World Health Organization
REGIONAL OFFICE FOR Europe

WHO European Region Food and Nutrition Action Plan 2014 – 2020

CONCEPTUAL OVERVIEW AND MAIN ELEMENTS OF THE ACTION PLAN

Vision

A health-promoting Europe free of preventable burden and impact of diet-related noncommunicable diseases, undernutrition and micronutrient deficiencies, premature death and avoidable disability at every age and those diseases and deficiencies are no longer a barrier to socioeconomic development.

Mission

To guarantee universal access to food, equity and gender equality for the nutrition of all citizens of the WHO European Region through intersectoral nutrition policies.

Overarching principles and approaches

- Human rights: right to food
- Diet-related noncommunicable diseases, undernutrition and micronutrient deficienciesare a challenge to social and economic development
- Universal access, equity and gender equality
- Life-course approach
- Evidence-based strategies
- Empowerment of people and communities

Goal

To avoid premature death and significantly reduce the burden of preventable diet-related noncommunicable disease, diseases, undernutrition and micronutrient deficiencies by taking integrated action, improving the nutrition related quality of life and making healthy life expectancy more equitable within and between Member States.

Objectives

- Objective1
  Strengthening surveillance, monitoring and evaluation, and research of nutritional health, nutritional status and influencing determinants and trends
- Objective2
  To reduce exposure to inequality-related and modifiable diet-related risk factors for diet-related noncommunicable diseases, undernutrition and micronutrient deficiencies through creation of nutritional health promoting environments
- Objective3
  To strengthen and reorient health systems to address prevention and control of diet-related noncommunicable diseases, undernutrition and micronutrient deficiencies through people-centered primary care and universal health coverage
- Objective 4
  governance for diet-related nutrition, including building intersectoral alliances and networks, and fostering citizen empowerment

ABSTRACT

The burden of diseases due to poor diet remains high and in many countries within the WHO European Region it is actually increasing. Chronic undernutrition is declining but continues to have a marked impact on health in some member states, while overweight, obesity and excess consumption of saturated and *trans* fats, sugars and salt, and low consumption of fresh vegetables and fruits, have become the leading risk factors for many noncommunicable diseases. Policies to tackle this disease burden have been developed through a series of strategic initiatives globally and at the European level, including the European Charter on Counteracting Obesity, the Action Plan for the Implementation of the European Strategy for the Prevention and Control of Noncommunicable Disease, and the Health 2020 framework. The present Action Plan proposes measures to implement nutrition health policies, developed through a consultative process within the WHO European Region. Although it is generally accepted that food safety has very strong links with nutrition as well as physical activity and also impact on nutritional health they will not be covered in this document.

Key words

NUTRITION POLICY

MONITORING

SURVEILLANCE

FOOD SUPPLY

OBESITY - PREVENTION AND CONTROL

REGIONAL HEALTH PLANNING

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1 Introduction

A relatively small group of health conditions is responsible for a large part of the disease burden in Europe. Of the six WHO regions, the European Region is the most affected by noncommunicable diseases, and their growth is startling. Noncommunicable diseases are linked by common risk factors, underlying determinants and opportunities for intervention – high blood pressure, high blood cholesterol, overweight, unhealthy diets and physical inactivity, tobacco use, harmful use of alcohol, hugely increased by lifestyle and demographic changes. Excess consumption of saturated fats and *trans* fats, sugars and salt, and low consumption of fresh vegetables and fruits, has become the leading risk factors for the burden of diet related noncommunicable diseases in the WHO European Region. It is important to note that the WHO European Region still faces a double burden of malnutrition that includes both undernutrition and overweight.

In order to address the risk factors associated with the diet related chronic diseases, the World Health Assembly in May 2004 endorsed the "Global Strategy on Diet, Physical Activity and Health" (DPAS).The Global Strategy emphasizes the need to limit the consumption of saturated fats, *trans* fatty acids, salt and sugars, and increase consumption of fruit and vegetables and levels of physical activity.

In 2006, the WHO Regional Committee for Europe at its fifty-sixth session adopted a comprehensive, action-oriented strategy for the prevention and control of noncommunicable diseases (NCD) (Resolution EUR/RC56/R2)(1). The Resolution EUR/RC56/R2 was a WHO European region-specific response to the *Global Strategy for the Prevention and Control of Noncommunicable Diseases* adopted by the World Health Assembly in 2000 (2). A Global Action Plan2008-2013 for the Global Strategy for the Prevention and Control of Noncommunicable Diseases was endorsed in May2008, which included requirements for the Member States to report on global progress in 2010 and 2012 (3).

In 2010, World Health Assembly passed a Resolution endorsing a *Set of recommendations on the marketing of foods and non-alcoholic beverages to children* subsequently supported by a *framework for implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children* in 2012 (4).

In 2006, the WHO European Ministerial Conference on Counteracting Obesity, held in Istanbul, adopted the *European Charter on Counteracting Obesity*(5), which committed Member States to strengthen actions in the fight against obesity and placed obesity as a public health burden high on the political agenda. The *Charter* identified a series of goals, principles and a framework for action, and asked for a Plan to translate the commitments of the Charter into specific action packages and monitoring mechanisms.

In 2007, the fifty-seventh Regional Committee approved resolution EUR/RC57/R4 (6) which endorsed the *European Action Plan for Food and Nutrition Policy 2007-2012* (7)identifying a range of actions to improve nutrition and food safety implemented across different government sectors and involving public and private actors, and which also called on Member States to develop, implement and govern food and nutrition policies.

The First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control took place in April 2011 which adopted the Moscow Declaration (8) subsequently

endorsed by the World Health Assembly in its resolution WHA64.11 (9). This meeting considered a number of 'best buys' including recommended actions on salt and *trans* fat consumption, limiting children's exposure to advertising for foods high in saturated fats, sugars and salt. This was followed in September 2011 by the United Nations High Level Meeting on Noncommunicable Disease which endorsed a Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases, whereby the sixty-sixth session of the World Health Assembly adopted a Resolution to adopt the Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases (10).

In 2011, the Regional Committee adopted resolution EUR/RC61/R3 endorsing the Action Plan for implementation of the European Strategy for the Prevention and Control of Noncommunicable Diseases 2012–2016 (11) which focused on priority action areas and interventions within a framework which attributed actions to different bodies and identified specific goals, outcome measures and process measures for achieving the actions. Of the five priority interventions, three priority interventions focus on "promoting healthy consumption via fiscal and marketing policies", "elimination of *trans* fats in food (and their replacement with polyunsaturated fats)"; and "salt reduction". In September 2012, the Regional Committee during the sixty-second session adopted a new European health policy framework, *Health 2020*. Health2020 aims to support action across government and society to: "significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centered health systems that are universal, equitable, sustainable and of high quality". Health 2020 recognizes that governments can achieve real improvements in health if they work across government to fulfill two linked strategic objectives which are improving health for all and reducing health inequalities together with improving leadership and participatory governance for health.The Health 2020 policy framework proposes four priority areas for policy action based on the global priorities set for WHO by its Member States, and aligned to address the special requirements and experiences of the European Region. These areas also build on relevant WHO strategies and action plans at the regional and global levels.

The four priority areas are to:

- invest in health through a life-course approach and empower citizens,
- tackle Europe's major disease burdens of noncommunicable and communicable diseases;
- strengthen people-centred health systems and public health capacity, including preparedness and response capacity for dealing with emergencies; and
- create supportive environments and resilient communities.

The European Action Plan (EAP) for Strengthening Public Health Services and Capacity form a key pillar of the overarching regional policy framework, Health 2020.

Through these Resolutions, WHO can support its Member States to strengthen efforts to reduce the burden of noncommunicable diseases and this proposed Plan of Action on Nutrition for the period 2014-2020, specifically aims to address the risk factors related to unhealthy diet and thereby addressing the double burden of malnutrition (undernutrition and overweight).

Food and nutrition policies appear to have developed successfully in the past decade. However, implementation of the policies seems to be a major challenge due to lack of funds, political commitment and coordination. More support could be given to the implementation and evaluation of policies and a shift towards stronger environmental approaches is needed (12). In

order to accelerate progress on the double burden of malnutrition, nutrition policies need to address governance as described within the key objective of WHO Health2020. Following the guidance on governance, provided through the WHO European Policy framework Health 2020, government leaders, policymakers and key stakeholders can mobilise political commitment to reduce the double burden of malnutrition and facilitate intersectoral cooperation across the national and local institutions, and among experts, civil society and the private sector.

In previous WHO European regional food and nutrition plans of action (2, 7), the issue of food safety was an important topic area, which in the present Action Plan is not addressed. Food safety and hygiene, is also important, not only for its potential threat to health but also for its consequences for nutritional status, and because nutritional status has an effect on vulnerability to food poisoning. The issue of food safety will be addressed in a separate context.

2 Food and nutrition policies in the WHO European Region

The last two decades have seen significant advances in the development of policies for the improvement of nutritional health status, health, wellbeing and the prevention of diet-related noncommunicable diseases in the WHO European Region. In addition to the commitments expressed at the European Regional Committee and at the European Ministerial Conferences, there have been a number of developments in global policy, research and guidance which have strengthened and supported the implementation of food and nutrition policies.
A first Food and Nutrition Action Plan of the WHO European region was endorsed in 2000 (2).This document stressed the need to develop food and nutrition policies and provided a framework of actions within which Member states could begin addressing the issue.
The second WHO European Food and Nutrition Action Plan 2007-2012 was published in 2008 (3) and defined diet-related noncommunicable diseases, obesity in children and adolescents, micronutrient deficiencies and food borne diseases as the main public health challenges. Six action areas were defined: “Supporting a healthy start, ensuring a safe, healthy and sustainable food supply, providing comprehensive information and education to consumers, taking integrated action to address related determinants, strengthening nutrition and food safety in the health sector, monitoring, evaluation and research.”

Following the first Action Plan, one third of the Member States developed policies on food and nutrition and nearly every Member state developed government-approved documents on food and nutrition, food security and food safety (13).

As mentioned before, following the second Action Plan, more than 90% of the Member States developed national policies tackling diet and nutrition related issues wherein concrete policy actions like food based dietary guidelines, subsidized school fruit schemes and legislation of labeling energy content of processed foods were envisaged to be implemented in the WHO European Region. Food and nutrition policies appear to have developed successfully in the past decade.

Simultaneously, the WHO Regional Office of Europe facilitated and supported the implementation of WHO Food and Nutrition Action Plan 2007-2012 through established Member States Action Networks which consists of groups of countries committed share country experiences, establish policy dialogue and strengthen synergies. Six WHO European Action Networks in place: “Childhood Obesity Surveillance Initiative”, “Reducing salt intake in the population”, “Nutrition Schools Initiative ”, “Hospital Nutrition” and “Obesity and Health

Inequalities". Member States interaction in these networks resulted in coordinated actions such as the establishment of a surveillance initiative focusing on childhood obesity and governmental policy/discussions (e.g. marketing on food and non-alcoholic beverages on children).

The legacy of nutrition policies in the WHO European region underlines the intrinsic value of a diverse range of monitoring mechanisms within national nutrition policies, where accountability for health and equity should is addressed to ensure intersectoral governance structures. Lessons learnt also indicate that nutrition policies should address the life-course approach, which includes counteracting growing inequalities and strengthening health systems to meet the changing needs of an ageing population.

3 Situational analysis in food and nutrition within WHO European Region

Poor diet, overweight and obesity contribute to a large proportion of noncommunicable diseases, including cardiovascular diseases and cancer, the two main killers in the WHO European Region. National surveys in most countries indicate excessive fat intake, low fruit and vegetable intake and an increasing problem of obesity, all of which not only shorten life expectancy, but also harm the quality of life.

Noncommunicable diseases such as overweight and obesity are serious public health challenges in the WHO European Region. Overweight affects 30–80% of adults in the countries of the WHO European Region. More than20% of children and adolescents are overweight, and a third of these are obese. The trend in obesity is especially alarming in children and adolescents. The annual rate of increase in the prevalence of childhood obesity has been growing steadily, and the current rate is 10 times that in the1970s. This contributes to the obesity epidemic in adults and creates a growing health challenge for the next generation. After infancy, unhealthy diets, too little physical exercise and obesity are often linked to each other and to a far more common cluster of risk factors in low income groups, compared with more affluent groups (14).

The double burden of malnutrition, including undernutrition and the challenge of micronutrient deficiencies also poses a threat to health, particular in vulnerable groups such as children, pregnant women and aged persons within the WHO European Region. It is not uncommon to find under-nutrition and obesity existing side-by-side within the same country, the same community and the same household.

3.1 Nutrition related disease burden in the WHO European Region

3.1.1 Overweight/obesity

- **In children**

  The figures resulting from the WHO European Childhood Obesity Surveillance Initiative (COSI), round 2 (2009/2010), show that, on average, one in every three children aged 6-9 years was overweight or obese. The prevalence of overweight (including obesity) ranged from 24% to 57% among boys and from 21% to 50% among girls. Simultaneously, 9–31% of boys and 6–21% of girls were obese (15).

- **In adolescents**

  The figures resulting from the Health Behaviour in School-aged Children (HBSC) study from 2009/2010 in the WHO European Region show for children aged 11 years, a prevalence of overweight and obesity between 11-33% , for children aged 13 years, a prevalence between 12-27%, for children aged 15 years, a prevalence between 10-23% . The HBSC study shows a higher overweight prevalence is associated with lower SES in some countries, which may be related to a more obesogenic environment (with limited access to healthy foods and fewer opportunities to engage in physical activity) in lower-affluence settings (16)

- **In adults**

The figures resulting from the WHO Global Health Observatory Data Repository (17) for adults aged ≥20 and above, show that, on average (crude estimate) 57.4% of adults (both sexes) is overweight or obese.

Unfortunately the picture is not improving in most countries of the Region. The rate of obesity in some areas of Eastern Europe has risen more than threefold since 1980. Overweight and obesity are estimated to kill about 320 000 men and women in 20 countries of Western Europe every year.

3.1.2 Diabetes and cancer

Diabetes is a chronic, and largely preventable, disease that can lead to cardiovascular disease, blindness, kidney failure, loss of limbs and loss of life. It causes suffering and hardship for the approximately 60 million people in the European Region currently living with the disease, while also straining the Region's economies and health systems.

Prevalence of diabetes is increasing in the European Region, already reaching rates of 10-12% of the population in some Member States. This increase is strongly associated with increasing trends towards overweight and obesity, unhealthy diets, physical inactivity and socioeconomic disadvantage. These risk factors also contribute to the development of the other three noncommunicable diseases (NCDs) that have become international public health priorities (cardiovascular disease, chronic respiratory diseases and cancer), making it imperative that the prevention of diabetes be integrated into population approaches to prevent NCDs as a group.

Cancer causes 20% of deaths in the European Region. With more than 3 million new cases and 1.7 million deaths each year, cancer is the most important cause of death and morbidity in Europe after cardiovascular diseases.
A large body of literature indicates that as much as 30% of all cancer cases is linked to poor dietary habits, and is therefore preventable. The proportion reaches 70% for cancers of the gastrointestinal tract. The notion that being overweight or obese increases the risk of some cancers is widely accepted. Research indicates that the 20% of people who have the lowest fruit intake have a 20% higher risk of lung cancer. In addition, evidence indicates that reducing salt and salt-preserved foods may reduce the incidence of stomach cancer.

Maintaining a healthy weight throughout life may be one of the most important ways to protect against cancer. It is probably the second most important factor, after avoiding tobacco use.

3.1.3 Undernutrition

Studies done among young children (0–5-year olds) in 2007-2011 showed that stunting is in fact prevalent in the Region ranging from 7% to 39%. The second round of the WHO European Childhood Obesity Surveillance Initiative (2009/2010) showed that stunting, thinness and underweight were not present among the 6–9-year olds in any of the COSI countries.

3.1.4 Micronutrient deficiencies

Micronutrient deficiencies include: anemia, mostly due to iron deficiency – which increases the risk of low-birth-weight babies, undermines physical capacity; iodine deficiency, which is the world's most prevalent, yet easily preventable cause of brain damage in children, and vitamin A deficiency. Acute and chronic undernutrition well documented in some countries of the WHO

European Region. At least in one of the countries within the Region every third child of less than five years old is stunted (low height for age). Iron deficiency has increased in the Central Asian Republics. Iodine deficiency is still common in the whole WHO European Region. Aged citizens living in institutions, but also those living in the community are a vulnerable population group in regards to micronutrient deficiencies.

3.2 Risk factors for diet related noncommunicable diseases

3.2.1 Foods high in saturated fats, trans-fatty acids, free sugars or salt (HFSS)

To address diet related noncommunicable diseases (NCD), action should be strengthened toward modifiable behavioral risk factors such as an unhealthy diet. It is evident that an increased intake of foods HFSS, is a fundamental cause for obesity and overweight. The modification of the high intake of foods high in fats, sugar and salt (HFSS) and the low intake of vegetables and fruit is recommended to be a key priority for action in the WHO European Region.

- Fat intake: saturated fatty acids and *trans*-fatty acids

Excessive dietary fat intake has been linked to increased risk of obesity, coronary heart disease and certain types of cancer ((18)(19)(20).Total fat intake as a proportion of total energy intake has gone up in many parts of WHO European Member States. Fat accounted for between 28and 45% of total energy intake in men and between 30 and 47% in women. Therefore, in many of the WHO European Region Member States, fat intake is above the maximum level recommended by WHO (30% of total energy intake). Furthermore, intake of saturated fatty acids is, in general, above the recommended level (<10% of total energy intake). To reduce the risk of noncommunicable diseases diets should provide a very low intake of trans fatty acids (TFA), that is, less than 1% of total energy intake (21).

- Sugar intake

Excessive intakes of dietary sugars have been linked to obesity, and a higher risk of chronic diseases, but the link with obesity is tenuous. The most consistent association has been between a high intake of sugar sweetened beverages and the development of obesity. WHO has suggested that intakes of free sugars should be less than 10% of the total energy intake (22).

- Salt intake

  Based on available data, it is estimated that dietary salt intake is between 5 and 18 grams per day(23). Less than 5 grams per day in adults aged 18+ is the established WHO recommendation for the prevention of cardiovascular disease. There are differences in salt intake between countries, but also associations between social inequalities and salt intake (23).

3.2.2 Intake of vegetables and fruits

The WHO/FAO recommends consuming a minimum of 400g of vegetables and fruit per day. Although harmonized data on the actual vegetables and fruit consumption for an international comparison are not available, consumption rates derived from net supply indicate that the

intake in many European countries is considerably below the level recommended by WHO (7). Fruit and vegetable consumption has gradually increased in western Europe, and even in central and eastern Europe, where consumption levels used to be low. , recent trends in many, but not all, countries have been favourable.

In addition, the volume of the EU fruit and vegetables market has shown a declining trend in the last decade which suggests that consumption rates are even decreasing. Net demand has diminished for years and prices are under pressure. One of the objectives of the reformed EU Common Market Organisation "Fruit and Vegetables" has been to encourage the stagnating consumption of fruit and vegetables, in particular for the most vulnerable consumers such as young people (24).

3.2.3 Breastfeeding and complementary feeding

The compelling body of evidence indicates that early nutrition factors such as breastfeeding may presents an 'ideal window of opportunity' for obesity prevention, which is highly relevant as prevalence of childhood obesity remains high in Europe (25, 26) World Health Organization (WHO) recommends the exclusive breastfeeding (EBF) for the first 6 months and introduction of complementary food after 6 months along with continued breastfeeding till 2 years or beyond.

Despite the several policy effort, breastfeeding prevalence especially EBF remained lowest in Europe among the WHO Regions. An estimated 18% of infants were exclusively breastfeed at 6 months in Europe as compared to 43% in South East Asia Region in between 2000-2008 (27).

Although benefits of exclusive breastfeeding are widely regarded, global recommendation on optimal duration of exclusive breastfeeding and introduction of complementary feeding is great concern of debate in developed countries (28, 29).

3.3 Vulnerable groups for diet related noncommunicable diseases

3.3.1 Life-course approach

Exposure to the risk of NCD accumulates throughout the life course, starting with influences that occur during pregnancy and continuing through early childhood, adolescence and adulthood. Therefore children, pregnant women, elderly people, malnourished people, and people who are ill or immuno-compromised, are particularly vulnerable. A healthy ageing experience consists of health promotion throughout life, a health-supporting environment that promotes coping with disability, social protection, and appropriate and accessible social and health services.

Aged citizens living in institutions, but also those living in the community are also a very vulnerable population group in regards to micronutrient deficiencies and undernutrition alongside noncommunicable diseases risk (30)(31)(32)(33). In Europe it is estimated that between 40 to 80% of residents of care homes and home care are at risk of being undernourished, even when high quality food is available(34).It is also widely accepted that undernutrition is associated with decreased health and functional status, increased dependency and disability as well as increased mortality (35)(36). Therefore undernutrition and the related problems can affect all aged citizens of a society (37). However, social and economic inequalities are increasing the risk for undernutrition (38). It is well documented that undernutrition not

only impacts the individuals' life but also adds an at least partly preventable economic burden to the health care system.

3.3.2 Inequalities and nutritional health

Variations exist in the prevalence of overweight and obesity not only between European countries (as described above) but also between socioeconomic groups within those countries with variations among regions, population subgroups (e.g. gender), and over time. This has major implications for the region, which comprises an extremely diverse population in geography, culture, lifestyle and level of economic development (39).Gender inequalities, i.e. differences between men and women that systematically favour one group, can lead to inequities between men and women in both health status and access to health care.

As observed in high-income countries and more recently in many middle-income countries, the social gradient in obesity reverses when the obesogenic environment changes, such as wider access to energy-dense and nutrient-poor food and, in time, obesity becomes associated with poverty and low social status. This has happened in western Europe, central and eastern Europe and the Commonwealth of Independent States (CIS).Given the dependence that exists between the size and direction of social gradients in obesity and nutrition and the stage of the epidemiological transition in a given country, the contribution of health behaviour to inequities in health at any time is likely to differ between (40).

4 Food and nutrition Action Plan 2014-2020

4.1 Rationale and guiding principles for the Food and Nutrition Action Plan 2014-2020

Poor nutrition and diet not only affect health, quality of life and life expectancy they are also related to noncommunicable diseases like cardiovascular disease, diabetes and cancer (41). Therefore, to enable Member States to reach the goals of HEALTH 2020, food and nutrition policies should address "improving health for all and reducing health inequalities; improving leadership and participatory governance for health" as an overarching policy approach.

Although, many achievements in nutrition policy development at national level were made after the endorsement of the First and Second WHO European food and nutrition action plans, it is still required to focus on monitoring these nutrition policy developments and implementation with regards to their impact on the desired health outcome as well as the need for an established surveillance system providing data on epidemiological trends.

Importantly, as social and economic factors strongly contribute to a unhealthy diet and poor nutrition, population wide strategies, which acknowledge the responsibility of governments and health ministries, but also other sectors and the different levels of policy decision making have to be reinforced to tackle the diet- and nutrition-related health risks to which all citizens of the WHO Member States are exposed to.

4.2 Scope

Several categories – nutrition over the life-course, nutrient deficiencies, undernutrition, and inequities in access to proper nutrition and knowledge about optimal nutrition (in particular individual economic and social aspects, support for breastfeeding and complementary feeding), nutrition education (knowledge and skills, school education, education and training curricula for healthcare professionals, marketing of foods and drinks high in sugar, saturated fatty acids, *trans* fatty acids, and salt (in particular label information and nutrient profiling, precognitive influence on behavior, pricing and placing strategies, marketing to energy dense foods to children) and global food security issues (food supplies, pricing, food access and food related facilities) – make the largest contribution to distortions of nutritional status and nutritional health and are the main focus of the action plan.

4.3 Aim

The action plan is intended to support coordinated and comprehensive implementation of strategies across nutritional health, diet-related diseases and nutritional risk factors, with an emphasis on integration across the life course and recognizing the mutually reinforcing nature of universal nutritional health coverage and prevention and control of diet-related noncommunicable diseases, undernutrition and micronutrient deficiencies. The aim is to provide an overall direction to support the implementation of national policies, strategies and action plans, where they have been developed, and the development of sound and feasible national action plans where none exist. The action plan will, therefore, provide a framework to support and strengthen implementation of existing regional resolutions, strategies and plans.

4.4 Vision

The vision behind the action plan is of the European Region in which all countries and partners sustain their political and financial commitments to reduce the avoidable burden and impact of diet-related noncommunicable diseases over the life-course, so that populations reach the highest attainable standards of health and productivity at every age and those diseases are no longer a barrier to socioeconomic development.

4.5 Goal

The goal of the action plan is to reduce the burden of preventable morbidity and disability and avoidable premature mortality due to diet-related noncommunicable diseases, undernutrition and micronutrient deficiency.

4.6 Time frame

The action plan will be implemented over the period 2014–2020 and the WHO Secretariat will support its implementation through biennial organization-wide workplans.

4.7 Overarching principles and approaches

The action plan relies on the following overarching principles and approaches:

- Human rights: Respect for and promotion and protection of human rights is an integral part of effective work for prevention and control of nutrition and diet-related noncommunicable diseases. Strategies to prevent and control diet-related noncommunicable diseases must be formulated and implemented in accordance with international human rights instruments.
- Diet-related noncommunicable diseases, undernutrition and micronutrient deficiency are a challenge to social and economic development: Strategies for prevention and control of diet-related noncommunicable diseases, undernutrition and micronutrient deficiency over the life-course must be formulated bearing in mind that these constitute a major challenge to social and economic development throughout the world. The adoption of the UN Political Declaration on Noncommunicable Diseases was a defining moment for development cooperation. The UN Political Declaration on Noncommunicable Diseases sets out a new global agenda that presents a historic opportunity to ensure that globalization becomes a positive force for present and future generations.
- Universal access, equity and gender equality: All persons should have equitable access to healthy food and opportunities to achieve the highest attainable standard of nutritional health, regardless of age, gender, ethnicity, disability or socioeconomic position.
- Life-course approach: A life-course approach is a key to prevention and control of nutritional status and diet-related noncommunicable diseases, undernutrition and micronutrient deficiency. It starts with maternal nutritional status and nutritional health, including preconception, antenatal and postnatal nutritional care, and continues through proper infant feeding practices, including promotion of breastfeeding and nutritional health promotion for children, adolescents and youth followed by promotion

of a healthy nutrition during working life, nutrition for healthy ageing and nutritional care for elderly people with diet-related noncommunicable diseases, undernutrition and micronutrient deficiency in later life and nutritional care for patients with disease related nutritional impairments.

- Evidence-based strategies: Strategies for prevention and control of diet-related noncommunicable diseases, undernutrition and micronutrient deficiency need to be based on scientific evidence and public health principles.
- Empowerment of people and communities: People and communities should be empowered and involved in activities for the prevention and care of diet-related noncommunicable diseases, undernutrition and micronutrient deficiency.

4.7.1 From nutrition to nutrition security – a new definition

Nutrition security is more than food security: it is the supply *and consumption* of the optimum nutrition for growth, health and the prevention of later NCD. Determinants of nutrition security include determinants of food security (sustainable and adequate supplies, hygienic and consistent quality, widespread availability, affordable and accessible to all) but also determinants of consumer choice and consumption patterns, including household distribution of foods, cultural practices, education and skills, information, product labeling and persuasive marketing practices, and whether these are promoting or impeding healthy dietary behavior and optimum nutrition for each individual. By looking at these wider determinants, nutrition security takes account of cross-cutting issues such as life course phases and social inequalities.

Nutrition security should be also interconnected with right to food which means proper nutrition and health are fundamental human rights. Ensuring nutrition security also means ensuring the enjoyment of the right to adequate food and of the right to health (42).

The United Nations Special Rapporteur on the Right to Food defined the right to food:

"The right to have regular, permanent and unrestricted access, either directly or by means of financial purchases, to quantitatively and qualitatively adequate and sufficient food corresponding to the cultural traditions of the people to which the consumer belongs, and which ensure a physical and mental, individual and collective, fulfilling and dignified life free of fear".

At the 19thSession of the Human Rights Council: Interactive Dialogue with the Special Rapporteur on the right to food on6 March 2012, the Special Rapporteur on the right to food (SR) presented the report on malnutrition and health (A/HRC/19/59) (43) highlighted three main ideas:

(1) Malnutrition cannot be fully attributed to "life choices"; it is a structural issue given that the wider environment created by policy (e.g. agricultural production) is conducive to overconsumption, unhealthy food, overweight and obesity;

(2) The globalization of the agro-food chain through international trade and investment is a major challenge, especially in developing countries;

(3) awareness-raising on nutritious food does not compare with the marketing practices of the food industry, particularly sweet drinks, snacks, fast food targeted at children. In conclusion, he recommended re-examining agricultural policies, taxing certain unhealthy foods and drinks,

promoting breastfeeding (incl. implementation of the WHO code), tackling marketing practices, and ensuring diversification and sustainability of local food production.

As a response to the update from the UN Rapporteur at the 19th Session, WHO responded, that the right to food could not be reduced to the right not to starve, warning of a "vicious cycle of intergenerational malnutrition". WHO's role is to support Member States to realize their health related human rights obligations, by creating an environment which empowers people to make healthier choices and to adopt lifestyle patterns that foster good health, for example through the promotion of breastfeeding.

Table 1.Examples of current issues in food and nutrition security

Food supplies	Global warming and extreme weather, urbanizing population, bio-fuel competition
Food prices	Commodity dependence, trade and market forces, subsides and taxes on , land, water, transport, carbon path and on food products themselves
Food access	Retail distribution, transport policy, remote area supplies of perishable foods
Facilities	Institutional, retail and domestic kitchens, price of fridges, freezers, cookers, cooking fuel
Nutrition education	Knowledge and skills, school curricula, health professionals training for nutritional counseling and early identification of an nutrition associated risk (i.e. obesity, age- and/or disease related undernutrition)
Right to food	It is recognized as an international human right, human right to food
Marketing	Messages and claims, label information including nutrient profiling, pre-cognitive influence on behavior, pricing strategies, placing
Inequalities	Household spending on food, cost of healthier foods, unit pricing distortions, support for breastfeeding, complementary feeding
Life course	Nutrition security and prevention of nutrient deficiencies (i.e. iodine, iron, vitamin D) at different stages, maternal obesity, breastfeeding, ageing

4.7.2 Equity lens: social determinants approach

Equity must begin at the bottom, hand in hand with healthy nutrition. The final report of the Commission, *Closing the gap in a generation*, concluded that achieving health equity requires action on the conditions in which people are born, grow, live, work and age and the structural drivers of these conditions at the global, regional, national and local levels (44).

The social determinants approach and the need to prioritize health equity are at the centre of the revitalized public health agenda by the adoption of HEALTH2020 which aims to increase equity and accelerate progress on achieving the right to health. The global economic downturn has profound importance for the health and well-being of populations and is likely to worsen health inequity. The people who are already most exposed to vulnerability and disadvantage feel the effects of the global economic downturn more strongly, for example reduced affordability of healthy foods (40).

Tackling nutritional inequalities across the social gradient and support for the most vulnerable people is necessary to achieve the biggest, but also affordable benefit for the nutritional health

of all citizens of the WHO European Region Member States in a time of limited resources. Already existing resources can be adopted and used efficiently.

4.7.3 Governance for nutrition and diet-related health

Governments can translate, consistent and coherent to HEALTH 2020, the four priority areas within HEALTH2020 (investing in health through a life-course approach and empowering people; tackling the Region's major health challenges of noncommunicable and communicable diseases; strengthening people-centred health systems, public health capacity and emergency preparedness, surveillance and response; and creating resilient communities and supportive environments) for the further development and implementation of nutritional policies in their country, but also in partnership with other countries.

Intersectoral Governance

Governments can implement policies developed in partnership from the different ministries promoting nutritional health and nutritional care, and facilitating the healthier nutritional choice (e.g. availability and affordability of vegetables and fruits). The intersectoral approach means addressing the social and environmental determinants of nutritional health to reduce nutritional inequalities more effectively. A whole-of-society and whole-of-government solution to lifelong secure nutrition is needed.

4.8 Structure of the Action Plan

The Action Plan has been developed in order to support Member States in the prioritization of national nutrition policies to improve nutritional health and prevent diet-related ill-health. The box below provides a conceptual overview of the main elements of the draft action plan.

CONCEPTUAL OVERVIEW AND MAIN ELEMENTS OF THE ACTION PLAN

Vision
A health-promoting Europe free of preventable global burden and impact of diet-related noncommunicable diseases and micronutrient deficiencies, premature death and avoidable disability at every age and those diseases and deficiencies are no longer a barrier to socioeconomic development.

Mission

All citizens of the WHO European Region will benefit from intersectoral nutrition policies ensuring universal access, equity and gender equality.

Overarching principles and approaches
- Human rights: right to food
- Diet-related noncommunicable diseases, undernutrition and micronutrient deficiencies are a challenge to social and economic development
- Universal access, equity and gender equality
- Life-course approach
- Evidence-based strategies
- Empowerment of people and communities

Goal
To avoid premature death and significantly reduce the burden of preventable diet-related noncommunicable disease by taking integrated action, improving the nutrition related quality of life and making healthy life expectancy more equitable within and between Member States.

Objectives

- Objective 1

Strengthening surveillance, monitoring and evaluation, and research of nutritional health, nutritional status and influencing determinants and trends

- Objective 2

To reduce exposure to inequality-related and modifiable diet-related risk factors for diet-related noncommunicable diseases, undernutrition and micronutrient deficiencies through creation of nutritional health promoting environments

- Objective 3

To strengthen and reorient health systems to address prevention and control of diet-related noncommunicable diseases, undernutrition and micronutrient deficiencies through people-centered primary care and universal health coverage

- Objective 4
  Governance for nutrition, including building intersectoral alliances and networks, and fostering citizen empowerment

5 Tools to address the risk factors for diet related noncommunicable diseases with a focus on the vulnerable groups and the health divide

In order to address this disease burden the proposed WHO Food and Nutrition Action Plan 2014-2020 will address dietary approaches that are sustainable and involve the whole-of-society and whole-of-government to ensure social, environmental and cultural aspects are covered.

5.1 Toolbox on monitoring and surveillance

Monitoring and surveillance is an important focus of the WHO Regional Office's work on nutrition. Increasing countries' potential opportunities for action and building their capacity to strengthen the national comprehensive nutrition and nutrition-related policies can be achieved with surveillance of nutrition and diet-related diseases, as obesity, diabetes, cancer, cardiovascular disease, and with the monitoring of nutritional policies and their impact on nutritional health. Surveillance and monitoring are crucial for strengthening the national policies and to match the HEALTH 2020 concept.
An example of a consolidated surveillance system is the WHO European Childhood Obesity Surveillance Initiative (COSI). COSI established a standardized European surveillance system focused upon childhood obesity and expanded to include 22 countries in 2013 (15). Another example of a cross-national surveillance collaboration between the Member States of the WHO European Region is the study on Health Behavior in School-aged Children (HBSC), which examines the physical and mental health of children and teenagers, including nutritional behavior.

Nutrition policies have been developed in the WHO European Region Member States however policy implementation together with monitoring and evaluation of the mentioned policy actions in these policy documents remains a challenge. This challenge needs to be addressed in terms of establishing assessment tools that will allow monitoring the nutritional trends and priorities. Such a tool is the WHO European database on nutrition, obesity and physical activity (NOPA) which was created in collaboration with national health ministries and with support from the EC. The NOPA database includes details of more than 300 national and sub-national policies in the European Region and is continuously updated. Furthermore NOPA is being integrated in NCD surveillance tools.

Acknowledging the need for standardized collection of data on the established risk factors that determine the major disease burden WHO provides with the STEPwise approach to chronic disease risk factor surveillance (STEPS) an entry point for low and middle income countries to get started on diet related NCD surveillance activities. The data collected with STEPS can help countries build and strengthen their capacity to conduct surveillance as the tools is improving and gains modules and sections which are more meaningful for diet and nutrition.

To support implementation of the WHO Second European Action Plan for Food and Nutrition Policy 2007–2012, WHO facilitates various action networks which consist of groups of countries committed to implementing specific action. The networks are led by countries that offered to take the lead in these areas, and WHO/Europe closely follows and supports their work. These Action Networks are a crucial tool to share country experiences and exchange policy developments between the members of the Action Networks.

- Childhood obesity surveillance
- Reducing marketing pressure on children
- Reducing salt intake in the population
- School Nutrition initiative
- Hospital Nutrition
- Obesity and health inequalities

Just as the monitoring of nutrition has moved from the monitoring of outcomes (nutritional status in the form of growth patterns and overweight, consequential diseases) to the monitoring of inputs (dietary surveys, household food purchase and consumption surveys) and food supplies, there is a need to consider the monitoring of food environments, in order to identify potential opportunities for action.

From this panoramic view of the influences on food choices it is possible to identify several opportunities for action, and which in turn require new approaches to policy monitoring their effects. Some opportunities for monitoring purposes are suggested here:

- Extent of food and beverage promotional marketing, including in new media, and the extent of children's exposure to HFSS food and beverage marketing;
- Effects on choice and consumption of portion size restriction, and of restrictions on marketing schemes (e.g. free toys) for HFSS foods and beverages;
- Effects on choice and on product reformulation of different forms of labeling and information display, and the use of nutrient profiling to control health claims, foster product reformulation and limit marketing to children and provide interpretative guidance;
- Extent of public sector purchasing power and its use to influence market pricing for healthier products [in concordance with support for carbon reduction measures] and effect on health in particular in kindergarten, schools, workplaces and health facilities (e.g. hospitals, nursing homes);
- Workplace environments and public environments for the support of breastfeeding and appropriate complementary feeding;
- Distribution of food outlets and outlets for confectionery, snacks and soft drinks, and for fresh fruit, vegetable and fish, and the potential role of planning regulations and economic development support.
- Variations in price and use of price elasticity and cross-price elasticity (especially for lower-income groups) to model the impact of price intervention, e.g. through tax and/or subsidies and duties;

5.2 Toolbox to address modifiable risk factors in relation with nutrition related health problems

5.2.1 Marketing

With regards to the promotion of foods, the leading categories of food being advertised are HFSS such as soft drinks, sweetened breakfast cereals, biscuits, confectionery, snack foods, ready meals and fast food / quick service outlets. Television remains a dominant medium for the promotional marketing of foods and beverages, but it is only one of many different media through which advertisers are now able to promote products, build brand awareness and generate consumer loyalty. Surveys in 2007 found over 50% of food advertisements on children's TV were for HFSS foods in Spain, UK and Sweden, over 60% in Italy and Greece, over 80% in Germany (45)and over 90% in Bulgaria (46). Voluntary measures taken by food companies to restrict advertising to children have had only modest effects in reducing their overall exposure (47)(48).WHO, encourages Member States in its "Framework for implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children" to follow a comprehensive or stepwise policy approach for restricting the marketing of foods HFSS by addressing "exposure" and "power"(4).

Nutrient profiling is one mechanism that Member States can use in implementing the set of recommendations on the marketing of foods and non-alcoholic beverages to children that were endorsed by the 63rd World Health Assembly (49). Developing guidance on nutrient profiling contributes to the implementation of Objective 3 of the NCD Action Plan (WHA61.14) as well within the priority intervention focusing on promoting healthy consumption of the WHO European Action Plan for the implementation of the European Strategy for the Prevention and the control of noncommunicable diseases (11). In January 2012, the Executive Board adopted resolution EB130.R7(50), on Prevention and control of noncommunicable diseases: *Draft action plan for the prevention and control of noncommunicable diseases 2013–2020.*

Nutrient profiling can be used for various applications, including marketing of foods to children, health and nutrition claims, product labeling logos or symbols, information and education, provision of food to public institutions, and the use of economic tools to orient food consumption but also can lead to food reformulation, as well as incentive to food reformulation and competitiveness of food items.

As detailed in the Action Plan for the implementation of the European Strategy on NCD; priority interventions addressing foods HFSS (marketing and fiscal policies) and food reformulation are described as evidence-based and cost-effective measures that are feasible, financially and politically, for implementation and scale-up in a range of country contexts (11). Within this Food and Nutrition Action Plan, marketing and food reformulation are proposed as priority interventions following the guidance of the previously endorsed European and Global Strategy on NCD. Proposed actions, detailed targets and indicators are provided within this Action Plan.

5.2.2 Food Reformulation

In most countries a large majority of the population are still failing to meet the targets for salt, saturated fat and *trans* fatty acid as well as vegetable and fruit intake (51-53). Despite real progress in reducing *trans* fatty acid levels in recent years, popular foods with high amounts of *trans* fats are still easily available and in Eastern Europe there are concerns about potentially

high intakes among the most vulnerable groups (21).Therefore food reformulation should be considered as a priority policy measure to take action forward. Nutrient profiling is a tool that can be used as a public health intervention leading to food reformulation. Nutrient profiling can help to provide clarity about which food products should be promotedand it facilitates the process of reformulation by providing a standard against which success in reformulation can be measured. WHO is in the process of finalizing a framework manual, which includes guiding principles for the development or adaptation of nutrient profile models. The nutrient profile models provided through the framework have been piloted in some of the Member states.

5.2.3 Salt reduction

Programs to reduce individual salt intake of the Citizens of the WHO European region are considered to build around “three pillars” (54):

- Product reformulation – considered as an area that should be approached in coordination with manufacturers, distributors and providers. This area included identification and monitoring of the main contributors to salt consumption as well as the implementation of monitoring mechanisms by means of qualified staff and an appropriate budget.
- Consumer awareness and education– to be pursued through campaigns focusing on clear and simple messages to be tested beforehand and carried out by previously identified key groups and individuals. An appropriate avenue of communication was to be determined with a view to targeting not only the general population but particularly the most vulnerable groups. Within the consumer awareness activities, provision of information on how to read and interpret nutrition labels was also proposed.
- Environmental changes– considered as a means of making healthy food choices easy and affordable for everyone, including through setting country targets and specific standards for food providers. Clear and comprehensive labeling was also considered a key element to environmental changes.

Salt reduction and salt iodization are compatible. Monitoring of salt intake and salt iodization at country level is needed so that salt iodization can be adjusted over time, depending on observed salt intake in the population, so that individuals consuming the recommended amount of sodium will continue to consume sufficient iodine (55).

5.2.4 Increased intake of vegetables and fruits

Evaluation report of the EU School Fruit Scheme was published October 2012 and assessed the implementation and impact of the EU School Fruit Scheme (SFS) since its start in autumn 2009. In their qualitative evaluation analysis the majority of Member States /Regions has observed a positive impact of the scheme on children’s fruit and vegetables consumption and indicates an increase of consumption beyond the fruit and vegetables distributed to the children (56).

Within this Action Plan, WHO consider the EU School Fruit Scheme as an example of a broad partnership between education, health and agriculture with the aim of improving the availability and affordability of vegetables and fruits.

5.2.5 Breastfeeding and complementary feeding

Scientific evidence is suggesting that the roots of NCD and the obesity problem originate from the first years of life and has obvious links with early nutrition. Therefore the entry point to address undernutrition as well as obesity and NCD lies in the first 1000 days period of life. This period of life seems to be of particular importance as the dietary habits and feeding patterns are introduced and established, as well as parental feeding practices.

Health services are expected to deliver a package of interventions during pregnancy and lactation aiming to ensure that women consume an adequate balanced diet.

Within this Action Plan, WHO Regional Office for Europe reinforces the need to increase incentives for breastfeeding and reduce practices that interfere negatively with breastfeeding.The interventions should include regular assessments of nutrition status, counseling on diet and care, micronutrient interventions when and where necessary. It is a common understanding that the above mentioned should be delivered at the Primary Health Care level.

5.3 Life course approach

5.3.1 Maternal and newborn health

Training for professionals in nutrition aims at building capacity to develop and update clinical guidelines. The WHO tool: Baby Friendly hospital Initiative for assessment of the quality of hospital care for mothers and newborns provides the hard evidence on which improvements to put in place. The revolutionary “regionalization of care” method rationalizes existing health care services to ensure that each pregnant woman and newborn is cared for in an appropriate environment.

5.3.2 Child and adolescent health

A systematic approach, known as the “Five S” approach, has been developed by WHO to support countries as they address adolescent health through developing youth-friendly policies and services. It recognizes the need for:

- supportive policies based on human rights principles
- strategic information
- service delivery modes that are youth friendly
- sustainable resources for adolescent health programmes
- cross-sectoral work

WHO Regional Committee for Europe adopted in 2005 the “European strategy for child and adolescent health and development”. The strategy is not prescriptive, and is designed to be used flexibly to meet countries’ needs. It is essentially a framework that gives a range of policy options based on the best evidence, and encourages countries and regions to set their own targets and indicators. WHO/Europe has developed four implementation tools for the strategy (on action, assessment, information and gender) and is pilot-testing two more (policy implementation monitoring and adolescents).

5.3.3 Healthy ageing

With regards to an aging society, in almost every WHO Europe Member State, efforts are needed to prevent over- and undernutrition, and frailty. To achieve the best attainable health and quality of life attention has to be paid to the intersectoral approach, as the care policies for aged people are organized within many different sectors in most countries.

In order to achieve the ultimate goal of healthy and active ageing, this Food and Nutrition Action Plan builds upon the existing WHO policy framework, which focuses on such areas as:

- preventing and reducing the nutrition related burden of disabilities, chronic disease, and premature mortality;
- reducing the nutrition related risk factors associated with noncommunicable diseases and functional decline as individual age, while increasing factors that protect health;
- enacting food and nutrition policies and strategies that provide a continuum of care for people with chronic illness or disabilities;
- providing training and education to formal and informal carers;
- supporting communities and families to be able to engage and support people as they age to maintain their contribution to economic development, to activity in the formal and informal sectors, and to their communities and families.

5.3.4 Gender

A goal of this Food and Nutrition Action Plan is to achieve gender equality. Gender mainstreaming to address nutritional health means taking into account, the role of social, cultural and biological factors, that influence nutritional health outcomes and in doing so improving programme efficiency, coverage and equity.

The challenge of a sex-differential imbalance can be tackled by:

- Nutrition policies addressing gender issues which includes raising awareness on the importance of nutritional health in both gender;
- Collection of sex-disaggregated data and gender analysis in nutrition policies;

5.4 Strengthen nutrition capacity within health systems

One resource to achieve affordable benefits for every citizen is the primary health care system, which is already in place in many member states. Member States can prioritise and coordinate their nutritional policies together with primary healthcare policies to match the HEALTH 2020 principles and priorities. Primary health care is addressing health problems in the community, providing health promotion, and preventive, curative and rehabilitation care. Information and counselling about healthy diet and the impact on overall health, but also nutritional care should be included into primary health care. To enable healthcare professionals on to provide their users with evidence based nutritional knowledge and nutritional care the current professional education systems, career structures and incentive mechanisms could be adjusted to strengthen this guidance function.

5.4.1 Education and Training for a better food and nutritional knowledge/literacy for all

Nutritional education together of the citizens: in general and specific nutritional requirements during pregnancy and breastfeeding, in early childhood, of children and adolescents, of aged persons.There is a need to build up the competencies of public health and clinical professionals in the field of nutrition. This needs to be done as part of undergraduate, postgraduate and continuing professional education strategies and approaches.

6 Targeted approach for policy implementation by actors and stakeholders

6.1 Objectives

- Objective 1

  Strengthening surveillance, monitoring and evaluation, and research of nutritional health, nutritional status and influencing determinants and trends

- Objective 2

  To reduce exposure to inequality-related and modifiable diet-related risk factors for diet-related noncommunicable diseases, undernutrition and micronutrient deficiencies through creation of nutritional health promoting environments

- Objective 3

  To strengthen and reorient health systems to address prevention and control of diet-related noncommunicable diseases undernutrition and micronutrient deficiencies through people-centered primary care and universal health coverage

- Objective 4

  Governance for nutrition, including building intersectoral alliances and networks, and fostering citizen empowerment

6.2 Monitoring framework, including indicators, and set of targets

Set of targets as appropriate within the national context and national programs for the prevention and control of diet-related noncommunicable diseases as well as nutrition within the WHO European Region to be achieved by 2020

Priority Actions	Target	Indicator
Mortality and morbidity		
Overweight/obesity • In children • in adolescents • in adults	By 2020 reduce the prevalence of overweight: • in children by 10% • in adolescents by 5% • in adults by 5%	Overweight: • Prevalence of overweight and obesity in children (defined according to the WHO growth standards for children (under 5 years of age), overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex) • Prevalence of overweight and obesity in children and adolescents (defined according to the WHO growth reference for school-aged children and adolescents, overweight – one standard deviation body mass index for age and sex, and obese – two standard deviations body mass index for age and sex) • Age-standardized prevalence of overweight and obesity in persons aged 18+ years (defined as body mass index ≥ 25 kg/m² for overweight and body mass index ≥ 30 kg/m²
Undernutrition	By 2020 eliminate the prevalence of undernutrition: • eliminate stunting	Undernutrition • Percentage of stunting (height-for-age less than -2 standard deviations of the 2006 WHO Child Growth Standards median) among children aged 0-5 years • Percentage of stunting (height-for-age less than -2 standard deviations of the 2007 WHO Child Growth Reference median) among children and adolescents aged 6-19 years

Micronutrient deficiencies	By 2020 reduce the prevalence of micronutrient deficiencies by ?: • iodine deficiency • Anemia • Vitamin A (?) • Vitamin D (?) • …	Micronutrient deficiencies • Median urinary iodine concentration (µg/L; 24h urine excretion) in children 6-12 • % Anaemia pregnant women (Hb<110 g/L • % Anaemia children <5 y (Hb<110 g/L) • % Subclinical vitamin A deficiency in preschool-age children (serum/plasma retinol <0.70 µmol/L)
Diabetes/cancer	By 2020 reduce the prevalence of diabetes and cancerattributable to nutritional factors by (?)	• Age-standardized prevalence of raised blood glucose/diabetes among persons aged 18 + years (defined as fasting plasma glucose concentration ≥ 7.0 mmol/l (126 mg/dl) or on medication for raised blood glucose)
Risk Factors		
Foods high in saturated fats, trans-fatty acids, free sugars or salt (HFSS)		
Fat intake Saturated fatty acids Trans fatty acid intake	By 2020, reduce the fractionof total energy derived from saturated fats by 3% and by 1% of total energy from *trans* fat: • Decrease the level of saturated fatty acids in processed foods and replace them with unsaturated fatty acids • Eliminate industrially produced trans-fatty acids from processed foods	Food consumption surye. Age-standardized Mean population intake of saturated and trans fatty acids per day in grams in pre-school and school children, and persons aged 18 + years
Salt/sodium intake	By 2020, reduce the intake of salt by 30%	Food consumption surye. Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 2-15 years Age-standardized mean population intake of salt (sodium chloride) per day in grams in persons aged 16 + years

Sugar intake	By 2020, reduce the intake of free sugars by 5% with a focus on sugar sweetened beverages	Food consumption suryey. Age-standardized mean population Intake of free sugar per day in grams in early childhood and pre-school and school children, and persons aged 18 + years
Intake of vegetables and fruits	By 2020, increase the daily intake of vegetables and fruits by three additional portions	Food consumption survey
Exclusive breastfeeding for the first six months and complementary feeding	By 2020, increase exclusive breastfeeding for the first six months of life to at least 70%	Child Health Record/Card (validated)
Life-course approach		
Maternal and newborn health	By 2020, ensure that this subpopulation group has a food intake according to the WHO/FAO recommendation	Food consumption survey
Child and adolescent health	By 2020, ensure that this subpopulation group has a food intake according to the WHO/FAO recommendation	Food consumption survey
Healthy Ageing	By 2020, ensure that this subpopulation group has an adequate food intake and that the nutritional risk is routinely evaluated.	Food consumption survey Age-standardized prevalence of nutritional risk
Health 2020: Social Determinants and Governance		
Inequalities and nutritional health	By 2020, ensure that nutrition surveys use the equity lens	Apply measures of inequity, use at least stratification by: • Sex; • At least two social markers At least one regional marker
Nutrition Governance:	By 2020, all Member States of the WHO European Region have implemented a national nutrition plan or strategy; By 2020, all Member States of the WHO European Region have established an evaluation mechanism with regards to their national nutrition plan or strategy; By 2020, all Member States of	Monitoring of development, implementation, evaluation of intersectoral mechanism, including budget and resource allocation for nutrition provided in the different settings (e.g. kindergarten, schools, hospitals). Monitoring of implementation, evaluation, intersectoral mechanism, budget allocation for nutrition and nutritional care of national nutrition polices with

	the WHO European Region have an existence of an intersectoral mechanism to address dietary intake and nutrition; By 2020, all Member States of the WHO European Region have developed their national dietary guidelines for vulnerable groups (e.g. children, pregnant and breastfeeding women, aged people); By 2020, all Member States of the WHO European Region have developed their national dietary guidelines at intersectoral level; By 2020, all Member States of the WHO European Region have established a regular nutrition monitoring and surveillance system; By 2020, all Member States of the WHO European Region have allocated a budget for monitoring and surveillance of the national nutrition plan, strategy or policy; By 2020, all Member States of the WHO European Region have a detailed nutrition and nutritional care in the health budget; By 2020, all Member States of the WHO European Region have strengthened their nutrition capacity within health systems; By 2020, all Member States of the WHO European Region have increased education and training for a better food and nutritional knowledge/literacy for all.	the WHO European Nutrition, Obesity and Physical Activity (NOPA) database. Nutrition is included in the curriculum for healthcare professionals. Percentage of trained nutrition professionals.

6.3 Proposed actions for Member States

6.4 Actions for the Secretariat

6.5 Proposed action for partners

We propose the actions to be discussed in detail in Tel Aviv and in the consultation process.

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