugoslavia (Serbia and Montenegro) reported that the protection of consumers through food safety and quality was a priority. In Albania an FAO project aims to protect consumers and the nutritive quality of foods and to improve food safety legislation. Despite the existence of a food safety law foodborne diseases are a leading cause of epidemics in the Federal Republic of Yugoslavia (Serbia and Montenegro). The majority of outbreaks occur in homes as a result of deteriorating hygienic conditions. The Federal Republic of Yugoslavia (Serbia and Montenegro) is harmonizing its legislation in line with EU directives, international standards (ISO 9000 and ISO 14,000) and Codex Alimentarius.

5. Data on breastfeeding were received only from Croatia where a national breastfeeding promotion and BFHI programme are under way. However most of the Balkan countries have active breastfeeding promotion especially where UNICEF offices exist[3]. Information on weaning was provided by Albania and in a 1993 a survey revealed a high degree of malnutrition

among children aged 12–13 months, indicating a need to improve complementary feeding practices.

6. Priority for caring for the deprived was mentioned by Albania, Croatia and the Federal Republic of Yugoslavia (Serbia and Montenegro) and in Albania the reduction of protein-energy malnutrition was a priority. In the Federal Republic of Yugloslavia (Serbia and Montenegro) special problems emerged with the arrival of large numbers of refugees. In mid-1996 there were 650 000 registered refugees and it was estimated that an additional 110 000 unregistered refugees could be added to this figure.

7. Iron and iodine deficiencies were prevalent in Albania, Croatia and the Federal Republic of Yugloslavia (Serbia and Montenegro). All indicated plans to reduce these deficiencies especially among children and pregnant women. In Albania a campaign to inform the public of iodine deficiency disorders (IDD) has been undertaken with the support of UNICEF, and iodine capsules for children and mothers have been distributed. Universal iodization of locally produced and imported salt has been chosen by the Government as one of the strategies in IDD elimination. In Croatia a re-evaluation of the iodine prophylaxis is under way. In the Federal Republic of Yugloslavia (Serbia and Montenegro) deficiency disorders appear not to be a major problem, however anaemia persists among young children and women.

8. Croatia and and the Federal Republic of Yugloslavia (Serbia and Montenegro) recognize the need to modify dietary habits to prevent the development of chronic noncommunicable disease (NCD) (cardiovascular disease, hypertension, obesity, diabetes, osteoporosis and cancer). In Bosnia and Herzegovina the background document on food, nutrition and health will include information of dietary-related health issues.

   The provision of health education and nutrition education is a priority in Croatia. In the Federal Republic of Yugloslavia (Serbia and Montenegro) an education programme should help the population promote their own health and wellbeing. There was an urgent need for updating recommended nutrient reference values and dietary guidelines in Bosnia and Herzegovina.

Collaboration and coordination

One of the strategies to help reach the overall objectives for nutrition policy in Albania includes building partnerships with the media, NGOs, other sectors and donors to achieve greater mobilisation and coordination within health sector.

Table 5: Balkan Region

	1. Developing Nutrition/Food Policy	2. Assessing nutrition situations	3. Improving food security	4. Protecting through food safety and quality	5. Promoting breastfeeding	6. C the and
Albania	•Nutrition integrated in National Health Programme (NHP, 1996–2000) • new health polices will incorporate nutrition objectives • National Plan of Action under way • National Advisory Body on Food and Nutrition set up in 1994	• national nutrition survey under way to assess prevalence of malnutrition, 1996	• policies to revitalise agroindustry and increase production • support for farmers and agroindustry • improve legislation	• protect consumer and nutritive quality • improvement of food safety legislation under way	• bad weaning practices result in malnourished children at 12-13 months	• redu mat • goa stre heal serv in r • redu ene
Bosnia and Herzegovina	• Ministry of Health, Institute of Public Health and WHO initiated activities on food and nutrition policy, 1994 • Nutrition Advisory Body to provide situation analysis to allow formulation of nutrition and food policy	• no regular data collection on national dietary patterns	no data	no data	no data	no da
Croatia	• Country Health Development Policy and Strategy (Master Plan) adopted and contains outline of nutrition policy • National Health Council supported food and nutrition	• development of national food consumption database • assessment of diet and nutritional status under way	• food security by local production is a priority topic	• food quality surveillance aimed at manufacturing healthier foods • introduce regulations which improve consumer awareness, food standards and safety	• national breastfeeding promotion and BFHI programme under way	• solv prol diet vuln

	policy, 1996					

	1. Developing Nutrition/Food Policy	2. Assessing nutrition situations	3. Improving food security	4. Protecting through food safety and quality	5. Promoting breastfeeding	6. C the and
Federal Republic of Yugloslavia (Serbia and Montenegro)	• measures for formulating nutrition policy should be undertaken • objectives should be established by multi-sectoral experts	• regular household budget surveys	• increase production of milk, vegetables, fruit and lean meat	• Law on Food Safety • control of food during processing/distribution/ sales-especially milk and meats • organic production • foodborne diseases leading cause of epidemics • harmonize food law with EU directives, international standards and Codex Alimentarius	no data	• imp and chil wor refu • foo diff and with

BALTIC REGION

1. In Estonia a nutrition policy has been formulated and in Lithuania a plan of action is being developed. Latvia's report focused only on food control, indicating that there is an urgent need for nutritional knowledge and expertise to be strengthened in Latvia.

2. In Estonia there are many different projects on evaluation and analysis of the nutrition situation but many methodological problems have arisen. In 1996 WHO facilitated a Baltic Project, funded by the Luxembourg Government, to support each country to carry out their first surveys on national food intake, nutritional status and knowledge of healthy lifestyles.

3. No information of household food security was provided by Estonia, Latvia or Lithuania.

4. Food quality and safety are priorities in all three Baltic States particularly in Latvia. The Latvian report focused entirely on food control. Inspection activities are guided by three laws in Latvia. In Estonia a new food law was passed in 1996 and this guarantees safe food for the population by means of a new food control system. The main priority of the Estonian National Food Agency is to increase exports and imports, harmonize with EU requirements and implement Codex Alimentarius, to facilitate joining EU and WTO. Foodborne diseases in Lithuania are largely due to the breakdown of the food control system. No sound legislation on food safety exists and no state policy has been developed yet for nutrition and food safety in Lithuania. The "Food Monitoring Programme" – based on principles of GEMS/Food-Euro activities – was started in 1994.

5. In Lithuania the percentage of breastfeeding mothers is very low (23% of women breastfeed infants until the age of 4 months and 10% until the age of 6 months) and the promotion of breastfeeding is poor. A national programme for "Improving infant and young child feeding" has been initiated with the aim of increasing the level of breastfeeding. However the programme also aims to commence local production of breastmilk substitutes and so care will be needed by health authorities to ensure this does not jeopardise breastfeeding levels. A breastfeeding project and implementation of BFHI are well under way in Estonia. It was stated in the UNICEF 1995 report[3] that a national breastfeeding committee was established in Latvia but this is not mentioned in this Latvian report.

6. In Lithuania the programme "Analysis of actual nutrition of school children" has shown food consumption to be unbalanced in school-aged children. To protect the health and ensure adequate nutrition the government confirmed activities to solve problems of child nutrition.

7. UNICEF initiated and financially supported a "Iodine Deficiency Disorder's Control Programme" in Lithuania, Latvia and Estonia in 1994 and an IDD elimination programme is in its final stage in Lithuania.

8. Estonia's action plan for 2000 includes "Make healthy choices the easy choice". The general goal of this project is to improve the population's eating habits, to increase physical activities and to reduce the consumption of alcohol. The specific aim of the "Man's Heart" project is to prevent noncommunicable disease by improving eating habits and lifestyle. To improve eating habits in Estonia consumer training programmes are under way and specialists will be educated and trained for this purpose. Health studies in Lithuania show that unhealthy nutrition is a major

cause of a large proportion (65%) of chronic noncommunicable disease and as a result a programme on healthy nutrition and weight control is being implemented.

Table 6: Baltic Region

	Estonia	Latvia	Lithuania
1.Developing Nutrition/ Food Policy	main objectives of nutrition policy fixed in 1994 by Public Health Department of Ministry of Social Affairs • in Action Plan for 2000 aim is to improve eating habits towards balanced diet • National Food Policy under preparation •Estonian National Food Agency to coordinate implementation of Food and Nutrition Policy	No data	•Ministry of Health authorized t and organize NPAN
2. Assessing nutrition situation	• different projects on evaluation and analysis of nutrition situation (methodological problems have arisen) • national nutrition databank • food consumption monitoring system under preparation	no data	• monitoring of nutrition and health status needed • prepare data of nutrition of schoolchildren
3. Improving food security	no data	no data	no data
4. Protecting through food quality and safety	• Food Law passed in 1996, guarantees safe food and food control system • harmonization with EU requirements • implementation of Codex Alimentarius a priority • implementation of HACCP	• inspection activities are guided by laws • National Environment Welfare Department investigates general food problems, food quality, hygiene, production, storage, transport (other agencies involved) • certification system of foods • legislation follows EU legislation to some degree	• no sound legislation on food safety, drinking water and nutrition – plans to consider and confirm Food Act and Drinking Water Act (95–96) • state policy in nutrition and food safety not developed • ineffective food control system • food monitoring programme 1994, based on GEMS/Food-Euro activities • establish system to ensure food quality and safety, 1998–1999 • create register of foodborne disease • plans to conform with Codex Alimentarius
5. Promoting breastfeeding	• breastfeeding project under way to increase breastfeeding rates • BFHI programme	no data	National programme for improving infant and young child feeding: • stimulate breastfeeding • production of new breastmilk substitute
6. Caring for the deprived and vulnerable	• working out national projects for different target groups	no data	• project to determine nutrition status of various population groups • protect infants, children and adolescent

7. Micronutrient deficiencies	no data	no data	• "IDD control Programme" initiated and funded by UNICEF • IDD elimination programme

	Estonia	Latvia	Lithuania
8. Appropriate diets and lifestyles	• recommended nutrient and guidelines established • improve eating habits, increase physical activity, decrease alcohol • Healthy school meal project • Man' s Heart Project -NCD • Consumer training programme using information, education, and media • education/training of specialists	no data	• "Healthy Nutrition and Weight Control" project • prepare recommended nutrient allowances and dietary guidelines (including school children) • low knowledge of nutrition among population

CENTRAL ASIAN REPUBLICS AND TURKEY

No reports submitted by Kyrgyzstan, Tajikistan and Turkmenistan

1. Turkey and Kazakstan are the only countries which developed a plan of action for nutrition. Kazakstan was seeking approval for a national nutrition policy and an action plan based on the draft policy. Uzbekistan developed a national programme on food in 1992. Turkey has indicated the need to form coordinating bodies for the development of a intersectoral nutrition policy.

2. Systematic national nutrition surveys of health status and food consumption surveys should be conducted in all countries although Kazakstan and Turkey reported that some data were available. In Kazakstan UNDP supported the first national survey of food intake and nutritional status.

3. Kazakstan stated that food security is included in the national nutrition plan but did not provide further information. Turkey plans to increase production of animals proteins.

4. Improving food safety and quality is a priority for Kazakstan, Uzbekistan and Turkey. In Uzbekistan quality and safety of foods is ensured through issue of hygienic certificates. In Turkey regulations and legislation concerning the production and inspection of foodstuffs are under preparation and projects for the future include the implementation of food safety and quality legislation and regulations. Turkey plans to develop agricultural polices in line with those of the EU and WTO.

5. Kazakstan and Turkey are actively involved in the promotion of breastfeeding and the BFHI initiative. In Turkey almost all children (95%) are breastfed for a period of time (mean duration of breastfeeding is 12 months) and according to UNICEF 56 hospitals have achieved their "baby-friendly" status (1995). One of the three priorities of the national food programme in Uzbekistan is the optimisation of children's food.

6. Caring for the deprived and vulnerable was not reported as a priority in any of the countries, possibly because almost all of their populations are vulnerable. In Turkey the promotion of women's socio-cultural status is seen as important.

7. Overcoming micronutrient deficiencies, particularly iron and iodine deficiencies, is a priority in Kazakstan and Turkey. Both countries are planning iron fortification programmes.

8. In Turkey diet-related NCDs such as obesity and CVD pose major health problems. In 1994 the prevalence of overweight (BMI above 25) was 35% for females and 27% for males. As a consequence improving levels of nutrition education in the population is a priority in Turkey. Through a mass media campaign Kazakstan aims to increase the nutritional knowledge of the population. In Uzbekistan the need for education in dietology is highlighted and there appears to be little recognition of the link between noncommunicable disease and diet. Given the high mortality rate from NCD in this region this link will require more attention in the future.

Table 7: Central Asian Republics and Turkey

	1. Developing Nutrition/ Food Policy	2.Assessing nutrition situations	3. Improving food security	4.Protecting through food safety and quality	5. Promoting breastfeeding	6. Ca the d and v
Kazakstan	• national nutrition policy (NNP) • plan of action • Nutrition Council formed in 1995	• assessment in pre-school- and school children • assessment of nutrition status of subgroups, 1996 (including iron deficiency) • introduction of growth monitoring planned	• mentioned in NNP but no further detail	• quality and safety of foods is a priority	• supporting breast-feeding and BFHI are priority • breastfeeding study planned	• inclu nutrit no fu
Uzbekistan	• National Programme of Food (NPF) developed, 1992	• survey on iron status carried ou data needed on food consumption and nutritional status	no data	• ecological safety is a priority • sanitary norms and criteria for agricultural products • national system of food product certification • need for European product standardization	• optimisation of children' s foods	no data

	1. Developing Nutrition/ Food Policy	2.Assessing nutrition situations	3. Improving food security	4.Protecting through food safety and quality	5. Promoting breastfeeding	6. Ca the d and v
Turkey	• NPAN developed and implemented	• surveys on nutritional status and food consumption survey are needed • growth monitoring started in 1994 • survey on prevalence of goitre, usage of iodized salt, nutritional status, feeding practices and growth monitoring, 1995	• promote food industry • increase production of animal protein • agricultural policies needed	• regulations on production and food sales, 1996 • training for personnel needed • laboratories in line with international standards needed • legislation under preparation to harmonize with EU and WTO	• promoting maternal, infant health and nutrition is priority • promotion of breastfeeding and BFHI is priority	• prom wome educa socio status

CENTRAL AND EASTERN EUROPEAN REGION

No report was submitted by Bulgaria.

1. All central European countries are active in developing nutrition policies, plans of action or strategies. A National Plan of Action for Nutrition (NPAN) was being: prepared in the Czech Republic; drawn up in Romania; included in the National Health Support Programme in Slovakia and included in Poland's National Health Programme. Formulation of food and nutrition policy is under way in Hungary.

2. There is a lack of national surveys of dietary habits and nutritional status in Poland and the Slovak Republic. In Poland surveys are conducted by various institutions but these are not nationwide and methods are not standardized to allow comparability with surveys carried out in other European countries. The Slovak Republic suggest the organization of workshops under the auspices of FAO and WHO oriented to the assessment of nutritional status in countries under transition.

3. In Romania food security is a priority particularly among socially and economically vulnerable groups. Its importance is highlighted with the formation of the National Board for Food Security, Nutrition and Health of the Population. Although Poland and Hungary are both self-sufficient in food production, household food security is an increasing problem for unemployed, rural families, elderly, families with many children and the poor. In some cases it is thought that daily requirements for energy and nutrients may not be achieved.

4. One of the goals of Poland's revised National Health Programme deals entirely with the quality of food. Changes in the control system (introduction of the HACCP system), restructuring of the state agencies and changes in food legislation are under way to harmonize with the international standards of WTO and the EU. Food control is also important in Hungary and Slovakia. In Hungary a New Food Act, in harmony with EU legislation, was introduced in 1996 and in Slovakia the new Food Law outlines a new food control system and also centres around gradual harmonization with EU legislation. In Hungary consumer protection has been strengthened by establishing the State Institution for Consumer Protection and by updating the Act on consumer protection. In Poland numerous acts and legal regulation are in preparation or in the process of validation, among them the Act on protection of consumers' rights.

5. In Poland promotion of breastfeeding was included in the National Health Programme. No data on breastfeeding were provided by the other countries.

6. In Romania up to 75% of the income is spent on food. Economic transition from a centrally planned economy to a market economy has resulted in the worsening of the nutritional situation of vulnerable groups in Slovakia and Poland. Food prices have increased since state food subsidies have been removed and price liberalisation implemented. In 1995, 40% of the average budget of a Polish family was spent on food in comparison to 22% in the EU[8] and so measures are included in the National Health Programme to provide government assistance for the most vulnerable (pregnant women, infants and pre-school children from economically and socially deprived segments of the society). In Slovakia the main goal of the nutrition policy is to take care of disabled people. People with diabetes, lactose intolerance, allergies etc. who are prescribed special dietary regimen are assisted.

7. The prevention of iodine deficiency is an issue in the Czech Republic, Poland and Romania. In Poland a countrywide programme on the prevention and control of iodine deficiencies has been carried out by the introduction, distribution and promotion of obligatory iodization of table salt. Another measure in Poland includes supplementation of folic acid to women of reproductive age. Iron deficiency is also widespread in Poland and there is growing concern about calcium deficiency. In Romania national programmes on: curing anaemia in children and women; iron supplementation of infant diets; and preventing vitamin A and D deficiency have started.

8. The Member States in CCEE have recognized the strong link between diet and noncommunicable diseases. In the Czech Republic the reduction of nutritional risk of developing noncommunicable disease is a high priority. According to estimates, about 33% of the Polish population is affected by diseases related to food and nutrition. Diseases related to overnutrition are now most common and appear to be a greater health risk than micronutrient deficiencies. As a result programmes on the prevention and early diagnosis of diet-related noncommunicable diseases are included in the National Health Plan. In addition a "Heart Protection Programme" and a "Cholesterol Prevention Programme" are being carried out.

   In Hungary it was estimated in 1994 that in half the deaths from CVD, 44% were nutrition-related and 50% of the population aged >35 years were overweight. In Hungary the food industry has taken steps to develop and produce food products with a more favourable composition. The Slovak Republic suggested a joint CCEE programme for developing optimum nutritional recommendations and dietary guidelines in order to try to solve similar problems in the region.

   Education of the public and of professionals is an essential activity in the Czech Republic, Hungary and Poland and some aspects of education are included in the Romanian action plan. In Poland school children, adolescents, pregnant women, young mothers and people at risk of developing diet-related diseases are targeted with specific nutrition education.

   Warsaw Agricultural Academy, Faculty of Human Nutrition and Home Economics grants master of science and doctoral degrees in the field of human nutrition. This is the only institution of its kind not only in Poland but in CCEE. In Poland the scientific staff involved in food and nutrition amounts to nearly 700 people with doctoral degrees, 3500 people in dietetic nutrition counselling and several thousand people are employed in food control services. In Hungary the main aim of the education of dietitians is to emphasize the link between nutrition and health and so emphasizing the need to promote consistent healthy eating messages rather than focusing on therapeutic diets for specific conditions.

Collaboration and coordination

One of the activities of the subregional FAO office in Budapest, suggested in the report from Slovakia, could be to form a database of institutions, experts and programmes active in human nutrition and so facilitate future international cooperation.

Table 8: Central and Eastern European Region

	1. Developing Nutrition/ Food Policy	2. Assessing nutrition situations	3. Improving food security	4.Protecting through food safety and quality	5. Promoting breastfeeding	6. Caring the deprived and vulnerabl
Czech Republic	• NPAN in preparation and plan to ratify nutrition policy • Nutrition Programme part of National Health Promotion Programme	• food consumption data needed • food composition tables needed	no data	no data	no data	no data
Hungary	·formulation of Food and Nutrition Policy under way • update consumer protection regulation	• health and nutrition surveys 1986-88 and 1992–1994 • food composition tables revised 1995	• sufficient quantity and quality of food provided but access is a problem for poor, elderly and children	• strengthen food control and harmonize with EU requirements • New Food Act will replace Food Law • quality assurance system (ISO 9000) • HACCP system • Codex Alimentarius	no data	• food insecur in vulnerable groups (elde children, poo

	1. Developing Nutrition/ Food Policy	2. Assessing nutrition situations	3. Improving food security	4.Protecting through food safety and quality	5. Promoting breastfeeding	6. Caring the deprived and vulnerabl
Poland	• NPAN introduced into the National Health programme (NHP), 1993-1995 • revision of NHP for 1996-2005 • National Nutrition Council proposed	• lack of national surveys on dietary intake and nutritional status • nutrition databased on household budget surveys	• self-sufficient in most foods • secure supply with food conforming to health requirements	• quality of foods is included in NHP • restructure food control services • harmonize with EU and WTO requirements • monitor production and food products • Act on ecological agriculture prepared • introduction of HACCP system	• continue breastfeeding programme	• implementat of schoolfeed systems • provide food socially and economically deprived
Romania	• Action Plan (AP) recommends formation of National Board for food security, nutrition and health	• need for nutrition and health monitoring included in AP	• food security is a priority issue • ensure sufficient food • symposium on "Building up a lasting and competitive agriculture in Romania" was attended by President	• aspects of food quality included in AP • harmonization with EU regulations	no data	• issues of inequity included in

	1. Developing Nutrition/ Food Policy	2. Assessing nutrition situations	3. Improving food security	4.Protecting through food safety and quality	5. Promoting breastfeeding	6. Caring the deprived and vulnerabl
Slovakia	• National Health Support Programme (NHSP), dealing with health and nutrition, 1990 • NPAN will be integrated in NHSP • nutrition policy	•systematic nutritional status monitoring needed •food data bank on food composition and nutrition loss during processing	no data	• Food Law, 1995 provides for new food control system • harmonization with EU legislation • parts of Slovak Food Codex being implemented • Analytical Quality Assurance	no data	•new strateg needed for children, yo people, mothers, disabled an other vulnerable groups

WESTERN EUROPEAN REGION

No reports were submitted by Belgium and the Netherlands.

1. In 1992 the United Kingdom was already in the process of drawing up and implementing a National Plan of Action for Nutrition when the ICN took place. A White Paper entitled "The Health of the Nation" sets out a framework for a structured and long term strategy for improving health in England (parallel initiatives exist in Scotland, Wales and Northern Ireland) The main obstacle to achieving the nutrition targets set out in the United Kingdom "The Health of the Nation" paper appears to be the inability or unwillingness of the public to translate what they understand about nutrition into practice. Germany and Switzerland were in the process of finalizing and adopting NPAN and Ireland published recommendations for a Food and Nutrition Policy in 1995. Luxembourg expressed intention of setting up an interdisciplinary group to develop a nutrition policy. No specific information regarding policy issues were provided by Austria and France.

2. A need for comprehensive data collection was reported by Luxembourg and as part of the mid-term strategy in setting up a nutrition policy, the Health Minister supported a nutritional survey and long-term surveillance of food consumption. A need for food consumption data was also indicated by Ireland and in Austria data on the nutritional status of the population are required. In general, except in the United Kingdom, there appears to be a lack of national nutrition information systems which regularly collect and present information on dietary intake and nutritional status.

3. Lack of food was not reported to be a problem in this region. In fact the opposite, since France showed concern about the large amounts of food (vegetables and fruit) being destroyed and dumped due to EU polices, rather than being distributed to the needy. They suggested more effective ways to distribute surplus vegetables and fruit. In 1993 the French Food Bank (created in 1984) dispensed 30 000 tons of food produce to 3000 associations which in turn distributed more than 60 million meals and/or food parcels.

4. The data provided in relation to food safety and quality were limited and this probably reflects a lack of coordination between nutritionists and food control specialists in western Europe. Due to EU regulations these countries all have well-developed food control systems. In Austria legislation to improve food quality and safety is continuously adapted. In Germany a safe supply of high-quality food is ensured. However, tougher regulations are needed to prevent epidemics from salmonella infections.

5. In Austria breastfeeding promotion is achieved through the use of brochures, advice and legislation. In Germany a National Breastfeeding Commission has been established and the International Code has been translated into law. In Ireland a national breastfeeding policy was launched in 1994 and information on breastfeeding and weaning is provided. The adoption of the Irish national breastfeeding policy has increased hospitals' interest in breastfeeding promotion. There was no mention of breastfeeding in the report submitted by France and the UNICEF progress report[3] states that France has made slow progress possibly due to lack of interest by health professionals, inadequate involvement by the UNICEF National Committee and a strong influence from the marketing of breastmilk substitutes.

6. Caring for the deprived and vulnerable is an issue in Germany, Switzerland and the United Kingdom. Research to identify these groups is a priority in Germany and Switzerland. In the United Kingdom particular needs of those on low incomes, ethnic groups and elderly are taken into account in the "Health of the Nation" strategy.

7. Little information on micronutrient deficiencies was provided and, in general, illness related to deficiency appears to have been largely eradicated. Iodine deficiency is possible in most countries of Europe but successful public health programmes preventing IDD have been implemented in Austria, Germany and Switzerland. In Germany regulations were passed allowing the commercial use of iodized salt in the manufacture of food and in the preparation of meals in mass catering.

8. The most prevalent nutrition-related problems in these countries are chronic non-communicable diseases related to excessive or unbalanced dietary intake. This was widely recognized and highlighted in all the country reports and the main priority of national polices is to promote information on correct diet and healthy lifestyles (Austria, France, Germany, Ireland, Switzerland, United Kingdom).

Table 9: Western European Region

	1. Developing Nutrition/ Food Policy	2.Assessing nutrition situations	3. Improving food security	4. Protecting through food safety and quality	5. Promoting breastfeeding	6. Ca the c and vuln
Austria	• no NPAN under development	• nation wide nutrition data needed • 1st nutrition report for Vienna, 1994, • food balance sheets, 1947-1992	no data	• continuous adaptation of legislation to improve food control • Austrian Codex Commission	• programme on promoting breastfeeding (brochures, advise) • legislation concerning advertising of infant-formula	no data
France	• different actions taken since ICN conference	no data	• aware of large amounts of foods being destroyed instead of being distributed to needy (several suggestions provided)	• to give general assurance of safety and quality	no data	• food b create • educat how t health an aff price • educat resear Africa

	1. Developing Nutrition/ Food Policy	2.Assessing nutrition situations	3. Improving food security	4. Protecting through food safety and quality	5. Promoting breastfeeding	6. Ca the c and vuln
Germany	• NPAN is being finalized • Food Law: hoped that regulations will soon be drawn up and harmonized with EU	• monitoring system established to register type and amount of substances ingested (including pesticides)	• sufficient and safe supply of quality foods at appropriate prices • stable provision of food due to efficient farming and food industries in the EU and global trade	• legislation to prevent food-borne infections (salmonella) • directions for producers and handlers regarding food • consumer protection guaranteed by national and EU legislation	• WHO' s Code of Breastmilk-Substitutes adopted in law • National Breastfeeding Commission established to promote breastfeeding • 1st BFHI certificates awarded • "Mother' s Milk Database" provides systematic and centralised record of harmful substances	• resear for rec state c and nu specifi are ca (night- worke care ce childre relatio betwe and di
Ireland	• Nutrition Advisory Group submitted report on "Recommendations for a food and nutrition policy for Ireland", 1995	• need for comprehensive survey of food consumption • National Nutrition Surveillance Centre concentrates on food consumption information	no data	• "Food Safety Advisory Board" established to advise on all aspects of food safety	• Health Promotion Unit (HPU) of Department of Health provides information on breastfeeding and weaning • National breastfeeding policy launched, 1994	• local p develo school women aimed overc financ to goo habits

	1. Developing Nutrition/ Food Policy	2.Assessing nutrition situations	3. Improving food security	4. Protecting through food safety and quality	5. Promoting breastfeeding	6. Ca the d and vuln
Luxembourg	•published "Health for All", 1994 •Health Minister expressed intention to develop a nutrition policy •interdisciplinary group set up to study "Nutrition and Health in Luxembourg", 1995	•national household budget survey, 1993 •lack of data on dietary behaviour •nutritional surveys needed •initiation of data-base for detection of food choice determinants	no data	no data	no data	no data
Switzerland	•Nutrition Council, 1948 •as follow-up to ICN, group to study food and health and develop proposal for NPAN, 1993 •proposal adopted by Nutrition Council, 1995 • detailed plan for NPAN developed 1996, not yet adopted	•monitoring and evaluating the effects of NPAN •monitor nutrient and energy intake •preparation of report on nutrition	no data	no data	no data	•improv informat analysin situation nutrition vulnerab

	1. Developing Nutrition/ Food Policy	2.Assessing nutrition situations	3. Improving food security	4. Protecting through food safety and quality	5. Promoting breastfeeding	6. Ca the d and vuln
United kingdom	•1992 White paper on "Health of the Nation" •work of task forces resulted in "Eat Well" programme followed by "Eat well II", 1996	•regular national diet and nutrition surveys •surveys monitor progress of white paper targets •national food survey is a continuous survey of food purchases, expenditure and nutrition in private households	•food security is in general not considered a problem in the United Kingdom	no data	no data	•those o incomes groups a •how to local pro assist th income e balanced diet

SOUTHERN EUROPEAN REGION

No reports were submitted by Monaco, Portugal, San Marino and Spain.

1. Greece appeared to be the only southern European country without any formal intention to develop a nutrition policy or an action plan. Italy is in the process of developing a National Plan of Action for Nutrition (NPAN) and Israel has adopted an NPAN. Nutrition policy is contained in legislation in Israel and Malta has had a formal policy on food and nutrition since 1988 which needs to be updated to include ICN proposals.

2. Since 1987 the National Nutrition Centre of Greece and the Greek Society of Nutrition and Food have undertaken a series of studies aimed at developing most appropriate way of using food and related data from household budget surveys. The outcome of this was the development of the DAFNE project (Data Food Network). DAFNE involves 10 European countries (Belgium, Denmark, Germany, Greece, Hungary, Ireland, Poland. Portugal, Spain and the United Kingdom) and is supported by the EU. In Italy a household food consumption survey, carried out in 1994–1996, will provide important information for planning appropriate nutrition interventions. The first National Nutrition Survey on nutritional status and food intake will be carried out in 1997 in Israel.

3. Food security was not reported as a priority since none of the country reports mentioned this either under food security nor under caring for vulnerable groups.

4. Food quality and safety was not mentioned in the reports except in Malta where an update of Maltese legislation on labelling included information concerning "use by" and "best before" dates.

5. Both Italy and Malta have active programmes on breastfeeding. Following the adoption of the EC Directive 91/321 Italy introduced strict limitations on labelling and marketing of infant formulas and prohibited the distribution of free samples. The Italian Government has also foreseen the obligation to indicate on the label of weaning foods "cannot be given to babies before the age of four months". According to the UNICEF report[3] a national breastfeeding committee has been established in Greece and in Israel the BFHI is moving rather slowly even though a breastfeeding committee has been set up.

6. Caring for the deprived and vulnerable was not highlighted in the national strategies of the southern European countries.

7. In Italy a campaign on the role of salt in the diet has been launched. The campaign aims to eliminate IDD through the promotion of iodized salt and at the same time to prevent hypertension and vascular diseases through the limitation of salt intake. A priority in Israel is the prevention and control of specific micronutrient deficiencies and a survey is planned for 1997.

8. A high priority in all the countries is the promotion of appropriate diets and lifestyles. The tools used to achieve this include the promotion of nutrition education and the dissemination of information. In Greece and Malta there is a strong recognition of the need to promote and revitalise the traditional Mediterranean diet and in Greece the "Mediterranean diet pyramid" was adopted in 1994. In Malta excess body weight is a problem. The reduction of obesity in

high risk groups (those with diabetes mellitus and high blood pressure) and increasing the awareness on correct weight for height in the population are priorities. To promote correct weight loss an 8-week weight reduction programme is held in health centres (free of charge to overweight people over 25 years). The aim is to reduce the prevalence of obesity through long term behavioural modifications. Several information campaigns have been conducted to educate the Italian consumer.

Table 10: Southern European Region

	1.Developing Nutrition/Food Policy	2.Assessing nutrition situations	3.Improving food security	4.Protecting through food safety and quality	5.Promoting breastfeeding	6.Caring for the deprived and vulnerable	7 d
Greece	•no official nutrition policy •series of uncoordinated activities	•DAFNE project which involves 10 European countries – household budget surveys provide data related to food •(EPIC)[11] * study of diet and cancer in Europe	no data	no data	•National Breastfeeding Committee established	no data	n
Israel	•NPAN adopted, 1994 •nutrition policy is part of legislation and adopted •since 1995 all clinical services disseminate nutrition policy	•1st national nutrition survey planned for 1997 •update food composition database •update recommended nutrient allowances	•included in NPAN	•included in NPAN	•included in NPAN	•nutrition survey to take account of poor and Arab population	•a d w

* EPIC is a study of diet and chronic disease that is in progress in seven European countries (France, Germany, Greece, Italy, the Netherlands about 400 000 adults on food intake, lifestyle and environmental factors, anthropometry and biological samples. The subjects will be followe in relation to epidemiological data and biochemical markers. The wide geographical distribution provides populations with dietary habits, ran and Spain to the "middle European" food patterns of Germany and The Netherlands.

	1.Developing Nutrition/Food Policy	2.Assessing nutrition situations	3.Improving food security	4.Protecting through food safety and quality	5.Promoting breastfeeding	6.Caring for the deprived and vulnerable	7 d
Italy	•Ministry of Health bill on "Measures to improve the nutrition of the Italian population and to reduce the risk of dietary related diseases" provides framework for national plan •priority is to establish multi-sectoral National Council for Nutrition	•establish nutrition information system •household food survey conducted in 1994/96 •pilot nutrition surveillance system designed to show link between food and dietary related diseases	no data	no data	•strict limits on marketing of infant formula and prohibition of free samples •control distribution and content of information on infant feeding •make maternity' s more "baby friendly" •avoid early weaning	no data	• o o ta • p ic o o
Malta	•national food and nutrition policy endorsed by Parliament, 1988 •nutrition policy needs to be updated to include the ICN proposals	no data	no data	•updating legislation on the labelling of foods including "use by" and "best before" dates	•increase awareness of benefits of breastfeeding •establishing a BFHI •enforce Code on marketing of breastmilk substitutes •improve infant weaning practices •draft policy to become law	•emphasis on the elderly, adolescents and pregnant women	n

COMMONWEALTH OF INDEPENDENT STATES

No reports were submitted by Georgia and the Russian Federation.

1. Both Azerbaijan and Belarus have indicated the need to establish a body for coordinating the work of different ministries in drawing up a national food and nutrition policy. Belarus hopes to draw on experience from other countries in establishing intersectoral committees to develop both a national food policy and a national plan of action on nutrition and monitor implementation. Adoption of its Food Law together with other legislative acts will lay the foundation for national food and nutrition policy as well as a national plan of action in Belarus. An NPAN is being developed in the Ukraine with the main aim of developing nutrition policy in 1997. The aim is to promote public health on the basis of the analysis of the nutritional situation.

2. A national survey into nutrition and health was carried out in Azerbaijan in 1996 with support and guidance from UNICEF, CDC and WHO. Data are needed on the nutrition situation in Armenia and a priority in the Ukraine is to develop a system of regular surveillance of nutritional status of the population.

3. There is a general need to protect the food security of vulnerable groups in this region. The solution to this problem is one of the most urgent in Azerbaijan and Armenia. As a consequence of economic crises, inflation, war, decline in industrial and agricultural production, population growth and impoverishment of a considerable number of the Azerbaijan population, the Parliament ratified documents for the protection of vulnerable groups. In Armenia insufficient quantity and quality of food is having a negative impact on the health of the population. Future actions include the development of effective farms and an improved infrastructure for agriculture. It is estimated that international financial organizations and bilateral donors will provide around US $1 billion of official assistance during the period 1996–1998. As Belarus was not a Member of FAO there was no ICN material in the Ministry of Agriculture and Food, and so this Ministry was not engaged in drawing up national policy for food and nutrition. The Republic of Moldova joined FAO in 1996 and an FAO representative is actively working in the country.

4. Improving food safety and quality is a priority in Azerbaijan where quality and safety of foods is ensured through issue of hygienic certificates. In Armenia the transition to market economy has affected the state food control system. Control institutions urgently need restructuring and strengthening but a tight budget prevents improvements and, as a result, the quality of vast amounts of food does not meet health standards. Quality of food and its safety are also concerns in the Ukraine. In Belarus quality and safety of food products is a priority and the system of state sanitary surveillance, together with food hygiene research establishments, ensure that an array of activities is carried out. In the Republic of Moldova a new system of food control is being implemented to ensure quality of both exported and imported food products.

5. Azerbaijan, Belarus and the Republic of Moldova are all active in the field of breastfeeding. As a result of a breastfeeding programme in Baku and districts of Azerbaijan, some maternity facilities are committed to becoming BFHI. In the Republic of Moldova a national breastfeeding committee established in 1996 and Ministry of Health has passed a decree regarding the creation of BFH and the promotion of breastfeeding. In spite of these efforts levels are low and still decreasing and so efforts in education and promotion of breastfeeding must intensify. In Belarus several bodies responsible for health care and sanitary control are responsible for the

promotion of breastfeeding in Belarus. A research project is being conducted into the effects of the Promotion of Breastfeeding Intervention Trial (PROBIT). The main objective is to evaluate the success of BFHI in prolonging the duration of breastfeeding. Belarus is planning to produce infant foods, and care will be needed by the health authorities to ensure this does not include the aggressive marketing of breastmilk substitutes which could jeopardise breastfeeding levels.

6. Socioeconomic changes have made a big impact on societies in the region. The Republic of Moldova has experienced a negative impact in the overall health of the society, particularly of mothers and children. In 1992 a "Programme of developing food production for children" was adopted. This includes providing equipment for producing various types of food for children of different ages. Azerbaijan adopted a document on norms of food consumption for the aged, the disabled and children living in institutions.

7. Both Armenia and the Republic of Moldova were identified as endemic goitre regions in the 1960s. A reduction in IDD was achieved during a period when the population used iodized salt and/or bread. However since 1992 the production of iodized salt has almost stopped in Armenia and as a consequence the problem of iodine deficiency is returning. With help from UNICEF a plan has been developed to produce iodized salt in Armenia. Similarly, in the Republic of Moldova the supply of iodized salt from the Ukraine was insufficient and a solution is being sought. UNICEF is also assisting Azerbaijan in preparing a draft law on salt iodization. To improve further the health of the Azerbaijan population, the necessity to provide fortified foods and vitamin preparations has been recommended to the government. Armenia and the Republic of Moldova have indicated a need for data related to vitamin A deficiency and with the support of UNICEF a survey has been carried out.

8. Armenia and Belarus have recognized that, in view of the increasing mortality due to NCD, preventive nutritional measures should be taken. Belarus is planning to improve the education for various population groups in the principles of healthy nutrition and healthy lifestyles. In Azerbaijan the need for education in dietology is highlighted and here there appears to be little recognition of the link between noncommunicable disease and diet.

Table 11: Commonwealth of Independent States

	1.Developing Nutrition/Food Policy	2.Assessing nutrition situations	3.Improving food security	4.Protecting through food safety and quality	5.Promoting breastfeeding	6.C the an vu
Azerbaijan	•no national nutrition policy •negotiations for setting up a committee	•nutrition information systems planned for 1996-1998 to enable policy development •nationwide survey into nutrition and health, 1996	•1992, minimum consumer budget ratified •protect population against inflation and scarcity of food	•Ministry of Health responsible for testing and issuing hygienic certificates for imported foods •food quality control system planned	•active programme on breastfeeding •maternity homes are taking up initiative of BFHI	•ad nor and boa and hor ins •inv stu pla
Armenia	•currently developing a NPAN, implementation is envisaged during next 5 years •intersectoral committee set up to work out the national nutrition programme	•investigation of nutrition status carried out, 1995 •regular monitoring on the nutrition situation of the population is necessary	•effective farms and new infrastructure needed for agriculture •first land reform on privatization, 1991 •"food for work" under sponsorship of UNWFP (reforestation, creation of irrigation and drainage)	•insufficient quantity and deficient quality of food •control of food in new "market" is lacking •laboratory control is far from perfect •number of imports has increased greatly •certification of food products •new regulating norms needed	no data	•mi pro •sir stu in Y vul and

	1.Developing Nutrition/Food Policy	2.Assessing nutrition situations	3.Improving food security	4.Protecting through food safety and quality	5.Promoting breastfeeding	6.C the an vu
Belarus	•no national food and nutrition policy or NPAN •draft food law is under consideration – foundation for drawing up national policy on food and nutrition as well as a NPAN •necessary to establish intersectoral body	•assessment of nutritional status of various population groups needed	no data	•monitor food establishments •monitor sanitary conditions in retailing and catering •improve radiological safety monitoring •improve analytical methods for food control •harmonization with international requirements	•assist with feeding of mothers, infants and young children •projects aimed at advocating breastfeeding (PROBIT project) •manufacture infant foods	no
The Republic of Moldova	no data	no data	•well developed agricultural production •agriculture main branch of economy •government introduced license system and quota of exports to protect food market	•new license system of food production standards is being implemented	•order passed on BFH and the promotion of breastfeeding, 1994 •national commission •training seminars for doctors, nurses and midwives	•fo for not phy req •pr dev pro chi
Ukraine	•NPA being drafted and will form basis for nutritional policy •develop state policy in nutrition and health •measures to realizee nutrition policy in 1997	•surveys on nutrition status carried out in Kiev and 5 regions •develop nutrition information system •develop computer programme	no data	•food quality and safety are major issues •develop surveillance on contamination of foods with xenobyotics	no data	no

NORDIC COUNTRIES

No report was submitted by Finland at the ICN consultation and the information from Finland was added later.

1. Denmark, Iceland and Sweden have all adopted a nutrition policy/plan of action. In the case of Iceland, a nutrition policy was developed and adopted before the ICN recommendations in 1989. Finland does not have an official nutrition policy.

   Norway has not developed an action plan; however the nutrition and food policy has a long history in Norway where it was first developed around 1930. The first white paper on nutrition and food policy was approved in 1976 as a direct result of the World Food Conference held in Rome in 1974. A follow-up white paper was presented in 1982, and in 1993 the nutrition and food policy was integrated into the health policy. To strengthen consumers' influence on the nutrition and food policy, a consumer policy that stimulates a health-promoting diet through differential prices, food availability, food labelling/claims and information and marketing will be implemented in Norway.

   The goal of Danish policy on food and nutrition is "To contribute to the encouragement of the population to choose a diet which promotes and preserves health and prevents disease. Furthermore consumers must be ensured wholesome foods".

   Sweden lacks an overall national strategy and more coordination between the various sectors working in the area of disease prevention and health promotion through nutrition is needed.

   Finland has a national nutrition council (nominated for period 1996–1999) by the Ministry of Agriculture and Forestry. They are currently revising their dietary guidelines based on the Nordic Dietary Recommendations (1996)

2. Data on the nutritional status and food intake are available in Denmark but coordination of these data is needed and the collection of relevant new data should be considered. A working group will be established to evaluate the possibility for constructing a central database which will make it possible to follow the development on the nutrition situation of the population of Denmark. In Iceland the initial project stipulated by the food and nutrition policy was a national nutrition survey carried out in 1990 and a second survey among school children was recommended. Regular nutrition monitoring is carried out in Finland.

3. Until around 1950 the main goal of the Norwegian nutrition and food policy was to ensure enough food for the population. After 1950 however the dietary problems changed in character and problems connected with over-nutrition became more prevalent. Norway stressed the importance of ecologically sound and sustainable food production and that food policies should include the protection of animals, plants and genetic and environmental resources.

   According to law Finland should have a one-year storage of grains and crops. The goal is to guarantee an energy intake of 2800 kcal/day/person. This goal is achieved through the work of permanent committees including one on public catering and welfare services.

4. In Denmark the main regulations concerning foods was laid down in the Food Act and a surveillance system enables monitoring of nutrients and contaminants in food and combating foodborne disease. In Denmark foodborne diseases have increased over the last ten years. As a consequence of a 64% increase in salmonella infections during 1991–1993 a plan of action for the prevention of salmonella in pork, beef and derived products was worked out and a Danish Centre for Zoonoses was established. In Sweden up-to-date food legislation and food control is established and a food-safety system guarantees adequate safe and nutritious food of a good quality. In Norway two of the four goals of the nutrition and food policy deal with food safety. Finland has a food law and regulations and a health protection law, which aims to protect consumers against health hazards, financial loss and misleading information.

5. A key objective in Denmark is to promote, support and protect breastfeeding of infants. Activities are already in progress to get as many hospitals as possible to meet the requirement of the BFHI. According to UNICEF, Sweden is the leading country in fulfilling BFHI and in 1995, 56 hospitals out of 66 maternities have been named as "baby-friendly". Even though breastfeeding rates are already high in Norway with approximately 98% of mothers breastfeeding at discharge (75% at three months and 50% at six months)[3] the Government intends to implement a policy that will continue breastfeeding at a high level. In Iceland a survey on infant and child nutrition will provide information on the extent of breastfeeding and other feeding practices.A breastfeeding working group was set up 1994–1996 in Iceland and the BFHI initiative started in 1996: 97% of mothers breastfeed at discharge and at age of 6 months 52% are still breastfeeding; 68% mothers breastfeed exclusively at 1 month and only 26% at 3 months.

6. In Sweden's plan of action a priority is to reduce the social gaps with respect to the incidence of diseases (unemployed, low-income earners children, adolescent, people in care, immigrants). To prevent diet-related health problems among immigrants, it was proposed that "food and consumer knowledge" should become a part in the introductory programme for refugees arranged by the municipalities. In addition information on eating and health should be translated into the major immigrant languages.

   In Sweden lack of awareness of the problems associated with nutrition is a problem in the institutions for the elderly and so a committee is to be set up to study these problems. In Denmark recommendations for the nutrient content and consumption of foodstuff in the institutional diet are prepared.

   In Finland elderly, hospitalized people seem to be the most vulnerable. There is 13% unemployment in Finland thus food poverty could be a problem. School children have received a warm meal, milk and bread free of charge since 1948. Day care centres provide two thirds of dietary needs of children. University students receive subsidized meals.

7. Deficiency diseases present no general problem in Nordic countries. However a possible problem of iodine deficiency has been discussed in Denmark. A working group has been set up to evaluate whether there is a need for an increased iodine intake. Similar working groups will be set up in Denmark for evaluating the need for possible enrichment of foods with folic acid, calcium and iron. Norway's fortification policy included addition of vitamin A and D to margarine, iodine to salt and iron to brown cheese and some infant foods. Finland has iodized salt since the 1950s and spreads are fortified with vitamins A and D. Juices and some other

beverages are enriched with vitamin C some of them with calcium. In Finland, there is no other general fortification, and folic acid supplementation is recommended for women at moderate risk of neural tube defects. Vitamin supplements are given and 95% of infants and young children (2 weeks to 2 years) receive vitamin drops. In Finland, Vitamin D is also provided for older children, pregnant and lactating women and the elderly during winter months.

8. High fat intake was identified as one of the major health problems in all Nordic countries since fat contributes to a high prevalence of CVD and cancer. In these countries one of the main objectives is to improve the dietary and exercise habits of the population to achieve better health as well as to prevent illness and premature deaths from diet-related diseases.

   One of the successes of the Norwegian food and nutrition policy was the information and public education done by the National Nutrition Council, especially by the use of programmes on television and nutrition campaigns. Surveys have revealed that the knowledge of food, diet, nutrition and health has increased in the population over the last 15 years and this is reflected in a change in the general diet. Therefore it is suggested that the nutrition and food policy has played and important role in changing dietary habits and thus contributed to the decline in heart disease. Nutrition education is an important instrument in the nutrition policy of Denmark and a Forum for Nutrition Education was established in 1994 to ensure an improved coordination and integration of the messages concerning nutrition. In Sweden "food and health" education in schools and colleges and the education of health-service staff are regarded as being particularly urgent. In Sweden a committee charged with specifying national goals for health is to be set up and the connection between diet and health will be one of the many questions to be studied. In Iceland ongoing education programmes focus on providing children with a healthy packed lunch and on educating kitchen staff.

   Finland has put emphasis on reducing quantity and improving quality of fats, reducing salt and addressing the problem of obesity. The role of mass catering is very important since on average each Finn eats 125 meals per year outside the home. New dietary guidelines will be prepared during 1998.

Collaboration and cooperation

On the Nordic level there is quite extensive cooperation in the area of food and nutrition administration, regulation and policy. This includes setting recommended nutrient intakes (Nordic Committee on Food guidelines), coordination of nutrition policy and a Nordic working group on nutrition education. Also Nordic cooperation on setting up a database concerning allergy has been established.

Cooperation with food industry and the retail trade has been of major importance in Norway, Iceland and Denmark.

The world food situation is taken into consideration in Denmark and Norway through the provision of aid and support to poor countries. The Danish Development Agency's (DANIDA) contribution to nutrition is within community development. The aim is to strengthen the ability of local communities and families to secure their own health and to participate in the planning of basic health services.

Table 12: Nordic Countries

	1.Developing Nutrition/Food Policy	2.Assessing nutrition situations	3.Improving food security	4.Protecting through food safety and quality	5.Promoting breastfeedin g	6.Caring deprived vulnerabl
Denmark	•NPAN published, 1995 •targeted food and nutrition policy established (part of Health Promotion Programme, 1989) •since 1994 counties and municipalities are obliged to work out a health plan	•nationwide dietary survey made 1995, results to be published in 1996 •plan for a nutrition information system has been developed	•self-sufficient in all basic foodstuffs •agriculture of great economic importance	•main regulations in Food Act •protect consumers against health hazards and misinformation and coordinate surveillance •monitor foods, foodborne disease and poisonings •reduce number of foodborne diseases	•promote and encourage breastfeeding of infants and babies during their first year •get as many hospitals to meet requirements of BFHI	•ensure that have diet tha provides the opportunity enjoy life •identify gro risk (children 3, children o immigrants, people, wom reproductive
Iceland	•NPAN developed in 1989 •national food and nutrition policy ratified and Parliamentary resolution in 1989	•national nutrition survey carried out in 1990 •survey among schoolchildren	no data	no data	•project on infants and young children expected to provide information on rates of breastfeeding	no data
Norway	•National Nutrition Council, 1937 •nutrition and food policy started around 1930, 1st white paper 1975, 2nd white paper 1982 •nutrition and food policy integrated into health policy, 1993 •strengthen consumers' influence on nutrition and food policy	•Monitoring nutrition situation at three different levels: food supply, household budget surveys (statistics Norway), individual level (food frequencey questionnaire)	•production should be ecologically sustainable on a long-term basis	•National Food Control authority, 1988 •foods free of infectious agents and not to contain additives in quantities of risk to health •meet consumers demands for food quality and safety •improve monitoring and warning systems for foodborne disease	•implementation of policy to ensure high level of breastfeeding •98% of women breastfeed at discharge, 75% after 3 months and 50 % at six months[4]	Give high pr eating habits school childr properly arra school meals canteens

	1.Developing Nutrition/Food Policy	2.Assessing nutrition situations	3.Improving food security	4.Protecting through food safety and quality	5.Promoting breastfeedin g	6.Caring deprived vulnerabl
Sweden	•draft NPAN presented 1994 and accepted 1995 •lacks national strategy and coordination of those in preventive nutrition and health •county councils obliged to do preventive work • increase consumer participation	•research into factors determining eating habits needed	no data	•up-to date food control •social food-safety system •up-to-date food legislation	•government report on BFH for the protection, support and encouragement of breastfeeding •95 % of mothers breastfeed on discharge and 65% at 6 months[4] •56 BFHs out of 66, 1995 [4]	•unemployee income, child adolescent, immigrants, disabled, •reduce socia respect to di related disea
Finland*	1938 nutrition policy published 1989 National Nutrition Council published proposal for policy 1996-99 Nutrition Council 1998 New dietary guidelines expected	Regular nutrition monitoring is carried out by Public Health Institute	goal to be self-sufficent (2800 kcal/day)according to Law. Finland should have one year storage on crops. Permanent committees incl. welfare catering	Food Law National Food Control Agency under MoTrade and Industry Food control agencies in municipalities National registration of foodborne diseases	Working group on BFHI 1996 97% mothers breastfeed on discharge and 52% at 6 months 68% exclusively breastfeed at 1 month and 26% at 3 months	Elderly, hosp people most vulnerable 13% unempl and resulting School childr (since 1948) warm meal a and bread fr Day care fac supply 2/3 c dietary need children Subsidized n students

* no report submitted at the ICN consultation, however information provided later by Finland

WHO CONCLUSIONS AND RECOMMENDATIONS

1. Developing food and nutrition policy

WHO Member States are congratulated and thanked for submitting very useful national reports in 1996 and so allowing this analysis to be carried out.

Around the time of ICN (1992) some Member States in central Asia, the former Soviet Union and the Balkan region were not fully independent and so were unlikely to have information about the ICN. Thus food and nutrition specialists in some parts of the WHO European Region were probably unaware of the ICN and so it is hardly surprising that many countries had not developed national policies or plans of action according to the ICN objectives.

Moreover a few WHO Member States are not members of FAO (1998) and others have only recently joined. This probably partly explains why there were more health than agriculture representatives present, 66% compared with 27%, at the consultation in 1996.

One of the difficulties when attempting to develop intersectoral policies is the level of commitment that each stakeholder has to public health versus their own possibly diverging interests. It is improbable that intersectoral polices will be implemented, unless all stakeholders are committed to the process. However, the long-term interests of the agriculture sector, the food industry, wholesale and retail representatives are enormously dependent on policies which have been developed in collaboration with the voluntary sector and consumers. Consumers, the customers of the food industry, want to be more involved in the process whereby food policy is developed.

Intrasectoral collaboration within the health sector

Good collaboration between nutrition and food safety is essential because the public and consumers perceive food in a holistic way. Consumers do not compartmentalise food or distinguish between food safety and nutrition – consumers want good wholesome food they can enjoy without fear. There appears to be more collaboration between the nutritionists and food safety specialists working in central and eastern Europe than those in western Europe.

There may be several reasons for the stronger collaboration in central and eastern Europe. Nutrition is a relatively new science and in eastern parts of Europe its evolution seems to be closely linked to "hygiene" and the sanitory-epidemiology system. In eastern Europe nutrition and food hygiene have evolved from the same post-graduate specialization, usually as a specialization of medicine. In former socialist countries food safety is traditionally under ministries of health, whereas in some western European countries only nutrition is under ministries of health and the responsibility for food legislation and enforcement may be with ministries of agriculture in the West. However this is changing, especially in some EU Member States, where ministries of health are taking a much more pro-active role in protecting consumers and their health.

Coordination between public health specialists working in food safety and nutrition is important for many other reasons (see section on food safety for more discussion on this issue). One is that from time to time food control authorities may issue warnings about food e.g. chicken that contains salmonella, or fish and vegetables which are contaminated. Meanwhile, as part of national campaigns, nutritionists promote consumption of vegetables, fish and poultry. Public health specialists must deliver consistent and reliable information to avoid public confusion. Closer cooperation between nutritionists and food safety specialists can prevent the promotion of conflicting messages.

Recommendation 1 – Encourage close collaboration between health professionals working within food safety and nutrition policy.

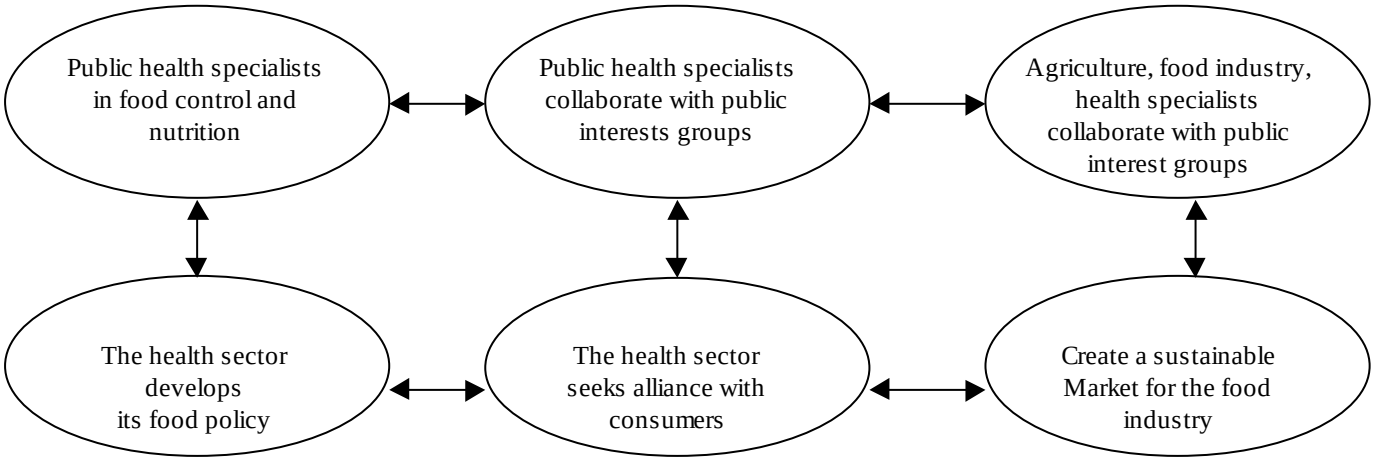
Intersectoral collaboration

Public health specialists dealing with food safety and nutrition should strengthen their collaboration with other sectors dealing with food, e.g. agriculture, food industry, wholesalers and retailers; voluntary sector and public interest groups representing consumer interests. Consumers have a vested interest in supporting the supply of safe food of good quality that is nutritionally healthy and the food industry has a vested interest in supplying healthy consumers. There is an opportunity for the health sector to strengthen health alliances with public interest groups working in the voluntary sector.

Surprisingly, in the country reports, there is very little mention about the importance of collaboration with consumer agencies except by Hungary, Norway, Poland and Sweden. In these countries there is an understanding that the food industry can profitably increase the availability of vegetables and fruit, low-fat milk and lean meat on condition that it is assured a market.

Recommendation 2 – Strengthen alliances with consumers, in order to create a sustainable market for foods such as vegetables and fruit.

Figure 1: From intra- to intersectoral policy development "food priorities for health"



2. Assessing the nutrition situation

Almost all countries reported a need to improve nutrition information systems. Some had no information, some use secondary data (Italy) or access nutrition information from national budget surveys (DAFNE) (see section on Southern Europe). Some had information from one-off surveys that were sponsored through international cooperation. The Nordic countries and the United Kingdom seem to have established the most comprehensive surveillance systems that provide information on food consumption and nutritional status on a routine basis. Clearly it will take time for some countries to achieve this level of sophistication but ultimately these data are essential to facilitate food and nutrition policy development.

It seems unlikely that, at least in the near future, national nutrition surveys will be carried out on a regular basis; therefore other strategies have to be found: members of DAFNE extract nutrition related data from household budget surveys; in Italy secondary data sources were used to develop a national food and nutrition policy and action plan. Mortality data are available from the WHO "Health For All" Database which is accessible through internet from WHO's web site[12]. These data allow comparison of mortality statistics between different countries. FAO food balance sheets provide data such as the percentage energy coming from carbohydrate, fat, protein and alcohol and the quantity of vegetables and fruits available nationally. These data are directly accessible from the FAO web-site[13].

Recommendation 3 – Where primary data are not available seek secondary sources of data related to the food and nutrition situation in order to facilitate policy development.

In the future the EU may encourage its member states, and those wishing to join, to develop standard nutrition information systems. This will allow comparison of data on dietary intake, nutritional status and diet-related behaviour in different EU member states and so facilitate the development of cost-effective strategies that enable countries to save money on treating preventable diseases.

3. Improving food security

After the Second World War the main aim in Europe was to increase the supply of food, especially animal products, e.g. meat and milk. However the postwar policy was too successful (Figure 2) and in the eighties until the present time Europe has surplus stocks of butter, meat and milk[14].

Figure 2: Food policy in 20th Century

1950s	*1960s*	*1970s*	*1980s*	*21st Century*
Food insecurity & perceived nutrient deficiency, especially protein	Increased food production & consumption especially of animal protein and fat	Surplus stocks of food, especially animal products	Links identified between mortality from *NCDs and diets high in animal fats and low in vegetables and fruit	The opportunity to change food policy to meet health and environmental recommendations

*NCD = noncommunicable diseases

Since the Second World War, new scientific evidence has lead to the level of recommended daily protein intake being reduced. For example the level of protein intake recommended by FAO, WHO and UNU in 1986 was 0.75g/kg day. This new level resulted in many countries reducing the level of their national recommended protein intakes for adults from 120g[15] to around 50g per person/day[16]. There is now some evidence suggesting that excess intake of some sources of protein, especially red meat, could be associated with ill health.

Various hypotheses exist to explain how meat consumption may contribute to chronic diseases such as heart disease and certain cancers [17]. Meat intake is associated with an increased intake of saturated fats[18] which are linked to increased risk of cardiovascular diseases and breast and colorectal cancer [19] [20]. Excessive protein intake may be associated with increased excretion of calcium and so possibly exacerbate the prevalence of osteoporosis[21,22]. Excess intake of protein is associated with increased risk of renal disease[23] [24], especially in infants, since the kidneys have to excrete excessive solute loads and so excess protein intake is perhaps linked to the risk of developing high blood pressure later in life. It is advisable that ministries of health review their national nutritional norms and recommended intakes to ensure that these are in line with current international recommendations

Lessons learned over the past 50 years suggest future food policies should ensure:

- cereal and potato production should be geared to supply >50% energy;
- vegetables (excluding potatoes) and fruit production should be geared to supply a consumption of, at least, 400 gram/day/per person[17];

Given the key recommendations, contained in most dietary guidelines, "to protect, promote and support the consumption of cereals, potatoes, vegetables and fruit" it is surprising that there was no mention of the need to increase the production of these foods in the country reports. Without a food policy which guarantees food security in the form of cereals, potatoes, vegetables and fruit it is difficult to see how national targets for a healthy diet[17] can be achieved.

Recommendation 4 – Review national nutritional standards to ensure that these are in line with international recommendations and base future food production targets on health recommendations.

One of the reasons why families, living in countries undergoing economic transition (CCEE and CIS), are not suffering from protein/energy deficiency, is because many produce a large percentage of their own potatoes, vegetables and fruit[25]. In Russia, town dwellers produce 88% of their potatoes, 43% of their meat, 39% of their milk and 28% of their eggs on urban household plots. This important share of production is generated on plots of 0.2 to 0.5 ha. which together constitute only 4% of the total amount of agricultural land in Russia. In addition imports from abroad have supplemented national food production and currently 50% of chickens[26] and 30% of meat[27] consumed in the Russian Federation is imported. In the short term imports are essential during times of hardship and economic transition, but in the long term agricultural polices should promote sustainable production and protect local food production.

In eastern Europe the agriculture sector forms a much higher percentage of national GDP[28] compared with western Europe. Almost 30% of the population in some CEE countries are employed in agriculture compared with only 1 or 2% in western Europe. Many economists are concerned about the impact when more countries join the EU because the Common Agriculture Policy (CAP) is not sustainable. The CAP receives almost half the EU budget and in 1995 it cost the EU taxpayers 39 billion ECU[29]. During the CAP reform process health recommendations and dietary guidelines should influence the reformed policy in addition to concerns about national employment and the national food security of the EU accession countries.

Recommendation 5 – Incorporate nutrition and health objectives into the new Common Agriculture Policy.

4. Protecting health through food safety and quality

In some reports there was no mention of the importance of food safety, especially in the countries of southern Europe. As mentioned in the introduction, it is vital to strengthen the collaboration between food control and nutrition agencies[30 31 32]. Some western governments are already attempting to bring these two disciplines under one food authority[33] and three-quarters (27 out of 35 countries) did include food safety in their ICN reports (Table 13). Close collaboration becomes even more essential as the line between food safety and nutrition becomes more and more blurred with the introduction of: pre-cooked foods; functional, novel and special dietary foods; and supplements. Moreover with the introduction of food into global trade, the public's need for information will be immense. To provide reliable information, both food safety specialists and nutritionists need data on food intake patterns. More effective use could be made of resources if joint surveillance and risk management of food intake is carried out together.

Recommendation 6 – Nutrition information systems should be incorporated in health information systems and linked to the surveillance activities of food safety services.

Foodborne diseases are among the most widespread health problems in the contemporary world. In rich and poor countries alike they impose substantial health burdens ranging in severity from mild indispositions to fatal illnesses. The emergence of new foodborne diseases is an ominous trend. Epidemics due to newly identified pathogens such as *Campylobacter jejuni*, *Listeria monocytogenes*, *E Coli 157:H7* and *Bovine Spongiform Encephalopathy* (BSE) have hit industrialized countries. Salmonella outbreaks are one of the main causes of epidemics in Europe. Global trade will make it more difficult to contain foodborne diseases within national borders and enforce national food laws. In addition chemical contamination, toxic materials, pesticides, veterinary drugs and other agrochemicals require constant surveillance to ensure their safe use. Similarly the use of food additives can improve the quality of the food supply but appropriate controls are necessary to ensure their proper use.

Most regions included in their country reports the need to harmonize their national food legislation with the EU and WTO in order to facilitate their accession to the EU. Many countries stated they are lining up to join either the EU or WTO (12 countries) and so intend to harmonize their national legislation with international directives set by the EU or Codex Alimentarius. It is essential that health professionals, especially those working in public health,

become more informed about international agreements on global food trade and take full part in the WTO Committee on Sanitary and Phytosanitary Measures (SPS Committee)[34]. Only if public health specialists, both from food safety and nutrition, participate can they hope to influence future food policies.

Recommendation 7 – It is of paramount importance that the health sector of each country fully participates in and contributes to the work of the CodexAlimentarius Commission and EU committees.

5. Promoting breastfeeding

Clearly there is a lot to be done in the European Region to promote breastfeeding. More than one third (13) of the 35 Member States made no reference to breastfeeding in their country reports (Table 13). This does not necessarily mean that there are no active breastfeeding programmes in the country (e.g. Romania) but it does mean that there is probably little coordination between those responsible for nutrition policy and those responsible for breastfeeding. Perhaps this is because breastfeeding is regarded as a clinical issue dealt with by midwives and primary health care workers. However public health nutritionists, and hygienists in CCEE and CIS do have an important role and should be active in the development of national breastfeeding policies.

National breastfeeding initiatives will only be successful if legislation is developed and enforced according to guidelines from the Baby-Friendly Hospital Initiative (BFHI) *(see footnote[1])* and the International Code for the marketing of breastmilk substitutes. Monitoring of national and regional trends (marketing strategies and breastfeeding levels) are needed to interpret the national situation and make recommendations to policy-makers.

The BFH initiative targets maternity services and hospitals particularly health workers and those responsible for policies to help mothers succeed in breastfeeding. To become a baby-friendly hospital every facility providing maternity services and care for newborn infants should implement the "Ten Steps to Successful Breastfeeding" outlined in the joint WHO/UNICEF statement entitled *Protecting, promoting and supporting breastfeeding: the special role of maternity services (see footnote[2])* and should end free and/or low cost supplies of breastmilk substitutes.

Recommendation 8 – Encourage collaboration between those working on the Baby-Friendly Hospital Initiative and food and nutrition policymakers.

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[1] BFHI: In 1991, WHO and UNICEF jointly launched the Baby-Friendly Hospital Initiative (BFHI). The aim of the programme is to enable women to choose and practice breastfeeding as the primary source of nutrition up to about six months by minimizing obstacles which make it difficult or prevent women from exercising their right to breastfeed and to ensure the cessation of free and low-cost infant formula supply to hospitals

[2] A joint WHO/UNICEF statement, WHO, Geneva, 1989

Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

1. have a written breastfeeding policy that is routinely communicated to all health care staff
2. train all health care staff in skills necessary to implement this policy
3. inform all pregnant women about the benefits and management of breastfeeding
4. help mothers initiate breastfeeding within a half-hour of birth
5. show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants
6. give newborn infants no food or drink other than breastmilk, unless medically indicated
7. practice rooming-in – allow mothers and infants to remain together – 24 hours a day
8. encourage breastfeeding on demand
9. give no artificial teats or pacifiers to breastfeeding infants
10. foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic

There is clearly a vital need to increase the number of Baby-Friendly Hospitals in Europe and develop and enforce national legislation which is based on the International Code of Marketing of Breast Milk Substitutes[35].

Recommendation 9 – Set targets to increase the number of Baby-Friendly Hospitals nationally and enforce national legislation on the marketing of breast milk substitutes.

In some countries there may be conflict between nutritionists, hygienists and new breastfeeding policies. Some hygiene standards and Decrees in the former Soviet countries, such as the recommendation that mothers should be separated from their babies after birth, contradict the current UNICEF and WHO recommendations to promote the "rooming-in" of babies with their mothers. In addition, National Nutrition Institutes that are involved with research and development of breastmilk substitutes and weaning foods may unintentionally interfere with breastfeeding promotion.

Complementary feeding (weaning) was not discussed in detail in any report and only mentioned very briefly in 2 country reports, Albania and Italy. Perhaps this is because the categories listed in the World Declaration of ICN do not specifically include complementary feeding, only breastfeeding. This was perhaps an oversight by the ICN committees since it is clearly important that all Member States address their policies on weaning practices. It is around the age of weaning when infant mortality and morbidity levels are at their highest. It is likely that the high prevalence of anaemia seen in some parts of the European Region is due to poor weaning practices[36]: such as the early introduction of foods and drinks, especially cow's milk and tea, before the age of 6 months.

Recommendation 10 – Increase the awareness for the need to improve complementary feeding (weaning) practices in Member States by developing WHO Regional guidelines.

6. Caring for the deprived and vulnerable

Caring for vulnerable groups was mentioned in almost three quarters (22) of the country reports. Many initiatives were related to the physiologically vulnerable, such as children, pregnant women or the elderly. In addition welfare safety nets, aimed at ensuring a minimum family income by setting minimum wages, pensions and unemployment benefits, were considered necessary for the economically vulnerable groups such as the poor, low income, unemployed and refugees or immigrants and those with large or one-parent families.

The gap between the rich and poor is increasing in many countries in Europe[37], and as a phenomenon of the economic transition in central and eastern Europe, unemployment has appeared in Slovakia and many others. If this trend continues the food intake and nutritional status of vulnerable groups should be monitored closely in order to develop safety nets and prevent food insecurity. Among European industrialized nations the United Kingdom was exceptional in the pace and extent of the increase in inequality in the 1980s and by 1990 the level of inequality was almost back to 1930 levels[38].

Poverty is a growing concern in Europe [39] [40], especially for those with incomes below societies' poverty lines. In 1994 it was estimated that 13.5% of the Polish population (about 5 million) had average monthly expenditures lower than the relative poverty line. In 1995, 4 million children in Britain lived in families with incomes below 50% of average earnings [38]. Lack of food is associated with poverty, which can be measured by estimating the percentage of disposable income spent on food: in Romania the average figure is around 60% [8]; and in Poland around 40%, compared with EU 22% [8].

Coping within a limited budget often means that healthier, safer foods are not affordable. In Lithuania increased food prices have caused socially deprived people to consume cheaper, less nutrient dense foods which are more likely to be contaminated. In Poland the prevalence of nutrient deficiencies is highest amongst the unemployed and low income families with many children. Poor people in the United Kingdom consume much lower quantities of vegetables and fruit[41].

There is growing evidence for the protective effect of vegetables and fruit against chronic diseases such as cancer and coronary heart disease. This suggests that the low intakes of vegetables by poor people may directly increase their risk of these diseases. Inadequate diets also have adverse consequences on a child's health, education and future employability and there are demonstrable costs to society in each instance[42].

In the Region around 70% of the population is suffering from physical and mental exhaustion as people cope with increasingly uncertain conditions related to very rapid economic and social change. This is especially true for the countries of the former Soviet Union where policymakers are not used to developing safety nets for vulnerable groups. The transition to a market economy has resulted in soaring consumer prices due to a reduction in subsidies while salaries have remained low. In addition there is rising unemployment as a result of

industrial restructuring and the new monetary polices have hit vulnerable groups in particular. Mechanisms must be developed to identify and protect the vulnerable groups in society.

Recommendation 11 – monitoring to identify vulnerable groups and policies to develop protection strategies and promote equity are needed

7. Micronutrient deficiencies

There is no doubt that, in the European Region of WHO, the most prevalent health problems related to diet are noncommunicable diseases such as cardiovascular diseases and cancers and not deficiency diseases. Nevertheless micronutrient deficiency does exist in certain European countries under certain circumstances.

Iodine

One of the most prevalent nutrient deficiencies is iodine. Iodine deficiency disorders (IDD) are prevalent throughout Europe and only 6 countries have no IDD (Finland, Iceland, Norway, Sweden, Switzerland, and the United Kingdom). Although this problem has been largely eliminated in some countries in western Europe it is re-emerging in some countries in CCEE and CIS. For example in Albania and Tajikistan iodine deficiency is severe[43] and in some other countries the prevalence of IDD is increasing.

The main public health strategy recommended to solve this problem is universal salt iodization. This means ensuring that all the salt used by the food processing industry, the mass catering sector and households is iodized. In some countries there is no universal iodization and only table salt is iodized (Italy, Poland). This could be a problem especially in western Europe where most of the population get their salt from processed food products and not from home-cooked food to which salt is added during cooking or eating[44]. Therefore nutritional epidemiologists should monitor where the population gets salt from and so iodine.

In addition to ensuring that iodized salt is used in food processing and mass catering policymakers should consider the need to include a recommendation to feed iodized salt to animals (cows). In the Nordic countries and the United Kingdom iodine is given to cows in the form of "salt-lick" and so milk and milk products supply around 40–70% of the iodine intake in humans. In addition to ensuring elimination of iodine deficiency this has the added benefit of limiting the amount of salt consumed by the population.

Recommendation 12 – Monitor source and quantity of iodized salt consumed by the population before deciding on optimum iodization strategy.

In CCEE and CIS cardiovascular diseases are responsible for 68% of all premature deaths while in the rest of Europe this figure is only 43%. Moreover proportionally cerebrovascular diseases is markedly higher in CCEE and CIS. Because of the strong link between high salt intakes and cerebrovascular diseases the WHO recommends a salt intake of no more than 6 grams/capita/per day [17]. In Italy a campaign on the role of salt in the diet was launched. This campaign aims to eliminate IDD through the promotion of iodized salt but at the same time prevent hypertension and vascular diseases through the limitation of salt intake.

Recommendation 13 – Industrialiodisation of salt should be based on the assumption of a *total* salt intake of not more than 6 grams of salt per person per day.

Iron

The other main nutrient likely to be deficient in European countries is iron. Iron deficiency was mentioned as a problem by one quarter (9) of 35 of Member States. Prevalence studies show that anaemia is widespread in central Asia and the Caucasus. For example in Kazakstan and Azerbaijan up to 70% of children less than 2 years of age have low haemoglobin levels. In addition 20–30% of women of childbearing age also have low haemoglobin levels. These problems may not be related solely to iron deficiency in the diet. For example it was already mentioned (in the breastfeeding section) that early introduction of cow's milk is a major cause of iron deficiency in the young. Anaemia in adults is associated with: the presence of iron-absorption inhibitors in the diet, such as tea and coffee, which is frequently consumed in eastern European countries; or lack of absorption enhancers, such as vitamin C from vegetables and fruit.

Recommendation 14 – Need for Regional guidelines on control of iron deficiencyanaemia and guidelines to improve complementary feeding (weaning) practices.

Folate

Folate deficiency is associated with neural tube defects[45 46]. Denmark, Poland and the United Kingdom mentioned national strategies related to solving this problem. Folate may also play an important role in the prevention of coronary heart disease by helping to reduce levels of homocysteine[47 48]. The main food sources of folate are brussels sprouts, asparagus, spinach, broccoli, cabbage, cauliflower, parsnip, iceberg lettuce, beans, peas and beef and yeast extracts – yet another reason why national food and nutrition polices and dietary guidelines should promote vegetable production and consumption.

Other micronutrients

There may be situations when the only solution to solve micronutrient deficiency is by food fortification of bread or salt for example (such as for iodine deficiency), or more rarely by supplements (during emergencies). However generally, where possible, WHO promotes primary prevention strategies such as increasing vegetable consumption rather than advocating consumption of nutraceuticals, food supplements or multivitamin tablets. Population strategies advocating the use of vitamin supplements are not the solution to micronutrient deficiencies in Europe. Vitamin supplements may have many disadvantages: side-effects[49 50]; cause nutrient imbalances; toxicity; malabsorption; create long-term dependency and lack of confidence in locally produced foods and finally supplements are an unnecessary expense.

Some CIS countries consider that vitamin deficiency has re-emerged because their national production of vitamin supplements has collapsed. Large scale vitamin deficiency due to lack of tablets is unlikely but much more likely is that the population is eating too little vegetables and fruit.

Decreased food intakes are also prevalent in many western countries where levels of decreased physical activity has resulted in a decreased need for energy, so that energy intake dropped by 205 kcal/per person per day between 1970 and 1990 in the United Kingdom[51]. In order to maintain body weight and prevent obesity, people who decrease their physical activity must eat less food and so the risk of developing micronutrient deficiency is high unless they eat food which is rich in micronutrients. Therefore the promotion of both increased levels of physical activity and increased consumption of micronutrient rich foods, such as vegetables and fruit is a good public health strategy to prevent micronutrient deficiency.

Recommendation 15 – In preference to prescribing vitamin and food supplements advocate increased physical activity and increased consumption of vegetables and fruit to prevent micronutrient deficiencies.

8. Appropriate diets and lifestyles

Countries of CAR and CIS must pay more attention to the link between diet and noncommunicable diseases (NCD), such as cardiovascular diseases, certain cancers, diabetes, hypertension and obesity. Some of the country reports focused too much on deficiency of protein and micronutrients (see food security section). In focusing on deficiency the link between premature mortality from NCD and a diet high in fat, salt, fatty red meat and fatty/sugary foods and simultaneously low in vegetables and fruit is neglected.

Recommendation 16 – the link between cardiovascular diseases, certain cancers, diabetes, hypertension and obesity and diet should be highlighted by developing national dietary guidelines.

Some countries in CIS and central Asia mentioned the need to increase the teaching of dietology/dietetics. There is still a tendency in some countries to prescribe many different types of diets for different disorders. Many of these dietary prescriptions have not been scientifically proven. In addition many of the individuals referred for dietary treatment are suffering from obesity, diabetes, heart disease, high blood pressure, and other conditions related to unhealthy lifestyles. These cases should be treated using the healthy nutrition principles developed for the population: increasing consumption of vegetables and fruit, eating >50% of their energy from bread, pasta and potatoes and reducing the amount of energy dense foods that provide little micronutrients and too much energy. Dental caries are also widespread in many European countries and there can be little doubt that this is related to frequent, high intakes of sugar as well as poor oral hygiene.

Some countries such as Albania, Israel, Kazakstan, Latvia, Romania, Slovakia, the Republic of Moldova, Ukraine and Uzbekistan made no mention of the link between diet and noncommunicable diseases. Moreover only one third (12) of 35 Member States mentioned obesity (Austria, Azerbaijan, Czech Republic, Denmark, Estonia, Hungary, Lithuania, Luxembourg, Malta, Poland, Turkey and the United Kingdom), despite the fact that the prevalence of obesity is high and appears to be increasing in every country in Europe. For example, the Russian Federation has one of the highest prevalences where 55% of the female population is overweight[25]. Little mention of obesity probably reflects the lack of data on body weight and height and illustrates the need for countries to collect anthropometric data as part of their health information system.

Physical activity and obesity

Obesity is a chronic medical problem caused by a combination of an energy dense diet leading to excess energy intake and lack of physical activity. There is abundant evidence that obesity is associated with a high risk of coronary heart disease, hypertension, diabetes mellitus, and gastrointestinal disorders[52]. The risk of cancers of a number of sites (endometrial, renal, colon, gallbladder and postmenopausal breast cancer) is also linked to obesity[17 18]. As treatment of obesity is difficult the need to readjust dietary energy intakes and/or physical activity permanently is essential. Other health advantages of high levels of physical activity include improved mental and psychological health.

Only 17% (6 of 35) of Member States made reference to the importance of increasing physical activity (Armenia, Estonia, Malta, Poland, Sweden and the United Kingdom). Environments which support improved eating habits and more active living are needed. It is recommended that prevention efforts are focused on population-based public health strategies. Such strategies need to go beyond traditional health promotion programmes and involve:

- urban design and transportation policies;
- economic incentives;
- regulations and legislation;
- improved catering standards and food preparation skills; and
- education and promotion.

Recommendation 17 – health information systems should include collection of data on measured heights and weights (converted to body mass index (BMI(wt(kg)/ht(m2)) and the percentage of population who are physically inactive.

Cooperation and collaboration

Cooperation and collaboration is needed throughout Europe and there is a need to share information and build alliances. In western Europe there exists the European Academy of Nutritional Sciences (EANS), the Federation of European Nutritional Sciences (FENS) and the Arbeitsgemeinschaft Ernährungsverhalten / Working Association for Nutritional Behaviour (AGEV) and many countries have their Nutrition Society. In CIS and CCEE there seems to be lack of coordination and nutrition networks or societies should be established to facilitate sharing of information and developments in the area of food and nutrition.

Recommendation 18 – A list of institutes and societies working in the area of food and nutrition policy should be drawn up and regularly up-dated in order to facilitate cooperation and collaboration.

Table 13: Data NOT indicated in ICN progress reports

	1. Developing Nutrition/Food Policy	2. Assessing nutrition situation	3. Improving food security	4. Protecting through food safety and quality	5. Promoting breastfeeding	6. Ca depri vulne
BALKAN						
Albania						
Bosnia and Herzegovina			x	x	x	
Croatia						
FR of Yugoslavia					x	
BALTIC						
Estonia			x			
Latvia	x	x	x		x	
Lithuania						
CAR and TURKEY						
Kazakstan						
Uzbekistan			x			
Turkey						
CCEE						
Czech Rep.			x	x	x	
Hungary						
Poland						
Romania						
Slovakia			x		x	
WESTERN EUROPE						
Austria			x			
France		x			x	
Germany						
Ireland			x			
Luxembourg			x	x	x	
Switzerland				x	x	
United Kingdom						
SOUTHERN EUROPE						
Greece			x	x		
Israel						
Italy			x	x		
Malta		x	x			
CIS						
Azerbaijan						
Armenia					x	
Belarus			x			
Republic of Moldova	x	x				
Ukraine			x		x	

	1. Developing Nutrition/Food Policy	2. Assessing nutrition situation	3. Improving food security	4. Protecting through food safety and quality	5. Promoting breastfeeding	6. Ca depri vulne
NORDIC						
Denmark						
Iceland			x	x		
Norway						
Sweden			x			
Finland (added later)	x	x	x	x	x	

Table 14: Data on the number of Member States providing/not providing information on the Action-oriented Strategies of the Plan of Action for Nutrition

Action-oriented strategies of Plan of Action for Nutrition	Information provided	Information NOT provided
Developing nutrition/food policy	33 (94%)	2 (6%)
Assessing nutrition situation	31 (89%)	4 (11%)
Improving food security	18 (51%)	17 (49%)
Protecting through food safety and quality	25 (77%)	8 (23%)
Promoting breastfeeding	22 (63%)	13 (37%)
Catering for the deprived and vulnerable	24 (69%)	11 (31%)
Micronutrient deficiencies	24 (69%)	11 (31%)
Appropriate diets and lifestyles	33 (94%)	2 (6%)

ABBREVIATIONS

AGEV	Arbeitsgemeinschaft Ernährungsverhalten/Work Association For Nutritional Behaviour
AP	Action Plan
BFH	Baby-Friendly Hospital
BFHI	Baby-Friendly Hospital Initiative The objective of the BFHI is to promote breastfeeding in accordance with WHO' s International Code of Marketing of Breastmilk Substitutes, first and foremost ensuring an early commencement of breastfeeding after birth at the obstetric and maternity wards of hospitals
BMI	Body Mass Index
CAR	Central Asian Republics
CCEE	Central and east European Countries
CDC	Centers for Disease Control and Prevention (USA)
CIS	Commonwealth of Independent States
CHD	Coronary Heart Disease
CVD	Cardiovascular Diseases
DAFNE	Network for the Pan-European Food Data Bank Based on Household Budget Surveys Countries participating in DAFNE project are: Belgium, Denmark, Greece, Germany, Hungary, Ireland, Poland, Portugal, Spain, United Kingdom
EANS	European Academy of Nutritional Sciences
EC	European Community
EPIC	The European prospective Study into Cancer and Nutrition EPIC is carried out in France, Germany, Greece, Italy, The Netherlands, Spain and United Kingdom
EU	European Union
FAO	Food and Agriculture Organization of the United Nations
FENS	Federation of European Nutritional Sciences
GEMS	Global Environment Monitoring System
HACCP	Hazard Analysis Critical Control Point The HACCP system identifies, evaluated and control hazards during production, processing, manufacturing, preparation and use of food to ensure that food is safe when consumed
HPU	Health Promotion Unit
ICN	International Conference on Nutrition
IDD	Iodine Deficiency Disorders
ISO	International Organization for Standardization
NCD	Noncommunicable Diseases
NGO	Nongovernmental Organizations
NHP	National Health Programme
NNP	National Nutrition Policy
NPAN	National Plan of Action for Nutrition
PEM	Protein Energy Malnutrition
PHC	Public Health Centres
PROBIT	Promotion of Breastfeeding Intervention Trials

	In collaboration with McGill University (which country) Belarus is conducting research into the effects of PROBIT
RDA	Recommended Dietary Allowances
SENECA	Survey in Europe on Nutrition and the Elderly: A Concerted Action The aim of SENECA us to study cross-cultural differences in nutritional issues and life-style factors affecting health and performance of elderly people in Europe (2,586 subjects in 19 towns across 12 European countries)
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNU	United Nations University
UNWFP	United Nations World Food Programme
WHO	World Health Organization
WTO	World Trade Organization

LIST OF TABLES AND FIGURES

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