WHO global strategy on diet, physical activity and health: European regional consultation meeting report

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Towards a WHO global strategy on diet, physical activity and health

Background

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

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

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

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

1997 *The world health report 1997. Conquering suffering, enriching humanity* described the high rates of mortality, morbidity and disability from the major NCDs and proposed the development of a global strategy for NCD prevention and control.

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

2000 The Fifty-third World Health Assembly endorsed the WHO global strategy for NCD prevention and control and urged Member States and WHO to increase efforts to combat NCDs (resolution WHA53.17).

2001 A WHO consultation called for urgent action to combat the growing epidemic of obesity, stressing the importance of prevention (*Obesity: preventing and managing the global epidemic. Report of a WHO consultation.* WHO Technical Report Series, No. 894).

2001 *Macroeconomics and health: investing in health for economic development*, the final report of the Commission on Macroeconomics and Health, noted that many NCDs can be effectively addressed by relatively low-cost interventions, especially prevention activities related to diet and lifestyle.

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

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

2002 *The world health report 2002. Reducing risks, promoting healthy life* described how a few major risk factors account for a significant proportion of all deaths and diseases in most countries. For chronic NCDs, some of the most important include tobacco consumption, overweight and obesity, physical inactivity, low fruit and vegetable intake and alcohol consumption, as well as the risks posed by intermediate outcomes such as hypertension and raised serum cholesterol and glucose levels.

2002 A joint FAO/WHO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases examined the latest scientific evidence available and updated recommendations for action (see below, *Phase I*, for details of its report published in 2003)

2003 The Framework Convention on Tobacco Control was adopted by the Fifty-sixth World Health Assembly in May 2003 (resolution WHA56.1).

Development of the global strategy

2003 ***Phase I***

Finalization and dissemination of *Diet, nutrition and the prevention of chronic diseases. Report of a joint FAO/WHO Expert Consultation* (WHO Technical Report Series, No. 916)

Phase II

Circulation of a consultation document to guide development of the strategy. Document made public through WHO web-site – January 2003

Six regional consultations to gather information that will form the basis of the strategy (March–June 2003).

Consultations with relevant United Nations and other international organizations, with civil society organizations and with the private sector (May–June 2003).

Phase III

Reference Group, a group of internationally recognized experts, to advise WHO on the preparation of a draft global strategy.

Completion of the draft strategy (September 2003).

2004 Submission of the draft strategy to the Executive Board at its 113th session (January 2004).

Discussion of the revised draft strategy at the Fifty-seventh World Health Assembly (May 2004).

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Preface

This report of the consultation in the European Region, on the global strategy on diet, physical activity and health, is the third in a series of six. Organized by the Regional Office for Europe, the consultation gave the Member States' perspective on the issues encountered and made specific recommendations on direction, both for the countries of the Region, and for the development of the global strategy. As a whole, the series of reports provides a summarized global account of the status of knowledge about the links between diet, physical activity and health, and the work in countries to address the pandemic of chronic diseases. Added to this will be contributions from consultations with other United Nations organizations, civil society and the private sector. Together these will provide the foundation for the development and formulation of the Global Strategy on Diet, Physical Activity and Health and subsequently for action to make measurable changes in diet and physical activity at population level, with positive consequences for the prevention of noncommunicable diseases (NCDs).

As a result of the regional consultation, the following key issues were identified and recommendations to address them formulated. In the European Region, noncommunicable diseases, especially cardiovascular diseases, cancer and diabetes, are major burdens, strongly impacting peoples' lives, the health care system and the economy. Changes in lifestyle are leading to an increasing decline in physical activity, high intakes of fat, especially saturated fats, high intakes of salt and sugar, low intakes of fruit and vegetables in many parts of the Region, and rising levels of overweight and obesity, especially in children.

While many European countries have well developed food, diet and nutrition policies and some have physical activity policies, there are difficulties in translating these policies into successful action at the national and local levels and in encouraging individuals to make healthier lifestyle choices. There are some success stories, however, and it will be important to learn from these to develop effective intersectoral interventions that emphasize disease prevention. This report summarizes the discussions at the consultation and outlines the recommendations made.

1. Introduction

Noncommunicable diseases, especially cardiovascular diseases (CVDs), cancers, obesity and type 2 diabetes mellitus, now kill more people every year than any other cause of death. The World Health Organization (WHO) has responded to the global rise in NCDs by giving increasing attention to their prevention and control in recent years (see Box).

Four factors in the epidemiology of these diseases – poor diet, physical inactivity, tobacco and alcohol use – are of overwhelming importance to public health. Diet and physical activity have recently been the subject of intensified high-level attention by a Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases.[2] The report of the Expert Consultation makes recommendations, inter alia, for optimum nutrition and for worldwide action to stimulate physical activity within a health context. WHO is currently developing a global strategy on diet, physical activity and health to give effect to these and other recommendations.

The European regional consultation on the development of the global strategy was held in Copenhagen, Denmark from 2 to 4 April 2003, and was attended by participants from 15 Member States, a representative of the European Commission, technical experts and WHO regional and headquarters staff (Annex). Participants represented a wide range of sectors including food and nutrition, physical activity, sport, agriculture, health promotion, environment and education. Ms Arnhild Haga Rimestad (Norway) and Dr Jožica Maucec-Zakotnik (Slovenia) were elected as Co-Chairmen and Mr Brian Brogan (Ireland) as Rapporteur.

The Regional Director, Dr Marc Danzon, said that he looked forward to learning what Member States were seeking in the area of diet, physical activity and health and how he could take their recommendations forward in the Region's work and, in collaboration with headquarters, at the global level. For some years, efforts have been made in the public health field to regroup activities that are connected either because of their origin or their solution, for example NCD prevention and control, and health promotion. Decisions on how to group these issues were best decided by the Member States themselves in accordance with their particular situations. In the search for integrated approaches, work was under way to expand the Regional Food and Nutrition Action Plan (FNAP) to improve the promotion of physical activity. Moreover, in 2004, he hoped to present to the Regional Committee a regional strategy that linked activities relating to NCDs, the FNAP, and physical activity and alcohol and tobacco consumption. In due course a component on mental health might be added to that strategy. He hoped that, over the next few years, there would be real progress in developing such integrated programmes in Member States. Dr Danzon thanked the participants from Member States for their active interest and contribution to the process of developing the global strategy and particularly for their contribution to the Regional consultation.

Dr Pekka Puska, Director, Noncommunicable Disease Prevention and Health Promotion at WHO headquarters, describing the process of formulating the strategy, stressed the value of country and regional input and thanked the participants for convening to share their experience.

From the WHO Regional Office for Europe, Dr Roberto Bertollini (Director, Division of Technical Support, Health Determinants) and Dr Gudjón Magnússon (Director, Division of Technical Support, Reducing Disease Burden) described the chief challenges facing the Region, noting that diet and physical activity are of major importance in relation to the rapid regional rise in NCDs. There is a double burden of disease in eastern Europe where NCDs are increasing but where the level of communicable diseases also remains high. The solution will need new partnerships and increasing collaboration, as well as better ways of communicating in order to convince populations to recognize the situation and adjust their lifestyles accordingly. Considerable work has already begun: a background document has been prepared which provides an overview of the evidence and actions to address NCDs; a regional task force on the global strategy on diet, physical activity and health has been formed combining representatives of all the

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[2] *Diet, nutrition and the prevention of chronic diseases. Report of a Joint FAO/WHO Expert Consultation.* Geneva, World Health Organization, 2003 (WHO Technical Report Series, No. 916).

relevant regional programmes including the innovative programme on transport and health; and the global strategy has been discussed at the recent (March 2003) Meeting of Nutrition Counterparts in the WHO European Region.

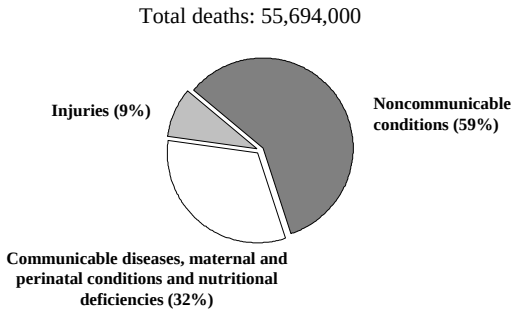
After a series of presentations by WHO staff, scientific experts and country representatives (summarized in sections 2 and 3), the participants worked in groups to examine the following topics in detail: *evidence*: data on the health implications of diet and physical activity; *policy-making*: turning evidence into policy; *implementation*: translating policies into action; and *monitoring and evaluation*: measuring the impact and effectiveness of policies (section 4). On the basis of the discussions in these groups, the consultation formulated a set of recommendations to be taken into consideration during development of the WHO global strategy on diet, physical activity and health at WHO headquarters (section 5).

2. The global perspective

2.1 Health in transition

The world's health is undergoing an unprecedented transition on several fronts: epidemiological, nutritional and demographic. The result, felt keenly at country level and substantiated unequivocally by scientific evidence, is a broad shift in disease burden. The majority of deaths (59%) are from NCDs (Figure 1).

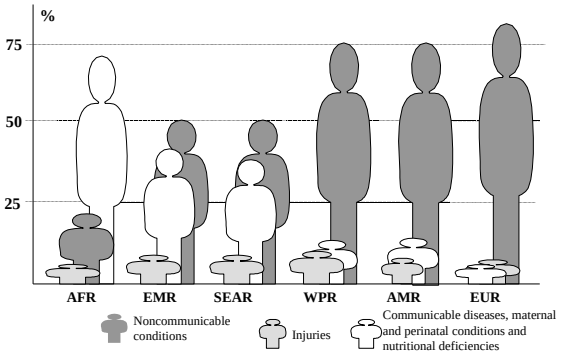
Figure 1
Death, by broad cause group 2000



Source: WHO, World Health Report 2001

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

Figure 2
Deaths, by broad cause group and WHO Region, 2000

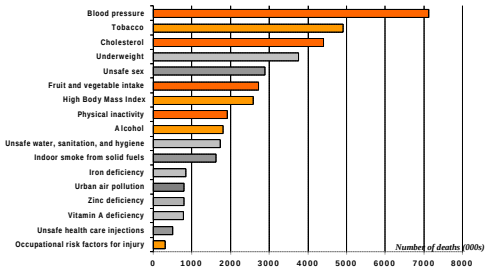


Source: WHO, World Health Report 2001

The African Region is also in transition and, while in many countries in the Region communicable diseases still predominate, the incidence of NCDs is rising rapidly.

A wealth of medical research shows the risk factors responsible for this growing pandemic and clearly points out the strategies needed to reduce their impact. The data gathered for *The world health report 2002* show high blood pressure to be the major contributing factor to all deaths in the world (Figure 3).[3] Of the ten leading risk factors, six relate to nutrition, diet and physical activity. Progress in these two areas, combined with reductions in tobacco and alcohol use, will have enormous importance for the prevention of NCDs and will lead to major health gains that are cost-effective.

Figure 3
Global deaths in 2000 attributable to selected leading risk factors



Source: WHO, World Health Report, 2002

The figures also make clear the important role played by undernutrition. This must not be forgotten in the concern to address overnutrition. In many countries, both forms of malnutrition co-exist. Balanced diet can play an essential role in improving population health. Childhood obesity too is a growing problem across the world, with physical inactivity a major factor.

Data from the Countrywide Integrated Noncommunicable Diseases Intervention (CINDI) programme show that, in most European countries, more than half of the population have elevated blood cholesterol levels and hypertension, and are overweight. Obesity is rising and physical activity is declining, especially in children. Moreover a high proportion of European populations are smokers.

Close to 80% of the NCD burden is now found in the developing world, moving to lower and lower socioeconomic groups and contributing strongly to inequities in health. The determinants of these changes are urbanization, changes in occupation and many global influences. The transition concerns adults and children alike.

NCDs are to a great extent preventable diseases. While genetic susceptibility to NCDs may be a factor, appropriate preventive action can alter environments, protect against risk factors and change life expectations. On a population scale, relatively modest behavioural changes affecting several of the risk factors simultaneously, can make swift, affordable and dramatic changes in population health.

Diet is a powerful instrument in this regard. In Finland, the North Karelia project reduced annual CHD mortality by 73% over 25 years through community-based activity encouraging a healthier diet. In Japan, reduction of salt intake resulted in lower blood pressure levels and greatly reduced stroke mortality; in Mauritius, changing cooking oil from palm to soy bean oil resulted in a 15% decrease in serum cholesterol in the population; and in Poland, a change in dietary fats resulted in a 20% decline in heart disease mortality.

There are many obstacles to implementing prevention activities, but they can be overcome. They include: outdated concepts such as seeing NCDs as “diseases of affluence”; a lack of understanding about the speed with which prevention activities can make an impact on

[3] *The world health report 2002. Reducing risks, promoting healthy life*. World Health Organization, Geneva, Switzerland, 2002.

morbidity; low public visibility for success stories in comparison with the needs of sick patients; powerful commercial interests that block policies and generate conflicting messages; traditional training of health personnel that emphasizes curative care; and inertia among institutions, financing bodies and services.

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

3. The regional perspective

3.1 Physical activity and health

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

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

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

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

3.2 Diet and health

Diet-related disease has become a major burden in terms of health impact and cost to the European economy, and tackling diet is therefore a key priority. Prevalence of CVDs is rising across the Region and these diseases are the leading cause of death in men in most countries, especially in eastern Europe, followed by cancer. In women, there are high rates of stroke, again especially in eastern Europe, and stroke is a leading cause of morbidity and loss of quality of life. Obesity and type 2 diabetes are rising too. For example, the United Kingdom has seen a threefold increase in obesity in 20 years. There is some evidence of a social gradient in this trend, with higher socioeconomic groups less likely to be obese.

Dietary patterns still vary across the Region, although there is a general convergence of diet and lifestyles. Intakes of total fat and saturated fat are high, particularly in northern and western Europe. Eating patterns are changing, with a tendency to eat frequent snacks rather than regular meals, and there has also been a rapid rise in eating outside the home. The percentage of fat in such food is often higher than in home meals. Fruit and vegetable intakes are quite high in the south but low in eastern and northern Europe. Evidence indicates that one additional portion of fruit and vegetables is associated with a 20% reduction in all-cause mortality, so that even small changes in diet can make big differences in health.

Fruit and vegetables, linoleic acid in oily fish and fish oils, high intake of potassium, and low-to-moderate alcohol intake decrease the risk of CVDs, while myristic and palmitic acids, *trans* fatty acids, high sodium intake, overweight, obesity and high alcohol intake increase that risk. There is some also some evidence to suggest that alpha-linoleic acid, non-starch polysaccharides, oleic acid, wholegrain cereals, plant sterols and stanols, and folate decrease CVD risk while dietary cholesterol and unfiltered boiled coffee increase risk.

There is convincing evidence that fruit and vegetable intake decreases the risk of oral cavity, oesphageal, stomach and colorectal cancers. Overweight, obesity, alcohol consumption and aflatoxin all contribute convincingly to the risk of various forms of cancer, and preserved meat, salt-preserved foods, salt, and high-temperature drinks and foods are probable risk factors.

Voluntary weight loss in overweight and obese people and increased fibre intake decrease the risk of diabetes. Overweight and obesity, abdominal obesity, maternal diabetes, high saturated fat intake and intrauterine growth retardation all increase the risk of diabetes. High fibre, healthy school and work environments and breastfeeding all reduce the risk of obesity, while high intake of energy-dense foods, high consumption of sweetened drinks and adverse social and economic conditions increase the risk of obesity.

No Member State in the Region has achieved the dietary goals recommended in *The world health report 2002*, although Greece, Portugal and Spain come close to the goals for fat intake. There have been some improvements in response to health education and promotion, however, including reductions in total fat intake, and switches to semi-skimmed rather than full-fat milk, to wholemeal rather than white bread and to grilling rather than frying of food. Campaigns to encourage people to eat more fruit and vegetables are under way in some countries. In England, for example, a “five-a-day” programme has been introduced, and a national fruit scheme offering free fruit in school to children aged four to six years is proving successful.

Supplies of fruit and vegetables across Europe are currently insufficient to meet the increased requirements for achieving a net 400 g per person per day, and producers will need to be encouraged to increase supplies. The impact of the European Union (EU) Common Agricultural Policy (CAP) on food supplies has been considerable, and health professionals should seek to influence the Policy in the interests of health (see section 3.2).

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

3.3 Public health aspects of the European Union Common Agricultural Policy

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

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

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

Some current CAP regulations are clearly detrimental to public health, including subsidies for withdrawal and destruction of good quality fruit and vegetables (€117 million per year) to maintain prices; consumption aid for butter (€460 million per year); consumption aid for high-fat milk products in schools (about €50 million per year); subsidies for distillation of surplus wine (€650 million per year),subsidies to promote sales of high-fat milk products and wine (€10 million every two years); and to support tobacco farming (€950 million per year). Moreover the rules concerning alcohol make it difficult for countries to encourage reduction in alcohol consumption by increasing taxes. Some EU food promotion messages are also not in the best interests of public health. A step forward is that these messages will have to be screened by public health specialists before being released in the future.

Changes in CAP that could promote public health include: phasing out of subsidies which currently support consumption of high-fat dairy products; focusing support to schools on low-fat content milk products (a switch from high to low-fat milk in schools would reduce fat consumption by 1.5 kg per child per year); introducing similar school support for fruit and vegetable consumption; redistributing agricultural support in favour of fruit and vegetable

production; and improving support for farmers who wish to cease wine and tobacco production. The health sector should provide sound evidence and encourage discussions at national and European level to ensure that CAP objectives are reformed in a healthier direction.

3.4 Regional food and nutrition action plans

Governments across the Region are taking steps to ensure an adequate supply of safe food for their populations. As mass production of food in the Region increases, mechanisms are being sought to deal with new food safety challenges that include an alarming rise in food-poisoning and other serious problems, such as bovine spongiform encephalopathy and dioxin contamination. Governments have instituted food safety legislation and regulations, and responsible elements of the food industry are keen to avoid incidents that damage consumer confidence. However, it is difficult to monitor all food outlets adequately.

Nutrition is also high on national agendas. Nutrition-related problems in the Region include iodine and iron deficiencies as well as the major NCDs, CVDs, cancer and diabetes.

In September 2000, the Regional Committee at its fiftieth session endorsed a five-year regional food and nutrition action plan integrating strategies on food safety, nutrition and a sustainable food supply. Implementation has included the publication of the *CINDI dietary guide: 12-steps to healthy eating*. Step 4 of the guide advises increased physical activity, since it is clear that this should be part of the guidance given with nutrition messages. A further report, *Food and health in Europe: a basis for action*, sets out the scientific evidence on which food and nutrition action plans should be based, and also includes some aspects of physical activity. The Regional Office has also been working with countries to support development of national FNAPs, inter alia, through a series of workshops across the Region, establishment of a public health nutrition network for the Baltic/Nordic countries, work on a similar network for southern, central and eastern Europe, and collaboration with the European Commission. Information on all these activities is available through the Regional Office website and a monthly electronic news service (http://www.euro.who.int/eprise/main/WHO/Progs/NUT/Home).

These activities were discussed at the Meeting of Nutrition Counterparts in the WHO European Region, held in Athens in March 2003. The 42 countries present unanimously agreed that a second regional FNAP should be developed for the period 2006–2010, which would incorporate physical activity, so giving greater emphasis to increasing physical activity and addressing obesity.

During 2004-2005, the Regional Office will continue to build on the progress already achieved in the lead up to a Ministerial Conference in 2006.

3.5 Country experiences

Denmark

Among other activities related to diet, physical activity and health, Denmark has implemented a national action plan against obesity, issued a handbook for doctors on prevention of NCDs through physical activity, undertaken a study of funding for physical activity initiatives, and instituted a “six-a-day” campaign to encourage increased consumption of fruit and vegetables.

However, 20–30% of the population are inactive, mechanical transportation is widespread and many jobs are now sedentary in character. As elsewhere in the Region, diets include high intakes of energy from fat and sugars and low intakes of fruit and vegetables. There is often a clustering of unhealthy behaviours.

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

The Danish national action plan against obesity (2003), focuses on obesity as a health problem, the need for lasting lifestyle changes and the avoidance of discrimination and stigmatization. It emphasizes finding appropriate balances in respect of weight stability and physical fitness, energy intake and expenditure, and individual and public responsibility. looking at various target groups, covering availability and accessibility, structural conditions, normative conditions, and education and information. The keys to success will be cross-collaboration, adequate training of professionals, encouraging changes in attitude and increased research.

Finland

Social and health problems are expensive for local communities so that cost-effective preventive measures are attractive. The city of Turku, population 170 000, has participated in the WHO Healthy Cities movement since 1987, and is the location for the WHO Collaborating Centre for Healthy Cities and Urban Health in the Baltic Region. It boasts a strong sports tradition and a sports research centre. The city took six steps to increase physical activity among its population: evidence-gathering to convince individuals and decision-makers of the benefits to health; formulation of policy focusing on a healthy environment, quality of life through well-being, and children; situation analysis emphasizing innovative intersectoral ways of working; strategy development and implementation; and monitoring and evaluation. The outcome was the Move 2000 project (1994–2000), funded by the city authorities in collaboration with Turku University. The project aimed to increase physical, psychological and social well-being across the life span by providing facilities and information, reaching out to break barriers and involve previously inactive people, and ensuring regular follow-up by questionnaire and a high level of media publicity. The project succeeded in raising awareness of the benefits of exercise for health and raising regular activity levels in both adults and children, and is being continued. Current challenges include improving integration of health promotion in health care services and intersectoral working, giving greater attention to reduction of tobacco and alcohol use, and increasing individual responsibility for health.

France

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

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

There have been national promotion campaigns to increase fruit and vegetable intake and there will be a campaign to promote physical activity in 2004. National food guides have been developed, using innovative designs and positive messages, for use in the general population and among health professionals. Guides for special population groups are planned. The guides

recognize differences among consumers and provide nonjudgemental advice on how to make changes that benefit health. Tools for clinical practice have also been developed. Monitoring and evaluation of the programme have been planned from the outset and will be undertaken by a special unit.

Hungary

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

A 2000 survey showed declining levels of physical activity, especially among children. New approaches aim to improve and expand sports facilities, encourage physical activity in the workplace, and promote daily physical education and activity in schools. A multisectoral approach to interventions for children draws in health professionals and various medical, physical education, teacher and parent associations, as well as relevant ministries and regional health institutions. Activities include supporting specific schools, and legislation on levels of activity to be provided. A primary prevention programme for cervical and lumbar discopathy, through physical education, is also being conducted in schools. Hungary participates in the health-promoting schools initiative. Legislation requires that health promotion activities to be undertaken in schools should be financed through the national budget.

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

Ireland

Epidemiological data indicate that the principal causes of death in 2000 were CVDs (>33%) and cancers (24%). For men, CVD death rates are falling but remain among the highest in Europe.

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

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

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

Overweight and obesity are increasing across all age categories. Initiatives include publicizing the food pyramid as a learning tool, developing healthy eating guidelines adapted for various target groups, and initiating an annual national healthy eating week. Schools, workplaces

and supermarkets are being targeted. In addition, more dieticians are being trained and fruit and vegetable cooperatives are being set up. Evaluation has shown that 60% of the population are aware of the campaign, and 30% have modified eating habits: 70% eat four or more portions of fruit of vegetables (including potatoes) daily.

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

Latvia

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

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

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

Implementation of policies is intersectoral: the ministries of health, agriculture, education and science, environment, and transport, the food safety agency, local authorities, nongovernmental organizations and the mass media are all involved.

Netherlands

Policies on physical activity and nutrition are linked, in particular in the area of combating overweight.

There are three main goals for physical activity by 2010: to increase the number of people undertaking healthy exercise from 40% to 50%, to reduce inactivity from 12% to 8% and to improve knowledge about healthy exercise from zero to 75%. Interventions include a physical activity campaign (2003–2005), mainly targeting adults, a sports participation policy, which focuses mainly on youth, and programmes for special target groups, e.g., people with chronic diseases and employees in the workplace. A cycling-to-work project aims, over the next two years, to encourage 5000 inactive people to cycle to work. In addition to an annual national survey of physical activity, 7000 people will be given a national fitness test (questionnaire and stress test) over one week and provided with fitness recommendations, in cooperation with commercial fitness centres. The test will be widely publicized and the results will be published. During 2003, 10 pilot community-based interventions will be implemented, targeting groups with low socioeconomic status.

The goals of the 1998 nutrition policy action plan are to increase fruit and vegetable intake by two pieces per day, reduce fat intake, and promote breastfeeding through baby-friendly hospitals. A pilot scheme in seven cities to provide free fruit in primary schools together with an education programme schemes in seven cities is under way in collaboration with the agricultural sector. It is hoped that this will encourage parents to provide more fruit for their families.

Government is in dialogue with the food industry to encourage lower levels of saturated and *trans* fatty acids in food products, and to influence portion size and marketing techniques for the benefit of health.

Some 40% of the adult population are currently overweight, 10% are obese and obesity is increasing in young people. Following an awareness campaign in 2002, the Health Council plans to provide further advice, and a multisectoral meeting in May 2003 will discuss cooperation with additional partners, with a view to formulating an action plan to counter this trend.

Norway

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

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

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

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

Russian Federation

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

In the first instance it is important to monitor functional status in healthy people and to intervene early in those with lower functional reserves, before disease develops, to maintain health. Systems for assessing levels of functionality e.g., of the cardiovascular system, have been

developed but there is no consensus as yet on methodology and there is a lack of sufficient resources to make such assessments on a large scale. Nevertheless, some programmes have shown successes e.g., physical exercise programmes for pregnant women have improved pregnancy outcome; and a combination of physiotherapy and other non-drug methods has succeeded in lowering respiratory disease rate in frequently sick children.

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

Slovenia

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

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

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

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

Switzerland

Switzerland has a national environmental health action plan (1997), which covers nutrition and food production, mobility and housing, and policies on sports (2000), nutrition (2001) and human-powered mobility (2003). Logos from the various agencies involved are all

used in publicizing the policies. A pyramid of recommendations for physical activity, similar to the food pyramid has also been developed. The objectives are to halt the decline in physical activity and increase the proportion of physically active individuals by 1% per year.

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

United Kingdom

All four countries in the United Kingdom follow the key dietary recommendations set by the Committee on Medical Aspects of Food Policy for prevention of CVDs (1994) and cancer (1998), which are: to maintain a healthy body weight; reduce intakes of fat, saturated fat, salt and added sugars; increase intakes of fruit and vegetables and dietary fibre; and undertake 30 minutes of moderate activity per day (60 minutes for children). The Food Standards Agency has responsibility for protecting health and the interests of consumers, for food safety and standardization, as well as food labelling and advice to the public on food safety, diet and nutrition. It has a strategic nutrition framework established by a board on which a wide range of interests is represented. The Agency also plays a strong role in encouraging nutrition research programmes for example on food acceptability and choice, and has developed an interactive CD-ROM on healthy eating for teenagers.

The four countries have separate policies in the area of diet and physical activity but all emphasize intersectoral collaboration at national and local level, include elements on capacity-building, education and training, and monitoring and evaluation, and focus on effective local delivery, with quantified targets, in various settings. Their aim is to strengthen the evidence base, make better use of resources, improve access and use innovative ways of reaching priority groups.

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

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

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

In England, national Department of Health policies include the physical activity component of the national health service plan, national service frameworks for service delivery and prevention, and the cancer plan, which have specific targets for physical activity and nutrition. In the area of physical activity, the departments of health, and of culture, media and sport have plans with specific targets. These are, for example to ensure that by 2006, 75% of 5–16-year-olds have a minimum of two hours per week of high quality physical education and sport, and that by 2020, the proportion of people undertaking physical activity for at least 30

minutes on 5 days per week rises to 70%. A sustainable farming and food strategy (2002) is committed to the development of a comprehensive, multisectoral food and health action plan.

4. Priorities for action in European Member States

The following issues are drawn from the collective experience of the Member States.

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

Reliable evidence on the magnitude of current NCD problems and on the health benefits of a good diet and physical activity is needed to strengthen the case for giving greater priority to action on diet, nutrition and physical activity. Countries should collect national data on mortality and morbidity from NCDs, risk factors for NCDs and relevant behaviours and their determinants, using indicators that will facilitate national and international comparisons. Indicators of short-term trends are useful to assess progress, and might include the changes in the number of short journeys made by car, the proportion of inactive people in the population, and the proportion of obese children. Data-gathering should be a multisectoral process, led by ministries of health. The evidence should be compiled and presented consistently and effectively to government and the general public alike.

Governments need sound and independent advice on the scientific interpretation of evidence and its use in developing policy. They should appoint multisectoral advisory boards, with transparent procedures and clear terms of reference, distinguishing between risk assessment and risk management.

WHO should support countries' efforts to strengthen national capacity in these areas and to ensure better dissemination of evidence.

4.2 Policy-making: turning evidence into policy

Countries should develop comprehensive national and local policies for nutrition and physical activity that include realistic, quantified targets and make the most of opportunities for action in different settings. Special attention should be given to reducing inequalities in health and ensuring that healthy choices are accessible and affordable for all sections of the population. Other key policies, at EU as well as national level should also take public health into account. The implementation of health impact assessments, cost-benefit analyses and burden-of-disease studies, use of evidence-based models, and compilation of databases of good-practices should all be encouraged to ensure the better use of evidence in the policy-formulation process and to facilitate the exchange of experiences within and between countries. Training curricula should be reformed in order to strengthen capacity-building in policy development and to include public health considerations in other sectors besides health.

Increased interaction with the private sector is needed at the international level through relevant United Nations and other intergovernmental organizations, as well as at the national and local levels. Efforts should focus on influencing changes in consumer demand and identifying strategies that will benefit both health and the private sector. National frameworks for initiating dialogue and cross-sectoral collaboration with the private sector and civil society, including nongovernmental organizations, will be needed.

Governments must communicate effectively with populations to raise awareness and convince them of the need for changes. Government experts, nongovernmental organizations, industry and the mass media should therefore be encouraged to deliver simple, clear and consistent messages about diet, physical activity and health.

4.3 Implementation: translating policies into action

Many countries in the Region have FNAPs and some have physical activity policies. The challenge is to turn these policies into effective action at the national and local level. Political commitment, backed by appropriate legislation, is a prerequisite for driving implementation,

sustaining funding and facilitating collaboration between the different sectors involved, with the health sector playing the leading role in many cases. The formation of a national council that addresses diet, physical activity and health is one way of coordinating activities. Health systems should be reformed to give greater emphasis to a preventive approach.

Effective action at the community level is crucial. Interventions, based on sound evidence, should therefore take into account socioeconomic, cultural and gender differences, and should be refined in the light of experience. Innovative methods, including the use of social marketing tools should be tried, but should avoid judgemental approaches.

There is a need to develop a wide range of cross-sectoral collaboration for action at the international, national and local levels in order to establish common ground and develop interventions that benefit all parties. The approach should be positive, emphasizing commercial opportunities where appropriate, but should take into account potential conflicts of interest. The current globalization of markets reinforces the importance of a global strategy.

4.4 Monitoring and evaluation: measuring impact and effectiveness of policies

Monitoring and evaluation of the impact of policies to improve health is vital in order to guide interventions and their refinement, and to map progress. Countries should therefore be encouraged to collect data on physical activity and nutrition as part of health behaviour monitoring. Data should be collected at regular intervals at national and, where appropriate, local levels to permit trend analysis. For all interventions, monitoring and evaluation of process, outputs and outcomes should be planned from the outset. Although monitoring and evaluation can prove expensive, it is important to allocate sufficient funding from the budget of policies and programmes to these components to ensure sustained follow-up. Research is needed to develop new monitoring and evaluation methods and refine existing ones.

Member States need to invest in education and training so as to develop the necessary expertise in monitoring and evaluation, including dissemination of the results.

5. Conclusions and recommendations

The participants welcomed the opportunity provided by the consultation to learn how other countries in the Region are tackling NCD prevention and implementing policies on diet, nutrition and physical activity, and to examine how the various sectors might work together to enhance action in these areas.

The consultation made the following recommendations to be taken into consideration during development of the WHO global strategy on diet, physical activity and health.

5.1 General conclusions

1. There is strong evidence of the benefits of a healthy diet and physical activity for the prevention of noncommunicable diseases. Therefore governments need to act without delay. Policies on nutrition and physical activity should be linked and should be developed and implemented in close collaboration with all relevant sectors – including concerned ministries, governmental agencies, nongovernmental organizations – and communities.
2. Core messages across sectors should be consistent, positive and non-judgemental.
3. Policies should be tailored to specific groups and settings.
4. Diet and physical activity should be promoted through appropriate economic and regulatory instruments (e.g., taxation and legislation).
5. Diet and physical activity policies should take into consideration the fact that food and physical activity should be enjoyed with confidence.

6. Accessibility, availability and affordability should be taken into consideration when developing diet and physical activity policies. Less privileged groups should have access to healthy choices. Equity between and within countries should be pursued.
7. In order to reduce inequalities in health, food production should ensure the availability of healthy, safe foods at affordable prices, and supplies of such foods should be sustainable. Food and nutrition policy should cover food safety, sustainable food supply and nutrition.
8. Agricultural, transport, leisure facilities and community planning policies need to take into account public health goals.
9. The media have an important role to play in promoting diet and physical activity.
10. Health impact assessments should be undertaken across all sectors.
11. Qualitative and quantitative measures should be employed so that both WHO and Member States can assess their progress in implementing the global strategy.
12. The global strategy should acknowledge that the six WHO Regions may be at different stages of nutrition and physical activity policy development and implementation. This is to ensure that those regions which have already done considerable work in this field – such as the European Region – can further benefit from the tools and mechanisms provided by the global strategy. This implies documenting progress, building on the existing regional action plans and policy frameworks, systematically analysing these policies to identify needs and gaps, and formulating appropriate strategies in regions.

5.2 Recommendations

Evidence

1. The process of gathering evidence should be a multisectoral process. In order to prioritize action on nutrition and physical activity and strengthen the case for action, ministries of health should take the leading role. They should be responsible for collaboration across governments and with other partners to collect and collate reliable data (e.g., through national surveys) to assess:
    a. mortality and morbidity – to demonstrate health outcomes;
    b. risk factors and behaviour – to demonstrate the magnitude of the problem;
    c. determinants – to identify the reasons for physical inactivity and poor diet (barriers to successful policy implementation); and
    d. quality of life and process indicators – to describe intermediate benefits.
2. To help build data globally and provide intercountry comparisons, countries should have a minimum set of indicators relevant to nutrition and physical activity (e.g., height, weight, life expectancy). Successful networks at local, national and/or international level such as CINDI and Healthy Cities should be built upon, and benefited from, in the gathering of evidence and the design and implementation of policies.
3. Governments should appoint advisory boards, which should have transparent selection procedures, clear terms of reference and transparent ways of working. Scientific advisory boards should include only independent experts/researchers in the fields of nutrition, physical activity and related topics. Policy advisory boards should be multisectoral and include technical experts and representatives of government agencies (including local authorities) and have an independent chair in order to ensure that scientific evidence is interpreted without any conflicts of interest. Scientific advisory boards should assess evidence and policy advisory boards should advise on necessary actions.
    a. Governments should consider establishing an NCD advisory board to coordinate advice and prioritize action on multiple morbidities and behaviours.
    b. Where multiple scientific boards operate, recommendations should be crosschecked for consistent messages.

   c. Ministries of health should collaborate with other bodies (e.g., other ministries, scientific institutions, local actors, nongovernmental organizations, etc.) to ensure that scientific evidence is presented consistently and effectively to government and to the general public.
   d. WHO should support countries to strengthen government capacity in this area.
4. Governments or their scientific advisory boards should use attainable short-term goals and markers (such as quality of life indicators) that represent stepping stones to longer-term health goals. Examples include short-term measures of health and quality of life indices at school, in the workplace, and at home, such as reduction in short journeys made by cars, higher productivity and reduced absenteeism. Comprehensive health-promoting schools programmes should contain elements concerning nutrition and physical activity. Governments should also adopt a staged approach to establishing standards.

Policy development

1. The use of evidence should be improved to inform the decision-making process, including the promotion of health impact assessment, cost-benefit analysis, national burden of disease studies, evidence-based models, scientific advice and dissemination of good practice.
2. Achievement of public health benefits should be a stated objective of key sectoral policies and a shared responsibility so that sectors other than health can take them into consideration (targeted advocacy). Ministries of health should take the leading role in providing information on how nutrition and physical activity are influenced by other sectors in the society.
3. The opportunities for other sectors to achieve their goals while at the same time contributing to the achievement of health objectives should be acknowledged and valued. This could also allow the identification of new sources of funding for action and build on opportunities offered by other sectors (e.g., national cycling and walking policies developed by the transport sector can become opportunities for physical activity).
4. Cooperation with the private sector should be improved on items such as precautionary principles, fortification, labelling, health and nutritional claims. At the international level, relevant intergovernmental organizations such as the OECD, Codex Alimentarius, World Trade Organization and others should assist in this cooperation. Win-win strategies should be identified for and by the public health sector and private industry (e.g., the food industry, employers, public transport providers, fitness centres) with attention to inequalities.
5. European Union policies and national policies concerning subsidies and tax regulations should optimally support healthy habits both nutritionally and in physical activity.
6. Opportunities provided by different settings (e.g., school and workplaces) should be better taken advantage of, for example walking or cycling to school and to work. Physical education should be part of the curriculum and should be promoted through education legislation and other relevant legislation.
7. National plans for nutrition and physical activity should be consistent and should reinforce each other. Health promotion strategies and communication should build on and make links between nutrition and physical activity for greater added value.
   a. At the national level:
      - Promotion of cross-sectoral collaboration, starting from the national level and allocating resources for application at subnational/local levels. This includes facilitating the exchange of experiences and creating databases of good practices, and addressing the challenge posed by possible competition between different sectors of the administration/government.

- Promotion and support of capacity-building on formulating public health policies for physical activity and nutrition, e.g., by supporting development of postgraduate curricula for health professionals and other relevant professionals.
- Increased awareness and understanding of health implications by other sectors (e.g., education, urban planning, transport, food production, agriculture, economy, media).
- Establishment of a framework for initiating collaboration and partnerships with the private sector and nongovernmental organizations.

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

c. At the local level, authorities can develop local action plans for health, which tailor action to fit the specific needs of the community. Local authorities can also develop win-win strategies to support local economies (e.g., tourism, local food production) while at the same time contributing to achieve health goals. For example, health aspects should be incorporated into Agenda 21 activities at the local level.

8. The public health sector should work with the media to build awareness of the need to use reliable sources of information, for example by emphasizing the need to use credible experts.

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

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

Policy implementation

1. Political commitment (by consensus or legislation), including the allocation of adequate funds, is essential at the implementation stage.
2. Effective implementation requires an assessment of the existing evidence and of needs and preferences of the target population as well as an understanding of cultural and gender sensitivity. Appropriate marketing tools should also be assessed.
3. Strong political support is needed through consensus and/or legislation involving a wide range of key partners on issues including action planning, labelling, and promoting health impact assessment.
4. Ministries of health should have the leading role in coordinating national and local cross-sectoral collaboration with governmental and nongovernmental organizations, communities, and the private sector for investment in capacity-building and preventive measures.
5. The role of local authorities in translating national strategies and policies into action relevant to individual communities is vital at the implementation stage.

Monitoring and evaluation

1. Member States should be encouraged to collect physical activity and nutritional data as part of health behaviour monitoring. This should occur at regular intervals (to enable trend analysis), at national level and where appropriate, at local level.
2. Member States should be encouraged to periodically monitor and report on progress in implementation of policies.
3. A standardized approach to data collection should be adopted to enable national and international comparison.
4. In addition to health behavioural data, other sources of data should be used, for example, data from health services (primary and secondary), transport, industry and other sectors. Monitoring and evaluation is needed at behavioural, policy and environmental levels.

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

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Annex List of participants

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Dr Gabor Zajkas, Deputy Director, National Institute for Public Health, Budapest, *(Rapporteur, working group on evaluation)*

Ireland
Mr Brian Brogan, Assistant Principal, Health Promotion Unit, Department of Health and Children, Dublin, *(Rapporteur)*
Mr Chris Fitzgerald, Principal Officer, Health Promotion Unit, Department of Health and Children, Dublin, *(Presenter, Chairman, working group on implementation)*

Israel
Dr Dorit Nitzan Kaluski, Director, Food and Nutrition Services, Ministry of Health, Jerusalem *(Rapporteur, working group on implementation)*

Kazakhstan
Mr Alexei Berezhnoi, Head, Agency for Tourism and Sports, Sport Mass Work Department, Astana
Dr Kazbek A Tulebayev, Vice-Director, National Centre for Healthy Lifestyles, Almaty

Latvia
Dr Uldis Armanis, Director, Latvian Food Centre, Riga *(Presenter)*
Dr Gunta Grisle, Head of Unit, Department of Public Health, Ministry of Health, Riga

Netherlands
Mr Thom GMA Rutten, Policy Officer, Sports, Exercise & Health Project, Sports Department, Ministry of Health, Welfare & Sport, The Hague *(Presenter)*
Professor Jaap C Seidell, Professor of Nutrition and Health, Faculty of Earth and Life Sciences, Free University of Amsterdam, Amsterdam *(Chairman, working group on evidence)*
Ms Karin CAM van Gorp, Senior Policy Officer, Nutrition, Public Health Department, Ministry of Health, Welfare and Sport, The Hague *(Presenter)*

Norway
Dr Sigmund A Anderssen, Associate Professor, Norwegian University of Sport and Physical Education, Oslo *(Presenter, Chairman, working group on evaluation)*
Dr Lena Klasson Heggebø, Adviser, Physical Activity Department, Directorate for Health and Social Welfare, Oslo
Ms Arnhild Haga Rimestad, Director, Nutrition Department, Directorate for Health and Social Welfare, Oslo *(Co-chairman)*

Russian Federation
Dr Larisa Merklina, Chief Specialist, Communicable Disease Prevention, Ministry of Health, Moscow
Professor Alexander Razumov, Director, National Centre for Rehabilitation, Ministry of Health, Moscow *(Presenter)*
Professor Viktor Tutelyan, Director, Institute of Nutrition, Russian Academy of Medical Science, Moscow

Slovenia
Dr Mojca Gabrijelcic-Blenkuš, Research Analyst, Food and Nutrition Department, Centre for Environmental Health, Institute of Public Health, Ljubljana *(Presenter)*
Dr Jožica Maucec-Zakotnik, State Secretary, Ministry of Health, Ljubljana *(Co-chairman)*
Dr Agata Zupancic, Counsellor to the Minister of Health, Ministry of Health, Ljubljana

Switzerland
Mrs Esther Camenzind-Frey, Deputy Head, Nutrition Unit, Federal Office of Public Health, Berne
Mrs Denise Rudin, Expert, Gesundheitsförderung Schweiz, Berne
Professor Hannes B. Staehelin, Head, Geriatric University Clinic, University Hospital; Swiss Nutrition Council, Basle
Mrs Ursula Ulrich-Vögtlin, Head, Health and Environment Unit, Federal Office of Public Health, Berne *(Presenter)*

The Former Yugoslav Republic of Macedonia
Professor Vladimir Kendrovski, Specialist of Hygiene & Environmental Health, Republic Institute for Health Protection, Skopje, *(Chairman, working group on development)*
Dr Shemsi Musa, Director, State Health & Sanitary Inspectorate, Ministry of Health, Skopje

United Kingdom
Ms Mary Allison, National Coordinator for Physical Activity, Scottish Executive, Edinburgh *(Rapporteur, working group on evidence)*
Ms Danila Armstrong, Acting Nutrition Programme Manager, Department of Health, London *(Presenter)*
Ms Maureen Howell, Nutrition Specialist, Higher Executive Officer, Health Promotion Division, State Health & Sanitary Inspectorate, National Assembly for Wales, Cardiff
Dr Paula Kilbane, Chief Executive, Eastern Health and Social Services Boar, Belfast,
Ms Debbie Lye, Head, Department for Culture, Media & Sport, Community Sport & Talent Development, London
Dr Alison Tedstone, Principal nutritionist, Food Standards Agency, London

Intergovernmental Organization

European Commission
Dr Antonio Doronzo, Principal Administrator, Directorate General, Health and Consumer Protection, European Commission, Luxembourg

Technical experts
Associate Professor Liselotte Schäfer Elinder, Research Manager, Diet and Physical Activity, National Institute of Public Health, Stockholm, Sweden (*Technical presentation: Public health aspects of the European Union Common Agricultural Policy*)
Professor Anna Ferro-Luzzi, Head, Unit of Human Nutrition, National Research Institute for Food and Nutrition, WHO Collaborating Centre for Nutrition, Rome, Italy
Dr Mikael Fogelholm, Director, UKK Institute for Health Promotion, Tampere, Finland (*Technical presentation: Physical activity and health*)
Professor Kaare R. Norum, Chairman Reference Group for the WHO Global Strategy on Diet, Physical Activity and Health, Institute for Nutrition Research, Faculty of Medicine, University of Oslo, Norway
Dr Janina Petkeviciene, Senior Research Fellow, Institute for Biomedical Research, Kaunas Medical University, Kaunas, Lithuania
Ms Imogen Sharp, Head, CVD and Cancer Prevention, Department of Health, London (*Technical presentation: Diet and health*)

WHO Secretariat

Dr Roberto Bertollini, Director, Health Determinants, Division of Technical Support, WHO Regional Office for Europe, Copenhagen, Denmark
Ms Ingrid Keller, Technical Officer, Global Strategy on Diet, Physical Activity and Health, WHO, Geneva, Switzerland
Ms Cécile Knai, Technical Officer, Promoting Health in Lifestyle, Environment and Development, WHO Regional Office for Europe, Copenhagen, Denmark
Dr Gudjón Magnússon, Director, Reducing Disease Burden, Division of Technical Support, WHO Regional Office for Europe, Copenhagen, Denmark
Dr Haik Nikogosian, Unit Head, Promoting Health in Lifestyle, Environment and Development, WHO Regional Office for Europe, Copenhagen, Denmark
Dr Mikael Ostergren, Medical Officer, Integrated Management of Childhood Illness, WHO Regional Office for Europe, Copenhagen, Denmark
Mrs S. Poole, report writer
Dr Pekka Puska, Director, Noncommunicable Disease Prevention and Health Promotion, WHO, Geneva, Switzerland (*Technical presentation: Towards a global strategy on diet, physical activity and health*)
Ms Vivian Barnekow Rasmussen, Technical Adviser, Promotion of Young People's Health, WHO Regional Office for Europe, Copenhagen, Denmark
Ms Francesca Racioppi, Technical Officer, Transport, Environment & Health, WHO Regional Office for Europe, Rome, Italy
Dr Aileen Robertson, Regional Adviser, Nutrition and Food Security, WHO Regional Office for Europe, Copenhagen, Denmark (*Technical presentation: Regional food and nutrition plans*)
Dr Aushra Shatchkute, Regional Adviser, Noncommunicable Disease Prevention, WHO Regional Office for Europe, Copenhagen, Denmark