OBESITY GOVERNANCE

D5  OVERVIEW OF NATIONAL INITIATIVES AND PROGRAMMES

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OBESITY GOVERNANCE
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The Obesity Governance project has been made possible by the means of a financial contribution from the Programme of Community Action in the Field of Public Health 2003-2008, of the European Commission.
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**Introduction**

This report, Deliverable 5 of Work Package 4 of the Obesity Governance project, aims at giving a broad overview of public-private partnership initiatives to counteract obesity and overweight in EU and Norway.

The Obesity Governance project focuses on public-private partnerships (PPP) around manufactured food as a means to counteract obesity and overweight in Europe. The project is a health promotion project funded by the Health and Consumer Protection Directorate General (DG SANCO) of the European Commission. The main objective of the project is to study innovative approaches, such as industry involvement and public-private partnership initiatives, to counteract obesity and overweight in Europe, particularly through reformulation of manufactured food.

The aim of Work Package 4 (WP4) is to identify and analyse national and local initiatives in reformulation of manufactured food in the EU27 and Norway, with the main focus on governance; the relationship between the political authorities on the one hand and the initiatives by the food industries and retailers on the other. The overview will also aim at identifying promising cases of public-private partnerships that will be selected for further analysis of best practices from a governance perspective (WP5).

Obesity and overweight have grown in Europe. According to the report “Health at a Glance: Europe 2010”\(^1\), the rate of obesity has more than doubled over the part 20 years in most EU countries, and over half of the adult population in EU are now overweight or obese. On average, 15.5% of the EU adult population is obese. The lowest rates are found in Romania (7.9%), Italy (9.9%), Norway (10.0) and the highest in UK (24.5%), Ireland (23.0%) and Malta (22.3%).

A study of food and nutrition policies in Europe (21 participating countries) showed that most of the countries have intersectorial food and nutrition policies (all 21 countries reported having a specific food and nutrition policy except Greece, Poland and Portugal, which reported having nutrition-related programs).\(^2\) All countries reported that they have included prevention of obesity in their policies.

In the case of counteracting obesity and overweight the role of industry and trade organisations has increasingly been attracting attention and at the pan-European level the European Platform for Action on Diet, Physical activity and Health has become a central focus of activity. There is a growing acceptance, confirmed at the Istanbul Ministerial Summit, that wider factors need to be taken into account if effective promotion of healthy eating is to be achieved. Public health experts have mostly been sceptical about the role that industry could play in supporting healthier eating habits. It has been argued that food industry will seek to maximise value and thus will tend to use marketing of unhealthy products and thus influence dietary habits in a negative way.\(^3\)

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Support for closer involvement of stakeholders including NGOs, civil society and the private commercial sector can be found in policy papers on nutrition and healthy eating from the EU and WHO. Both governments and food trade associations have launched initiatives and policy papers on corporate nutritional responsibility and partnership approaches to healthy eating.4

The main private actors are the food industry and retailers, but also non-governmental organisations (NGOs) play an important role. In some countries public authorities are regarded as the driving force in regulation, while corporate involvement and self-regulation is more predominant in others.

Policy outcomes include initiatives aimed at improving healthy eating, such as product innovation, public and private labelling schemes, campaigns and education programmes and marketing programmes (for example, code on food advertising to children).

Perceptions of PPP vary and PPP has been used in different contexts – in many government circles PPP is used for private contracts to run public services.5

Our definition of PPP is relatively wide to comprise a wide array of different initiatives. An ideal typical Public-Private-Partnership consist of co-operation between 1) public institutions on national, regional or local level, 2) businesses within primary agricultural production, food industry or retailers and 3) Non-governmental organisations from civil society. In our selection of cases we include cases that cover at least two of these three possible partners. This means that PPP in defined as partnerships beyond Governmental-Business cooperation. We also include partnerships between public institutions and NGOs, representing the civil society. Furthermore, possible cooperation between NGOs and businesses also fulfills our criteria. The main types of PPPs included are policy programmes, research programmes, labels, programmes directed at schools, codes of conduct, in-store marketing, and campaigns and other (we have not specifically included platforms and networks).

National policy and cultural context varies across Europe. Europe has been divided into zones that represent various regulatory regimes (Anglo-American zone, Mediterranean zone, Nordic zone, and Eastern European zone). The role of the state, civil society and private sector are embedded in particular historical traditions, structural positions, dependencies and power relations. Public authorities still represent an active force in nutrition policies in some countries (for example, Norway) and at the same time NGOs work in close collaboration with health and food authorities. In Southern and Eastern Europe, recent historical experiences have challenged the legitimacy of public authority to a larger extent than what has been the case in Northern Europe. Elsewhere, such as in the UK, there are cases where private business and retailers contest public governance by introducing their own healthy eating campaigns or rival labelling approaches that run independently of public initiatives.

The report includes country reports from 28 European countries (27 EU and Norway), which have been grouped geographically into four groups (South, Central and East, West, and


North). The country reports include information about identified PPPs and some country context. The Conclusion chapter gives a summary of the identified PPPs and presents which of these identified public-private partnerships will be selected for further analysis of best practices from a governance perspective in WP5. A separate appendix includes more detailed information on each PPP identified.
Methods

The overview is mainly based on desk-top research. Literature and information has been identified by searches on Internet and by sending e-mails (or in some cases phone calls) to relevant authorities and organisations in the various countries.

The responsibility for searching for information from the countries was divided between the partners (Norway: Norway, Sweden, Finland, Estonia; UK: UK, Republic of Ireland, Germany, Austria; Denmark: Denmark, Belgium, Luxembourg, France; Spain: Spain, Portugal, Italy, The Netherlands; Poland: Poland, Lithuania, Latvia, Czech Republic; Greece: Greece, Cyprus, Malta, Bulgaria; Hungary: Hungary, Slovakia, Romania, Slovenia).

The following instructions for identification of PPPs were distributed:

1st step:
Initial search for informants (and initiatives) from
- Data bases: Earlier/ongoing projects, WHO, etc.
- Professional and other networks
- Web information on obesity policies and programmes – European, national

2nd step:
In each country we should aim at contacting at least:
1-2 public government authorities – nutrition and food (if divided)
1 consumer organisation
1-2 branch organisations, trade association (not companies directly)
1-2 relevant professional organisations (e.g. heart association, obesity network)
Due to the expected variability there may also be additional organisations/actors that can provide information that we are searching for, for instance university and research institutions

3rd step:
Direct questions to key persons in these organisations via e-mail, telephone, perhaps face-to-face interviews in own country.

A template was developed for recording the following information for each PPP:
-name of initiative
-source of information
-substantial description
-goal/character (policy programmes, research programmes, labels, programmes directed at schools, codes of conduct, in-store marketing, campaigns and other)
-main stakeholders
-who took initiative
-financial matters
-legal matters
-conflicts and alliances among stakeholders
-results
-other relevant information
-candidate to in-depth analysis in WP5?
In addition, each partner was also asked to collect some basic information on the countries he/she is responsible for, in order to contextualise the description of the initiatives. International data bases (Eurostat)\(^6\) and reports\(^7\) have been used for background information (population, GDP, obesity etc.) about the countries.

\(^6\) http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home
Country reports

SOUTH

CYPRUS

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

For Cyprus 2 initiatives were identified. We came in touch with the Ministry of Health, Cyprus Society of Cardiology, Cyprus Heart Foundation as well as the Cyprus Dietetic Association (CDA). The ministry of health responded that they are pretty confident there were no PPP activities in Cyprus as otherwise they would definitely be aware of it. On the other hand, the CDA re-assured us that they will send all relevant information which never happened even after repeated reminders. The Society of Cardiology although initially promised to follow up to our requests, they never did.

Information about one initiative in Cyprus was provided by Coca-Cola Hellas. The second initiative was found through internet searches.

The challenge in Cyprus was the unwillingness to co-operate. The institutions we approached were not really motivated to share information. Even though language was not a barrier, at some point snowballing methods were not effective any more. The size of the country may have played a role in this. The number of initiatives identified probably reflects the real picture in Cyprus and not broken communication channels.

1.2. Different types of PPPs

1.2.1. Best example cases

It might worth exploring in depth the FOOD PRO-FIT initiative and this might concern more than one partner countries in the project. The FOOD PRO-FIT project is concerned with developing what they call the Hazard Analysis Nutritional Critical Point (HANCP), a new self-evaluation tool including obesity-related nutritional criteria such as: total amount of fat, saturated fats, trans-unsaturated fatty acids, sodium (salt) and free sugars concentration. It has an original consortium composed from universities, ministries, private companies, public services and NGOs.

2. Country context

2.1. Background information

Population, total in 2010: 803 147
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 98
Unemployment rate, January 2010, %: 6.3
Healthy life years at birth, 2008, m/f: 64.5/65.1
Obesity rates among adults, 2008 (or nearest year available), %: 15.6
2.2. Overweight and obesity

Obesity rates for Cyprus come from published academic studies. The studies are scarce:

Lazarou et al. (2008)\(^8\) studied a sample of 1140 children (mean age 11 ± 0.98 years) and their parents (mean age 42.5 ± 5.8 years, total \(n = 1954\)). Overweight and obesity prevalence among girls was 18.3% and 2.9% respectively (according to IOTF criteria), while in boys, 19.0% and 6.0%. Among parents, OW/OB prevalence was, respectively, women, 22.6% and 5.8%; men, 47.1% and 14.1%.

Savva et al. (2005)\(^9\) studied a sample of 1412 children 2-6 years old and found that the prevalence of obesity (IOTF definition) was 1.3% in 2 year olds and 10.4% in 6 y olds. Overweight and obesity prevalence were higher in rural (16.1%) than urban children (12.8%).

Savva et al. (2001)\(^10\) studied a sample of 2467 children 6–17 years of age during October 1999 to June 2000. The prevalence of obesity in males (females) was 10.3% (9.1%) using the NHANES I definition and 6.9 (5.7%), respectively, using the IOTF definition. There were an additional 16.9% of males and 13.1% of females defined as overweight with the NHANES I definition and 18.8% and 17.0%, respectively, using the IOTF definition.

2.3. National policies on nutrition and obesity

2.3.1. The retail structure

Table 4 and Figure 4 exhibit retail value of grocery stores in Cyprus. For Cyprus it looks like the vast amount of sales goes through supermarkets, grocery retailers as well as food/drink/tobacco specialists. Hypermarket sales have been developing rapidly over the last 5 years while sales through kiosks and speciality stores have been declining constantly.

| Table 4. Retail value excluding sales taxes in current prices (in US$ mn, year on year exchange rates) |
|--------------------------------------------------|---|---|---|---|---|---|---|---|---|---|
| Cyprus                                           | 1999 | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 |
| Hypermarkets                                     | -    | -    | -    | -    | -    | 50.4 | 125  | 187.3| 203  | 205  |
| Supermarkets                                     | 231.9| 264.1| 276.2| 260.1| 309.3| 347.9| 364.3| 372.5| 372.2| 407.2| 399.4|
| Small Grocery Retailers                          | 247.5| 270.3| 294.9| 270.9| 305.9| 337.6| 354.1| 364.8| 331.5| 347.1| 316.3|
| Food/Drink/Tobacco Specialists                   | 112.7| 137.2| 153.2| 155.5| 188.1| 226.2| 271.3| 324.9| 311.9| 329  | 320.6|
| Other Grocery Retailers                          | 206  | 211.5| 206.7| 206.7| 192.6| 207.5| 217.9| 216.1| 210.6| 192.9| 182.8|
|                                                 |     |     |     |     |     |     |     |     |     |     | 169  |


Table 5 and Figure 5 show that foodservice values have been declining for restaurants but have been increasing for cafes/bars and fast foods. Other foodservice categories possess a low market share as compared to total foodservice value.
Table 6 and Figure 6 exhibit volume of consumption of soft drinks in Cyprus during the last decade. Volume sales for soft drinks and bottled water have increased during the last decade. Fruit and vegetable drinks have also increased but at a much lower pace. Functional drinks constitute the smallest portion of total volume sales. Tea/coffee volume sales have quadrupled their sales during the last decade but they still are a small part volume sales relative to soft drinks.

**Table 6.** Soft drinks total volumes (in mn litres)

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</thead>
<tbody>
<tr>
<td>Soft drinks</td>
<td>52.5</td>
<td>54.2</td>
<td>56.1</td>
<td>60.7</td>
<td>67.6</td>
<td>75</td>
<td>80.9</td>
<td>87</td>
<td>93.7</td>
<td>93.9</td>
<td>96.1</td>
<td>100.7</td>
<td>94.8</td>
</tr>
<tr>
<td>Fruit/vegetable drinks</td>
<td>8.7</td>
<td>9.1</td>
<td>9.6</td>
<td>10.8</td>
<td>12.1</td>
<td>13.3</td>
<td>14.4</td>
<td>15.5</td>
<td>16.8</td>
<td>16.6</td>
<td>16.9</td>
<td>17.8</td>
<td>16.3</td>
</tr>
<tr>
<td>Bottled water</td>
<td>10</td>
<td>10.6</td>
<td>11.3</td>
<td>14.1</td>
<td>19</td>
<td>24.3</td>
<td>29.2</td>
<td>33.8</td>
<td>38.7</td>
<td>41.1</td>
<td>43.2</td>
<td>46.5</td>
<td>42.3</td>
</tr>
<tr>
<td>Functional drinks</td>
<td>0</td>
<td>0</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
<td>0.1</td>
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<td>0.1</td>
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</tr>
<tr>
<td>Concentrates</td>
<td>0.6</td>
<td>0.6</td>
<td>0.7</td>
<td>0.7</td>
<td>0.8</td>
<td>0.8</td>
<td>0.8</td>
<td>0.9</td>
<td>0.9</td>
<td>0.9</td>
<td>0.8</td>
<td>0.9</td>
<td>1</td>
</tr>
<tr>
<td>Tea/Coffee</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.2</td>
<td>0.3</td>
<td>0.3</td>
<td>0.4</td>
<td>0.5</td>
<td>0.7</td>
<td>0.8</td>
</tr>
</tbody>
</table>
2.3.2. Health oriented non-governmental organizations (NGOs)

Cyprus Dietetic Association
Society of Cardiology
Medical and Nurses Associations
Cyprus Heart Foundation
Cyprus Medical Association

2.3.4. National nutrition policy and obesity

The National Nutrition Action Plan was finalized in 2005, and resulted in the Ministry of Health organizing several activities to motivate Cypriots to change to a much healthier lifestyle. Some of the activities organized to raise awareness of a healthy lifestyle were:

Healthy Children Programme, a preventive programme whose main components are education in general and in particular healthy nutrition and healthy nutritional habits;

Education of women from rural areas organized by the Ministry of Agriculture, involving lectures on nutritional issues to promote healthy nutrition in the family;

A community educational programme involving the preparation of recipes based on the Mediterranean diet pyramid;

An educational programme organized by the Ministry of Health and the Ministry of Education through which a healthy breakfast, composed of cereals and low-fat milk or a sandwich with brown bread and low-fat cheese and milk, is offered to students;

A decision jointly by the Ministry of Health and the Ministry of Education to change the types of food sold in school canteens, and legislation on food sold in canteens; and

A program inviting all people to gather in their neighborhood park for physical activities organized by the Ministry of Health.
As Cyprus has moved away from the traditional Mediterranean diet in the last 10 years, a programme for schools entitled “Mediterranean diet – back to our tradition” was recently launched. The principles of a healthy diet are taught, and children cook for their parents and invite them to taste the Mediterranean diet. Another initiative is “Five minutes for five fruits”, whereby once a week school lessons are interrupted for five minutes, during which the students eat fruit and discuss its benefits.

GREECE

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

For Greece 7 initiatives were identified. The primary methods of identifying initiatives were from personal contacts and snow-balling techniques. A nutritionist professor was initially contacted and provided contact information of people in the Coca-Cola company. Other personal contacts were used which brought us in touch with several organizations/companies like Nestle, Unilever, the branch of EPODE network in Greece, the Aristedes Daskalopoulos foundation, Nutritionist associations, the Hellenic Heart foundation, the Federation of Food and Drink industries in Greece (SEVT), ministry of Health, ministry of Education etc. Internet searches were utilized as well, mainly through Google where keywords such as ppp, public private partnerships, obesity, overweight, Greece were entered either in isolation or in combination, in Greek or in English.

The challenges were not as many as in other countries. However, some issues are worth mentioning: it seems like there is no public organization with central knowledge of initiatives or that these are not well-communicated or transparent to the public. In every case no-one was willing to share financial information about the activity or wasn’t aware what the other partners are contributing. In addition the term PPP (or even its long form public private partnerships) is almost absent from the Greek or English vocabulary (minor exception is the EPODE analogue in Greece, PAIDEIATROFI). Furthermore, while we were promised much more help in identifying PPP’s from our contacts it turned out that they were not as enthusiastic as we thought they were. After a while, and in consultation with the project leader, we decided to terminate our efforts of contacting them due to time constraints.

1.2. Different types of PPPs

1.2.1. Typical PPPs

A typical and good example of a PPP is PAIDEIATROFI which is the analogue of the obesity prevention programme EPODE implemented in 1991 in two cities in France. Currently it is implemented in 13 cities and is under the auspices of 3 ministries, about 10 associations/organizations/foundations and private companies (e.g. Carrefour, Nestle). It has a scientific committee of 7 academics or doctors. PAIDEIATROFI is an intervention program through educational tools. The partnership is evaluated for its effectiveness through BMI measurements of children during the first and last year of the program. Several process and output indicators will be produced.
Another typical PPP is the “Skeftomai kai Troo” (eat and think) developed with Nestle’s initiative. This is an educational program as well and is targeted at schools. It is under the auspices of the Hellenic Institute of Nutrition and the General Secretariat for Youth (Ministry of National Education & Religious Affairs). The structure of this initiative is similar to other initiatives that are supported by a public authority in the sense that the role of the public body is not concrete and/or it’s not clear whether the public body exerts any kind of control on the initiative. Our feeling tells us their role might be rather passive.

Similar with the above is the “Change tactic, be active” by Coca-Cola.

1.2.2. “Atypical” PPPs

“Atypical” PPPs might be specific to the initiatives taken from the Aristedes Daskalopoulos Foundation. The foundation typically takes several initiatives mainly educational in the form of building websites or organizing one-day events that aim in raising awareness about the importance of nutrition. Typically each event is under the auspices of some public body e.g. Panhellenic Association of Dieticians or the city of Athens (as stated before their role is not very clear). Even though all these activities seem to be separate and onetime events, the frequency by which these occur makes it look like it is a grand-educational initiative broken down to small pieces, which are not necessarily related, but ultimately aim in raising nutrition awareness.

1.2.3. Best example cases

The PAIDEIATROFI initiative seems promising in terms of final output given that it is an intervention project.

Additionally, we would prefer seeing how certain private bodies that are very active in taking such initiatives are evaluated in terms of final output. The Aristedes Daskalopoulos foundation seems like a prominent case study since it is constantly involved in small PPPs.

2. Country context

2.1. Background information

Population, total in 2010: 11.3 million  
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 93  
Unemployment rate, January 2010, %: 11.1  
Healthy life years at birth, 2008, m/f: 65.4/65.8  
Obesity rates among adults, 2008 (or nearest year available), %: 18.1

2.2. Overweight and obesity

Tambalis et al. (2010)\textsuperscript{11} report data from an epidemiological survey that examined 11-year trends (1997–2007) in underweight, overweight, and obesity in Greek children. Population data derived from a yearly, school-based health survey carried out between 1997 and 2007 in

>80% of all Greek schools. Height and weight measurements from 651,582 children, aged 8–9 years (boys: 51.2%) were analyzed. The prevalence of overweight rose between 1997 and 2007 from 20.2 ± 0.2% to 26.7 ± 0.2% for girls and from 19.6 ± 0.2% to 26.5 ± 0.2% for boys (P < 0.001).

Vardavas et al. (2009) examined 502 farmers (18–79 years old) from Crete. 42.9% had a BMI of 25.1–30 kg/m² and were overweight and 43.2% were obese with a BMI > 30 kg/m².

Georgiadis and Nassis (2007) report on a 1991 data collection from 6448 students (50.4% boys, 49.6% girls) 6-17 years old. The overall prevalence of overweight was 17.3% (16.9% for boys, 17.6% for girls). The rate of obesity was 3.6% (3.8% for boys, 3.3% for girls).

Manios et al. (2007) report results from a study of 2374 children (1218 males and 1156 females) aged 1–5 years carried out from April 2003 to July 2004. The prevalence by the CDC method of at risk of overweight and overweight was 16.3 and 16% in boys and 16.2 and 15.5% in girls, respectively. The prevalence by the IOTF method of at risk of overweight and overweight was 12.9 and 6.2% in boys and 15.5 and 8.1% in girls, respectively.

Kapantais et al. (2006) report data from an epidemiological, cross-sectional nationwide survey providing self-reported data. A total of 17,341 men and women aged from 20 to 70 years and classified into five 10-year age groups participated. The overall prevalence of obesity was 22.5% (26% in men, 18.2% in women) while that of overweight was 35.2% (41.1% in men, 29.9% in women). Abdominal obesity was more frequent among women than men (35.8% vs. 26.6% respectively), especially after the age of 50.

Mazokopakis et al. (2004) collected data from 274 men of a Greek warship, aged between 19 and 38 years. 26.5% of participants were classified as overweight and 4.7% as obese.

Karayiannis et al. (2003) report data from a nationwide study of 4299 students, 51.3% girls and 48.7% boys. Self-reported weight and height data were used. 9.1% of girls and 21.7% of boys were classified as overweight, and 1.2% of girls and 2.5% of boys as obese (according to IOTF). Corresponding values using CDC growth charts were 8.1% of girls and 18.8% of boys for overweight, and 1.7% of girls and 5.8% of boys for obese.

2.3. National policies on nutrition and obesity

2.3.1. The retail structure

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Table 1 and Figure 1 exhibit retail values of grocery stores in Greece. As evident sales through supermarkets and food/drink/tobacco specialists increased through years while sales through small grocery retailers has decreased. Hypermarket sales are increasing but their sales are still a small portion of the overall sales of the grocery stores. A big portion of sales goes through “other” grocery stores which includes kiosks and regional speciality stores.

**Table 1. Retail value excluding sales taxes in current prices (in € mn)**

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<th>1999</th>
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<tr>
<td>Hypermarkets</td>
<td>250</td>
<td>300</td>
<td>450</td>
<td>500</td>
<td>625</td>
<td>650.3</td>
<td>792.6</td>
<td>820.2</td>
<td>855.5</td>
<td>872.7</td>
<td>829.2</td>
</tr>
<tr>
<td>Supermarkets</td>
<td>3991.4</td>
<td>4590</td>
<td>5320.8</td>
<td>6032.3</td>
<td>6819.6</td>
<td>7697.3</td>
<td>8665.6</td>
<td>9531.1</td>
<td>9914.3</td>
<td>10164.1</td>
<td>9973</td>
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<tr>
<td>Small Grocery</td>
<td>3105.7</td>
<td>3093.7</td>
<td>3141.5</td>
<td>3131.7</td>
<td>3076.7</td>
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</tr>
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<td>Retailers</td>
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<tr>
<td>Food/Drink/To</td>
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<tr>
<td>bacco Specialists</td>
<td>2321.5</td>
<td>2451.6</td>
<td>2683.1</td>
<td>2900.6</td>
<td>3148.8</td>
<td>3577</td>
<td>4164.4</td>
<td>4352.1</td>
<td>4515.6</td>
<td>4566.6</td>
<td>4664.4</td>
</tr>
<tr>
<td>Other Grocery</td>
<td>2956.3</td>
<td>3787</td>
<td>4461.3</td>
<td>4740.2</td>
<td>5116.7</td>
<td>5421.4</td>
<td>5742.4</td>
<td>6140.7</td>
<td>6700.1</td>
<td>6989.6</td>
<td>7076.3</td>
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<tr>
<td>Retailers</td>
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</tbody>
</table>

**Figure 1. Retail value excluding sales taxes in current prices (in € mn)**

Table 2 and Figure 2 show that Cafe/bars and full service restaurants exhibit the highest market size, albeit this market size decreased slightly in 2008 and 2009. Market size of fast food restaurants remained relatively stable over the last decade. Delivery/takeaway, self-service cafes as well as kiosks exhibit a similar stable trend over the decade. Their market size is relatively small compared to the other categories.
Table 2. Foodservice value in current prices (in € mn)

<table>
<thead>
<tr>
<th>Greece</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery/Takeaway</td>
<td>281.9</td>
<td>289.6</td>
<td>313.2</td>
<td>331.3</td>
<td>350.3</td>
<td>376.2</td>
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<td>398.4</td>
<td>410.2</td>
<td>443.5</td>
<td>457.6</td>
</tr>
<tr>
<td>Cafes/Bars</td>
<td>5189.8</td>
<td>5303.1</td>
<td>5370.8</td>
<td>5319.9</td>
<td>5426.3</td>
<td>5523.6</td>
<td>5603.4</td>
<td>5691.5</td>
<td>5721</td>
<td>5500</td>
<td>4739.1</td>
</tr>
<tr>
<td>Full service</td>
<td>4368.1</td>
<td>4471.3</td>
<td>4616.1</td>
<td>4672.9</td>
<td>4898.1</td>
<td>5142.7</td>
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<td>5440.1</td>
<td>5580</td>
<td>5070.2</td>
<td>4321.1</td>
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<td></td>
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<td></td>
<td></td>
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<tr>
<td>Fast Food</td>
<td>1194.3</td>
<td>1232.7</td>
<td>1258.7</td>
<td>1301.8</td>
<td>1351.3</td>
<td>1382</td>
<td>1406.1</td>
<td>1458.3</td>
<td>1524.8</td>
<td>1486</td>
<td></td>
</tr>
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<td>Self service</td>
<td>1.4</td>
<td>1.7</td>
<td>4.7</td>
<td>5.3</td>
<td>6</td>
<td>7.4</td>
<td>8.3</td>
<td>8.8</td>
<td>11.5</td>
<td>15.5</td>
<td>18.5</td>
</tr>
<tr>
<td>cafes</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Kiosks</td>
<td>28.9</td>
<td>29</td>
<td>29.4</td>
<td>31.5</td>
<td>32.4</td>
<td>33.7</td>
<td>35.2</td>
<td>35.9</td>
<td>36.9</td>
<td>39.9</td>
<td>38.7</td>
</tr>
</tbody>
</table>

Figure 2. Foodservice value in current prices (in € mn)

Table 3 and Figure 3 exhibit volume of consumption of soft drinks in Greece during the last decade. Volume sales for soft drinks and bottled water have increased during the last decade while fruit/vegetable drinks have only increased slightly. Functional drinks constitute the smallest portion of total volume sales although their volume has gone up six times relative to 1997. Tea/coffee volume sales have doubled their sales during the last decade but they still are a small part volume sales relative to soft drinks.
Table 3. Soft drinks total volumes (in mn litres)

<table>
<thead>
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<tbody>
<tr>
<td>Soft drinks</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Fruit/vegetable drinks</td>
<td>122.4</td>
<td>125.1</td>
<td>128.7</td>
<td>133.9</td>
<td>135.6</td>
<td>137.2</td>
<td>139.8</td>
<td>144.1</td>
<td>150.3</td>
<td>155.9</td>
<td>161.7</td>
<td>169.7</td>
<td>177.5</td>
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<tr>
<td>Bottled water</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional drinks</td>
<td>120.3</td>
<td>123.8</td>
<td>126.8</td>
<td>129.3</td>
<td>131.7</td>
<td>135.8</td>
<td>140.0</td>
<td>148.3</td>
<td>154.9</td>
<td>159.0</td>
<td>162.6</td>
<td>167.1</td>
<td>165.1</td>
</tr>
<tr>
<td>Concentrates</td>
<td>387.0</td>
<td>399.1</td>
<td>427.5</td>
<td>465.1</td>
<td>490.4</td>
<td>496.2</td>
<td>518.7</td>
<td>546.3</td>
<td>610.4</td>
<td>665.7</td>
<td>726.4</td>
<td>802.5</td>
<td>884.1</td>
</tr>
<tr>
<td>Tea/Coffee</td>
<td>1.3</td>
<td>2.7</td>
<td>3.2</td>
<td>3.7</td>
<td>4.0</td>
<td>4.4</td>
<td>4.9</td>
<td>5.4</td>
<td>5.9</td>
<td>6.4</td>
<td>6.7</td>
<td>7.4</td>
<td>7.8</td>
</tr>
</tbody>
</table>

Figure 3. Soft drinks total volumes (in mn litres)

2.3.2. Health oriented non-governmental organizations (NGOs)

Heart Foundation (member of the European Heart Network)
Nutritionist Associations (3)
Medical Association for Obesity (and many other medical associations e.g. Diabetes association, Cardiological society)

2.3.4. National nutritional policy and obesity

In 2002, the Supreme Scientific Health Council of the Ministry of Health and Social Welfare launched the Dietary guidelines for adults in Greece. In the same year, the Ministry of Health
and Social Welfare established the National Nutrition Policy Committee. The Committee set priorities and the following initial goals:

- to reduce the consumption of meat;
- to increase the consumption of fish;
- to reduce childhood obesity;
- to reduce the consumption of pulses and vegetables;
- to improve the quality and safety of food provided through mass catering services and increase consumer awareness of food quality and safety.

The Committee consists of five subcommittees, one for each of the above-mentioned issues. The final reports have been compiled and unified into an action plan.

In March 2006, the Committee submitted its proposals for the development of a European Green Paper on the promotion of healthy diet and physical activity and the prevention of overweight, obesity and other chronic diseases.

In the context of addressing the issue of childhood obesity, the Committee has also developed an action plan for the implementation of national nutrition guidelines in schools. Furthermore, dietary recommendations have been formulated for nursery schools and summer camps. The establishment of national obesity clinics and research centers is also under way with the aim of providing free medical and dietetic care to patients who require specialist help and support. Regarding Primary Education, the National Foundation for Youth and the Ministry of Education has published two manuals for school based health promotion activities in this field: (a) Nutrition and Dietary Habits and (b) Physical Activity and Health Indices. Both of these manuals aim to provide a bases and guidance for activities in these thematic areas and promote the adoption of a healthier way of leaving among children and their families.

In 2010 a National Committee for the promotion of Mediterranean-Greek diet was established. The mission of the committee is to make policy suggestions for the continuous and long-term promotion of the Greek diet as a mean to:

- Improve the health of the Greek population, focusing at fighting childhood obesity.
- Highlight and support the identity of the local recipes and markets throughout Greece.
- Support the farmers and Greek families with the strengthening, among others, of agrotourism.
- Reinforce the Greek identity abroad.
- Develop the ecological consciousness in terms of agricultural production and nutrition.
- Inform and encourage the shift of the young consumers and producers to healthier and traditional Greek food products.

Responsible for carrying out nutritional policies:

Greece reported having an advisory body with a written responsibility for providing scientific advice to policy-makers. It was established in 1992 and then reorganized in 1997, but only in 1999 was the emphasis on nutrition. In 1998/99 it was stated that the Hellenic Food Authority was going to organize collaboration between parties involved in nutritional issues. In 1994/95 it was reported that the National Centre for Nutrition was

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responsible for collection of dietary data and for providing information to relevant policy-makers. However, in 1998/99 it was stated that this was the responsibility of the medical school of the University of Athens. In 1994/1995 it was stated that the Ministry of Health and Ministry of Commerce was responsible for the nutrition education of the public. In 1998/1999 this was a shared responsibility between the Directorate for Health Education, the Ministry of Health, the Ministry of Education and the Hellenic Food Authority. Ministries collaborated when it was necessary, but the Hellenic Food Authority was expected to undertake the coordination of regular intersectoral consultations between different governmental, private or voluntary sectors. Currently the Hellenic Food authority and the Ministry of Health are responsible for carrying out nutritional policies.

ITALY

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

We collected the information from the web. The most important pages that we visited are the Italian Ministry of Health website, National Center for Prevention and control of Diseases, and other nongovernmental pages like obesita.org. Search words are related with the obesity term, including, “obesity program”, “partnership obesity”, “health and obesity”, etc. In Italy we found nine PPPs to mitigate the obesity problem. These programs are the following: “DIAMOCI UNA MOSSA: New lifestyles for children and families”, “PROGETTO OBESITÁ PIEMONTE: Informational-educational intervention aimed at subjects with obesity”, “DAI PESO AL PESO”, “GUADAGNARE SALUTE: Making healthier choices easier”, “OKKIO ALLA SALUTE: Health promotion and healthy growth in children of primary school”, “PUBBLICITÀ CHE INGRASSA: Altoconsumo against childhood obesity”, “EBP E OBESITÀ: Effective Prevention Programs”, “MANGIA BENE CRESCI MEGLIO: Awareness campaign on importance of a healthy and proper diet” and “FRUTTA NELLE SCUOLE”.

We found that it is more common the treatment of the childhood obesity problem. For this reason most of the programs are focused on the objective to control and reduce childhood obesity and its activities are developed around this.

1.2. Different types of PPPs

We found that in this country the PPP initiatives are from different points. There are initiatives from the Ministry of Health in collaboration with other ministries like the Ministry of Education or Agriculture, but we also found some initiatives from Medical and Nutritionist Centers or Sport Centers like Union of Italian Sports for all (UISP). Some programs are implemented in schools, this is the case of “OKKIO ALLA SALUTE”. In this program collaborates the National Center for Epidemiology, Surveillance and Health Promotion (CNESPS) and the Institute of Health (ISS) assisted by the Regional Education for Lazio which handles relations and communications with the regional education offices and schools. Additionally, we found that there are a close relation between local, regional and national institutions. We saw that the most important objective is focused in childhood obesity. Moreover, we found that there are some initiatives with similar activities and objectives like
“DIAMOCI UNA MOSSA” whose objective is to promote physical activity and create chances for family’s lifestyle to mitigate obesity problem. “OKKIO ALLA SALUTE” has the objective to teach how healthy eating and physical activity helps to control obesity in children, for this reason this program is linked with primary schools. Other program based on healthy eating is “FRUTTA NELLE SCUOLE”, this program has the objective to increase fruit consumption on schools, the program provides the distribution of seasonal fruit and vegetables in over 5,000 primary schools around Italy. On the other hand, “PROGETTO OBESITÀ PIEMONTE” is concerned more specifically in adults aged between 20 and 70 years with weight problems. It is important to note that despite of childhood obesity is an important problem, adult obesity is important too; for this reason it is important the existence of programs like this concerned about adults problems and which try to reduce it. The strategy of “GUADAGNARE SALUTE” is focused on the main risk factors and identifying four areas: promotion of healthy eating behavior, tobacco control, fight against alcohol abuse and promotion of physical activity. This program is very interesting because is concerned about tobacco and alcohol consumption habits and tries to fight the problem of obesity through them.

Although we did not find specific results, because most of the programs have not been evaluated yet, we emphasize the preliminary experiences of the following programs: "DIAMOCI UNA MOSSA": because the response of children and adults has been very encouraging when evaluating the results, derived from a comparison of questionnaires at the beginning and end of the project, it is confirmed the change in lifestyle and eating habits.

“PROGETTO OBESITÀ PIEMONTE”: Until now it has been implemented in 6 local Health Authorities of Piedmont. The methodology used was effective in the medium term: the persistence of good results at 12 months when “not only is not observed, a return of the weight lost, if not that increasing the percentage of subjects with very positive results (loss = 5%) and effective cost-benefit.

“OKKIO ALLA SALUTE”: This program has yielded valuable information, at a limited cost and little time. The synergy between health care and education and the participation of families have led to the success of initiative. The frequency of data collection will allow to monitor the phenomenon and to evaluate the effectiveness of interventions over time.

2. Country context

2.1. Background information

Population, total in 2010: 60.3 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 104
Unemployment rate, January 2010, %: 8.3
Healthy life years at birth, 2007, m/f: 62.8/61.9
Obesity rates among adults, 2008 (or nearest year available), %: 9.9

The Italian territory is mainly made up by the Italian peninsula and two largest islands in the Mediterranean Sea, Sicily and Cerdeña. According to the ISTAT19 data published in December 2009, Italy is the fourth most populated country in Europe. Its population was

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19 Istituto nazionale di statistica.
around 60,340,328 habitants. The distribution of the population presents significant differences between North and South. The concentration of the Italian population in urban areas (69% of urban population) has generated a homogeneous network of large cities, which play the role of regional centers with two nationally prominent focuses: Rome (2,718,768 hab.), the political capital, and Milan (1,299,633 hab.), the economic capital. The unemployment rate of this country, according to ISTAT data is around 8.3% in September 2010.

2.2. Overweight and obesity

The most popular food of Italy is pizza, pasta and risotto, but Italian food is included within the Mediterranean gastronomy. It’s characterized by a high consumption of vegetable products (like fruits, vegetables, etc.); bread and other cereals; olive oil and wine in moderate amounts. Despite of this, the number of people who have weight problems has been increasing over the years. Last data from ISTAT showed that in year 2005, the 44% of Italian population between 18 and 100 years were overweight. If we breakdown this percentage, we find that in Italy 53% of adult men have overweight; this percentage is lower in female case whose rate it’s 35.70%. The pre-obese population was 42.50% in adult men and 26.60% in women; this make a total of 34.20%. If we analyze obese data, we find that the 9.80% of Italian population have obesity problems, this percentage is greater in male population (10.50%) than in female population (9.10%). Moreover, we found data collected between year 1993 and 2001 about children between 5 and 17 years. Observing these data, it shows that in Italy, 26.6% of boys and 24.8% of girls are overweight.

2.3. National policies on nutrition and obesity

If we observe information about evolution of eating habits in Italy in the last ten years, we found an increase on fast food consumption. Moreover, the frequency to visit full service restaurants, although was always high; in last ten years has also a significant increase. On the other hand, if we observe consumption habits, we saw that there are an increase on bottled water and soft drinks, which are the most consumed. This increase is lower if we talk about fruits and vegetables or coffee and tea.

The Global Strategy on Diet, Physical Activity and Health Worlwide recognizes that no transmissible diseases have grown quickly and eating habits and physical inactivity are among the main causes of these diseases. The high consumption of high energy food, poor in nutrient but high in sugar and salt, is identified as a risk factor. In this context, the role of marketing, advertising, sponsorships and promotions is emphasized. For this reason the Global Strategy diet recommends to economic operators to “practice marketing in a responsible manner to support the Strategy, especially when it comes to promotion and marketing foods rich in saturated fats, trans fats, sugars and salt, against to children.” Moreover, the European Chapter on Counteracting Obesity includes in its framework for action, "the adoption of rules designed to substantially reduce the scope and impact of commercial promotion of foods and high energy drinks, especially to children, through an international focus, such as the adoption of a code on advertising to children in this area".

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20 Information from World Health Organization (WHO), available in: http://apps.who.int/bmi/index.jsp
The Proposal for an International Code of Marketing of food children and soft drinks gives the following recommendations:

- The importance of limiting the promotion of foods and beverages high in energy, poor in nutrients and high in fat, sugar or salt to children and the need to allow the marketing of food in accordance with OMS dietary recommendations.
- The public health imperative to ensure the protection of all children.
- The importance of addressing the Code and consider all existing and potential forms and techniques of marketing promotion to the same extent.

2.3.1. Socio-economic reasons for obesity

According to Italian Ministry of Health, physical activity and healthy eating habits help to prevent obesity problems. We must give special attention to childhood obesity which is favored by the reduction of movement and a growing interest in TV, video games and computer.

According with Banterle and Cavaliere (2009) analysis, socio-demographic, economic and cultural variables affect the obesity grow rate. Their results shown that, people with a low level of education are more susceptible to have obesity and overweight problems. Moreover, the study also shows that older people have a greater probability to suffer this problem. Every day people spend more time watching TV or in front of a computer and lower doing any physical activity. For this reason there are a negative relation between physical activity and Body Mass Index (BMI) too. Below we summarize the main PPPs found.

MALTA

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

For Malta 1 initiative was identified.

In Malta we initially came in touch with the Department for Health Promotion and International Health of the Ministry of Health. The department acknowledged that they are not aware of any PPPs in Malta. We also contacted the editor in chief of Journal of the Malta College of Pharmacy Practice as well as several individuals of Maltese nationality working for the WHO. Some of the contacts did not respond albeit we made several attempts to get in touch with them, while other showed initial interest on our project but were later uninterested/unwilling to provide further information.

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Although our mapping of PPPs in this country was not fruitful, our information searches led to information for a PPP mapping project running by WHO which we shared with the project leader.

Internet searches were also utilized and this is how we eventually tracked down the mapped initiative. Several attempts were made to get more information about the initiative albeit with no success.

1.2. Different types of PPPs

Since only 1 PPP was identified, there are no criteria to classify typical and “atypical” cases.

2. Country context

2.1. Background information

Population, total in 2010: 412,970
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 81
Unemployment rate, January 2010, %: 7.0
Healthy life years at birth, 2008, m/f: 68.7/71.9
Obesity rates among adults, 2008 (or nearest year available), %: 22.3

2.2. Overweight and obesity

Obesity rates for Malta were very difficult to gather, due to the fact that there are not many official reports or published academic studies on that subject.

The size of the obesity problem in Malta is probably one of the biggest in Europe. According to WHO’s projections for 2010 concerning the obesity rates of the European countries, Malta is ranked second for male individuals over 15 years of age (28.15% obese) and first for women of the same age (36.5% obese).24

According to the first national health interview survey conducted by the Health Promotion Unit of the Department for Health Promotion and Disease in 2003, with a sample of 3866 individuals of age 16-100 years old, 25% of males were classified as obese while for females the corresponding percentage was 21.3%.25

The National Statistics Office conducted in 2007 the Lifestyle Survey of Malta. The results of this study revealed the same pattern as the prevalence of obesity was found to be 22.2% for males and 19.3% for females26

Smalls bits of information were found in other published studies:

• The prevalence of overweight (pre-obese+ obese) and obese youth in Malta are 25.4% and 7.9% respectively.\(^\text{27}\)

• Overweight prevalence rates for children (7-11 years old) are estimated at 35%.\(^\text{28}\)

• Obesity prevalence rates are estimated at 35% for women and 22% for men.\(^\text{29}\)

2.3. National policies on nutrition and obesity

2.3.1. The retail structure

Table 10 and Figure 10 exhibit retail value of grocery stores in Malta. Hypermarkets and other grocery retailers are completely absent for the market probably reflecting the small size of the country. The predominant value of sales goes through supermarkets. Small grocery retailers contribute with half of what supermarkets contribute in the total value of sales and food/drink/tobacco specialists with about one fourth.

**Table 10.** Retail value excluding sales taxes in current prices (in US$ mn, year on year exchange rates)

<table>
<thead>
<tr>
<th>Malta</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypermarkets</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Supermarkets</td>
<td>199.1</td>
<td>188.7</td>
<td>172.9</td>
<td>185.2</td>
<td>211.1</td>
<td>247.5</td>
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<td>262.6</td>
<td>264.8</td>
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<td>277.4</td>
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<tr>
<td>Small Grocery</td>
<td>100</td>
<td>92.8</td>
<td>89.6</td>
<td>94.2</td>
<td>103.6</td>
<td>119.7</td>
<td>108.5</td>
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<td>133.9</td>
<td>132.9</td>
<td>134.2</td>
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<td>Retailers</td>
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<td>52.9</td>
<td>52.3</td>
<td>55.7</td>
<td>61.3</td>
<td>62.4</td>
<td>56.9</td>
<td>55.9</td>
<td>53.2</td>
<td>52</td>
</tr>
<tr>
<td>Food/Drink/Tobacco Specialists</td>
<td>0.7</td>
<td>0.7</td>
<td>0.5</td>
<td>0.6</td>
<td>0.6</td>
<td>0.7</td>
<td>0.7</td>
<td>0.7</td>
<td>0.7</td>
<td>0.6</td>
<td>0.6</td>
</tr>
</tbody>
</table>


Table 11 and Figure 11 show that foodservice values have been slightly increasing for restaurants, cafes/bars and fast foods in Malta. Other foodservice categories possess a low market share as compared to total foodservice value.

Table 11. Foodservice value in current prices (in US$ mn, year on year exchange rates)

<table>
<thead>
<tr>
<th>Malta</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery/</td>
<td>3.4</td>
<td>3.3</td>
<td>3.2</td>
<td>3.9</td>
<td>4.5</td>
<td>5.2</td>
<td>5.6</td>
<td>6</td>
<td>6.3</td>
<td>6.8</td>
<td>7.3</td>
</tr>
<tr>
<td>Takeaway</td>
<td></td>
<td></td>
<td></td>
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Table 12 and Figure 12 show that volume of consumption of soft drinks and bottled water for Malta have been constantly increasing for the last decade. Volume sales for fruit/vegetable and functional drinks have also increased while concentrate drinks have remained relatively stable.

Table 12. Soft drinks total volumes (in mn litres)

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<tr>
<td>Bottled water</td>
<td>8.3</td>
<td>8.5</td>
<td>8.9</td>
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<td>11.1</td>
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<td>Concentrates</td>
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<tr>
<td>Tea/Coffee</td>
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</tbody>
</table>
2.3.2. Health oriented non-governmental organizations (NGOs)

Medical Associations
Maltese Cardiac Society (member of the European Society of Cardiology)
Maltese Diabetes Association
Malta Exercise Health and Fitness Association

2.3.4. National nutritional policy and obesity

The participants at the First Conference on Nutrition in Malta, held in August 1986, reviewed available data on the food and health situation in Malta and concluded that the prevalence of noncommunicable diseases was high and that the dietary habits of the Maltese population needed to be improved.

The participants at the Second Conference, held in October 1988, made even stronger recommendations for the improvement of the nutritional status of the population, and highlighted the need for political support for action in the field of food and nutrition.

The Food and Nutrition Policy was adopted by Parliament in the 1990s and was followed by several campaigns between 1992 and 2002 to implement aspects of the Policy. A breastfeeding policy (2000) and a committee for breastfeeding were established and guidelines on a Mediterranean diet for Malta were published.

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**Figure 12.** Soft drinks total volumes (in mn litres)

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The projects and initiatives undertaken to prevent overweight and obesity in Malta are mainly carried out by the health sector through its Department of Health Promotion (http://www.sahha.gov.mt/pages.aspx?page=26). The department regularly organizes activities in collaboration with partners, such as other government entities and the private sector, with the aim of encouraging the general public to adopt a healthy diet and a more physically active lifestyle.

These activities are carried out as part of health campaigns such as “5-a-Day”, “The Mediterranean Diet”, “Cancer Prevention”, “Move for Health Day” and “World Health Day”. Publications produced by the Department of Health Promotion are then distributed and available to the public all year round. Such efforts are given prominence by the media through press conferences, press releases, interviews, radio and television talk shows, and articles in local newspapers and magazines.

Interventions on healthy eating and the promotion of regular physical activity are carried out at the request of schools and local councils. In May 2006, the walking buses concept was launched as a pilot project at a local school.

The Taskforce for Appropriate School Nutrition Environments is currently working to draw up a national policy for a healthy school nutrition environment. The main aim will be to call on schools and communities to recognize the health and educational benefits of healthy eating and the importance of making it a priority in every school.

Tackling obesity is one of the areas for action that has been included in Malta’s draft National Strategy for Sustainable Development. As part of this area of action, a national weight-reduction program is offered free of charge to the public and aims to help overweight individuals lose weight safely and manage their weight. In addition, the Department of Health Promotion offers a free service of group therapy sessions to people with eating disorders, facilitated by a psychotherapist.

An interministerial committee is in the process of being set up for the finalization and implementation of the revised National Environment and Health Action Plan, to include child-specific actions (2006–2010). The goals of WHO’s Children’s Environment and Health Action Plan for Europe (CEHAPE) to prevent injuries and create supportive environments relating to overweight and obesity form the basis for this process.

A transport and environmental committee has been set up to promote safe transport, including the promotion of physical exercise such as walking or cycling to school. This committee is represented by the Malta Transport Authority, Malta Environment and Planning Authority and the Ministry of Health.

In addition, there is a health representative on the Malta Environment and Planning Authority Board of Directors, which enables the health department to have a voice and express concerns about health issues, such as the inclusion of safe recreational spaces during urban planning. To achieve a more coordinated approach, a proposal for a multisectoral committee is under consideration.

Responsible for carrying out nutritional policies:
In 1994/1995 it was reported that the Nutrition Unit of the Ministry of Health was responsible for the implementation of the nutrition policy, whereas in 1998/1999 it was stated that the National Advisory committee on food and nutrition had become non-functional. In 1999 the Health Promotion Department advised on nutrition policy matters. The Health Promotion Department acted as an advisory body for policy-makers and was established in 1992. The Government covered the budget.

**PORTUGAL**

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

We have collected information from internet, especially from websites, including the Ministry of Health, Ministry of Education, the Newspaper “Público”, and Faculty of Human Kinetics (FMH). The most important words used in the search are related with obesity, and these are: “obesity program”, “partnership obesity”, “health and obesity”, etc.

In Portugal, we found ten programs to mitigate obesity. These PPP are the following: “National Program to Combat Obesity”, “Program to Combat Childhood Obesity in the Region of Algarve”, “PESSOA Program: Exercise and Health Promotion in Sedentary lifestyle, Obesity and Anorexia”, “PESO Program: Promoting Health and Exercise in Obesity”, “Platform Against Obesity”, “XXI Generation Project: Born and Raised in the Beginning of the Millennium”, “ACORDA: Obese Teens and Children Under the Diet and Physical Activity”, “JEEP Program: Youth in Exercise for Loose Weight”, “Educational Project ‘Healthy Lifestyles’” and “Sports Candy Campaign: Lazy Town (Vila Moleza)”.

It’s interesting to note that, although the PPs deal with the obesity issue in general, most of them are focused on prevention of childhood and youth obesity. For this reason, some of them are implemented on schools and others have physical activities to attract attention of children and young people.

1.2. Different types of PPPs

Much of the PPP initiatives come from the Ministries of Health, Education and others, in lesser extent from the Ministries of Economy and Agriculture, in collaboration with some University’s and schools like Algarb University, University of Porto or Secondary School of Algarve. Moreover, other associations such as Portuguese Society of Endocrinology, diabetes and Metabolism; National Association of Municipalities and other civil associations participate in the programs to mitigate this problem. In addition, there exists a collaboration of companies like Nestlé and Danone in “PESO Program” whose objective is to promote the physical activity, reduction of calories in food, etc.

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Observing the information above, we find that there exists a close relation between public and private sector to control the obesity problem in this country. Inside all of these PPP initiatives we find common objectives and similar activities to be developed in order to reduce obesity. In this sense, PPPs like “National Program to Combat Obesity”, “Platform Against Obesity” or “ACORDA Program” are most popular because they are focused on promoting physical activity and adoption of healthy eating habits. They try to achieve these objectives creating activity groups and try to show consumption and sport habits to reduce the number of obese and overweight people.

On the other hand, we found some programs with some different objectives. Although all the programs dealt with obesity problem, we found that “PESSOA Program” also is concerned with youth anorexia and for this reason it develops a model to prevent obesity and anorexia in Oeiras schools. “PESO Program” has also some differences too. This program tries to investigate the relationship between exercise, nutrition and health. It’s focused on women between 25-50 years apparently healthy and without menopause symptoms and who are overweight or obese. “Sports Candy Campaign” is a little bit different too. Its objectives are also related with the promotion of eating more fruit and vegetables and practice more exercise but its methods are a little bit different.

At the moment, we don’t have a lot of information about the results of these initiatives. However, we found three initiatives with a fair amount of information, and apparently their results have been good. For example:

1. “Program to Combat Childhood Obesity in the Region of Algarve”: This program increases consumption of fish and vegetables in school menus.
2. “XXI Generation Project: Born and Raised in the Beginning of the Millennium”: This program collects a lot of information useful to know the importance of pregnancy on subsequent development and health status of children.
3. “Sports Candy Campaign”: This program has been a great success. Thousands of children participate in the program and have increased their fruit and vegetables consumption.

2. Country context

2.1. Background information

Population, total in 2010: 10.6 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 80
Unemployment rate, January 2010, %: 10.4
Healthy life years at birth, 2008, m/f: 59.0/57.2
Obesity rates among adults, 2008 (or nearest year available), %: 15.4%

Portugal is a country located in southwestern of Europe, on the Iberian Peninsula, bounded on the East and North by Spain and the south and west by Atlantic Ocean. Taking into account the last data known, Portugal has about 10.680.258 habitants, and the population growth is very low about 0,3% per year. The distribution of the population presents significant differences between North and South, and between coast and inland. The Northern coast has significantly higher population densities than rest of the country. Regions like Lisboa and Oporto have about 600hab/km² while others like Branganza have 3hab/km². As many other countries, Portugal is also going through a tough crisis, which has even questioned at some
point the country’s creditworthiness. However, its unemployment rate is not the highest, in August 2010 stood at 10.7% level.

2.2. Overweight and obesity

According to data collected by the International Obesity Taskforce (IOTF) about Portugal of adult people between 2003 and 2005, the rate of overweight males is 45.2% and for obese males is around 15%, which together amount to a 60.2% of the male population with weight problems. In females, the rate is somehow lower, being 34.4% of them overweight and 13.4% obese,, which covers a total of 47.8% of female population. We also find in this database data about childhood obesity. These data show that in the population segment between 7 and 9 years the 29.5% of boys are overweight. This number is even higher for girls whose overweight rate is 34.3%.32

2.3. National policies on nutrition and obesity

Due to this location, Portugal has an Atlantic diet like the North of Spain. This diet is based on large consumption of meat, eggs, milk and vegetables. Moreover is also characterized by a very high consumption of fish (sea and river) and selfish (mollusks and crustaceans). In general we would say that is a healthy diet but, in the case of Portugal, the observed data show otherwise because its overweight and obese population rate is worrisome. If we look at consumption data, we observe that in the last twelve years, in this country has increased the consumption of soft drinks, bottled water and tea/coffee. Moreover, although it seems inconsistent with obesity data, we find that in last twelve years there are a significant increase in consumption of fruit and vegetables. According to the National Program to Combat Obesity from Ministry of Health of Portugal (2005); in the Portuguese population with more than 55 years the prevalence of overweight and obesity is higher, respectively, 1.9 and 7.2 times.

Moreover, we also have information about the evolution of food services from 1999 onwards. We observe a big increment on the frequency of eating at fast food restaurants in last ten years. On the contrary, eating at regular restaurants has remained at the same level more or less over the years.

The obesity problem carries many costs to society in this country so it’s a societal problem because it affects half the population. It is estimated that in Portugal, direct costs (prevention, diagnosis, treatment, rehabilitation, research) from obesity are about 3.5% of total health costs33. For this reason we find a close relation between nongovernmental organization, private sector and public organizations.

2.3.1. Socio-economic reasons for obesity

According to the National Program to Combat Obesity from Ministry of Health of Portugal (2005); the Portuguese population with lower education levels presents greater obesity problems. Therefore the prevalence of obesity is a problem more pronounced in the lower social classes. Also there are regional disparities in the prevalence of pre-obesity and obesity stages, being worst in the north and central area of the country, where it reaches the higher

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32 Information from International Association for the Study of Obesity (IASO), available in: http://www.iotf.org/database/index.asp
33 Programa Nacional de Combate à Obesidade: Direcção Geral da Saúde, 2005
prevalence of pre-obesity, and in Alentejo and Setúbal, where the highest prevalence of obesity is found.

Moreover, according to the National Program to Combat Obesity abovementioned there are more aspects which have influence on the obesity levels. Some of these aspects are the following: According to a higher level of parental education has a lower prevalence of obesity; more hours of television, electronic games or computer games increase obesity level and more urban area of residence also helps the prevalence of obesity. The pre-obesity and obesity are thus related with a positive energy balance, resulting from an excess intake in relation to spending. In addition, physical activity is important too. If we divide Portuguese population between people who don’t practice any physical activity and people who practice any sport at least 3.5 hours per week, we found that more of half of the population doesn’t practice regularly any physical activity and this contributes to the overweight and obesity trend. Also it's important to note that genetic factors also have influence because is frequent to see obese children whose parents are obese too. In female case, pregnancy and menopause can contribute to an increase in overweight stages.

**SPAIN**

1. **Overview of PPP initiatives**

1.1. **Assessment of accessibility of information on PPPs**

We found twelve PPP initiatives in Spain collecting information from various internet sources and newspapers. The visited websites for this search was among others the Ministry of Health, AESAN website, Ministry of Education’s website, the electronic newspaper “El País”, etc. For this search we use words like “obesity partnership”, “obesity initiatives”, “obesity Governance”, “obesity”, “obesity program”, “obesity strategy” and several similar concepts.

The PPP initiatives found are: **NAOS Strategy, PERSEO Program, THAO Children’s Health, Food: Fighting Obesity Through Offer and Demand, Moving Kids, ETIOBE: Comprehensive Care Program of Obesity in children and Adolescents, The Warrior of Health: The Adventure of Eating Well, EVASYON Project, MOVI DA VIDA (Physical Exercise Program For School), Learn to Grow Healthy with MAX, AMED: Mediterranean alimentation and The Food Pro-Fit European Project.**

Most of these programs are focused in children’s obesity. The reason of this is because a healthy diet and appropriate nutrition are important in all stages of life and particularly during the childhood because at this stage is where eating habits are acquired.

1.2. **Different types of PPPs**

Most of the PPPs are from Ministry of Health and Ministry of Education which focus on the problem on children and youth. These Ministries collaborate with regional governments of Spain, European Commission and other associations or foundations like AESAN or
Mediterranean Diet Foundation among others. Moreover, there exists a collaboration agreement with the two main national commercial chains, the Association of Large National Distribution Company (ANGED) and the Association of Spanish Distributors and Supermarkets (ASEDAS). In some projects we can find University’s collaboration like University of Santiago de Compostela and University of Valencia among others, and collaboration of companies like Nestlé.

PPP initiatives that we can consider typical in Spain are: the NAOS Strategy, which involves the PERSEO Program; the THAO Children’s Health and Moving Kids. Its initiatives are especially related to the promotion of physical activity, increase consumption of fruits and vegetables, promote healthy kitchen and improve eating habits in general.

However, there are many other initiatives that may not be as common in all programs such as those mentioned above. Beyond the common objectives of all the initiatives found there are some more specific ones focused on parents and teachers for example, this is the case of The Warrior of Health: The Adventure of Eating Well. This is due to the fact that children’s education depends, in great amount, on them. The analysis of the genetic susceptibility and its interactions with the lifestyle and rate of biological parameters and lifestyles related to nutrition and metabolism are some objectives of the EVASYON Project. Despite of the increase in obesity, in recent years this cannot be attributed only to genetic factors although it plays an important role on obesity development too. Furthermore, MOVI DA VIDA Program deals with social aspects which are discussed such as building confidence, self esteem and image that we have of ourselves to mitigate obesity problem. Other important initiative is Learn to grow healthy with MAX. This initiative is based on a collection of stories that help children, educators and parents to raise awareness about the importance of preventing childhood obesity.

Analyzing the results of that we found on the PPP initiatives, we consider that the most successful initiatives are:

1. NAOS Strategy: Despite of results of these Strategy “may be known in 10 years,” we think that the impetus was a mobilizing strategy which has successfully encouraged healthy eating in the autonomous communities and enhance and promote the regular practice of physical activity among citizens” as said the President of the Spanish Agency for Food and Nutrition (AESAN).

2. Moving Kids: This program has been applied to 81 children and the results shown that 88.9% of children decreased his body mass index and percent body fat.

3. MOVI DA VIDA: After analyzing data from the first year the program concluded that the study has been effective in reducing the rate of overweight/obesity by 6% in girls and 2% in children.

2. Country context

2.1. Background information

Population, total in 2010: 46 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 103
Unemployment rate, January 2010, %: 19.1
Healthy life years at birth, 2008, m/f: 63.7/63.2
Obesity rates among adults, 2008 (or nearest year available), %: 14.9
Spain is a country located in Southern Europe. This country is the fourth largest country of the European continent after Russia, Ukraine and France. Its distribution throughout the territory is very irregular: the most densely populated areas are concentrated along the coast, Guadalquivir and Ebro valley and the metropolitan area of Madrid; while the rest of the interior is very weakly populated. According to latest official data published, its population is approximately of 46,951,532 habitants at January 2010. Actually, it is governed by the Socialist Party and goes through a tough economic situation characterized by an unemployment rate of about 20.9%.

2.2. Overweight and obesity

Traditionally, Spain has been characterized by taking a healthy living and eating styles. A sign of this is the Mediterranean and the Atlantic diet. Both are equally healthy, but they are characterized by a different pattern of consumption of products. The Mediterranean diet is characterized by a high consumption of vegetable products (like fruits, vegetables, etc.); bread and other cereals; olive oil and wine in moderate amounts. On the contrary, in the areas situated on the Atlantic Ocean a higher consumption of protein, especially red meat accompanied by a higher consumption of eggs, milk and vegetables is quite typical. However, we must emphasize that data of obesity in this country is more worrisome every day. In 2009, in the total adult population in this country, 16,17% of habitants were obese and 34,72% were overweight, this means that one of every two people had a weight greater than recommended (50,89%). Furthermore, and according to data from Ministry of Health and Consumption (Ministerio Sanidad y Consumo) MSC and the National Statistics Institute (INE), obesity in this country increases as age increases, reaching levels of 19,49% and 22,14% in men and women over 65 years. However, this doesn’t mean that childhood obesity data are more optimistic; in 2006, 7,04% of children had obesity and 14,64% overweight. For all these reasons, there is a great concern about the obesity problem, and as the result of these, numerous public policies and private projects are developed to try to mitigate this important health problem.

2.3. National policies on nutrition and obesity

In Spain, the obesity problem has been gradually becoming a social problem, in addition to being also an individual issue. This is because costs of this problem are higher than in the past. The Ministry of Health estimates that health costs arising from obesity exceed 2,500 million euro per year and represent approximately 7% of health spending.

In the last ten years, people from this country have increased the frequency of going out to eat, to fast food and full service restaurants. This fact shows how people spend less time into the kitchen mainly because the busier life implemented in recent years. Furthermore, in the last twelve years, consumption of soft drinks and bottled water have suffered a high magnification. Functional drinks consumption grew too, but in a minor quantity. On the opposite, consumption of fruit and vegetables although also has increased, this growth was much lower than experienced by other items.

Due to these reasons, the Ministry of Health has decided to conduct several policies and actions to try to mitigate the obesity problem through the Spanish Agency for Food Security

34 Data from Ministry of Health and National Institute of Statistics (INE).
and Nutrition (AESAN). In this sense, recently in 2010 it has been adopted a law from the AESAN. The law has defined an informational system of food security to provide the data exchange between professionals, researches and government departments. Moreover, it provides the creation of a Spanish Network Control Laboratory for Food Safety and some aspects to promote healthy eating habits and a ban of obesity discrimination and establish some criteria to minimize the content of trans fats and it does not permit the sale of food and drinks that fail to meet a number of nutritional criteria in schools.

2.3.1. Socio-economic reasons for obesity

According to the Ministry of Health, Spain has experienced a “nutrition transition”. Several changes in the diet, related with economic, social, demographic and health factors are responsible for that. The main causes of obesity are increased consumption of energy-dense foods and reduction in physical activity at work and during leisure time. But these aspects not only affect the adult population. Children and adolescents diet is characterized by an excess of meats, sausages, milky and energy-dense foods. All of this, coupled with the large time spend in front of the computer and game console, makes childhood obesity increase in alarming rates too.  

Conclusions from the Ministry of Health are according to studies about obesity in which it is explained that the increase of obese people is probably due to changes in lifestyle. A busy life, with a little time for physical activities and without a proper and healthy food are some of the trigger factors. Due to this concern, more and more the Ministry deasl with the obesity problem, and its rapid growth. Some studies show that socioeconomic disparities are significant in the probability of being obese. In this way, Costa-font and Gil (2008) showed that not only there are differences related with income levels in the probability of being obese but that there are other factor like education level and other demographic variables which have an important influence on such probability. Other studies are more worried by specific factors that contribute to the growth rate of obesity. This is the case of Loureiro’s and Nayga’s (2005) study. They determined that in OCDE countries, aspects like women’s participation in the workforce, high levels of income per capita and consumption of higher-calorie products have a significant influence on the occurrence of obesity in practically all countries.

References


Instituto Nacional de Estadística: http://www.ine.es/


Ministerio de Sanidad: http://www.msp.es/

CENTRAL AND EAST

AUSTRIA

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

Austrian websites do provide plenty of useful information. As a first step, the government ministries responsible for nutrition/health/food (and ultimately, obesity) related matters were identified. Their web pages were searched for any relevant initiatives, reports and organisations they have links with. Their web pages were also searched.

The search terms employed were “Übergewicht” (= overweight), “Adipositas” (= obesity), and, if this did not turn up anything, “Gewicht” (= weight).

The organisations/institutions searched were entered into a spreadsheet, with notes and contact details.

A particularly helpful website was that of Fonds Gesundes Österreich (FGÖ), a public sector organisation, which administers public funds, and whose primary role is to support health-oriented projects. It has six key priorities, two of which are exercise and nutrition. The organisation deals with those projects, which require funding above €10,000, and it funds between one and three thirds, rather than the entire project. This essentially means that all the projects listed on its project database are partnerships.

Several hundreds of projects are listed on this database (http://www.fgoe.org/projektforderung/gefoerderte-projekte/fgoe_project_search_form). The database is constantly updated. However, restricting the search to the three key search terms mentioned above proved too limiting in this case, because it did not pick up many potentially relevant projects. This meant that most of the project descriptions outlined in FGÖs online project list had to be read and assessed for potential suitability one-by-one.

1.2. Different types of PPPs

1.2.1. Typical PPPs

Initiatives, which seek to improve food consumed in a school setting, aimed at children aged 6-14, can be considered typical for the country. The same goes for company health initiatives, which are, however, often more aimed at improving employees’ health in general, rather than being particularly focused at obesity prevention, and hence we are not certain that these warrant inclusion.

One example of a company initiative is Leicht&Fit (later developed into Kantineetta). Its aim was to offer a healthier menu in the staff canteens of the Austrian Federal Railways (ÖBB). However, as with many other initiatives, it is questionable whether this initiative is suitable, as there is no private company involvement.

An interesting comment made by one of the people involved in the X-Team initiative was that big companies (Adidas, Nike) had declined to get involved in their initiative as
supporters/sponsors, giving the reason that Austria was too small, and they preferred to
sponsor projects in Germany or Switzerland. Furthermore, the informant said that “if you’re
not in Vienna, you don’t stand a chance of getting sponsorship”.

NGOs and professional organisations/groups of professionals were found to engage in
potentially suitable projects. For example, the not-for-profit organisation SIPCAN (Special
Institute for Preventative Cardiology and Nutrition, http://www.sipcan.at), runs a number
of school-based projects, which can be considered typical PPPs. SIPCAN was founded in 2005,
and its aim is health promotion and the prevention of chronic diseases caused by lifestyle
factors. The prevention of diabetes, obesity, metabolic disease and CVD are its core
objectives. It is worth noting that it only employs 2.5 members of permanent staff, although it
does employ experts/specialists on a contract basis to help implement and run its projects.

All of SIPCAN’s projects are PPPs, as they involve private sector partners, such as beverage
companies and retailers. Examples are Schuljause mit Vorrang, Schlau Trinken, and
Gesund essen an Wiener Schulen. Refer to the Appendix for details about these projects,
which also feature some potential points of conflict between the stakeholders. For SIPCAN’s
school projects, obesity and malnutrition prevention are primary aims, alongside optimising
concentration and scholastic performance. The dietary guidelines established by
Forschungsinstitut für Kinderernährung (Research Institute of Child Nutrition) Dortmund
(Germany) are employed.

<table>
<thead>
<tr>
<th>School/day care facility legal requirement changes creates new opportunities for PPPs</th>
</tr>
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<tbody>
<tr>
<td>It was and still is very common in Germany and Austria for school children to return home after curriculum classes finish around 1pm. (Some may return to school for afternoon classes.) This means that lunches are mainly eaten at home and that many schools did/do not provide catering beyond snacks and sandwiches. This situation is now starting to change, however, with the introduction of more Ganztagsschulen (“whole day schools”).</td>
</tr>
<tr>
<td>In Austria in 2006, legal requirements were put into place, which made it mandatory for schools to provide facilities and staff to supervise children in the afternoons, instead of sending them home after classes had finished. According to this new regulation, if more than 15 pupils need afternoon supervision, the school must provide this. This created a need to look at the quality of food provision in schools, prompting the emergence of PPPs, such as “Gesundes Schulessen – einfach genial, genial einfach” in Salzburg.</td>
</tr>
</tbody>
</table>

Also, there are a number of initiatives, whose status as to whether they are suitable for
inclusion in this study or not, is uncertain, because although there are many partners involved,
they mostly come from the public sector, consisting of local authorities/cities and hospitals.
Sometimes, professional organisations are also involved, which may qualify them for inclusion. Examples are VorsorgeAktiv and Rund(um) g’sund (FEM).
1.2.2. “Atypical” PPPs

None of the projects found were strikingly “atypical”, but, as already touched upon above, there are a number of projects, which, although they are partnerships, whose partners are drawn exclusively from the public sector. Examples are Rund um fit und gesund and Schlank ohne Diät.

It needs to be established whether, in the final phase, we actually want to include projects, which do not involve a private sector player as part of the partnership.

1.2.3. Best example cases

Most of SIPCAN’s school-centred projects initiatives are suitable. As mentioned above, they have involvement from partners from all three corners of the PPP triangle. SIPCAN projects are the first ones listed in the Appendix.

One of SIPCAN’s core objectives is to make their projects transferable, so that they can effortlessly be rolled out across all interested schools/educational institutions, rather than being specifically tailored to one. An interesting comment made by SIPCAN in an interview was that, although they had little trouble getting funding for new pilot projects, they experienced considerable difficulty raising funds for larger-scale roll-outs, even if the pilot projects had proven very successful.

2. Country context

2.1. Background information

Population, total in 2010: 8.4 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 124
Unemployment rate, January 2010, %: 4.5
Healthy life years at birth, 2008, m/f: 58.0/59.5
Obesity rates among adults, 2008 (or nearest year available), %: 12.4

2.2. Overweight and obesity

Statistik Austria (http://www.statistik.at) collects national statistics. Statistics pertaining to BMI, overweight and obesity in Austria were published in the „Österreichische Gesundheitsbefragung 2006/07“ (= Austrian Health Survey). The pdfs/excel spreadsheets with the data can be downloaded from this link http://www.statistik.at/web_de/statistiken/gesundheit/gesundheitsdeterminanten/bmi_body_mass_index/index.html

In summary, in Austria, 44% of men and 55% of women are of normal weight (using the WHO’s BMI parameters). More than half of the male population are overweight (43%) or obese (12%). Fewer women are overweight (29%), but the share of obese women is slightly higher than in men (13%). This means that 860,000 Austrians over 15 years of age are obese in Austria, 400,000 men and 460,000 women.

2.3. National policies on nutrition and obesity
2.3.1. Societal Organisation: Austria’s Social Partnership model

The following information pertaining to Austria’s societal organisation has largely been taken from Eurofound, a tripartite EU agency which provides expertise on industrial relations as well as living and working conditions in Europe. (http://www.eurofound.europa.eu)

By international standards, Austria is considered to be a country, in which corporatist structures are most highly developed. Austria refers to its brand of corporatism as a “social partnership”. This entails that the three main economic groups – industry, agriculture and labour – are officially represented through four mutually recognised organisations: the chambers of commerce, agriculture and labour and the Austrian Trade Union Federation (ÖGB), and that decisions are reached by negotiation and mutual consensus.

The collaboration between state and the social partners is an important connecting link between industrial relations and government policy. It provides the means of attuning collective bargaining to national economic and social policy and, conversely, opens up all aspects of that policy to possible influence by the social partners.

In accordance with the structure of the Austrian state, a distinction is made between the Federal Government and the individual Länder, with most social and economic policy issues falling within the purview of the Federal Government's legislative powers. Accordingly, the focus of social partnership lies at Federal Government level, although its importance at individual Land level has increased in recent years. The influence of the social partners on public policy is formally institutionalized in a wide range of corporatist councils and committees.

In addition to this formal aspect, there are the informal discussions which take place at central level between representatives of government and the social partners. In cases where the social partners, in this context, are able to present a united front on a given issue, their influence amounts to far more than just consultation; their joint position usually becomes the guideline for government policy. In addition to tripartite concertation, the social partners have individual opportunities to influence government opinion, through their right to be consulted on all matters affecting their members. Compared with other structures of interest representation, the social partners are accorded a de facto privileged voice in social and economic policy. As a result, in order to gain support for their particular interests organizations outside the social partnership system have to direct their lobbying at the social partners rather than at the government.

2.3.2. Market structure and trends in Retail and Consumer Foodservice

According to Euromonitor International data, supermarkets is still the dominant channel in Austria, claiming almost 40% of grocery retail value rsp sales in 2009. Discounters, however, are the fastest-growing, with their value sales having more than doubled over the 1999-2009 period. Small grocery retailers are in decline. This picture/trend is fairly consistent with what is going on in the rest of Europe. Unlike in Germany, Austria's supermarket channel is not in decline, but has been growing moderately at an average rate of just over 3% annually over the past decade. Also in line with the rest of the region, Austrian consumers are looking to keep their spending on grocery products low and are increasingly drawn towards convenience options. (Euromonitor International 2010)
As elsewhere, supermarkets are trying to convey a responsible image. For instance, Billa, Austria’s largest supermarket chain (owned by the German Rewe Group), introduced the Billa Eat Card, which is meant to tell the shopper, by virtue of comparing food labels with the Billa Eat Card, which amounts of sugar, fat and sodium contained in foods are to be considered “high”, “medium” and “low”. It is worth noting that the colour scale used on the card is dark green for “high”, medium green for “medium” and light green for “low”. In effect, this turns the traffic light labelling concept on its head, telling the consumer that nothing is “bad”.

Euromonitor International data also shows that among consumer foodservice channels, burger fast food grew most dynamically over the 1999-2009 period, increasing its value sales by 75%. Overall fast food grew by 46%.

In the soft drinks sector (off-trade and on-trade sales combined), although volume sales of carbonates declined slightly between 1997 and 2009 (by 5%), those of functional drinks (sports drinks & energy drinks) rose by 168%, and ready-to-drink tea, which is just as sugary as carbonates, by 95%. A possibly positive trend is that regular cola carbonates declined by 17%, while those of low calorie collar carbonates increased by 34%. Also, bottled water sales increased by 54%. Total volume sales of carbonates and bottled water, however, were fairly similar in 2009, at 616.5 million litres and 671.3 million litres, respectively.

There currently are no regulatory advertising restrictions in place, which, for instance, limit the advertising of foods high in sugar/fat/salt to children.

2.3.3. National Obesity Policy and its development

From interviews, it emerged that obesity in Austria (just like in Germany) is still very much viewed as a personal problem and an individual’s responsibility to tackle, however, it appears that the concept of the “obesogenic” environment is starting to gain acceptance.

The Federal Health Ministry (http://www.bmg.gv.at) has widespread responsibilities in the field of health. Relevant areas of responsibility [pertaining to overweight and obesity] include Health Promotion and Prevention, Non-Communicable Diseases, as well as Food and Consumer Safety. For a full list of the Ministry’s areas of responsibility, see http://www.bmg.gv.at/cms/site/bereich.html?channel=CH0518

In 1997, the Austrian Federal Ministry for Education, Arts and Culture issued guidelines for school catering companies, which state that high sugar foods and beverages should not feature amongst their offerings. Instead, the Ministry called for the inclusion of wholegrain products, milk drinks, mineral water, yoghurt, seasonal fruit, hot soups and mueslis, and recommends organic products (BMUK 1997).

In 2002, The Ministry of Agriculture published a report entitled Austrian Strategy for Sustainable Development. This report may be considered a first step towards a national obesity policy, as it recognised the prevalence of obesity among lower socioeconomic groups, and highlighted the importance of targeting them (Kuipers 2010).
In **2006**, the Austrian Obesity Society (Österreichische Adipositas Gesellschaft) (an NGO) produced the country’s “first obesity report”, a 354-page document, written in both German and English (all in the same document) and available here: [http://www.adipositas-austria.org/](http://www.adipositas-austria.org/)

This report was also financed and/or otherwise supported by a health insurance company (WGKK = Wiener Gebietskrankenkasse), Pfizer, Sanofi Aventis (pharmaceutical companies) and the Federal Ministry for Health and Women – so this report in itself could be considered a PPP effort.

Two years later, Austria’s Federal Health Ministry produced the **2008 Austrian Diet Report**. It concluded that there was much room for improvement in the national diet. 42% of Austrian adults were classed as overweight, and 11% as obese. Men and people over 40 years of age are most affected. Among children and teenagers, 19% are overweight, and 6% obese. Obesity has increased since 2003, despite calorie consumption having stayed the same, so energy expenditure must have decreased to cause a rise in obesity.

Some of the report’s conclusions are:

- Too much as well as the wrong types of fats are being consumed. Although there is a decline in saturated fat consumption, intakes remain too high. The reason for this is too much meat and meat products.
- Children consume too much sugar.
- Not enough fruit and vegetables are being consumed, nor enough potatoes, it seems.
- The most popular beverage is drinking water, energy-rich beverages only play a minor role.
- Alcohol consumption levels are “tolerable”, but a source of empty calories: overweight individuals were found to consumer more alcohol than those of normal weight.

In January 2010, the Austrian Ministry of Health published a draft document, entitled **National Diet Actionplan** (Nationaler Aktionsplan Ernährung). This action plan underwent a public consultation stage which ended in April 2010, inviting feedback from all stakeholders. The final National Diet Action Plan is due to be published at the end of 2010.

The core aim of the action plan is a reversal of, or at least curbing the increase, Austria’s obesity rates, in particular among children and teenagers.

Reference is made to EU and WHO reports/papers/objectives in terms of tackling obesity, and the Austrian Diet Actionplan is based on this work.

Page 29 of the document includes the following suggestions:

- **Reformulation of frequently consumed foodstuffs** (reduction of fat, saturated fats, trans fats, salt and added sugar)
- **Improved dialogue with the food industry** and the provision of specialist expertise for small manufacturers
- **Creation of incentives** through quality assurance schemes and accreditation/labelling schemes
- **Strengthening of cooperation and/or strategic collaboration** with farmers, food and beverage industries. → This could potentially create an impetus for PPPs
It will be interesting to see whether the “reformulation” suggestion, in particular, survives the consultation stage.

2.3.4. Socioeconomic reasons for obesity in the Country

There is a general trend observed across Europe and other highly developed countries where there is notably higher obesity prevalence among lower socioeconomic groups, and groups with an immigration background are particularly affected. The reasons for this are widely discussed in the literature, and do not appear to differ in Austria from those of other Western European countries. Population segments with an immigration background are a particular focus in some of the initiatives identified, e.g. Rund(um) g’sund.

References


http://www.bmukk.gv.at/ministerium/rs/1997_53.xml

http://www.eurofound.europa.eu/emire/AUSTRIA/ANCHOR-SOZIALPARTNERSCHAFT-AT.htm


BULGARIA

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

For Bulgaria 2 initiatives were identified. Initial internet searches were not very fruitful due to language barriers. Several associations and institutions were identified through official English documents36 but internet searches did not allow us to locate websites, emails or telephones (probably due to these being in Bulgarian). Fortunately, our contacts in Coca-cola in Greece provided us with information about initiatives of Coca-cola Bulgaria since the Greek branch is responsible for these initiatives as well. All our attempts, however, to contact Coca-cola Bulgaria were unsuccessful. Contacts were also provided for the Nestle branch but did not respond either even after repeated reminders.

The initiatives provided by Coca-cola provided details about institutions that participated in the organized initiatives. We therefore found information and contacted the National Center

for Public Health Protection (which is under the Ministry of Health) and the State Agency for Youth and Sports. Although we were able to establish contacts they never responded back to our requests. Language was a problem in communicating with these organizations as well. Apparently, the person that could speak English was always absent. After repeated calls we were promised to be sent all the relevant material which never happened even though we repeatedly sent reminders. Other contacts, through universities, academics didn’t work either.

1.2. Different types of PPPs

The lack of many PPP examples from Bulgaria can be attributed either to the failure of establishing communication channels with organizations and institutions in Bulgaria or to the real absence of such initiatives. In any case we cannot claim either and is therefore hard to qualify a PPP as a typical example when only two of them were identified.

2. Country context

2.1. Background information

Population, total in 2010: 7.6 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2008: 44
Unemployment rate, January 2010, %: 9.0
Healthy life years at birth, 2008, m/f: 61.9/65.5
Obesity rates among adults, 2008 (or nearest year available), %: 11.5

2.2. Overweight and obesity

For Bulgaria very few studies exist with respect to reports on adult BMI. The most recent published estimates are from Ivanova et al. (2008)\(^{37}\) which studied 1006 adults (453 males and 553 females) in a survey of 2004-2006 and found that for adults 30–60 years of age, 35.1% were overweight and 6.2% were obese. The proportion of overweight and obesity was higher among men than women (44.8% vs. 32.4% and 6.0% v. 4.7%, respectively).

2.3. National policies on nutrition and obesity

2.3.1. The retail structure

Table 7 and Figure 7 exhibit retail value of grocery stores in Bulgaria. For Bulgaria the retail structure looks more traditional since the vast amount of sales goes through small grocery retailers as well as food/drink/tobacco specialists. Hypermarket and supermarket sales have been slowly increasing.

| Table 7. Retail value excluding sales taxes in current prices (in BGN mn) |
|-------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Bulgaria                | 1999  | 2000  | 2001  | 2002  | 2003  | 2004  | 2005  | 2006  | 2007  | 2008  | 2009  |
| Hyper-markets           |       |       |       |       |       |       |       |       |       |       |
| -                       | 27.7  | 59.8  | 92.1  | 109.4 | 158.2 | 206.1 | 291.7 | 314.2 | 376.3 | 412.8 |
| Super-markets           | 110.3 | 163   | 326   | 419   | 506.4 | 601.2 | 689.2 | 847.4 | 1039.4| 1264.9| 1330.4|

Table 8 and Figure 8 show that foodservice values have been increasing for restaurants and cafes/bars albeit more steeply for restaurants. Foodservice values for cafes/bars less than doubled during the last decade while it almost quadrupled for restaurants. Other foodservice categories possess a low market share as compared to total foodservice value.

Table 8. Foodservice value in current prices  (in BGN mn)

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery/Take away</td>
<td>5.9</td>
<td>6.1</td>
<td>6.6</td>
<td>7</td>
<td>7.1</td>
<td>7.4</td>
<td>7.9</td>
<td>10.2</td>
<td>17.5</td>
<td>24</td>
<td>28.4</td>
</tr>
<tr>
<td>Cafes/Bars</td>
<td>592.3</td>
<td>625.3</td>
<td>714.1</td>
<td>774.3</td>
<td>733.8</td>
<td>752.7</td>
<td>778.3</td>
<td>828.6</td>
<td>875.2</td>
<td>1013</td>
<td>1096.7</td>
</tr>
<tr>
<td>Full service restaurants</td>
<td>580.5</td>
<td>625</td>
<td>763.9</td>
<td>844.9</td>
<td>1048.3</td>
<td>1157.5</td>
<td>1199.4</td>
<td>1287.7</td>
<td>1620.2</td>
<td>1956.6</td>
<td>2046.6</td>
</tr>
<tr>
<td>Fast Food Self service cafes</td>
<td>98.8</td>
<td>107.8</td>
<td>124.3</td>
<td>126.1</td>
<td>135.4</td>
<td>150.7</td>
<td>153</td>
<td>172.5</td>
<td>198.3</td>
<td>248</td>
<td>267.8</td>
</tr>
<tr>
<td>Kiosks</td>
<td>186.8</td>
<td>201.8</td>
<td>205</td>
<td>209</td>
<td>214.9</td>
<td>219.5</td>
<td>223.6</td>
<td>232.7</td>
<td>242</td>
<td>276.4</td>
<td>291.2</td>
</tr>
<tr>
<td>Other Grocery Retailers</td>
<td>223.8</td>
<td>263.6</td>
<td>283.8</td>
<td>282.5</td>
<td>275.5</td>
<td>269.2</td>
<td>254.7</td>
<td>251.7</td>
<td>248.3</td>
<td>252.2</td>
<td>257.6</td>
</tr>
<tr>
<td>Small Grocery Retailers</td>
<td>2431.8</td>
<td>2780</td>
<td>2830.6</td>
<td>2852.3</td>
<td>2923.5</td>
<td>2955</td>
<td>3040.3</td>
<td>3120.1</td>
<td>3076.5</td>
<td>2980.6</td>
<td>2911.7</td>
</tr>
<tr>
<td>Food/Drink/Tobacco Specialists</td>
<td>568.9</td>
<td>731.2</td>
<td>774.2</td>
<td>797.6</td>
<td>832.2</td>
<td>874.1</td>
<td>918.6</td>
<td>935.3</td>
<td>953.4</td>
<td>1085.4</td>
<td>1120.2</td>
</tr>
</tbody>
</table>

**Figure 7.** Retail value excluding sales taxes in current prices (in BGN mn)
Table 9 and Figure 9 exhibit a steep increase in volume sales for soft drinks and bottled water in Bulgaria. Soft drinks volume sales have tripled over the last decade while bottled water sales have gone six times up. Fruit and vegetable drinks have more than tripled during the last decade. Functional drinks and concentrate drinks constitute the smallest portion of total volume sales.

Table 9. Soft drinks total volumes (in mn litres)

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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Soft drinks</td>
<td>448.4</td>
<td>581.6</td>
<td>626.2</td>
<td>673.8</td>
<td>722.6</td>
<td>772.1</td>
<td>844.8</td>
<td>937</td>
<td>1034.1</td>
<td>1132.3</td>
<td>1253.4</td>
<td>1368</td>
<td>1342.4</td>
</tr>
<tr>
<td>Fruit/vegetable drinks</td>
<td>47.2</td>
<td>72.1</td>
<td>77.9</td>
<td>78</td>
<td>88.8</td>
<td>99</td>
<td>113.1</td>
<td>117.1</td>
<td>129.2</td>
<td>144.9</td>
<td>160.1</td>
<td>174.8</td>
<td>168.8</td>
</tr>
<tr>
<td>Bottled water</td>
<td>102.8</td>
<td>151.1</td>
<td>196.6</td>
<td>220</td>
<td>249.5</td>
<td>278.6</td>
<td>322.4</td>
<td>382.7</td>
<td>439.3</td>
<td>490.7</td>
<td>575.4</td>
<td>658.3</td>
<td>643.2</td>
</tr>
<tr>
<td>Functional drinks</td>
<td>-</td>
<td>-</td>
<td>0.3</td>
<td>0.6</td>
<td>1.2</td>
<td>2.2</td>
<td>2.7</td>
<td>3.1</td>
<td>3.9</td>
<td>4.5</td>
<td>5.3</td>
<td>6.4</td>
<td>5.9</td>
</tr>
<tr>
<td>Concentrates</td>
<td>5</td>
<td>5.4</td>
<td>4.5</td>
<td>4.6</td>
<td>3.1</td>
<td>2.7</td>
<td>2.6</td>
<td>2.5</td>
<td>2.4</td>
<td>2.3</td>
<td>2.1</td>
<td>1.9</td>
<td>1.8</td>
</tr>
<tr>
<td>Tea/Coffee</td>
<td>0</td>
<td>0</td>
<td>0.2</td>
<td>0.4</td>
<td>0.7</td>
<td>1.2</td>
<td>2.4</td>
<td>4.4</td>
<td>7.2</td>
<td>10.4</td>
<td>13</td>
<td>16.8</td>
<td>19.4</td>
</tr>
</tbody>
</table>
2.3.2. Health oriented non-governmental organizations (NGOs)

Bulgarian Association for Diabetes
Bulgarian Association for the Study of Obesity and Related Diseases
Bulgarian Society for Parenteral and Enteral Nutrition
Bulgarian Scientific Society for Nutrition and Dietetics

2.3.3. National nutritional policy and obesity

The National Food and Nutrition Action Plan (NFNAP) was launched in December 2004 and adopted by the Council of Ministers in August 2005. Its strategic goal is to improve the health of the Bulgarian population by improving nutrition and the reduction of the risk of food-borne and diet-related chronic diseases.

The action plan covers three strategic areas: nutrition, food safety and food security. It aims at a multi-sectoral approach involving the private sector and nongovernmental organizations, and includes activities addressing people of low socio-economic status. Other activities targeting overweight and obesity relate to the development of new standards for the nutritional content, labelling and marketing of foods, incentives to encourage the production and sale of healthier foods, and the training of health professionals.

The action plan describes a significant difference in the availability of food products depending on population income and a lower availability of the majority of foodstuffs in low income households, in households with 6 and more members, those with 3 and more children.
and households where the head is unemployed is established, comparing to the average availability per capita in the country.

Since 1997, six national surveys have been conducted on the diet and nutritional status of the population older than one year, as well as of specific risk groups. Special software was developed to monitor foods consumed and calculate intake of energy and nutrients at individual and population levels. The results of this survey have been used as a basis for the development of the above mentioned National Food and Nutrition Action Plan.

The national bodies, which are responsible for the nutrition and food policy in Bulgaria, are Ministry of Health, Ministry of Agriculture, National Center for Health Education, Regional Hygiene and Epidemiology Inspectorates.

**CZECH REPUBLIC**

1. Overview of PPP initiatives

Three PPPs, platform, action plan and campaign, have been identified.

2. Country context

2.1. Background information

Population, total in 2010: 10.5 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 82
Unemployment rate, January 2010, %: 7.7
Healthy life years at birth, 2008, m/f: 61.2/63.3
Obesity rates among adults, 2008 (or nearest year available), %: 17.1

2.2. Overweight and obesity

The prevalence of child overweight has increased among Czech children, but the rates of overweight and obesity among 4- to 18-year-old children is relatively low (13% in 2001) compared with Europe (19%).

Self-reported data among adults showed that 62% of men and 39% of women reported overweight and obesity in 2002.

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GERMANY

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

German institutions and organisations do tend to publish plenty of information online. As a first step, the government ministries responsible for nutrition/health/food (and ultimately, obesity) related matters were identified. Their web pages were searched for any relevant initiatives, reports and organisations they have links with. Their web pages were also searched.

The key search terms employed were “Übergewicht” (= overweight), “Adipositas” (= obesity), and, if this did not turn up anything, the more general term “Gewicht” (= weight).

The organisations/institutions searched were entered into a spreadsheet, with notes and contact details.

Because of so much activity across Germany and its 16 fairly independent Länder (federal states), the mapping was by no means comprehensive. Rather, the largest and most nationally significant PPPs were focused upon. Consequently, many smaller, local and possibly promising initiatives may have been omitted.

Predictably, most of the PPPs identified are targeted at young children in day care facility settings and primary schools.

1.2. Different types of PPPs

The key finding was that in Germany, unlike in most other European countries, a national platform designed specifically to foster PPPs aimed at preventing/reversing the obesity trend, exists. It is called “Platform für Ernährung und Bewegung“ (platform for diet and exercise), Peb for short.

Peb was founded in 2004, as a means of turning In Form (“the German national initiative to promote healthy diets and activity”, see section 2.3 for context) into reality.

In January 2004, the then Federal Minister for Consumer Affairs, Renate Künast, announced that the food industry would be forced to make obligatory payments into a Fund, which was going to finance public health campaigns aimed at improving the nation’s eating habits. As expected, there was much objection (particularly from industry quarters) to this proposal, and Peb constitutes the compromise that was subsequently reached (Foodwatch 2004).

Peb aims to halt the progression of obesity in children and teenagers [by 2010] and revert to 1990 levels [by 2020] by encouraging healthy eating and exercise through educational play. It considers diet and exercise to be of equal importance.

Peb claims to be Europe’s biggest network for the prevention of obesity in children and teenagers. It is designed as a “round table” for getting together the different stakeholders and facilitate the inception and collaboration of various initiatives.
Peb founding members include a number of prominent organisations on the PPP triangle, such as

- Federal Ministry of Food, Agriculture and Consumer Protection (BMELV)
- Bund für Lebensmittelrecht und Lebensmittelkunde (BLL) [A food industry organisation]
- Centrale Marketing-Gesellschaft der Deutschen Agrarwirtschaft [German Farmers’ Marketing Society]
- Deutsche Gesellschaft für Kinder- und Jugendmedizin [German Society for Child and Youth Medicine]
- Bundeselternrat (A parents’ organisation)

At present, over 100 organisations have signed up to Peb, including all the major food companies (Mars, Unilever, Nestle, Danone, Kraft, McDonald’s etc.). For the full, up-to-date list of members, see For full list of members, see http://www.ernaehrung-und-bewegung.de/mitglieder/

Several Peb projects serve as good examples of PPPs, and it is a requirement for all Peb projects to undergo an independent evaluation.

However, it is worth noting, that although Peb is a national initiative, only four Bundesländer (Northrhine-Westphalia, Bavaria, Lower Saxony and Saxony-Anhalt) have so far (Oct 2010) signed up to it.

1.2.1. Typical PPPs

Typical PPP initiatives are geared towards young children in day-care settings or at primary school. The general consensus is that it is better to prevent obesity in the early years than to treat it later on in life, and hence efforts have to be aimed at a young target group and their parents.

Gesunde Kitas – Starke Kinder (healthy daycare – strong children), which is a Peb project and TigerKids – Kindergarten Aktiv, are typical examples, as they are centred around dietary interventions, education and physical activities conducted in a daycare environment. (See appendix for these projects’ details).

1.2.2. “Atypical” PPPs

There were several initiatives, which, although not unusual in their targeting, had certain “atypical” aspects to them.

One example is PowerKids, a 12-week behavioural therapy programme aimed at children aged 8-12. It targets eating and lifestyle behaviour in the domestic setting, i.e. at home, rather than this taking place in institutions (schools, daycare centres), which is the usual venue. The programme has had 30,000 participants so far. Participants receive a PowerKids suitcase, which contains a range of materials, including DVDs with instructions and activities, booklets, diaries, etc. There is also a PowerKids website, which hosts three forums – one for children who are considering getting on board, one for enrolled participants and one for children who have completed the programme and which provides aftercare.
One possible drawback of this approach is that access, in practice, is limited to those children who have internet access at home, even though the programme has been set up so that it is, in theory, accessible to all. In order to benefit from the online support, which may be a crucial component for families and children to remain motivated and connected, computer access is needed. Therefore, there is the risk that most vulnerable of children from poorer homes may be excluded, or not get the full benefit. However, considering that the internet has become an integral part of many children’s lives, and this trend is still gathering strength, this type of PPP holds much future potential. After all, effective obesity prevention by means of lifestyle changes cannot be the sole responsibility of educational institutions, especially in countries like Germany (and Austria), where most children attend school only between 8am and 1pm, consuming all of their main meals at home.

Another “atypical” example is Peb & Pebber is an educational TV programme for young children and their parents. It has its critics, but because of its national coverage, it has a very large target audience. One could argue that, if TV advertising for unhealthy foods is apparently so successful, why should there be no benefit at all to promoting healthy lifestyle choices with an engaging children’s programme? This initiative is part of the Peb platform, has been and is being independently evaluated, so far with positive results. The third season started in spring 2010. See appendix for details.

The Peb platform is about to launch another initiative, called Junge Eltern, which will focus on the very early years, from 0-3 years, when important behavioural patterns are formed. Peb has recently completed an exploratory study in preparation of a pilot project, which is due to commence in the near future. An intervention targeted specifically at these very early years in a child’s development can be considered “Atypical” and promising, and hence it may be worth following up on the results once the pilot project has been completed (likely to happen sometime during 2011).

1.2.3. Best example cases

All the Peb projects have potential for being put forward as “best practice examples” and suitable for WP5. For example:

- **Regionen mit Peb:** (Part of the Peb platform.) The most important aspect of this project is getting local actors together in events/seminars/congresses/meetings with the intent of promoting national and local networking. Core targets for Regionen mit Peb are kindergartens, schools, parents, sports clubs and other actors in direct contact with children and communities.

- **Gesunde Kitas – Starke Kinder:** The project focuses on diet, exercise, relaxation and on establishing a “health dialogue” with parents. The pilot phase of the project commenced in June 2007 ended in July 2009 and involved 46 day care facilities in two Laender (Bavaria and North Rhine-Westphalia). See appendix for details.

2. Country context

2.1. Background information

Population, total in 2010: 81.8 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 116
Unemployment rate, January 2010, %: 7.3
Healthy life years at birth, 2008, m/f: 55.8/57.4
Obesity rates among adults, 2008 (or nearest year available), %: 13.6

2.2. Overweight and obesity

The Statistische Bundesamt Deutschland (http://www.destatis.de) collects German national statistics. They are an independent federal authority and part of the Ministry of the Interior.

According to a press release dated 02-06-2010 (available http://www.destatis.de/jetspeed/portal/cms/Sites/destatis/Internet/DE/Presse/pm/2010/06/PD10_194_239.psm.html), which quotes data from the Mikrozensus-Zusatzbefragung 2009 (Microcensus Supplementary Survey 2009), 51% of the adult population (60% of men and 43% of women) were overweight in Germany in 2009. In comparison with 1999, the share of overweight people has risen (men 56% and women 40% in 1999). The detailed report is downloadable from the publications service on https://www.ec.destatis.de/csp/shop/sfg/bpm.html.cms.cBroker.cls?cPath=structur,sfgsuchergebnis.csp&action=newsearch&op_EVASNr=startswith&search_EVASNr=239

Further official national statistics are available from Gesundheitsberichterstattung des Bundes (Federal Health Reporting) www.gbe-bund.de, which includes overweight/obesity statistics, including the graph below:

2.3. National policies on nutrition and obesity

2.3.1. Societal Organisation

In a 2003 paper, written by Unni Kjærnes, entitled “Food and nutrition policies of Nordic countries: how have they been developed and what evidence substantiates the development of these policies?”, published in the Proceedings of the Nutrition Society, and where different European systems are compared, Germany is described as a “corporatist” type of welfare state, “where the state is hesitant about market intervention, but where there is also a clear distinction between public and private responsibilities”.

Unni points out that in Germany, although professional recommendations [pertaining to nutrition policy] have been established, implementation is relegated to the very local level, and that the whole principle of a comprehensive nutrition policy has been neutralised on the basis of individual autonomy. So, far, my research concurs with her findings.

Early post-war policies still bear influence over societal organisation in Germany. At the end of the war, the allied forces sought to steer societal organisation away from its previous centralised, authoritarian structure and towards federalism. Family units were regarded as the ideal place for children to be brought up in, and the setting up of any form of permanent, communal catering was duly avoided (Thoms 2009).

This conservative family model led to the firm entrenchment of the half-time school system, which still prevails today. Children attend school in the mornings, and then return home for
lunch and homework. (Although, with a steadily rising number of households where all the adults are working full-time, daycare and after-school care facilities are available, which provide main meals to children).

So, unlike in other countries, like the UK, hot main meals are not generally served in German schools. This means that many PPPs successful in other European countries, which focus on school catering and food provision, are only partially applicable to a German setting.

2.3.2. Market structure and trends in Retail and Consumer Foodservice

According to Euromonitor International market research data, Germany’s food retail landscape is dominated by discounters (e.g. Aldi, Lidl). In 2009, 36% of grocery retail value sales (EUR168.7 billion in total) were accounted for by discounters. In 1999, it was 24%, and supermarkets dominated then with a 32% share.

Over the 1999-2009 decade, the discounter channel experienced the largest increase in value sales (79%), while those of independent small grocers declined by almost 30%. Supermarkets also declined, while hypermarkets, convenience and forecourt retailers managed to grow their sales. This pattern reveals two major underlying trends: On the one hand, people want to pay as little for their food as possible (growth of hypermarkets and discounters, decline of supermarkets, which have more premium-priced branded foods), but on the other hand, they are prepared to pay a bit more for convenience, as demonstrated by the growth of the forecourt retailer and convenience store channels. Food offerings in the latter two channels are heavily geared towards snacks, confectionery and soft drinks, i.e. anything that can be eaten on-the-go (e.g. during a car journey) and prepared very quickly at home (e.g. microwaveable food).

German shoppers tend to be very price conscious when it comes to buying groceries, and often resent paying more for branded products, which are commonly viewed as exactly the same as discounters’ own brand offerings. German consumers are often quite well informed about which discounter products are made by which brand manufacturers (there are books published on this, and they are popular). Because of widespread consumer awareness, the quality of private label products sold by German discounters is generally very high, although this does not necessarily extend to their nutritional content.

Although the overall consumer foodservice sector in Germany is in slow decline, the fastest growing channel (by value sales) over the 1999-2009 period was chicken fast food, which increased by a significant 244%. For comparison, burger fast food increased by 36%, and overall fast food by a fairly moderate 17%. Chicken fast food tends to be very popular among Muslim children and teenagers, who tend to avoid “conventional” fast food outlets, as pork products may also be served there. This tends not to be the case with fast food outlets specialising in chicken. Due to their low socioeconomic status, immigrant populations, such as Turkish Muslims, which constitute the largest ethnic minority group in Germany, are at much higher risk of developing obesity compared to the population average.

With regards to soft drinks in Germany, the sector, which showed the highest volume growth (off-trade and on-trade volumes combined) was functional drinks (energy drinks & sports drinks), registering an increase of 361% over the 1997-2009 period. This is a common trend, and a potential concern, seeing that sports drinks are positioned to convey the image of being active to a population which is physically fairly inactive. Overall soft drinks sales rose by
26%, those of bottled water by 49% and carbonates by 30%. Bottled water sales in 2009, at 11.1 billion litres, were higher than those of carbonates at 7.3 billion litres.

2.3.3. National Obesity Policy

A web search yielded a paper (of unclear authorship), which outlines Germany’s institutions of consumer policy, available on ec.europa.eu/consumers/overview/.../DE_web_country_profile_en.pdf. Although its core focus is on the much wider topic of consumer policy, this paper outlines the state organs involved in drawing up and implementing food & nutrition policy and summarises their relevant responsibilities:

- The Federal Ministry of Food, Agriculture and Consumer Protection (Bundesministerium für Ernährung, Landwirtschaft und Verbraucherschutz = BMELV) is responsible for consumer policy, consumer protection and general matters regarding consumer information. This includes consumer health protection (as well as protection from deception with regard to food), food and nutrition policies and dietary education. Most consumer rights and rules and regulations on the information and labelling requirements of suppliers, however, are laid down in laws for which other Federal Ministries are technically responsible.
- Federal Office of Consumer Protection and Food Safety (Bundesamt für Verbraucherschutz und Lebensmittelsicherheit = BVL) forms part of a network of European authorities to combat cross-border violations of consumer rights. The BVL is an independent higher federal authority within the purview of the Federal Ministry of Food, Agriculture and Consumer Protection.
- The Federal Institute for Risk Assessment (Bundesinstitut für Risikobewertung = BfR) is the scientific agency in Germany that draws up expert opinions and statements on issues relating to the safety of foods, substances (e.g. cosmetics) and products handled by consumers and informs about possible hazards. It is an independent body governed by public law within the purview of the Federal Ministry of Food, Agriculture and Consumer Protection.

Each of the 16 Federal States has its own bodies involved in food & nutrition policies set at that level.

The Bundeszentrale für Gesundheitliche Aufklärung BZgA (= Federal Centre for Health Education) is part of the Federal Health Ministry. Its task is to

- Draw up policies and educational programmes for practical health education and implement them
- Train professionals working in the field of health education
- Co-ordinate and strengthen national health education
- Collaboration with international partners

Although the tackling of obesity is not explicitly listed among the BZgA’s current three core health education objectives, it is implicit in its third point, “Promotion of children’s and youth health (healthy development, diet, exercise and mental health)”.

Current Obesity Policy and how it developed

The results of health reporting by the Federal Government, the German Health Survey 1998, the German Health Survey for Children and Adolescents 2006 (KiGGS) and the National
Food Consumption Study II 2007 showed that poor eating habits and inadequate physical activity are major problems in Germany.

In June 2008, The Bundesministerium für Ernährung, Landwirtschaft und Verbraucherschutz (BMELV) (= Federal Ministry of Food, Agriculture and Consumer Protection) signed off the National Action Plan for the Prevention of Unhealthy Eating, Lack of Exercise, Obesity and Related Diseases. (= Action plan Healthy Diet and Exercise). The report states that 66% of German men and 51% of women aged between 18 and 80, and 15% of children and adolescents aged 0-17 years are overweight or obese.

The Action Plan is aimed at all age groups, although the prevention of obesity in children and adolescents is a core focus. The national initiative borne from this Action Plan is called In Form.

In Form – “the German national initiative to promote healthy diets and activity” – is meant to supplement and build on existing national action plans and federal programmes to promote cross-topic and cross-stakeholder synergies.

The National Action Plan is meant to act on two levels:

- The bedrock of the National Action Plan consists of measures launched to achieve the common goals [of the Länder, communes and civil society]. They are to be coordinated by the Federal Government, Länder, communes and civil society in order to achieve structural improvements that help people to assume responsibility for a healthy lifestyle. Hence, there is a need for an orientation towards quality, target groups and the achievement of sustainability.

- A nationwide campaign will bundle the numerous activities on the topics of nutrition and physical activity and promote a healthier daily life. The campaign will draw on the engagement of the stakeholders but also fascination with the topic. After all food and physical activity are also pleasurable experiences and are closely linked to enjoyment, sharing experiences, discovery and learning.

The National Action Plan aims to sustainably improve the dietary habits and patterns of physical activity in Germany. It mentions two primary goals:

1. For adults to live healthier lives, for children to grow up more healthily and to enjoy a better quality of life as well as improved performance in education, professional and private life.
2. To reduce the diseases caused by an unhealthy lifestyle, a one-sided diet and a sedentary lifestyle.

The National Action plan focuses on five key action areas:

1. Public authorities serve as an example
2. Education and information about diet, physical activity and health
3. Physical activity in daily life
4. Improving the quality of away-from-home catering
5. Fresh impetus for research

Note: The National Action plan very much emphasizes the role of personal
responsibility: “The schemes for nutrition and physical activity education enable people to lead healthy lives and heighten their own sense of responsibility.”

By 2020 visible results are to be achieved. An interim report is expected in 2011.

According to an interview given by the German Obesity Society (Deutsche Adipositas Gesellschaft), in 2009, obesity research was turned into a core research focus by the German government, and the Kompetenznetz Adipositas (Obesity Competency Network, see www.kn-adipositas.de) was created with a budget of around €50 million.

2.3.4. Socio-economic reasons for obesity

The literature confirms the general trend observed across Europe and other highly developed countries where there is notably higher obesity prevalence among lower socioeconomic groups, and groups with an immigration background are particularly affected (BZgA 2005). The reasons for this are widely discussed in the literature, and do not appear to differ in Germany from those of other Western European countries.

Population segments with an immigration background are a particular focus of many of the initiatives identified, for example the “Gesund essen mit Freude” initiative (see attached).

References


Kjærnes, U (2003) Food and nutrition policies of Nordic countries: how have they been developed and what evidence substantiates the development of these policies? Proceedings of the Nutrition Society (2003), 62, 563–570 DOI:10.1079/PNS2003269


HUNGARY

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

In Hungary eleven PPP initiatives were identified. PPPs were explored via the internet with the help of the combination of more than 20 keywords: half of them reflected the form of partnerships (e.g. codes of conduct, choice editing, education, campaign etc.), the others were the variations of the expressions “obesity”, “health” or “food” (e.g. obesity, health, healthy lifestyle, healthy eating, energy intake, diet, healthy meal). Close to fifty relevant websites were found, but only a few of them introduced programmes proved to be PPPs. Additionally to the internet search eight expert interviews were conducted and resulted in the discovery of new programs. Finally only few cases matched the PPP criteria: those were elaborated in which partners were involved at least from two sectors (government, academia, business, NGO etc.) and which directly addressed obesity.

1.2. Different types of PPPs

The majority of the cases (6) were different kinds of education programs in Hungary. The second most popular kind of PPP was that of campaigns (4), and two complex programs with more than two components were also realised recently. On average six partner joined in a partnership, business being the most active sector. 31 business, 19 governmental, 9 civil organisations, only 5 professional organisations participated in the mapped initiatives. Surprisingly, the presence of academia (universities, research institution) is entirely missing.

1.2.1. Typical PPPs

The “Health Bag of the Think Healthily Programme” is directed towards the youngest generation. Its goal is to promote healthy lifestyle (holistic approach) and healthy eating as one subtopic. A bag with a 100 pages Think Healthily! book, product samples and other leaflets and publications distributed yearly since 2006 to parents of kindergarten kids (who just start going to kindergarten). 55 000 bags are distributed in 1600 kindergartens each year, reaching 180 000 families so far. Results are measured by feedback questionnaire: how did the pack impact the life of the family, have they known the products before. Think Healthily! book covers 11 topics – among others obesity and healthy eating is covered. The book is targeted to the parents and has a magazine style with celebrity interviews, articles, tips. The program was initiated by the Gondolkodj Egészségesen! Alapítvány (Think Healthily Foundation), and year by year several business organisations join, mostly these provide funding for the program, as companies pay for adverts (educational PR article style) in the book and product placement in the bag. Civil society organisations with relevant messages may join free of charge (for example in 2010 the Association of Conscious Consumers joined by promoting eating seasonal and local vegetables). This is a typical example of how good intention, societal goals and ethically doubtful business purposes meet. The advertisement of children is a serious and ethically loaded question, which has a weak regulation in Hungary. Advertisement in educational institutions is prohibited except the cases of health, environmental or cultural promotion. This program provides opportunity for the participating companies to reach the most vulnerable consumer group. Such methods are quite wide spread in Hungary especially on the field of health.
1.2.2. “Atypical” PPPs

Although the “Healthy Vásárhely” is a complex program with ambitious perspectives and with committed stakeholders, such programs are not typical in Hungary. The initiative, named after the city of Vásárhely is a complex program with several components. In 2008 the local government of Hódmezővásárhely ratified the 10 year health development programme that was elaborated together with the local Erzsébet Hospital. Six partners have joined for the program: one civil society organization, three local governmental bodies, two business organisations and one professional body. The program has many elements, some of which tackle obesity and healthy eating. As part of the program lifestyle choices (health development) as a subject being taught in schools since 2008-2009, and healthy eating – another subject for introduction in schools – is now under development. There are some experiences in this subject, such as cooking clubs and presentation on healthy eating in schools. In 2008 and 2009 extensive research was conducted on citizens’ health. The initiative enjoys the support of wide range online activities: citizens had access to self-evaluation health tests a healthy eating tips online. On the professional part a half year training for doctors was held on prevention of heart and vascular diseases with the support of Egis (one of the major pharmaceutical companies) and Országos Alapellátási Intézet (OALI, Association of Family Doctors) partners. Doctors who participated in the training were provided with a software helping in prevention and screening. Doctors involve patients with high risk factors in the programme for half a year.

1.2.3. Best example cases

The study kitchen and cook book of the “Egészséges Településekért Alapítvány” (Foundation for Healthy Settlements) is a nominee for best practices for its pragmatic approach. The Foundation organises cooking courses in schools mainly for parents (mothers and grandmothers 25-60ys) to teach healthier cooking since 2005. A course runs over 4 weeks, participants meet once a week (3 hours an occasion). The course is held by well known cook Júlia Frank, who is also one of the founders of the organisation. The course is for free. In the previous years several famous women (celebrities, well known professionals, politicians) promoted the course. As a part of the program a cookbook with the recipes is published. The income of the cookbook is spent on the Healthy School Buffet programme which is an other initiative of the Foundation. The number of partners fluctuates, but it has several contributors from the business sector and from governmental or semi-governmental institutions. The cookings are sponsored by companies, and they also contribute ideas to project and network for spreading the message. The National Institute for Food and Nutrition Science (OÉTI), the National Institute for Health Development (OEFI), the National Sport Authority and a publishing house supports the cook book. Financial support is received by Erste Bank and from a printing house. Additional corporate sponsors include retail companies, crockery factories and an office supply retailer. The organisers do not track results separately for this programme, but they have tenders for settlements for community building activities (study kitchen is sometimes part of this), and they do monitor the winners of these.

2. Country context

2.1. Background information

Population, total in 2010: 10.0 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 65
Unemployment rate, January 2010, %: 11.1
Healthy life years at birth, 2008, m/f: 54.6/58.0
Obesity rates among adults, 2008 (or nearest year available), %: 18.8

2.2. Overweight and obesity

Childhood obesity has been increasing in Hungary by 60% between 1999 and 2007 (HCSO, 2008). More than 50,000 children, approximately 3% of the population under 18, were registered in the Hungarian national healthcare system with obesity resulting from imbalanced caloric intake in 2007 (HCSO, 2008), and the number of overweight and obese children who are not registered may be even higher. The growth, close to 80%, was the most significant among children under the age of 3 (HCSO, 2008). School children between the ages of 7 and 14 are also greatly affected – one out of five living in Budapest, the capital of Hungary, was found to be overweight, with 3 to 4% obese (Szűcs, 2007).

According to the results of recent governmental surveys, two third of the adult population is obese or overweight (OÉTI, 2009). The middle-aged and retirees are especially overrepresented among the obese (TÁRKI, 2007).

Regional comparison of obesity rates in the CEE region

<table>
<thead>
<tr>
<th>Ratio of population, who is:</th>
<th>Hungary</th>
<th>Slovakia</th>
<th>Romania</th>
<th>Slovenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese</td>
<td>18.8</td>
<td>14.3</td>
<td>8.6</td>
<td>12.3</td>
</tr>
<tr>
<td>Overweight</td>
<td>33.8</td>
<td>32.4</td>
<td>33.1</td>
<td>36.2</td>
</tr>
<tr>
<td>Total</td>
<td>52.6</td>
<td>46.7</td>
<td>41.7</td>
<td>48.5</td>
</tr>
<tr>
<td>Underweight</td>
<td>3.3</td>
<td>4.7</td>
<td>3.3</td>
<td>3.5</td>
</tr>
<tr>
<td>Normal</td>
<td>44.1</td>
<td>48.6</td>
<td>55.3</td>
<td>48.0</td>
</tr>
</tbody>
</table>

2.3. National policies on nutrition and obesity

2.3.1. Societal organisation

According to statistics there are about 3000 health oriented non governmental organisations, two third of them are foundations, one third is association. The number of such NGOs in on decline.

There are two main types of health NGOs in Hungary. The first group supports certain institutions (e.g. hospitals), while the other helps patient groups or individuals. The representative of the first kind of organisations usually operates as a foundation and its main activities complements ambulances, hospitals, fundraising for these institutions, supply of medical instruments or other public health programs. The member of the second group is usually an association and its main activities are advocacy, health education or therapy.
(alcohol, drug, mental hygiene). About one sixth of health NGOs are involved in health education.  

2.3.2. National nutritional policy and obesity  

The main institutions responsible for carrying out nutritional policies are: State Secretariat for Health within the Ministry of National Resources, National Institute for Food and Nutrition Science, National Health Development Institute.

In the past decade Hungarian health government documents have repeatedly identified obesity and more specifically childhood obesity as a serious problem. Regarding childhood obesity two significant attitudes dominate Hungarian health policies: the first focuses on changing the settings by changing the institutions where children spend most of their time while the second approach prefers the promotion healthy lifestyles rather than trying to restrict diets (e.g. Retail of unhealthy food). Promotion and prevention are the key measurements directed towards the adult population as well. This reflects a non-restrictive approach to the corporate sector. In 2003 the Hungarian government announced the “Béla Johan Health Decade – National Health Program” (Program in the following), that is the main health policy document. The Program identifies unhealthy nutrition (namely increased calorie, salt and fat intake) as a problem and aims to promote healthy nutrition in conjunction with exercise and physical activities especially for younger generations. Despite its goals, setting up obesity prevention is not listed among the priorities; the goal of limiting sugar intake is mentioned but only in the context of dental hygiene.

The Program’s purpose is to change lifestyle setting by intervening in market supply through the development of institutions with various powers: making decrees, starting campaigns, conducting adult education, developing and promoting labeling standards – these purposes are emphasized in several parts of the document. Due to this approach one of the main developments effect the younger generation. The most wide spread of them has been making school cafeterias healthier. Nevertheless it is a weakness of the program that among the expected outcomes there is no reference made to nutrition or to the health indicators of minors.

A good example for how the government intends to change the settings is the so called “buffet decree”. In 2005 the minister for education issued a decree in which he ordered schools to assess whether the foods in the school buffet met the requirements of a healthy diet. Contracts with buffets that did not follow the health recommendations prepared by the National Institute for Food and Nutrition Science were supposed to be broken.

The ministerial decree was supported by a competition where school buffets could apply for the “Healthy School Buffet” title and the best ones were awarded with monetary rewards. As a follow-up to the decree, in 2006 the Hungarian National Public Health and Medical Officer Service (responsible for coordinating public health programs) examined more than 1000 school buffets and canteens. According to their observations in those counties where an information campaign had been delivered, with the involvement of parents and kids, about

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45 Egészség Évtizedének Johan Béla Nemzeti Programja.
two third of the buffets had a healthier assortment, while in other counties it was under 50 percent. (TÁRKI, 2007) Two years later four fifth of the school buffet joined the program, that means that they offered fruits, vegetable and bottled water – however the vast majority of them also offered sweet soft drinks and other unhealthy food. The same survey concludes that about seventy percent of the school counteens disregard health priorities: fresh fruits or vegetables are offered only once a week, vegetable based meals once in two weeks, only 1/5 offered diet menus (OÉTI 2009 b)47.

The Program prefers promoting healthy lifestyles rather than directly restricting unhealthy diets. The Program thus neglects the need for the regulation of retail, of advertising or any kinds of restrictive measures against unhealthy foods.

2.3.3. Socio-economic reasons for obesity

The obesity epidemic is a complex phenomenon which is influenced by several factors; here we just highlight the most obvious of them. According to various surveys conducted in Hungary, the most influential proxies for adult obesity or overweight are social image, education, activity and age. Obesity and overweight is more prevalent among the middle aged, the elderly, the less educated and among those who are marginalised on the labour market or retired. An interesting observation that may contribute to the increasing spread of obesity is that adults systematically underestimate their weight and not consider themselves overweight even if their real weight is in the “alarm zone” (TÁRKI, 2007).

References


POLAND

1. Overview of PPP initiatives

Eight PPPs, mainly educational initiatives aimed at children and adolescents, were identified in Poland.

2. Country context

47 http://www.oeti.hu/download/menza_vegleges_boritoval_20091123.pdf
2.1. Background information

Population, total in 2010: 38.2 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 61
Unemployment rate, January 2010, %: 9.4
Healthy life years at birth, 2008, m/f: 58.4/62.6
Obesity rates among adults, 2008 (or nearest year available), %: 12.5

Poland which was not in the system of free economy for many years but under central planning system. Resulting of this some times there was a problem with the enough accessibility of all the group of food. Therefore it was caused the increase of the growth of social dissatisfaction. After the political changes in 1989 which as well known were started in Poland, also the time of market economy was started. The lot of goods as well as food in the market was caused the dynamical increase of consumption even though the fact of pauperism in the most of inhabitants in Poland. The over consumption of food was positive correlated with the growth of private cars and personal computers for example and how it seems with the diminishing of physical activity.Because of that we have a big problem with the prevalence of overweight and obesity and resulting from that – other non-communicable chronic diseases.

2.2. Overweight and obesity

The results of the prevalence of overweight and obesity for the boys and men (Fig. 1) shows that the percentage of overweight in the group of children aged 4-14 years studied in Poland exceeded 10%. In the group of adolescents aged 15-18 years the situation in overweight seems to be not serious. In many groups of boys the percentage of obesity did not exceeded 5%. Both overweight and obesity prevalence of Polish adults elderly men exceeded 70%.

Polish girls aged 4-18 years were characterized by the highest prevalence of overweight (13-17%) (Fig. 2). The prevalence of obesity was the highest in the Polish young girls. Women aged 19-64 years were characterised by the prevalence of overweight equal 40% or more.
Obesity and obesity-related diseases are one of the most serious public health problems. Overweight and obesity are the main factors responsible for widespread cardiovascular diseases, type 2 diabetes and cancers.

Treatment of obesity and its pathological complications are consuming about 21% of expenses on the health care (similarly in other countries 12-20%). Costs of health care of overweight and obese people are higher by the 44% than people with normal body mass. Obesity probably causes 1.5 mln hospitalizations yearly in Poland. In 2002 in Poland suffering patients on obesity-related diseases spent 130 pln on medicines (minimum wage in 2002 - 800 pln, average wage 2100 pln).

Socio-economic reasons for obesity:
Lack of physical activity and sedentary behaviors of children and adults. A lot of absences of pupils on the physical education at school in Poland.
Increase of consumption of sugar and fat. In 1950 sugar intake in Poland was 21 kilos per person/year and in 2004 the intake increased to 37.6 kilos. Fat consumption was appropriately 11 kilos in 1950 and 30 kilos in 2004.
Easy access to fast food.
Irregularity of meals.
Excessive body weight gain during pregnancy. About 50% of pregnant women in Poland achieve gestational weight gain above recommendations. Excessive maternal weight gain is associated with offspring obesity and causes that women less frequently return to their prepregnancy body mass after delivery.
2.3. National policies on nutrition and obesity

2.3.1. Health oriented non-governmental organisations (NGOs)

Polish Society of the Research on the Obesity
Polish Society of the Research on the Atherosclerosis
Federation of Consumers

2.3.3. Relation between the state and food industry

Polish Federation of Food Industry cooperates with scientific and research units. As a result of this cooperation some of the food producers declare reformulation of the product, mainly by reducing the amounts of sugar and fat and increasing the amount of whole grain and dietary fibre.

According to European regulation nutritional value on the label of food product in Poland is voluntary, but because of increasing interest of producers to placement nutrition and health claims on the label it cause the increase of numbers of products with nutritional value on the label (obligatory condition).

There is an increasing interest of producers to placement Guideline Daily Amounts (GDA) information on the label. In the light of the data by the Polish Federation of Food Industry, the GDA marking in Poland involves several thousands of products. Some companies provide the GDAs for all their product lines. 54% of consumers state that the GDA system is useful when making purchase decisions.

ROMANIA

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

In Romania five PPP initiatives were identified. PPPs were explored via the internet with the help of the combination of more than 20 keywords: half of them reflected the form of partnerships (e.g. codes of conduct, choice editing, education, campaign etc.), the others were the variations of the expressions “obesity”, “health” or “food” (e.g. obesity, health, healthy lifestyle, healthy eating, energy intake, diet, healthy meal). Additionally to the internet search five phone interviews were conducted and resulted in the discovery of a new program. Finally only few cases matched the PPP criteria: those were elaborated in which partners were involved at least from two sectors (government, academia, business, NGO etc.) and which directly addressed obesity.

1.2. Different types of PPPs

The majority of the cases (3) were different kinds of campaigns in Romania, and we also identified a school and a policy program. On average three partners joined in a partnership, business being the most active sector. 7 business, 6 governmental, 2 civil organisations and 3
professional organisations participated in the mapped initiatives. Surprisingly, the presence of academia (universities, research institution) is entirely missing in this country as well.

1.2.1. Typical PPPs

As other in countries it seems to be typical in Romania too that health professionals, namely cardiology doctors are involved in the communication of health campaigns. The “We take care of your heart” campaign is one of the typical initiatives. The Romanian Society of Cardiology signed a partnership with the National Audiovisual Council of Romania in order to carry out a long term nation-wide information campaign to prevent cardiovascular diseases. On the 10th February 2010, RSC founded the Romanian Heart Foundation, as member of the World Heart Foundation. The general aim of the RHF is the education of the population in order to prevent cardiovascular diseases. The 'Take care of your heart' campaign of the RSC-CNA makes part of this general program. The campaign is meant to inform the public on the prevention of cardiovascular diseases by a lifestyle change: ‘eat healthy, move daily and don’t smoke’. The first step of the campaign has been a television spot with famous Romanian sportsmen, implemented by the National Audiovisual Council. The campaign, do not addresses obesity directly, but rather its potential consequences, which is again a typical approach. The initiative still lasted at the time of the research.

1.2.2. “Atypical” PPPs

The “Fat tax” initiative is a rare example of PPPs in the entire region. This is a policy programme that was initiated by a local community group, later supported by state actors. In 2007 a strong parents’ community from Cluj Napoca has campaigned against fast food sold in schools. Mircea Giurgiu, an independent MEP from Cluj proposed a new “fat tax” that would charge unhealthy junk food and drinks, and would contribute to the income of the Ministry of Health. The proposal raised a huge public debate, with the representatives of food and drink industry opposing severely the anti-junk food law, and raising arguments for its inefficiency. At the same time, a growing number of NGOs and public health institutions from Romania, as well as the European Public Health Alliance (EPHA) raised in support of the case. Elena Oana Antonescu MEP (EPP, RO), a member of the Committee on Environment and Public Health, expressed her support for the proposal at a plenary session of the European Parliament in Strasbourg. In January 2010, Ministry of Health Attila Cseke announced the introduction of the new law in March. At the time of the PPP mapping (2010 spring) the case was on the ministerial level and was still in progress, once passed, it would be the first anti-junkfood tax in the EU. Since then there is no information on the initiative.

2. Country context

2.1. Background information

Population, total in 2010: 21.5 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 46
Unemployment rate, January 2010, %: 7.3
Healthy life years at birth, 2008, m/f: 60.0/62.6
Obesity rates among adults, 2008 (or nearest year available), %: 7.9

2.2. Overweight and obesity
In Romania, approximately 30% of the population is obese. The number of obese children has increased with 18% in the last 10 years, and 40% of Romanian children are obese. 27% of adult Romanian men and 29% of adult women are obese (Center of Sanitary Statistics, Ministry of Public Health, 2010). While over 3.5 million Romanians are obese only every ten of them go to medical control, and only 1% take part in national education programs against obesity (Abbot Laboratories, 2010). Romanian women are usually underweight until the age of 30, and then gain weight due to sedentary lifestyle and unhealthy alimentation. 15% of women between 20-29 are underweight when young, and 38% surpass normal weight after the age of 50. In the age group 50-65, 26% of women suffer from grade I. obesity, 10% of grade II and 2% of morbid obesity. 78% of women between ages 20-29 have normal weight, in this age group, only 15% is obese. In the age group 50-65, only 23% is normal weight. Among Romanian men, in the age group 50-65 there are 85% obese; in that of 40-49, 79%, in the 30-39 group, 73%, and in the 20-29 group, 49%. The main causes are lifestyle, a diet rich in empty calories and industrial food (anthropometric BMI index study of the National Institute of Research and Development for Textile and Leather Industry, 2010). According to the study of the Parhon Institute of Endocrinology (2010) in Romania almost 4 million people are overweight, due to unhealthy diet and lack of physical exercise; and that unhealthy diet correlates with low income.

Regional comparison of obesity rates in the CEE region

<table>
<thead>
<tr>
<th>Ratio of population, who is:</th>
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<td>33,8</td>
<td>32,4</td>
<td>33,1</td>
<td>36,2</td>
</tr>
<tr>
<td>Total</td>
<td>52,6</td>
<td>46,7</td>
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2.3. National policies on nutrition and obesity

2.3.1. Societal organisation

According to the Romanian Civil Society Development Foundation’s Romanian NGO Directory Project, currently there is no systematic and reliable information on the size and structure of the NGO sector in Romania. Almost two decades after the regime change in Romania civil society remains one of the least visible actors within the Romanian society. The most visible actors of civil society in the health domain are professional organizations linked either to health care institutions or medical domains, like the Romanian Federation of Diabetes, Nutrition and Metabolic Diseases, the National Institute of Endocrinology C. I. Parhon, or the Healthy Nutrition Foundation (professional nutritionist organization).

2.3.2. National nutritional policy and obesity

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48 EUROSTAT Body mass index (BMI) by sex, age and activity status (%) [hlth_ls_bmia]
In 1998 the government adopted the National action programme for health and the environment, which also addresses nutrition. Among the activities the surveillance of the health status and dietary habits of the population, the elaboration of new food composition tables, nutrition education for professionals and consumers, support to and training of food producers, and research and development etc. Since 2002 the National Council for Alimentation and Nutrition is working towards the development of a National Action Plan for Public Alimentation and Nutrition. Recommendations for the plan were already present at a WHO workshop in 2004.49

Since 2005, the Romanian Ministry of Health collaborates with Component One of the Stability Pact for South-East Europe: Food Policy, Strategy and Legislation. The Stability Pact was initiated by the EU, and embodied in a cooperative process launched at the First SEE Health Ministers Forum in 2001. Component One of the Pact aims to decrease the number of diseases generated by alimentation, to control and prevent them on a central, regional and local level. In 2005, the concept for a National Committee for Alimentation and Nutrition and a National Action Plan for Public Alimentation and Nutrition was set up. In 2006, the government established the National Committee for Alimentation and Nutrition, its general objective being to elaborate nutrition policies and strategies in order to make the Romanian population healthier. The Committee has a consultative role towards the Ministry of Public Health, and an integrative role regarding the sectorial programs elaborated by other ministries in this domain. It is responsible for surveying and monitoring the nutritional status and risks of the population, for setting up a National Action Plan for Public Alimentation and Nutrition, to evaluate food legislation, for proposing and monitoring policies for the Ministry of Public Health, and for collaborating with public authorities and institutions, NGO-s and other actors to fulfil its obligations. The Committee has members from the Ministry of Public Health, local Institutes of Public Health, professional institutions like the Institute of Diabetes, Nutrition and Metabolic Diseases, the Institute of Endocrinology, and the Institute of Mother and Child Protection, as well as from medical universities.

The National Action Plan for Public Alimentation and Nutrition elaborated by the Committee designates five main domains for action:

- to guarantee optimal nutrition and prevent nutritional diseases (malnutrition)
- to guarantee good quality alimentation for the whole population ("food security" in FAO/OMS terminology)
- to prevent diseases resulting from contamination ("food safety")
- to enhance education on alimentation and nutrition
- to stimulate scientific research on alimentation, nutrition and nutritional pathologies

It is part of the Plan that the Ministry of Health appoints "Physiological alimentation norms recommended for the population of our country", that contains the necessary calories, nutrients, and a list of foods that bring those nutrients. It is the role of the Committee to help the work of the Ministry by the monitoring of nutritional needs and behaviour of the population, collaborating with the National Committee of Statistics, the National Institute of Economic Research, the Institute of Life Quality Research etc. It is part of the Plan to carry out a national program to supervise child nutrition, and to detect malnutrition – undernutrition as well as hiperunrition – in its early phase, before it produces symptoms that have to be medically treated.

49 Nutrition, physical activity and the prevention of obesity: policy developments in the WHO European Region, WHO 2007
To fight obesity, cardio-vascular diseases, diabetes, chronic alcoholism etc, it is part of the Plan to support the production and import of hipocaloric/low fat, salt, sugar food; to continue and coordinate the programs of the Ministry’s Commission of Cardio-Vascular Diseases and Commission of Diabetes, Nutrition and Metabolic Diseases; to encourage and create material support for sport, excursion and other physical exercise facilities; to support the production of non-alcoholic beverages; to encourage food producers to use methods that enhance nutritive values, keep foods fresh, uncontaminated etc; to extend the percent of functional food (rich in fibres, probiotics, prebiotics, vitamins etc.) on the market, and to create food categories for babies, children, elderly people, ill people etc. It is part of the Plan that the Ministry of Health will proceed to enhance the number of experts specialised in diabetes, nutrition and nutrition pathology, create, together with the Ministry of Education and Research, the educational basis for their formation, and to enlarge the nutritional section in county hospitals. According to the above Romanian policies have a more than encouraging, but explicitly supporting attitude towards the food industry, as they mention the explicit support of the market launches of new products and of R&D activities. On the other hand we can witness a slightly restrictive attitude as well. In 2008, the Ministry of Health put together a list of "Food not recommended to children and schoolchildren", with food too rich in calories, sugar, salt, fat, unsatisfactory packaging etc. It is forbidden by law to cook, serve and sell food on this list in educational institutions. The criteria of inclusion into this list were recommended by the National Committee of Alimentation. The official press release of the Ministry about this law states that healthy nutrition and the fight against obesity are priorities of public health. The Ministry considers that a simple inhibition by law is insufficient in this respect, and that the implementation of this law is just a first step towards a long-term national nutritional strategy. For a successful implementation, the press release says, the Ministry has to stay in permanent dialogue with producer associations, which should adhere to the principles of healthy nutrition.

As to nutritional education, the Plan appoints the use of mass-media, conferences, brochures etc., the introduction of “education for health” in schools, that would include the instruction of teachers. To stimulate scientific research in the domain, the National Committee for Alimentation will propose programs and themes for existing health research institutions and recommends the establishment of a National Institute for Alimentation and Nutrition.

In terms of responsibilities, the Plan mentions besides the National Committee for Alimentation the National Committee of Statistics, the National Institute of Economic Research, and the Institute of Life Quality Research as collaborating partners in establishing the "Physiological alimentation norms recommended for the population of our country". There are no deadlines appointed in the Plan, except that the Ministry of Health will proceed to enhance the number of experts specialised in diabetes, nutrition and nutrition pathology, create, together with the Ministry of Education and Research, the educational basis for their formation, and enlarge the nutritional section in county hospitals “in the next 5-6 years”.

2.3.3. Socio-economic reasons for obesity in the country

Similarly to other countries the risk of obesity is higher among men and older people and to the less well-off (see above). According to the relevant literature, sedentary lifestyles and unhealthy diet are the main causes of the phenomenon. All studies mention sedentary lifestyle as cause. The Parhon Institute of Endocrinology mentions unhealthy diet, lack of physical exercise, and that unhealthy diet correlates with low material status. The anthropometric BMI
index study of the National Institute of Research and Development for Textile and Leather Industry (2010) shows that both among men and women, obesity risks are higher with age, and higher among men than women. It mentions cheap industrial food rich in empty calories as one cause of obesity. Among others, Dr. Mirela Ivan from the Parhon Institute states that traditional Romanian kitchen with its hypercaloric diet is a reason for obesity. According to these studies obesity is rather seen as an individual problem than a societal one, since much of the emphasis is put on individual choices (lifestyles, choosing of "bad" products).

\section*{SLOVAKIA}

\subsection*{1. Overview of PPP initiatives}

\subsubsection*{1.1. Assessment of accessibility of information on PPPs}

In Slovakia five PPP initiatives were identified. PPPs were explored via the internet with the help of the combination of more than 20 keywords: half of them reflected the form of partnerships (e.g. codes of conduct, choice editing, education, campaign etc.), the others were the variations of the expressions “obesity”, “health” or “food” (e.g. obesity, health, healthy lifestyle, healthy eating, energy intake, diet, healthy meal). Additionally to the internet search four phone interviews were conducted and resulted in the discovery of new programs. Finally only few cases matched the PPP criteria: those were elaborated in which partners were involved at least from two sectors (government, academia, business, NGO etc.) and which directly addressed obesity.

\subsubsection*{1.2. Different types of PPPs}

The majority of the cases (3) were different kinds of education campaigns in Slovakia. The second most popular kind of PPP was that of school programs. On average three partners joined in a partnership, state/governmental organisations being the most active sector. 8 governmental, 5 business, 1 professional organisation participated in the mapped initiatives. Surprisingly, the presence of academia (universities, research institution) and of civil society organisations is entirely missing.

\subsubsection*{1.2.1. Typical PPPs}

All, but one PPPs were carried out with the cooperation of state and businesses in Slovakia; in this sense the Adamko project is a typical initiative. This is a campaign to children with the slogan “Be healthy playfully!” The main goal of the initiative is to raise health-awareness among children in order to prevent obesity and related diseases. ‘Be healthy playfully!’ is a health-educational project for children, teachers and parents. The aims of the project are: (1) providing information about protecting health, (2) raise health-awareness among children, (3) cultivate the foundations of prevention and understanding its importance. Teachers and kindergarten teachers deliver the main messages with the help of “Little Adam” (Adamko), a puppet. The main topics of the education are: hygiene, healthy eating, nature conservation, sport. The partners involved in the project are the Public Health Authority of the Slovak Republic and the Burda Toys.

\subsubsection*{1.2.2. “Atypical” PPPs}
The school fruit project has at least five partners which is the highest number of partners joining for a PPP in Slovakia, most of the PPPs involve 2 or maximum 3 partners. The program is part of a Europe wide initiative whose main argument is that eating more fruit and vegetables can play an important role in combating obesity, and fruit and vegetables reduce the "energy density" of the diet and play a preventing role in combating heart disease, cancer and diabetes. The program intends to disseminate information about the nutritional values of different fruits and vegetables, and explains that the consumption of fruits and vegetables at an early age may contribute to reducing the prevalence of obesity among children. As a part of the initiative local farmers provide fruits and vegetables to schoolchildren. The project is being implemented during three school years in the period 2009 - 2012. The main partners of the program: the Ministry of Agriculture of the Slovak Republic and the Agricultural Paying Agency; the European Commission, the Slovak Fruit and Vegetable Growers, the Ministry of Education of the Slovak Republic and the Public Health Authority of the Slovak Republic. At the time of the mapping period of the Obesity Governance project the above program was still at an early stage, therefore there is no information on its results.

2. Country context

2.1. Background information

Population, total in 2010: 5.4 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 73
Unemployment rate, January 2010, %: 14.5
Healthy life years at birth, 2008, m/f: 51.8/52.3
Obesity rates among adults, 2008 (or nearest year available), %: 16.9

2.2. Overweight and obesity

There is no comprehensive survey about the number of obese and overweight people in Slovakia at the moment, the last publicly accessible research was carried out in 2001. Information from the Eurostat data shows that almost half of the population (46.7%) is either obese (14.3%) or overweight (32.4%)\textsuperscript{50}. The Slovak Obesity Prevention Program is based on the CINDI survey\textsuperscript{51}, which is representative only to the Banská Bystrica county and Velký Krtíš county. According to the CINDI report, obesity among adults (age 25-64) has been decreasing, but the prevalence of overweight increased between 1993 and 2003\textsuperscript{52}. According to the same survey children between the age of 7-12 are also greatly affected. At the age of 11, 17.5% of the boys and 12% of the girls was found to be overweight (the proportion of obesity at that age is 9.8% and 6.9%). On average 13.2% of the children between 7-12 is either obese or overweight\textsuperscript{53}.

\textsuperscript{50} EUROS\textsuperscript{T}AT Body mass index (BMI) by sex, age and activity status (%) \cite{hlth_ls_bmia}  
\textsuperscript{51} WHO Countrywide Integrated Noncommunicable Diseases Intervention, Health Monitoring Survey \cite{CINDI}  
\textsuperscript{52} Slovak Obesity Preventing Program; \url{http://www.uvzsr.sk/docs/info/podpora/Narodny_program_prevencie_obezity.pdf} downloaded: 25. november 2010  
Regional comparison of obesity rates in the CEE region

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2.3. National policies on nutrition and obesity

2.3.1. Societal organisation

We could not find a comprehensive register of NGOs on this field. Our impression is that most of the health NGOs represent either patient groups or a group of professionals. For example the Association for Health and Diet (Združeni pre zdravie a výživu, www.zzv.sk) was founded in 1995 as a voluntary association open to nutrition specialists. The main goal of the association is to influence public awareness and education on healthy eating and healthy lifestyles. The aim is to highlight the responsibility of citizens for their own health and active approach to prevention. Their activities include organising conferences and seminars. The other leading NGO of the field is the Slovak Obesitological Association (Slovenská Obzitologická Spoločnosť, http://wp.sos-obezita.sk), which is an independent voluntary organisation. SOA is a kind of think tank organisation whose mission is to develop professional level of obesitology as a multidisciplinary branch of medicine.

2.3.2. National nutritional policy and obesity

The two main governmental institutions responsible for the resolution of the obesity epidemic are the Ministry of Health of the Slovak Republic (Ministerstvo Zdravotníctva SR, www.health.gov.sk) and the Public Health Authority of the Slovak Republic (Úrad Verejného Zdravotníctva SR, www.uvzsr.sk). The main regulatory framework that addresses obesity is that of the State Health Policy Concept of the Slovak Republic. According to the recent report of WHO this document was updated and approved by the Government in 2006. As one of the key priorities, the health development strategy includes the support and improvement of citizens’ health, the protection of citizens threatened by biological, chemical or environmental factors and carry for the citizens with bad health conditions. A complex approach, called Health in all Policies should be taken in order to accomplish the objectives – the document says. Health is addressed as an inherent part of all development policies that cannot succeed without accepting health as one of the basic human rights (e.g. a decrease of employment could not be successful after creating new jobs if the employees did not achieve the necessary working efficiency due to chronic diseases, etc.). Obesity is not addressed among the objectives of the policy paper, but the following four priorities are determined for the State Health Policy of the Slovak Republic: 1. Chronic diseases, 2. Infectious diseases, 3. Environment and health, 4. Tobacco and alcohol. Obesity is seen as part of the first priority among cardiovascular and oncology programmes. Among the policy documents the Slovak

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54 EUROSTAT Body mass index (BMI) by sex, age and activity status (%) [hlth_ls_bmia]
55 Nutrition, physical activity and the prevention of obesity: policy developments in the WHO European Region, WHO 2007
56 State Health Policy Concept of the Slovak Republic; http://www.uvzsr.sk/docs/kspz/koncepcia_SP_zdravia_SR.pdf downloaded: 27. November 2010
Obesity Prevention Program is the one that addresses obesity directly. The overall aim of the program is to reduce the prevalence of obesity in all population groups by promoting healthy nutrition and physical activity. The main focus of the program is to prevent childhood obesity and overweight, to stop the increasing prevalence of obesity and overweight. The two basic areas where the main activities are carried out: nutrition and physical activity. The above referred WHO document says that this program has “a multidimensional approach” and puts emphasis on the involvement of individuals, communities and several public policy sectors. “The program proposes to take action in community settings, such as schools, workplaces, catering services, public health and health care services, and through public education. The economic regulation of lifestyle through subsidies, marketing and the tax system has been also proposed (WHO, 2007). Since the above documents put more emphasis on changing the social settings probably obesity is rather evaluated as a social, than an individual problem. The Ministry of Health and the Public health Authority are responsible for the execution of this program. But in general the National Veterinary and Food Administration (Štátna veterinárna a potravinová správa Slovenskej republiky, www.svsr.sk) and the Ministry of Agriculture and Rural Development (Ministerstvo pôdohospodárstva a rozvoja vidieka, www.mpsr.sk) is responsible for carrying out nutrition programs.

The main regulatory framework for the food industry is the System for security of food safety in the Slovak republic. Among others it prescribes essential obligations for the process of food production, it sets provisions for management and marketing, food labelling, notification of food production and terms of marketing, system of rapid information exchange, import and export of food and also prescribes tasks for the traceability of food. This framework does not reflect the obesity problematic and yet there is no regulation on the retail and advertisement of unhealthy food.

2.3.3. Socio-economic reasons for obesity

We have no information on the special risk groups for obesity in Slovakia, but we assume that these might be similar to other countries in the region (male, elderly, inactive etc.).

**SLOVENIA**

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

In Slovenia four PPP initiatives were identified, one of them is an international program with partners from Bulgaria, Hungary, Austria, Finland, Norway, UK, Italy. PPPs were explored via the internet with the help of the combination of more than 20 keywords: half of them reflected the form of partnerships (e.g. codes of conduct, choice editing, education, campaign etc.), the others were the variations of the expressions “obesity”, “health” or “food” (e.g. obesity, health, healthy lifestyle, healthy eating, energy intake, diet, healthy meal). Many relevant websites were found, but only a few of them introduced programmes proved to be PPPs. Additionally to the internet search four phone interviews were conducted, but unfortunately did not resulted in the discovery of new programs. Finally, only few cases

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57 [http://www.potravinarstvo.com/pksr/obsah_pksr.htm](http://www.potravinarstvo.com/pksr/obsah_pksr.htm)
matched the PPP criteria: those were elaborated in which partners were involved at least from two sectors (government, academia, business, NGO etc.) and which directly addressed obesity. For Slovenia, we have to mention that several times we could receive only general information even in personal or in e-mail communication. For example when we asked about project partners, the answer was “NGOs” instead of naming the organisations. On the other hand we experienced a great transparency of policies and governmental initiatives, which is not typical to the CEE region.

1.2. Different types of PPPs

Three out of the four programs were complex programs with more components, and one of them was a campaign. The accessible information was not always clear on how many partners join for the programs, but in general we can conclude that these programs are characterised by a multistakeholder approach, and involved many partners from various sectors. Each program had nearly or more than a dozen of partners.

1.2.1. Typical PPPs and best example case

Although we are sure that due to the language barriers our research is biased, we had the impression that complex, multistakeholder programs are typical to Slovenia. This approach well characterises the “Programme MURA – Investment for Health and Development in Slovenia”. The program was awarded as the best example of successful cooperation between different sectors in promoting health by healthy nutrition and regular physical activity. For this reason we also recommend it as a best practice. The program took place between 2001 and 2007. The goal of the program was to achieve better health and quality of life for the people in the Pomurje region (one of the most deprived regions in Slovenia), and to make people understand health as a development potential of the region. On the operative level, the following working priorities were set up: improvement of healthy lifestyles, increasing healthy food production and distribution, developing healthy tourism products and programmes, preserving the natural and cultural heritage and reducing the ecological burden. The priorities were organised into three focus areas:

- **Healthy community**: health promotion in local community, marginalised groups, schools and kindergartens, workplace.
- **Healthy food**: agriculture-food industry- more fruits and vegetables, ecological farming, local supply chains, safe & healthy food.
- **Healthy tourist offer**: healthy & traditional offer in gastronomy, recreation programs, prevention programs in health spas, ecotourism.

From these the first two are relevant to our research. The complex initiative was taken by the Institute of Public Health of Murska Sobota and by the Ministry of Health. Partners include Murska Sobota, Centre for Health and Development, various local coordinators, Primary Health Care Centres, Hospitals, Schools, Kindergartens, Local authorities, NGOs, Agricultural extension service, tourist associations, food industry, health spa resorts, Chamber of Commerce & Industry, Employment Service, Regional & Local development agencies, Landscape Park Goricko. The program received funding from the European Union. According to the project documents, as a result of the “Let’s live healthily” campaign (part of the Healthy community result area), almost all participants started to change their lifestyle, especially in the field of nutrition and physical activity. The highlighted results of the program also include the formulation of a health strategy to tackle health inequalities, the elaboration
of healthy food standards, introduction of new products on the market, setting up local supply 
chains, healthy nutrition campaigns in spas and restaurants.

1.2.2. “Atypical” PPPs

Among the “atypical” initiatives we highlight the only NGO run program that we have found 
in Slovenia, and as far as we can conclude from this research, initiatives taken by consumer 
organisations are quite rare. This is a campaign by the Association of Consumers in Slovenia. 
The program started in 1999 and still lasted in the time of the inquiry. Via direct 
communication with the Association we were informed that their aim was to contribute to the 
decrease of obesity by marketing and food profiling means. Their direct goals were to achieve 
changes in marketing techniques, to achieve the reformulation of food products or change in 
profiling, to empower consumers to make better choices, and to disseminate their relevant 
research results. As a result the Slovene Advertising Codex of Conduct was changed, the 
Association published some teaching materials for schools, and according to their evaluations 
they have achieved some changes in consumer awareness. The program also received good 
media coverage. The partners collaborating in this initiative include other consumer NGOs, 
independent non-governmental associations and health institutes.

2. Country context

2.1. Background information

Population, total in 2010: 2.0 million  
GDP per capita in Purchasing Power Standards (EU-27 =100), 2007: 88  
Unemployment rate, January 2010, %: 6.6  
Healthy life years at birth, 2008, m/f: 59.4/60.9  
Obesity rates among adults, 2008 (or nearest year available), %: 16.4

2.2. Overweight and obesity

issued by the minister of Health in 2005, 54.6% of adult population are overweight, 15% are 
obese, while international (Eurostat) statistics based on BMI calculations, estimate the same 
rate as 12.3 percent for the obese, and 36.2 percent for the overweight (total 48%). Variation 
may be due to measuring different age cohorts and using different methods. The latest European Health Interview Survey (2007) by the Institute of Public Health of the 
Republic of Slovenia shows that 55.1% of residents aged 15 years or more were overweight 
or obese, 43% had normal weight and less than 2% were underweight. More men (64.9%) 
than women (45.4%) were overweight or obese. As regards obesity, 17% of men and 15.8% 
of women were obese.58 According to the outcomes of the EHIS 2007 survey among young 
people (15–29 years) an above-average number of people (5.2%) was undernourished; a 
below-average number of people but still over 20% (22.7%) was overweight and 6.4% of 
them were obese.59

In summary we can conclude that more than every second Slovenian is either obese or 
overweight, and we can assume that age, gender and rural environment are proxies for obesity

of overweight. It also worth noticing that according to the National Health Enhancing Physical Activity Programme 2007-2012 obesity rates have been showing an upward trend.

Regional comparison of obesity rates in the CEE region

<table>
<thead>
<tr>
<th>Ratio of population, who is:</th>
<th>Hungary</th>
<th>Slovakia</th>
<th>Romania</th>
<th>Slovenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obese</td>
<td>18.8</td>
<td>14.3</td>
<td>8.6</td>
<td>12.3</td>
</tr>
<tr>
<td>Overweight</td>
<td>33.8</td>
<td>32.4</td>
<td>33.1</td>
<td>36.2</td>
</tr>
<tr>
<td>Total</td>
<td>52.6</td>
<td>46.7</td>
<td>41.7</td>
<td>48.5</td>
</tr>
<tr>
<td>Underweight</td>
<td>3.3</td>
<td>4.7</td>
<td>3</td>
<td>3.5</td>
</tr>
<tr>
<td>Normal</td>
<td>44.1</td>
<td>48.6</td>
<td>55.3</td>
<td>48</td>
</tr>
</tbody>
</table>

2.3. National policies on nutrition and obesity

2.3.1. Societal organisation

We have no data on retail and on the NGO sector for Slovenia.

2.3.2. National nutritional policy on obesity

The main institutions responsible for carrying out nutritional policies in Slovenia are: Ministrstvo za zdravje RS (Ministry of Health of the Republic of Slovenia) and other ministries and institutions. Since the Slovenian government uses a well elaborated multi-stakeholder approach for realizing its health (and anti-obesity) policies, many institutions are involved. Just to mention a few: Ministry responsible for agriculture and food, Ministry responsible for education, Ministry responsible for higher education and science, Ministry responsible for finance, Ministry responsible for labour, family and social affairs, Government Office of the RS for Local Self-government and Regional Policy, National Education Institute of the RS.

One of the main governmental programs is The National Programme of Food and Nutrition Policy 2005-2010 (NPFNP). In this document obesity is not addressed directly, but the pillar of well-balanced and protective nutrition correlates to this problem. The Programme intends to achieve healthy nutrition and articulates several goals from value communication and education, through the improvement of health services and monitoring systems, to the some light market pressure (e.g. implementation of food composition table).

The problem of obesity is explained in the National Health Enhancing Physical Activity Programme 2007-2012 which emphasizes the importance of physical activity, especially because it can have positive effects on health independently of dietary habits. The Programme more or less works with the same approach and intends to use the same means as the

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previously mentioned one. Obesity and the resolution of related issues are mentioned among the goals of the *Health Enhancing Physical Activity Strategy from 2007 to 2012* by target groups of the population of the Republic of Slovenia. The Strategy aims at reducing the rate of overweight or obese children and adolescents by 10% in the 18-age group, in other cohorts the documents concentrates on the increase of physical activities and on the reduction of sedentary lifestyles.

We also have to mention the *Resolution on the national programme of food and nutrition policy 2005-2010*, which was adopted by the National Assembly of the Republic of Slovenia, in May 2005. It has three basic pillars: food safety, balanced nutrition and local food supply. The major goals are to ensure safe food, to establish, preserve and strengthen healthy nutritional habits, and to ensure adequate sustainable supply with high-quality health-beneficial food. Among the midterm goals of the document we find the reduction “of share of the adult population over nourished and overweight (ITM>25 kg/m2) by 15% and of children and young people by 10%.”

From these documents we can conclude that obesity is clearly addressed as a social problem and not an individual one. Both the approach and the resolution schemes suggest that the phenomenon is a result of changing social environment (lifestyles e.g.) and therefore should be handled in the same way. For example the *Health Enhancing Physical Activity Strategy* not only targets different cohorts but also different lifestyle groups (e.g. working people, pregnant women), and it intends to build supportive environments. The intensive involvement of stakeholders also suggests that more emphasis is put on the social approach.

Business organisations are only symbolically addressed in policy documents when their shared responsibility is mentioned. However some of the actions will affect them. For example the preparation of food composition tables and of composition of foodstuffs, raw materials and products in all foodstuff groups (proteins, fats, dietary fibre, vitamins, macro- in micro-elements, fatty acid and amino acid composition), the promotion and encouragement of the offer of health-beneficial nutrition in catering and tourism or the introduction of an accreditation system for providers of healthy nutrition education outside the formal school system, as well as the promotion of offer and demand for good-quality and health-beneficial foods produced locally in a sustainable manner. In brief rather an encouraging than a restrictive approach characterises the Slovenian health policy in respect of business activities.

2.3.3. Socio-economic reasons for obesity

The national *Health Enhancing Physical Activity Programme 2007-2012* refers to a survey, which concludes that the proportion of obese population (17.4%) is higher in the rural residential environment than in the suburbs (15.0%) and urban environment (11.8%). The same study also states that gradually decreasing physical fitness of children as well as adolescents is one of the causes of the increasing obesity epidemic. Overeating, and the consumption of insufficient amounts of fruit and vegetables compared to sweets and sugary drinks are also recognised as an important influencing factor. The study adds that the number

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64 Resolution on the national programme of food and nutrition policy 2005-2010
of daily meals and the eating rhythm of an average person are inappropriate, the energy value of an average meal is too high, and in general people consume too much fat. The Resolution on the national programme of food and nutrition policy 2005-2010 identifies the following risk groups: men, lower socio-economic classes, low educated, active employed population, inhabitants of rural residential areas, East Slovene Health Region, population aged 25 to 49 years. Briefly, besides some basic demographic proxies (see also 2.2.2) lifestyles are considered as a complex reason for obesity.

WEST

BELGIUM

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

Information on various interventions within the field of obesity prevention and health promotion is available. However, there is a need to make some reservations with regards to answering on accessibility as it is impossible to say whether there are interventions that have not been identified. Primary source of information has been the internet: databases for scientific articles, websites for ministries and private companies, newspaper archives and random searches through search-machines like google.

1.2. Different types of PPPs

If partnerships are being defined as: involving two partners & voluntary & formal & targeted at obesity, then partnerships in Belgium can generally be divided into: partnerships with a specific aim (health education or policy analysis), partnerships with specific issues (answer to government wishes of involvement) and partnerships with international potential.

The activities carried out in partnerships are quite diverse: analysis of policy options, codes of conduct, interventions in schools, public campaigns etc.

1.2.1. Typical PPPs

In general, public authorities have put focus on obesity prevention and health promotion through the creation of the national plan for nutrition and health (PNNS). Several types of collaborations exist, but most commonly it seems to be in a combination of either public authorities and private companies or between NGOs and private companies.

1.2.2. Best example cases

The criteria for selecting cases according to proposal from MSJ and BEMI are: sustainability embedded, adverse effects addressed and relevant stakeholders involved. However, evaluation of interventions are in some cases difficult to find/non-existent and, hence, criteria for selection are mentioned below:

FEVIA’s code of conduct: important partners in terms of possible impact

Created in 2005 in accordance with the national plan for nutrition and health (PNNS-b). The code of conduct stresses a wish to put an end to advertising of energy dense and nutrient poor foods and beverages to children. Furthermore, the text put emphasis on overall principles as: obeying statutory law, loyalty towards the spirit of the code of conduct, correctness with regards to actual content of food items and beverages, abstention from encouraging excessive eating and attention to children’s imagination.

Partners: FEVIA-members (Belgian Food and Drink Federation)

Potential problems: No sanctions have been identified, no specifications with regards to media used for advertising have been found
Bon Appetit: possible high impact from private partner in health education
Created in 2004. An educational game, that teaches children to identify food families and educate in food choices and food habits. In addition to the game, there are children’s books, videos and posters
Partners: Developed by Danone in collaboration with teachers, pediatrics and nutritionists
Potential problems: In teacher’s material, one of three key advice is that children need to take in dairy products (http://www.bonappetitlasante.be/pdf/Guide%20de%20l%27enseignant.pdf)

2. Country context

2.1. Background information

Population, total in 2010: 10.8 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 116
Unemployment rate, January 2010, %: 8.3
Healthy life years at birth, 2007, m/f: 63.3/63.7
Obesity rates among adults, 2008 (or nearest year available), %: 13.8

2.1.1. Food production

1.365.155 ha of land is cultivated in Belgium (Belgian Federal Government, 2009 (b)), corresponding to more than a third of the country’s total area. Belgium is a producer of top quality potatoes and meat, but the quantity of production makes up for only a small part of total GDP.

2.1.2. On Belgian food culture

Distinct traditional and/or regional recipes have their origin in Belgium, and some even refer to Belgium as Europe’s best kept culinary secret (Schollier & Geyzen, 2010). The inspiration from German and French dishes prepared by Belgian cooking methods, in which beer is an often used ingredient, makes the traditional Belgian food distinctly different from the traditional dishes of the neighbouring countries (Schollier & Geyzen, 2010). Among the traditional Belgian products are more than 80 cheeses, more than 400 sorts of pralines, not to mention the huge number of beers, traditionally brewed in the monasteries.

Studies indicate that Belgians, similarly to the French, have a pleasure-related attitude towards food (Rozin, Fischler et al, 1999). However, identifying the average Belgian with this general image is problematic. Today, less families share meals prepared at home (Duquesne, 2010) and the increasingly sedentary lifestyles have consequences for the general health of Belgian citizens (Willems et al, 2007). A national study of Belgians’ health in 2001 revealed that the prevalence of overweight and obesity was significantly higher among persons with little or without education, and, furthermore, that this disadvantage was passed on to their children (Institut scientifique de la santé publique, 2001). A renewed study was made during 2008.

2.1.3. The State

Belgium is a constitutional monarchy, in which the King’s constitutional role implies that he must ensure unity among Belgians in all areas. As such, the King is symbolically the guarantee of the existence of the Kingdom (Belgian Federal Government, 2009 (a)). This
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Overweight and obesity

Data on overweight and obesity are uncertain and it is stated in the Belgian national program for nutrition and health that there is a need to develop structured data collections in this field (PNNS, 2005). A larger study realised in 2005 on Belgian’s food habits contain information on weight, too, and this study reveals that approximately 30% of the Belgian population suffers from overweight, whereas approximately 11% suffer from obesity – if and only if the sample of 3.200 persons are representative of the population as such (Institut scientifique de Santé Publique, 2004). Furthermore, the study reveals that extremes are found among the female population both in terms of underweight and obesity. Socio-economic inequalities are clear as the prevalence for obesity among the highest socio-economic group is estimated to be 8%, whereas data indicate 23% for persons with the lowest income and least education (Institut scientifique de Santé Publique, 2004).

Statistics of overweight and obesity among children are not available at a national level. Various studies have been conducted during the past ten years and they reveal obesity rates between 6% and 8% for the younger children, and between 6% and 7% for children up to 13 years. Overweight is approximately 20% (Institut scientifique de Santé Publique, 2004). These number are largely corresponding to the latest data from IASO, estimating child overweight at 26.8% for girls and 27.7% for boys in 1998-99 (IASO, 2007)

2.3. National policies on nutrition and obesity
The Belgian national program for public health nutrition was set up in 2005 and is supposed to run until the end of 2010 (PNNS, 2005). Contrary to the French PNNS, the Belgian PNNS-b has a more “problem-focused” approach on costs of chronic diseases and nutritional disorders, rather than the association of food with taste and the joy of sharing. The point of departure is the before-mentioned nationwide study carried out in 2004 (Institut scientifique de Santé Publique, 2004). The strategy of the PNNS-b is based on a set of recommendations that emphasises the respect for the individual’s choice according to taste and culture, but at the same time stresses nutritional guidelines for macro- and micronutrients. The means of inducing changes are described at a meta-level: communication and information, engaging the private sector and a call for scientific research in nutrition and nutritional behavior (PNNS, 2005).

At a concrete level a number of initiatives have been started. As schools are perceived as a major arena for health promotion, a special logo has been created and is given to schools having done specifically well in this area (Circulaire 2154, 2008). Also, websites like “mangerbouger” propose concrete actions. With regards to future goals, the PNNS-b wishes the industry to develop ethical codes for marketing and advertising and, furthermore, there is a wish of reaching the level of Sweden in terms of breast-feeding by 2015 (PNNS, 2005). A new PNNS is planned for 2011–2015. The main objectives were presented in Parliament in March 2010, but the final document of the PNNS 2011-2015 has not been found. Newsmedia indicate that differentiated taxes will make fruit and vegetables cheaper and that schools will have to implement menus without meat once a week.

Labeling of food is also an issue, and is well known in Belgium in so far as traditionally grown and produced items have been labelled with AOP (appellation d’origine protégée), which indicates the geographic origin of the product or IGP (indications géographiques protégées), which emphasise geographical origin, too, but for ingredients in the product and not for the whole product. Lastly, the labeling STG (spécialité traditionelle garantie) stresses the traditional character of the product, used as labeling of Belgian beer etc. Even if there is an increase in the overall consumption of processed foods in the Belgian population, a growing interest in locally grown and traditionally produced Belgian food items has been detected among parts of the population (Duquesne, 2010).

2.3.2. Health-related non-governmental organisations (NGOs)

A number of NGOs are involved in nutrition policies and health promotion in Belgium. The Heart Ligue, the European Cancer Ligue based in Belgium as well as consumer and family organisations are active. Furthermore, NGOs linked to the French and Flemish communities are influential.

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FRANCE

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

Information on various interventions within the field of obesity prevention and health promotion is available. However, there is a need to make some reservations with regards to answering on accessibility as it is impossible to say whether there are interventions that have not been identified. Primary source of information has been the internet: databases for scientific articles, websites for ministries and private companies, newspaper archives and random searches through search-machines like google.

1.2. Different types of PPPs
If partnerships are being defined as: involving two partners & voluntary & formal & targeted at obesity, then partnerships in France can generally be divided into: partnerships with a specific aim (reformulation of product or a service), partnerships with specific issues (answer to government wishes of involvement) and partnerships with international potential.

The activities carried out in partnerships are quite diverse: reformulation of meals in hotels and restaurants, sustainable change in local environment, change in nutrition policies in schools, codes of conduct, public campaigns etc.

1.2.1. Typical PPPs

In general, public authorities have put focus on obesity prevention and health promotion through the creation of the national plan for nutrition and health (PNNS). Several types of collaborations exist, but most commonly it seems to be in a combination of either public authorities and private companies or between NGOs and private companies.

1.2.2. “Atypical” PPPs

None identified as in doubt of what is required to fall into this category

1.2.3. Best example cases

The criteria for selecting cases according to proposal from MSJ and BEMI are: sustainability embedded, adverse effects addressed and relevant stakeholders involved. However, evaluation of interventions are in some cases difficult to find/non-existent and, hence, criteria for selection are mentioned below:

**Epode**: long-running, political attention, massive funding, high profile

Community based intervention aimed at preventing child obesity through social marketing. The intervention involves local stakeholders in the towns that take part in the intervention (167 towns in France). From 1992 to 2004, a longterm intervention program pilot study was carried out in two cities in northern France (Fleurbaix Lavantie Ville Santé (FLVS)). Over the years, two different approaches were used, first an intervention focusing on nutritional education, secondly an intervention focused on mobilising the community. In terms of obesity rates, the second period was clearly the most successful. This experience led to the development of Epode in cooperation with Protéines, a company specialised in strategic health communication. The point of departure is a behaviour-centred approach focussing on education and non-stigmatisation in the fight of childhood obesity. However, changing of the environment is mentioned as a tool in fighting obesity, but a tool that has to be followed up by sustainable behavioural changes. The key consideration is to prevent children from becoming obese by acting on the behaviour of the whole family, changing its environment and social norms. Positive apprenticeship through experience of a balanced diet is used, while stigmatisation is avoided. That is, the target groups are met in their daily lives and in their normal surroundings. Administratively, national involvement is encouraged through the participation of public and private actors as well as NGO’s. Locally, municipalities bear the responsibility acting through project managers who are assisted by local resource teams that gathers expertise among health professionals, in schools and restaurants and among retailers etc.

Partners: sponsored by EAHC. Carried out by private actors and public institutions. Started by FLVS (Fleurbaix Lavantie Ville Santé), led by Protéines. Intervention is carried out in local
communities. Sponsored by Mars, Ferrero and Nestle. Research in PPPs, social marketing etc is carried out by 4 universities

Potential problem: It is, however, not easily discernable what it means that Epode is a methodology rather than a program & how results from Epode are separated from the general result in terms of obesity rates in France

**Food:** low profile but large scope
Focus on health promotion in workplaces through an offer of healthier lunches. The project is based on the program ‘Nutrition and Balance’ that was launched in 2005 and is spread in 12 countries (in 2008). This program aims at raising awareness of nutritional recommendations among customers holding food vouchers. In France, 1400 restaurants are committed to the program (in 2008) and Accor Hotels in 14 countries have signed a commitment charter

Partners: Sponsored by EAHC. Carried out by private actors (Accor Service) and public institutions (universities, public services)

Potential problem: evaluating results

### 2. Country context

#### 2.1. Background information

Population, total in 2010: 64.7 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 108
Unemployment rate, January 2010, %: 9.9
Healthy life years at birth, 2008, m/f: 62.4/64.2
Obesity rates among adults, 2008 (or nearest year available), %: 11.2

**2.1.1. Food production**

18.330.815 ha of land is cultivated in France (INSEE, 2010), corresponding to approximately one third of the total area. France is the number one producer and exporter of agricultural products in Europe (France Diplomatie, 2007) and the number three exporter worldwide (France Diplomatie, 2007)

**2.1.2. The French paradox**

The French seem to have a special relationship to food. In nutritional terms, this relationship is often referred to through the notion “the French Paradox” (Dolnick, 1990), but the French population’s relation to food has been discussed in more than a decade (Brillat-Savarin, 1862; Fischler & Masson, 2008). To health professionals and scientists, the paradox consists mainly in the astonishment of, how French nationals can consume red wine and eat five-course dinners including full fat sauces and cheeses and, at the same time, have a low prevalence for coronary heart disease (Renaud & Lorgeril, 1992) and obesity (Fischler & Masson, 2008). Data on the French food culture indicate, that the special relationship is rooted in a high quality of food products, less snacking and the pleasure of sharing a meal (Holdsworth, 2008). However, identifying the French population as such with this image is problematic. From 1981 to 2003, disparities between groups of citizens have been detected: obesity is increasing much more in groups with lower education and lower income, and this tendency is also visible geographically, meaning that eastern and northern France has a much higher
prevalence for overweight and obesity than Île de France and the southern and western part of France (Insee, 2007)

2.1.3. The State

France is a republic, the main ideas of which are found in the Enlightenment and inscribed in the declarations of rights and of citizenship (Offerlé, 2004). It’s a nation in Western Europe, but is constituted also of several overseas territories. The President has extensive powers, including the possibility of dissolving the National Assembly, but generally the executive powers are exercised in cooperation with the Prime Minister, the ministers and the Parliament (Offerlé, 2004).

2.1.4. Government, ministries & health

Politically, France is characterised by two opposing fractions: the PS (socialist group) and the UMP (right-wing group). Currently, the right-wing is forming the government and holds the majority in the parliament. The number of ministries isn’t fixed (Offerlé, 2004) and, hence, health does not always have its own minister; currently the minister for health is also minister for sports and youth. Inter-ministerial committees exist and in the case of the PNNS, the program is lead by an inter-ministerial committee, in which the ministers of health, agriculture, education, social cohesion and science are involved through annual meetings where strategic decisions for nutritional policies are made (French Ministry of Agriculture and Fisheries, 2007).

2.1.5. Regulation

Since the beginning of the century, French policy makers have introduced a number of laws and other regulatory initiatives in order to counteract overweight and obesity. Examples of laws passed: strengthening of educational approach to food in schools & reformulation of school meals (Circulaire 2001-118, 2001), limitations in advertising of food products and banning of vending machines in schools (Loi no 2004-806, 2004). Furthermore, a number of French companies have introduced self-regulatory initiatives. Examples of self-regulatory codes of conduct: guide for responsible communication (CSA, 2009), nine objectives of the food industry (ANIA, 2004).

2.2. Overweight and obesity

Since 1990, obesity has become a problem causing growing concern in France. Not the least due to the geographical and socio-economic differences that can be drawn from the numbers. In northern and eastern France, obesity rates are increasing significantly, whereas the Parisian and the Mediterranean zones have a much lower prevalence. Obesity is increasing strongly among farmers and workers, whereas individuals with higher education are less numerous in the statistics of obesity. Furthermore, a growing number of people declare following a diet in order to lose weight, but these persons are not identical to those who actually need to lose weight (INSEE, 2007).

In general for France, the prevalence for obesity increased from 5% to 10% for men and from 6% to 10% for women from 1992 to 2003. That is, in 2003 3.6 million French citizens under the age of 65 were obese, and, furthermore, among women the increase was significantly
higher among younger women which may indicate an even higher rise in the number of obese citizens in the future (INSEE, 2007).

According to a recent study, obesity rates among children is stabilising between 1999 and 2007. However, there is a large negative gradient between socio-economic groups and childhood overweight/obesity with a prevalence of 8.8% in high socio-economic groups and a prevalence of 22% in the most disadvantaged groups (AFSSA, 2008). Numbers from IASO are in accordance with these findings, showing that obesity rates among 7 – 11 year olds in France are approximately 18% for both boys and girls (IASO, 2007).

2.3. National policies on nutrition and obesity

PNNS was set up in 2001. The first program was planned to run from 2001 to 2006 and became the official French reference in nutritional strategies. The point of departure was the association of public health with the taste and the pleasure of food and the specific mentioning of French ‘terroirs’ (PNNS, 2001). This concept is rooted in the Mediterranean food culture and associates food with natural products from specific geographical areas, drawing upon inherited knowledge of local foods. Hence, the concept indicates a certain reserve with regards to imported habits like fast food and processed foods. Also to be understood in this context, is the National Institute of Origin and Quality (INAO) that was created in 1935 with the aim of defending classified wines, but now with the purpose of defending French gastronomy and other traditional French products like cheese, too (French Ministry of Agriculture and Fisheries, 2007). Much in the same line is the barometer of the perception of food, which analyses the food practices of the French consumers and their perception of the link between health and nutrition (Institut national de prévention et d’éducation pour la santé, 2002). Overall, this means that instead of prohibiting specific foods, the French approach in the first PNNS was based on the pleasure and the shared enjoyment of food. The tools used for making the initiative known to the public were information and education.

The second PNNS was formulated in 2006 and runs until 2010 (PNNS, 2006). From an overall point of view, the approach is in line with the first program, but there has been a slight turn from the emphasis on food pleasure towards stressing food health (French Ministry of Agriculture and Fisheries, 2007). The general principles are still rooted in the French food culture, but more emphasis is put on nutrition and nutritional disorders; obesity is specifically mentioned as a point of concern to be addressed by health professionals at all levels – at the same time as it is stressed that there is to be no stigmatisation of obese individuals (PNNS, 2006). Another specific area that has been integrated into the second PNNS is the cooperation between public and private actors with the aim of improving the offer of food, making it coherent with the recommendations in PNNS 2 (PNNS, 2006). The tools used for achieving the aims are initiatives on food supply and treatment of obesity as well as information to consumers (French Ministry of Agriculture and Fisheries, 2007).

PNNS 3 is in a preparatory state. A commission presented a number of suggestions for the fight of obesity in December 2009 (report not official yet), and it is expected that this work will have a certain impact on the formulation of the PNNS 3. Furthermore, the French Society for Public Health has set up a campaign, in which the organisation asks for proposals for the PNNS 3 (Société française de santé publique, 2010).

Policies on nutrition in PNNS1 and 2 have been presented through mass media campaigns in papers and television. They have been distributed through guides and websites, and through
various initiatives that present French agriculture to the population, ex the yearly “Train of the earth”. Labelling of foods is also an issue, but a study carried out in 2006 showed that French consumers are unwilling to accept labelling that would make products like French cheese and fois gras incompatible with healthy eating habits (DGAL, 2006). Labelling of food and beverages is well known in France, though, but has traditionally been focusing on the origin and quality of food products: AOC for wine, Red Label for products of a superior quality, AB for ecologically produced products. Labelling of nutritional content is used by less than 50% of Parisian consumers, mostly because the consumers were not interested in this type of information (Mannell et al, 2006).

2.3.1. Retail structure

75% of retail sales is through supermarkets (Global Agricultural Information Network, 2009), of which Leclerc is by far the largest with 32% of sales, followed by Carrefour (16%), Auchan (9%) and Géant (8%) (LSA, 2004). In 2008, the average consumer spent 12.4% of total spendings on food, 7.8% was in retail food outlets (Global Agricultural Information Network, 2009).

2.3.2. Health-related non-governmental organisations (NGOs)

A large number of NGOs are involved in nutrition policies and health promotion in France. The French Heart Foundation, Association Francaise d'Etudes et de Recherches sur l'obesite (AFERO), family organisations and various consumer organisations. Also, community based NGOs like FLVS (Association Fleurbaix Lavantie Ville Santé) are influential.

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THE REPUBLIC OF IRELAND

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

The Republic of Ireland (ROI) has open on-line access to information and this also applies to Irish companies, trade bodies and NGOs. Information is generally easily accessible in this country because of its small population (less than 4.5 million). National bodies and information sources are based in Dublin although agricultural bodies and research bodies are located regionally. Local authorities operate through twenty-nine administrative counties and five cities. The counties are grouped into eight regions for statistical purposes.

As part of the Good Friday Agreement (2 December 1999), the ROI entered into new cooperative arrangements with Northern Ireland through a new Northern Ireland assembly and through a power-sharing executive, new cross-border institutions and a body linking devolved assemblies across the UK with Westminster and Dublin. These arrangements include elements of food policy (SafeFood). Besides ROI information therefore there are also all-Ireland forms of information as well as mutually influencing UK (Northern Ireland) information.

1.2. Different types of PPPs

- All Ireland, government supported NGO organised PPPs to promote healthy eating (no commercial sector involvement) in some cases through establishing small businesses (e.g. community café)
- Government agency led PPPs to reformulate foods
- Commercial industry led PPPs to promote healthy eating and knowledge of food
- NGO-led PPPs involving commercial sector
- Public research agency-led food industry and academic PPPs (Food reformulation)
- Smaller PPPs which operate once yearly or irregularly – not considered.
1.2.1. Typical PPPs

Government sources emphasise that the ROI food policies, particularly around food safety, are heavily influenced by its membership of the European Commission. Another form of influence is that a significant part of the Irish export market is focused on the UK, which implies an additional influence through British food standards procedures. Although the food industry states that its food reformulation efforts are broad in scope the ROI has fewer government-led PPPs than Northern Ireland, which has a food standards system which is part of the UK-wide Food Standards Agency and PPPs led by the FSA. The Salt PPP is distinctive therefore and a major effort by the Irish food standards body which is an exemplar for other potential efforts into the future.

Food policy in Ireland has always been mindful of its agricultural industries, focussed particularly on dairy. A functional food research project, with industry, therefore forms a major investment and PPP. A further PPP, directly linked to the ROI’s nutrition and obesity policy is around school children’s diet, which is part funded by the European Commission.

Industry developed PPPs range from information and policy development to direct support for healthy eating initiatives, the strongest example being schools.

NGOs in Ireland consider food poverty a major issue, not only in its own right but as a causative factor in obesity.

1.2.2. “Atypical” PPPs

There are a variety of healthy eating initiatives which occur once a year (e.g. Irish Heart Association) which have not been included.

1.2.3. Best example cases

The critical initiatives are those which apply to product reformulation or product size since these have a direct bearing on consumption, assuming that overall patterns and choice mechanisms are maintained. The main PPPs in this regard are those which focus on food poverty since poverty is a major factor in explaining the consumption of less healthy diets. In this respect the Healthy Food Alliance is a critical PPP, albeit there is little or no commercial input to it.

The salt initiative is an important PPP since it particularly focuses on processed foods and bread and provides a potential pathway to further state/industry partnerships on reductions of saturated fat, etc. However, despite a positive start the progress of the level of reduction towards the optimal salt consumption has met with setbacks, in part, it has been suggested, caused by Ireland’s economic difficulties.

PPPs are established (Food Dudes, Incredible Edibles, Nutrition and Health Foundation) which attempt to change behaviour and patterns of choice.

There is often a close association between Irish nutrition and agriculture, in particular through the role of the dairy industry. The research based PPP developing functional foods, based on dairy, may have a role to play but this will be in the future and the outcome is uncertain.

2. Country context
2.1. Background information

Population, total in 2010: 4.5 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 127
Unemployment rate, January 2010, %: 12.8
Healthy life years at birth, 2008, m/f: 63.2/65.0
Obesity rates among adults, 2008 (or nearest year available), %: 23.0

2.2. Overweight and obesity

National statistics around nutrition and nutritional diseases for a number of years focused on cardiovascular disease (and which also linked to the ROI’s highly proactive tobacco control policies.) Ireland has the highest mortality rate from IHD in males and the 3rd highest rate in females in the European Union. It has also witnessed a sustained decline in mortality rates from IHD since 1985. 68 Almost 44% of the reduction was attributable to better, and more timely, treatment and secondary prevention. Just under half of the figure (48%) was attributable to sharp falls in smoking, which accounted for over 25% of the decline, and in cholesterol, which accounted for 30%. Falls in high blood pressure accounted for 6%. 69 These improvements in IHD are now being offset by a sustained rise in obesity and associated diseases and unlike cardiovascular diseases, there appears limited so far in reversing trends. The 2007 Survey of Lifestyle, Attitudes and Nutrition (SLAN) in Ireland shows adult rates of obesity have increased when compared to the previous reports in 1998 and 2002. Self-reported obesity rates in adults (18 – 65+ years) were 11%, 15% and 14% in 1998, 2002 and 2007 respectively. A similar trend applies for overweight, these being 31%, 33% and 36% of the population for the years 1998, 2002 and 2007 respectively. In 2008, 19% of teenage boys were found to be overweight compared to 6% in 1990. This information was based on self reports and thus assumed to underrepresent the full picture. For example, the World Health Organisation Childhood Obesity Surveillance Initiative (2008) found that 22% of 7 year olds were overweight or obese (26% girls, 18% boys). 70 In 2008, 19% of teenage boys were found to be overweight compared to 6% in 1990. The “Growing up in Ireland 2009” study found that one in four 9 year olds overweight or obese. 71

The other side of the picture to weight gain has been persistently consumption of fruit and vegetables and high consumption of foods high in saturated fat, sugar and salt. Recent dietary surveys have reported some positive findings on fruit consumption, but the SLAN noted that a significant proportion of the excess calories in the Irish diet were derived from foods high in fats and sugar.

2.3. National policies on nutrition and obesity

68 Mary B. Codd, 50 Years of Heart Disease in Ireland: Mortality, Morbidity and Health Services Implications, The Irish Heart Foundation, Health Promotion Unit February 2001
2.3.1. Societal Organisation

Ireland is among the smallest of the states in the EU, the 7th lowest in terms of population. The Republic of Ireland joined the EU, then the European Economic Community, in 1973 and over the next three decades was “transformed from an isolated country with an over dependence on the UK as a main trading partner to become a prosperous member of the European Union.”

Although the Irish economy became synonymous with rapid economic growth, in the first two decades of EU membership economic growth was slow and led to major economic emigration. The period between 1993 and 2000 was unprecedented in terms of both output and employment growth. National output increased by almost 8 per cent each year on average while employment growth was nearly 5 per cent. The country faced a severe economic downturn from 2008, which, according to the Economic and Social Research Institute, led to an economic contraction of 14%. Nevertheless, the period of rapid economic growth substantially changed Irish society in numerous importance respects.

One major driver of social change has been to its standard of living; in some considerable part influenced by the EU’s financial support and the economic changes this set in train. Between 1973 and 2007 Ireland was granted €43 billion in aid; the equivalent of €10,000 for every person. As a then primarily agricultural economy, the Common Agricultural Policy also made a large difference to agriculture not only through the impact of subsidy system but also by extending the market for Irish farm goods to mainland Europe. In 1973, almost 60% of the total value of exports went to the UK, followed by Other EU (21%). By 2008, exports to the UK had fallen to 17% while exports to the rest of the EU had risen to 43%. Between 1973 and 2003 the Irish GDP increased more than four fold in real terms. As an indicator of the importance on the standard of living, up until 2001 the proportion of income devoted to food declined from just under one third of total disposable household income to about one fifth. Agriculture itself was transformed over this period: in 1973 24% of the population worked in agriculture; three decades later it had fallen to 7%. Also significantly, the number of women in the workforce increased from 27% of total employed to 42%.

These economic and social structural transformations have led to new social patterns and social forms. Since 1987, a key part of economic policy has been Social Partnership, which is a corporatist style of voluntary ‘pay pacts’ between the Government, employers and trade unions. At time of accession to the EU, the ROI was strongly influenced by not only by its primarily agricultural economic character but also by the involvement of religious bodies in the operation of its social affairs and its welfare system, a situation in which the Catholic Church was held to be “a strong and active force in everyday life”. In the post-independence (from Britain) period the Catholic Church governed most aspects of state policy, including social policy. If the creation of the National Health Service in Britain was determined by its war time experience, in Ireland the shape of the health care (also education) was determined by the involvement of the Catholic church and what has been described as a ‘Catholic Corporatist’ paradigm of welfare regime has been said to apply. Nevertheless, as with the wider economy, EU influence, in particular the anti-monopolisation requirements

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74 ESRI predicts 14% economic decline over three years, Irish Independent, Wednesday April 29 2009
governing private insurance markets, has opened the private health insurance to competition. [3] Despite some trends of social and institutional secularization, the health care system continues as a church-influenced public/private mix.  

2.3.2. Food and Nutrition

It has been noted that there are few health policy documents in the post independence period and those which were published tended to focus on organisational concerns. Not until the 1990s were framework health policy strategies drawn up, accompanied by strategies for particular aspects of the health services. [4] Historically speaking, discussion about nutrition in Ireland are often overshadowed by the Great Famine (1845), the worst experienced in Europe in the nineteenth century. In fact before this time the Irish diet was frequently observed to be of reasonable quality while in the post-famine period the standard diet of nutritious home-produced oatmeal and potatoes was increasingly abandoned for less nutritious shop-bought foods: tea – an increasingly major outlay, white bread, commercially-produced jam, biscuits, and fatty American bacon. The ten-fold increase in sugar consumption between 1859 and 1904 contributed to an increase in the rates of tooth decay and diabetes. [5]

Food law in Ireland also dates back to this early period and continually amended over the years. Today, most if not all, of Irish food legislation derives from Ireland’s membership of the European Union. Then, as today, food policy has focused on food safety, in the nineteenth century on adulteration, but today on a far more diverse range of factors, such as nutritional claims. In 1998 the government established the Food Safety Authority of Ireland (FSAI). The FSAI is now the single, regulatory authority with responsibility for the enforcement of food safety legislation in Ireland. This work is mainly carried out for the FSAI under contract by staff in the local authorities, health boards, Department of Agriculture and Food, Department of Communications, Marine and Natural Resources and the Office of the Director of Consumer Affairs. Food legislation places obligations not just on food business operators, but also on the enforcement authorities who must carry out official controls and to take action where non compliance is detected and more specifically when consumers are put at risk. Practically, however, there are strong public health links across the (increasingly indistinct) border, represented by the all-island Institute of Public Health, an NGO. Furthermore, while the Food Standards Agency operates in Northern Ireland and the Food Safety Authority operates in the ROI, a new body known as safefood, the Food Safety Promotion Board, is an additional implementation body established under the Good Friday Agreement. The governing legislation confers the following specific functions on the board:

• Promotion of food safety
• Research into food safety
• Communication of food alerts
• Surveillance of foodborne disease
• Promotion of scientific co-operation and laboratory linkages
• Development of cost-effective facilities for specialised laboratory testing.

The Board also has a general remit to act as an independent source of scientific advice. It might be noted however, that safefood – as the name suggests – did not originally include

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http://www.esri.ie/publications/search_for_a_working_pape/search_results/view/index.xml?id=2474
nutrition, which is part of the broadening remit of the FSA in the UK. However, nutrition is emerging as one focus and research undertaken among young people by the FSAI and safefood.

Nevertheless, unlike food safety, the central nutritional focus has been slower and less distinct than the food safety emphasis. A Food Advisory Committee report titled "Considerations for a Food and Nutrition Policy in Ireland" outlined the need for food and nutrition policy to improve the health and well-being of the population (Food Advisory Committee 1979). Subsequent reports of the Advisory Committee reports focused on the need for better systems of nutrition surveillance. The Nutrition Advisory Group\textsuperscript{76} was established by the Minister for Health in June 1991, with the following terms of reference:

- To assist in the formulation of a national food and nutrition policy to improve nutrition and health in Ireland;
- To review and update dietary guidelines in the light of new scientific and surveillance information;
- To advise the Minister for Health and the Department of Health on specific nutrition issues such as very low calorie diets or nutritional labelling;
- To advise and represent the Department of Health on media issues relating to nutrition as appropriate;
- To identify specific sub-groups in the population with particular nutritional needs;
- To combat misinformation on nutrition.

2.3.3. Food industry market structure

As noted, the place of agriculture in the Irish economy has appeared to be subject to relative decline. However the word ‘relative’ strongly applies. The food industry remains of considerable importance, with about 64% of the total land area used for agriculture. Food and Drink Industry Ireland (FDII), a division of the Irish Business and Employers Confederation (IBEC), observes that the industry has a gross output of over €18 billion and total employment linked to the sector at 230,000; it is thus “a vital part of Ireland’s economic and social framework.”\textsuperscript{77}

The FDII represents the interests of over 150 food, drink and non-food grocery manufacturers and suppliers in three main categories: Consumer Foods, Dairy and Meat and it is “the main trade association for the food and drink industry in Ireland.” The FDII lists the range of voluntary initiatives which indicates its role in the tackling of obesity. These include:

- Participation on the National Taskforce on Obesity (2003-2004)
- Establishment of the Nutrition & Health Foundation (2005-Date)
- Active collaboration with the Food Safety Authority of Ireland in their 'Salt & Health' initiative (2003-Date)
- Targeted reduction of key nutrients of concern in existing food and drink products, including salt, fat, trans fat, saturated fat, sugar etc
- New product development to expand the range of 'better for you' options available to consumers


\textsuperscript{77} Food and Drink Industry Ireland, Enabling Healthy Lifestyles, 2009
Provision of better nutrition information to consumer through Guideline Daily Amount food labelling
Promotion of physical activity through targeted sponsorships - no other sector does more to encourage physical activity

As one example of its mode of working in 2005, the food industry came together in what referred to as “a significant pre-competitive move” to provide consumers with information on the nutritional content of food and drink products based upon the Guideline Daily Amount (GDA) standards. In 2008, 19 of the top consumer foods companies in Ireland launched a €400K integrated communication strategy to promote GDAs. In addition, and via the FDII, its members committed to European, International and national advertising codes, especially as they related to children’s food and drink advertising. Improvements in product composition in terms of salt, saturated fats, and sugar, are presented in the FDII report Enabling Healthy Lifestyles.

A further example of its involvement in raising the profile of its involvement in nutrition and health was the establishment of the Nutrition and Health Foundation (see appendix), funded by the food industry, which is described as a multi-stakeholder organisation that communicates evidence-based information on nutrition, health and physical activity to encourage an improved and healthier society in Ireland.” The stakeholder involvement is provided through links with the Irish Universities Nutrition Alliance (IUNA), the Exercise and Sports Science Association of Ireland (ESSAI), the Irish Nutrition & Dietetic Institute (INDI), the National Dairy Council (NDC), University College Dublin and St. Angela's College, Sligo.

2.3.4. National Obesity Policy

The Department of Health document, Shaping a Healthier Future, noted that about two-thirds of adult men and nearly half of adult women were overweight. Ireland’s strategic approach to population weight and obesity was defined in May 2005 Report of the National Taskforce on Obesity, Obesity the Policy Challenges. The report aimed to provide the policy framework and in particular childhood obesity. It saw that overweight and obesity could be attributed to many factors, making it thus essential to apply a multi-sectoral approach. The report provided 93 recommendations for action aimed at six sectors. These included:

- 5 aimed at high level government
- 22 for the education sector
- 13 that targeted the social and community sector
- 24 for the health sector
- 9 for food, commodities, production and supply
- 20 for those responsible for the physical environment

There have been divergent opinions on the degree of effectiveness of the implementation of these recommendations. In relation to the 9 recommendations for food, commodities, production and supply, an official review of their success made the following observations.

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79 Food and Drink Industry Ireland, Enabling Healthy Lifestyles, 2009
<table>
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<tr>
<th>Recommendation</th>
<th>Current Position</th>
<th>Implementation Status</th>
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<tr>
<td>1. The Department of Enterprise, Trade and Employment, the Department of Health and Children, together with the private sector and consumer groups should immediately take multi-sectoral action on the marketing and advertising of products that contribute to weight gain, in particular those aimed at children.</td>
<td>There have been a number of initiatives by Government, Regulators, Private Sector and Consumer groups in relation to the practice of advertising of foods and beverages at Children. Codes, Rules and practices have been developed. Work is ongoing and includes measures in the Broadcasting Bill 2009 to prohibit TV and radio advertising of HFSS (high fat, sugar and salt) products subject to public concern in respect of the general public health interests of children.</td>
<td>Partial</td>
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<td>2. The Department of Agriculture and Food should review policies in partnership with other government departments to promote access to healthy food. Such policies should encompass positive discrimination in the provision of grants and funding to local industry in favour of healthy products.</td>
<td>It must be recognised that there would be constraints on putting such measures in place in that positive discrimination may not be possible under EU state aid and competition rules.</td>
<td>Not possible due to legal constraints</td>
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<tr>
<td>3. The Department of Agriculture and Food together with the Department of Health and Children should promote the implementation of evidence-based healthy eating interventions.</td>
<td>Since publication of the Report, the Department of Agriculture, Fisheries and Food has funded a number of research programmes and has through Bord Bia rolled out the Food dudes Programme to 1,000 primary schools. DoHC has funded the Observatory (see appendix for details).</td>
<td>Progressing</td>
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<tr>
<td>4. Guidelines for food and nutrition labelling should be reviewed and further developed by the appropriate food agencies in conjunction with industry and consumer groups, to ensure that labelling is accurate, consistent, user-friendly and contains information on portion sizes and nutrient content.</td>
<td>Ireland is taking part in discussions at EU level on food labelling, i.e. a Proposal for a Regulation of the European Parliament and the Council on the provision of food information to customers. The DoHC supports front of pack labelling. Food and drink companies have created and promoted a front of pack Guideline daily Amount (GDA) campaign amongst its members and retailers to provide nutritional information on products in a consumer-friendly way.</td>
<td>Partial</td>
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<tr>
<td>5. There should be a rigorous and regular review of all products that claim to support weight loss. Food and beverage slimming products should be reviewed by the appropriate food agencies, while medical products should be reviewed by the Irish Medicines Board.</td>
<td>There are constraints in this area given that applicants can apply to the EU to have products licensed within the EU area.</td>
<td>Partial</td>
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<td>6. A single representative industry body should be established to implement and monitor consistently the relevant Taskforce recommendations as they relate to that sector and to specifically collaborate on issues relating to partnership in this strategy.</td>
<td>Food and Drink Industry Ireland and Retail Ireland have agreed to work as part of a wider industry group with the Department of Health and Children to implement this recommendation.</td>
<td>Partial</td>
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<td>7. The food and drinks manufacturing industry, the retail sector, the catering industry and the suppliers to these should promote research and development investment in healthier food choices.</td>
<td>A number of initiatives have been undertaken by key stakeholders, examples of which are outlined in the appendix.</td>
<td>Partial</td>
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<td>8. The food and drinks industry should be consistent in following the lead of those who have already abandoned extra-large-value individual portion sizes.</td>
<td>DoHC participates in the EU Platform on Diet and Physical Activity, which is beginning to prioritise portion sizes in the food industry as a key factor in implementing the EU Strategy for Europe on Nutrition, Overweight &amp; Obesity-related Issues. The Nutrition and Health Foundation have undertaken a literature review on the benefits for both the consumer and restaurants with regards to the provision of (a) reduced portion sizes in addition to regular portions, (b) increasing the fruit and/or vegetable content of a meal and (c) a combination of both. The NHF are seeking to engage the Restaurants Association of Ireland on this initiative.</td>
<td>Partial</td>
</tr>
<tr>
<td>9. A practical healthy nutrition programme should be established by the health services, the appropriate food agencies and the catering institutions to ensure that all catering facilities provide healthy options.</td>
<td>A number of excellent examples, covering initiatives promoting healthy food choices have been adopted at commercial and educational level and are included in the appendix. The salt reduction procurement programme provides an excellent model for further initiatives. (see appendix for details).</td>
<td>Progressing</td>
</tr>
</tbody>
</table>
In 2007, building on the government heart and obesity strategies, the Irish Heart Foundation published its own recommendations, based on the expectation that a national nutrition strategy was soon to be published (and by implication include these recommendations.) These recommendations included:

- a shift away from dietary responsibility being placed exclusively on the individual, to looking at the broader environment
- better coordination to influence the environment to provide healthier food choices,
- health impact assessment of government policy with an impact on health
- front and back of pack food labeling
- fiscal polices could promote healthier food choices
- Long term elimination of industrially-produced trans fatty acids from food products
- Collaboration with industry to reduce salt in processed foods should continue.
- Policies to control marketing and advertising of foods high in fat, sugar and salt to children

Nevertheless, even though an Irish Nutrition Strategy has been promised since the obesity task force in 2005, NGOs have since made criticisms that the promised strategy had not been made available and have addressed reasons why this should be so (including the economic downturn, lack of departmental capacity, etc.)

2.3.5. Socio-economic reasons for obesity

The most recent SLAN study warned that “the high prevalence of overweight and obesity in Irish adults poses a major threat to the health and well-being of the Irish population, with significant negative implications for healthcare expenditure over the next decade.” The all-Ireland Irish Institute of Public Health has predicted that between 2005 to 2015 in Northern Ireland there will be a 26% increase in the number of people with Type 2 diabetes. Based on these current trends an estimated 84,226 in Northern Ireland and 193,944 in the Republic of Ireland will have adult diabetes by 2015, a total of 278,170 people across the island. The Irish Medical Organisation estimate that that around 10% of the current healthcare budget is spent on diabetes care, 60% of which is used for treating people who have developed complications from Type 2 diabetes.

According to analysis by the Department of Health, Social Services and Public Safety (DHSSPS), levels of obesity in children living in Northern Ireland estimated that, if no change is effected in obesity levels, the costs of obesity to Northern Ireland over the next twenty years would be £14.2 million in lost productivity, £90 million to DHSSPS in treating obesity

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84 http://www.publichealth.ie/news/iphgivesevidencetonorthernirelandassemblyhealthcommitteeinquiryintoobesity
related disease and a total lifetime economic cost through obesity related deaths of £340 million. Studies on inpatient care in Ireland, based on the 2001 figures for cost per inpatient bed day, suggest that the annual hospital cost was 4.4 Euromillion in 1997, increasing to 13.3 Euromillion in 2004.[6]

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LUXEMBOURG

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

Very little information on interventions within the field of obesity prevention and health promotion has been found. However, there is a need to make some reservations with regards to answering on accessibility as it is impossible to say whether there are interventions that have not been identified. On basis of the searches, it seems that the majority of interventions are made by the ministries behind the national plan for nutrition and health

Primary source of information has been the internet: databases for scientific articles, websites for ministries and private companies, newspaper archives and random searches through search-machines like google.

1.2. Different types of PPPs

If partnerships are being defined as: involving two partners & voluntary & formal & targeted at obesity, then the identified partnerships in Luxembourg are: outsourcing of food services, collaboration with celebrity cook to boost recipes in public meals and collaboration with distributors of fresh food products

1.2.1. Typical PPPs

http://www.niauditoffice.gov.uk/pubs/workinprogress.asp
In general, public authorities have put focus on obesity prevention and health promotion through the creation of the national plan for nutrition and health (Gesond iessen, méi bewegen). There are partnerships that are presented through the website of the Ministry of Health (portail santé), but it has been difficult to identify partners other than public authorities.

1.2.2. Best example cases

As only very few partnerships have been identified, and none clearly within this definition, no best example cases have been chosen.

2. Country context

2.1. Background information

Population, total in 2010: 502 066
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 271
Unemployment rate, January 2010, %: 4.8
Healthy life years at birth, 2008, m/f: 64.8/64.2
Obesity rates among adults, 2008 (or nearest year available), %: 20.0

2.1.1. Food production

127.000 ha of land are cultivated in Luxembourg (Ceja, 2002), corresponding to approximately half of the total area. Luxembourg is a producer of top quality pork meat and butter and also wines from the Moselle area and eaux-de-vie have a good reputation (Chambre de Commerce, 2010).

2.1.2. On food culture

With its location in central Europe, Luxembourg has been a crossroad for European cultures and alongside with the agricultural tradition this has had an important impact on the culinary tradition (Luxembourg Presidency, 2004).

2.1.3. The State

Luxembourg is a Grand-Duchy. The Grand Duke or Duchess is the ceremonial head of state, but the state as such is a representative democracy led by a prime minister, who is the head of a sixty-member Chamber of Deputies, elected every five years (État Luxembourg, 2010).

2.1.4. Government, Ministries & health

The current government was elected in 2009 and consists in a coalition between Christian-Democrats and the Socialist Party. The number of ministries is currently 19. The program “Gesond iessen, méi bewegen” is led by a multi-ministerial group, in which the ministries of Health, Education, Family and sports are represented (Gesond iessen, méi bewegen, 2006).

2.1.5. Regulation
With the introduction of the program “Gesond iessen, mé bewegen” a number of initiatives were planned: supplementary education of employees in canteens, upgrading of offer in canteens towards healthier choices, removal of sugary drinks from vending machines and associating the pupils in the making of food (Gesond iessen, méi bewegen, 2006). At a concrete level, there have been initiatives such as an offer of fruit in schools, thematic weeks in schools with focus on food items and distribution of information on healthy eating habits to parents (Luxembourgian Ministry of Health, 2010). Exhaustive data on the fate of the initiatives mentioned in the initial program has not been found. Example of legislation: advertising within five minutes before and after children’s programs is forbidden (UFC Que Choisir, 2007). In some sources there are indications of a ban of vending machines in schools, but no definitive sources have been found to confirm this.

2.2. Overweight and obesity

Reliable data on overweight and obesity in Luxembourg are scarce. Data from OECD indicate overweight rates among the adult population at 34.4% and obesity at 18.4%, but these numbers are self-reported, and, hence, not fully reliable (OECD, 2005). Data from 2009 indicate similar tendencies with regards to obesity (OECD, 2009). According to IASO, 44.6% of adult population have a BMI > 25, but there are no indication of the year of collection (IASO, 2010). At a national level, a study published in 2010 presents figures indicating rates of overweight are stable and obesity rates are increasing: in 1995 37.3% of adult population were overweight and 14.3% obese, whereas in 2008 37.4% of adults were overweight and 17.7 were obese (PSELL, 2010). The study is based on national statistics, but it is not entirely clear whether figures are self-reported or measured. Socio economic disparities are found. Among citizens without or with little education the prevalence of overweight/obesity is 43%/23%, and among those with higher education the prevalence is 32%/11% (PSELL, 2010).

With regards to overweight and obesity among children and adolescents, there were no standardized data until 2006 (Ministry of Health, 2006). Data from IASO show that 15% of boys between the age of 11 and 15 and 10% of girls of the same age are obese, but these data are self-reported (IASO, 2005/06). There are, however, indications of the size of the problem prior to 2006. A study carried out in the educational system showed that 25% of the pupils/students between the age of 10 and 27 were overweight or obese and that the frequency of overweight was identical for girls and boys, whereas the prevalence for obesity was higher for boys (Santé Publique, 2004).

2.3. National policies on nutrition and obesity

In the years following the turn of the century, public authorities in Luxembourg received unsettling data from different sources. In 2002, a study revealed that between 30 and 40% of Luxembourgian children did not eat sufficient amounts of fruit and vegetables (Wagener, 2002) and in 2004, medical services at schools estimated that more than 20% of children and adolescents in schools were overweight (Service de médecine scolaire, 2004). These data led to the creation of the first national program for nutrition and health that was launched in 2006 and is expected to run until 2012. At a general level, the approach is “problem-oriented”, expressing concern that especially children lack knowledge of and access to healthy food, that they move too little and that the consequences of such conditions are costly for the society. (Gesond iessen, méi bewegen, 2006).
The program is multi-disciplinary and has the intention of involving both public and private sectors. Schools have been designated as the primary arena and teachers, medical services, school restaurants and a number of organisations have been asked for a mutual effort with regards to the goals of the program (Wagener, 2008). The means of inducing change are first and foremost information and education, but all disciplines are invited to engage in the work in whichever way is suitable (Gesond iessen, méi bewegen, 2006).

At a concrete level, a number of initiatives have been taken with regards to food. “Gesonde start an d’schoul” addresses the eating habits of smaller children and offers information on breakfast habits (Luxembourgian Government, 2008). Furthermore, schools can request the right to use the logo of the national program and gain access to didactic tools (Gesond iessen, méi bewegen, 2006). Within the scope of “Gesond iessen, méi bewegen”, a program aimed at promoting breast-feeding of infants was adopted in 2007 (Luxembourgian Government, 2006).

The program is supposed to be dynamic and initiatives have been added since the official launch of the program in 2006. The current program runs until 2012, and no plans for the follow-up have been identified.

2.3.1. Health-oriented non-governmental organisation (NGOs)

Information on NGOs that are active in the field of obesity prevention and health promotion has been difficult to identify. The initiatives described are primarily run by the ministries in charge of the program, but family organisations have been involved in the interventions in schools. Furthermore, the Diabetes Association and the Dieticians Association have issued papers on obesity.

THE NETHERLANDS

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

We collected information of obesity programs from the web. Most of the programs we found are from Netherlands Nutrition Center, which is a member of the Dutch Federation of Public Health (NPHF). Rest of programs are founded from specific pages of programs like program “JUMP-in KINDEREN BEWEGEN”. Search words are related with obesity term such as “obesity program”, “partnership obesity”, “health and obesity”, etc.

We found fifteen PPP initiatives in this country which are the following: “Voedingscentrum Eerlijk Over Eten (Nutrition Center)”, “Fruit and Vegetable at School Campaign”, “Hidden Fat”, “Gezond Eten op School (Healthy School Canteens)”, “Balansdag (The Balance Day)”, “Food Quality Campaign”, “Borstvoeding Verdient Tijd (Breastfeeding Deserves Time)”, “GO4KIDS”, “Dikke Vrienden Club Overgewit (Club of Friends of Fat)”, “Kids Obesitas Programma (Childhood Obesity Program)”, “Jump-in Kinderen Bewegen”, “Leeker Fit!”, “Project O.K.!: Program for Children with Obesity”, “Jongeren op Gezond Gewicht (Jogg)” and “Finally Lyfestyle Programma”.

1.2. Different types of PPPs
In this country, most of the PPP initiatives come from the independent organization Netherlands Nutrition Center, in co-operations with Central Bureau of Food Trade and the Federation of Dutch Food Industry. There are a close relationship between public and private sectors because we can see how a lot of companies like Kellogs or LU biscuits, among others, takes part on several programs. We also found a closer relation between Ministry of Health, Welfare and Sports with a lot of Medics Services, like Dutch Association of Pediatrics or Dutch Society of Obstetrics and Gynecology, and with Scientific Organizations like Netherlands Organization for Scientific Research and Medical Sciences (NOW-MW).

Most of the PPP initiatives are related with childhood obesity; for this reason are focused in the prevention and treatment of this problem in children. To deal with children the easiest way is implementing the programs into the schools. In this sense we can highlight programs like “Gezond Eten School” which is focused in promotion of healthy food products in the schools canteens because this can help to make aware young people of benefits of healthy eating and avoids the excess of high fat food and drinks. Other PPP initiative that we emphasize is “Dikke Vrienden Club Overgewicht”. This program consists in the creation of groups of children between 8 and 12 years who has overweight problems and help they addressing both medicine, food, movement and psychological aspects. In this way, experts in childhood obesity can teach to children how a chance in consumption behavior together with physical activity helps to mitigate the problem. However, some programs emphasize the importance of sports to prevent obesity problems. This is the case of “JUMP-in KINDEREN BEWEGEN”. This program is focused on children between 1 to 8 years and wants to make aware, both parents and children, of importance of sport and exercise. The reason is because it’s a fact that overweight children in Amsterdam do very little exercise.

We found some programs with “Atypical” and innovative ideas. In this sense we found “BALANSDAG”. This is a PPP initiative whose objective is restore energy balance and combats the obesity problem through an equilibrate consumption and practice physical activity each day. We also found “HIDDEN FAT”. It’s a program which finally is gives information to consumers and achieve co-operation of companies to elaborate food with a lower fat content. “Borstvoeding Verdient Tijd” is an initiative focused on the health’s benefit of breastfeeding because this is the best food for babies and there is evidence that prevents obesity and other diseases. Its objective is to increase the number of children who are breastfed and therefore is focused on women.

We only have results of two programs and it’s the following:
1. “BALANSDAG”: 47% of people said that this program really has a positive effect and sometimes they indicates that they feel more in shape.
2. “Dikke Vrienden Club Overgewicht”: Scientific research has demonstrated its positive effects.

2. Country context

2.1. Background information

Population, total in 2010: 16.6 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 131
Unemployment rate, January 2010, %: 4.5
Healthy life years at birth, 2008, m/f: 62.4/59.8
Obesity rates among adults, 2008 (or nearest year available), %: 11.1

Netherlands is located in northwestern Europe, bordered to the north and west by the North Sea, to the south with Belgium and to the east with Germany. The capital and biggest city is Amsterdam, although the government is located in La Haya. This country is one of the most densely populated (399,494 hab./km$^2$) in the world and one of the most developed states. According with World Bank data his population in 2008 was around 16,445,593 habitants. Randstad metropolitan region has a population around 6,5 million of habitants (40% of the total of Netherlands) and the Randstad region (a socio-economic association) has around 7,6 million of habitants. This country had an unemployment rate of 4,5% of working population in August 2010 according with World Bank data.

2.2. Overweight and obesity

Netherlands cuisine is characterized by a big consumption of bread and potatoes with meat or vegetables. The cheese, like Gouda or Edam, is also very popular. Actually, the time that people spend in the kitchen is lower than previously. The lunch time is usually quickly, today’s is preferable the fast food to make something swiftly and uncomplicated. In this sense, observing information about consumption habits of Netherland people, we found that, although the consumption of soft drinks, bottled water, fruit and vegetable has been an increase, in last ten years they eat a lot of fast food and go to full service restaurants more than to other restaurants. Perhaps for this reason Netherlands has an elevated rate of overweight people.

Observing data from IOTF we saw that in Netherlands, 43,5% of men has overweight and 10,4% are obese. This percentage it’s much lower in female case where 28,5% has overweight and 10,1% has obesity problems. However, childhood obesity rate is lower that most of countries of EU27. This rate is measured with IOTF criterion in children between 5 and 17 years in year 1997. According with this data in Netherlands 8,8% of boys and 11,8% of girls has overweight problems.87

2.3. National policies on nutrition and obesity

In the Netherlands, the proportion of total general medical costs attributable to obesity and overweight are around 3-4%. It’s an important proportion of the health costs and for this reason obesity isn’t just an individual problem, it’s a social problem which affects a lot of aspects of our lives.

Most Dutch laws and regulations are derived from European Union directives. Many of the decisions and agreements are included in the Commodities Act. Other important laws are the Agricultural Quality Act., the Pesticides Act. And Veterinary Medicines Act. The main control is the Dutch government and business organizations. Food security in the Netherlands (VWA) is responsible for the implementation of food safety policy under the Ministry of Agriculture Nature and Food Quality (LNV).

2.3.1. Socio-economic reasons for obesity

87 Information from International Obesity Taskforce (IOTF), available in: http://www.iotf.org/database/index.asp
The principal causes of overweight and obesity are two. First, an increasing on consumption of “energy dense” foods and drinks, promote excessive “calorie” consumption and supports a “snacking culture”. There are recent evidence highlights of an increase of appetite control by these foods, drinks and their frequency of consumption. Second, the reduction of physical activity culminates in a sedentary state which carries overweight and obesity problems. These diet and inactivity problems mainly affects to the poorest economic and social classes. Bellow we summary the main partnerships initiatives.

**UNITED KINGDOM**

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

British state institutions, commercial organisations, commercial trade associations, and NGO and third sector organisations (charities, voluntary organisations, etc.) have a strong online presence and information on policy and activity is generally freely available, albeit not always in detail.

Institutionally the UK is a complex setting and is in the process of becoming more complex as the devolution process continues. The UK is composed of four nations of very different size and demography. For this study UK government agencies and ministries (England, Northern Ireland, Scotland and Wales) responsible for health and food and related matters were identified. Their web pages were searched for any relevant initiatives, reports and organisations with which they have links. A similar process applied to local government, commercial organisations, commercial trade associations and NGOs. This report shows that the UK is rich in activity around private public partnerships, the policy theme of obesity and weight gain, and that commercial organisations and NGOs have made considerable effort to formulate a response.

The issue of information accessibility is also important for developing cultural shifts in the food industry, by public health or nutrition bodies, and by consumers. The Food Standards Agency website provides consumer information\(^{88}\), Change4Life \(^{89}\) (and Change4Life Wales) \(^{90}\) has been primarily an information and cultural campaign (terming itself “a movement”), Food Vision, \(^{91}\) a website promoting local good practice in establishing PPPs and partnership efforts.

1.2. Different types of PPPs

There is a rich format of PPPs in the UK and they are numerous. A simple principle of classification for defining type of PPP is that of instigating organisation, that is to say whether the PPP led by commercial organisation, by a government organisation, and so forth. There

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\(^{88}\) [http://www.food.gov.uk/](http://www.food.gov.uk/)

\(^{89}\) [http://www.nhs.uk/change4life/Pages/change-for-life.aspx](http://www.nhs.uk/change4life/Pages/change-for-life.aspx)

\(^{90}\) [http://wales.gov.uk/hcwsubsite/healthchallenge/individuals/change/?lang=en](http://wales.gov.uk/hcwsubsite/healthchallenge/individuals/change/?lang=en)

\(^{91}\) [http://www.foodvision.gov.uk/](http://www.foodvision.gov.uk/)
are PPPs representing all these dimensions and more, for example those led by government-supported research bodies or those by NGOs established by, but operationally independent of, commercial bodies. Additionally, there are government-originated PPPs (as with School Food Trust, which manages ‘Get Cooking’) which are government-funded charities and partially corporate-inspired NGOs like the Oxford Health Alliance which retain strong bonds with corporate sponsors.

The UK part of the appendix is not intended as a comprehensive documentation of all PPPs in the UK but rather a selection of the main types, showing some of these dimensions of management, control and span of relationships.

The appendix shows:

- UK government-led PPPs, including those of non-departmental government agencies, including efforts to engage companies in product reformulation
- Devolved administration and English government-led PPPs – operating at the supra-organisation level
- Local Government and NHS-led PPPs (example cited include partnerships with nurseries or commercial providers of takeaway foods)
- Public research agency-led PPPs (focused on food reformulation)
- Commercially-led PPPs (Pepsi Cola) involving on partnerships which assist product reformulation strategies
- NGO-led PPPs (Oxford Health Alliance, School Foods Trust - Get Cooking)

1.2.1. Typical PPPs

Given the profusion of types of PPP in the UK, the concept of typicality is problematic. Typicality of PPP might be defined according to its type of instigating organisation and its remit. For example PPPs developed by local government are always focused on an area or geographical basis, however even company-led PPPs may be located in only in one area of the country; central government agency-led PPPs are possibly the simplest model for typicality since their approaches are scalable.

1.2.2. “Atypical” PPPs

Given the variety of PPP types, the notion of “atypical” initiatives has not been closely considered. “Atypical” PPPs ruled out of consideration have been those which has been organised for brief, irregular periods only.

1.2.3. Best example cases

Critical initiatives are those which apply to product reformulation or product size since these have a direct bearing on consumption, assuming that overall patterns and choice mechanisms are maintained.

2. Country context

2.1. Background information
Population, total in 2010: 62.0 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 112
Unemployment rate, January 2010, %: 7.9
Healthy life years at birth, 2007, m/f: 64.9/66.1
Obesity rates among adults, 2008 (or nearest year available), %: 24.5

2.2. Overweight and obesity

The UK has a high risk profile for population weight and obesity.

Public health targets for reducing obesity have been in existence for almost two decades. In the 1992 policy report (a ‘white paper’ in British policy language), *The Health of the Nation*, targets were set to reduce obesity prevalence rates in England for men from 7 percent in 1986-1987 to 6 percent by 2005 and for women for the same period from 12 percent to 8 percent. The latest Health Survey for England (HSE) data shows that in 2008, 61.4% of adults (aged 16 or over), and 27.3% of children (aged 2-10) in England were overweight or obese, of these, 24.5% of adults and 13.9% of children were obese. In 2008, 26.8% of adults in Scotland were obese and 65.1% were overweight; for children the corresponding rates were 15.1% and 31.7%. A not dissimilar picture applies to Wales and Northern Ireland. In all parts of the UK both adult and child obesity has risen rapidly over a two-decade period.

Data on obesity in the UK is drawn from the following sources:

- The Health Survey for England is an annual survey undertaken since 1991. This is currently the most robust data source to monitor trends in adult obesity in England. Since 1995 the survey has also covered children aged 2-15 years and children under 2 since 2002.
- The Health Survey for Scotland was introduced in 1995 and was followed by surveys in 1998, 2003 and 2008 and has run continuously since then. The survey includes adult and child obesity, cardiovascular disease, hypertension and diabetes, physical activity and diet.
- The National Child Measurement Programme was established in 2005 in which children in school reception and Year 6 are weighed and measured during the school year to inform local planning and delivery of services for children and gather population-level surveillance data to allow analysis of trends in growth patterns and obesity.
- The National Diet and Nutrition Survey was set up in 1992 by the Ministry of Agriculture, Fisheries and Food (MAFF) now the Department of Environment, Food and Rural Affairs (DEFRA) and has been operated by the Food Standards Agency (FSA) since 2000. The annual programme surveys a national sample of adults aged 19 to 64 years and aims to provide a comprehensive, cross-sectional picture of dietary habits and nutritional status of the population of the UK.
- The Expenditure and Food Survey (EFS) was run by the Office for National Statistics (ONS) since 2001. Energy and nutrient intakes were calculated using standard profiles for each of some 500 types of food. ‘Family Food’ reports based on the survey analysis published annually by DEFRA. These reports provide detailed national-level information on purchased quantities, expenditure and nutrient intakes from food and drink (including food eaten out). The set sample was 12,000 addresses a year. Self reported diaries of all purchases, including food eaten out, over a two week period, is collected from a sample of UK households. Includes adults (aged 16 and over), and children (aged 7 - 15 years). From January 2008, the EFS questionnaire become known as the Living Costs and Food (LCF) module of the Integrated...

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94 National Diet and Nutrition Survey (NDNS) www.food.gov.uk/science/dietarysurveys/ndnsdocuments/
Household Survey (IHS). The LCF is a continuous survey of household expenditure, food consumption and income. The primary uses are to provide information about spending patterns for the Retail Price Index, and about food consumption and nutrition. The results of the new survey were to be published by the two departments. ONS publishes the data in 'Family Spending' and DEFRA the results on food consumption and nutrition in 'Family Food'.

- The Low Income Diet and Nutrition Survey (LIDNS) was commissioned by the Food Standards Agency to provide nationally representative evidence on eating habits, nourishment and nutrition-related health of people on low income. A sample of 3728 adults and children (aged 4 and above) from 2477 households across the UK were surveyed between November 2003 and January 2005.


Specific information and interpretation of population weight is collected and analysed by the National Obesity Observatory (NOO) which is part of a network of Public Health Observatories (PHOs) working across Britain and Ireland (Northern Ireland and Republic of Ireland) and which is a member of the Association of Public Health Observatories. PHOs produce information, data and intelligence on health and health care for practitioners, policy makers and the wider community.

The Food statistics pocketbook is an annual compendium, ranging from food prices to food supply, and including data on food safety, consumer demand, public health alongside statistics about the economic contribution of the UK food chain and the environmental impacts of UK food production and consumption. The collection of statistics gives a picture of all stages of the food chain, from production to consumption.

2.3. National policies on nutrition and obesity

2.3.1. Societal Organisation

The UK is often identified as a highly individualistic, market-oriented society. Esping-Anderson’s three-regime model of welfare society delineates between 1) Liberal regimes 2) Social Democratic Regimes and 3) Corporatist Regimes. The UK, along with the USA and Canada, are identified as being representative of ‘Anglo-Saxon’ or ‘Liberal’ regime model types. [1] Seen from an overall economic perspective this might appear an accurate generalisation and unsurprisingly so given the UK’s history as the global prime mover in the transition to market capitalism.

In terms of institutional structure and culture the underlying picture is far more nuanced and mixed. The UK has undergone numerous historical shifts creating an institutional system and cultural ethic of rich complexity and anomaly. In the twentieth century, often precipitated by wartime pressure to consolidate society, policy was developed under state corporatist assumptions while at others, particularly from the early 1980s on, policy development was explicitly neo-liberal, or drawn in the terms of British political language, ‘Thatcherite’. After

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95 http://www.statistics.gov.uk/statbase/product.asp?vlnk=361; Living Costs and Food Survey (LCFS);

96 Low Income Diet and Nutrition Survey, Vol 2 2007
www.food.gov.uk/science/dietarysurveys/lidnsbranch/

97 http://www.ic.nhs.uk/pubs/opad10

98 www.inispho.org.uk/.
the Conservatives left office in 1997 there was strong elements of neoliberal policy continuity through a 13 year period of Labour party in government. The Conservative-Liberal Democratic coalition government which took office in May 2010 has substantially reverted to earlier neo-liberal model of the 1980s.

While these observations might confirm the Esping-Anderson thesis, this might ignore government interventions to address market failure and policy survivals from past periods of collectivist, or corporatist, administration. For example while the current coalition government is formally committed to significantly reduced public spending and the shrinking of state structures, the National Health Service, which is free at the point of use and funded from taxation, remains largely unaffected, although in other spheres, such as housing, do represent a retreat from direct state provision (once a commitment of all major political parties).

2.3.2. Welfare society and nutrition

War and ideological contest provide a large part of the explanation for the process of market-replacement or market supplementation by the state in the twentieth century, but Britain’s mid-nineteenth public health legislation preceded either of these explanations and occurred at a time when liberal economic ideology was at its peak. The pressure to make large investments made in sanitation to combat infectious disease was therefore material necessity. [2] Food security might also provide a similar case. More than any other European country, the UK has been heavily reliant on food imports, particularly necessary in the wake of its early industrialisation and accompanying rapid rise in population. While parts of the UK - now the Republic of Ireland - were blighted by famine, in the main the population of the UK had become the best-fed in Europe. Nevertheless, an official framework for nutrition did not come until much later. An expert committee to provide scientific advice on diet and nutrition was established as late as 1931, and then in response to requests from a League of Nations Commission, and although the a social class gradient associated with unequal nutrition had been clearly revealed a half century before it was only in the immediate period prior to the outbreak of WW1 that serious measures were introduced, in particular a Ministry of Food. The establishment of this ministry, despite the considerable supply problems meant that “the national diet as a whole was unquestionably better balanced during the war than before it”. [3]

2.3.3. Food policy

The Ministry of Food became part of MAFF after the war and the independent focus on nutrition was lost. At the end of World War 11 food security concerns prompted fresh measures to boost homeland food production and raise agricultural efficiency and the era of ‘productionist’ food policy had begun, with similar pressures in mainland Europe leading to the formation of the Common Agricultural Policy. Although, as with the national political economy as such, the overall framework for agriculture maintained its ‘market-oriented’ character, the degree and form of state intervention, fluctuating over the period, has been and continues to be, highly significant. The state-supported productionist emphasis in agricultural policy led to a far higher use of technological inputs (machinery, seeds, fertilisers, etc) which produced a pattern of environmental effects and rapid employment dislocation. It was only many years later, with British farming then within the CAP framework, that the British governments, as with other members of the EU, began to question the productionist consequences of agriculture in terms of environmental, food safety and social effects. In particular the outbreak of Bovine spongiform encephalopathy (BSE), commonly known as
mad-cow disease, which first became apparent in 1984 and was later linked to human (new) variant Creutzfeldt-Jakob disease was a potential spur to policy change. In fact the cost and social implications of the disease directly led to the establishment of the UK Food Standards Agency (FSA) and the replacement of the Ministry of Agriculture, Farming and Food (MAFF) by the Department of Environment, Food and Rural Affairs (DEFRA) in 2001. At first the emphasis of the FSA was food safety, but, and in the face of opposition by the food industry, it gathered a nutritional remit.

In fact, these changes were overdue from another perspective, that of the make-up and economic balance of the food supply chain and importance of the food industry. While agriculture had been historically the most prominent feature of the food sector, from the end of World War 1 the role of agriculture became increasingly marginalised by the food manufacturing, food retail and food service industries. In July 2008 the Cabinet Office Strategy Unit published, Food Matters: Towards a Strategy for the 21st Century. The report looks at long-term trends in food production and consumption, and the impacts that food production and consumption has both on our health and on the environment. The report set out a series of actions for Government to address the challenges presented by the health and environmental implications of the food supply chain and consumption in an integrated way. For Defra, this means working with the agriculture sector to look at ways to mitigate and adapt to climate change, working with the food supply chain to reduce food and packaging waste, and engaging with all stakeholders in the food system – primary producers, food manufacturers, retailers, and consumers – to develop a vision for the future of food.

2.3.4. Nutrition policy

Not until the establishment of the Committee on Medical Aspects of Food and Nutrition Policy (COMA) in 1964, to advise UK health departments, was a singular, independent focus on nutrition restored since the demise of the war time Ministry of Food. COMA was replaced in 2001 by the Scientific Advisory Committee on Nutrition (SACN); also providing advice to the Food Standards Agency. Historically, the reports of COMA pointed to continuing weaknesses in the British diet but its members often disagreed on the actions to be taken, causing confusion for those politicians willing to address dietary deficiency. [4]

In the very recent period SACN has been more positive about the diet of the adult population, pointing to a fall in the intake of fat and saturated fat, red meat, and processed meat and an increase in fruit and vegetable consumption. However, while diet was improving overall there were continuing structural deficiencies in the diet of children and poorer groups. These included low fruit and vegetable consumption – it was noted that 20 percent of children consumed no fruit and vegetables during the survey week – , that adults’ mean salt consumption was 50 percent above that of guidance amounts, and that rising prevalence of obesity was coupled with low nutrient intakes while the biochemical status of children and young adults suggested diets too high in energy and sugar and too low in fruit and vegetable content, leading to poor vitamin and mineral status. Consumption surveys seemed to show that mean energy intake was falling and yet obesity was rising, to which SACN observed that that this fact reflected likely resulted from under-reporting of intake and overestimation of energy requirements for physical activity.

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www.cabinetoffice.gov.uk/media/cabinetoffice/strategy/assets/food/food_matters1.pdf
2.3.5. Public health institutions

Government obesity policy is in part explained by the UK’s institutional system for public health. From the mid-nineteenth century public health legislation until the mid-1970s, public health matters below the level of central government were matter for local authorities, unrelated to the National Health Service (established in 1948.) After that time, the medically-directed aspect of public health service was transferred to the National Health Service while non-medical aspects - housing, sanitary services, food protection and infection control - remained with local authorities. When the public health policy field was reviewed in the late 1980s, the professional field remained divided between separate National Health Service and local authority orientations, the former more medical, the latter more environmental, incorporating food safety, and statutory requirement, and nutrition, a discretionary function.

The lack of an integrated framework became obvious in the national response to HIV/AIDS but was only partially addressed in a new national health strategy (solely for England but influential in the rest of the UK) published in July 1992. *The Health of the Nation - A Strategy for England* (with separate policies for Scotland, Wales and Northern Ireland), was accompanied by aspirational targets for health improvement (five key areas and with 27 individual targets).

The Health of the Nation is probably the first national public health document worldwide to establish targets for the reduction of obesity. The target was a 30% reduction - from 10% to 7% overall. The Eat Well Action Plan, devised by a Nutrition Task Force was published in 1994 to help achieve the Health of the Nation’s targets on diet and health. The food industry was encouraged to undertake a “fat audit” of all products to identify the opportunities for fat reductions. In addition it called for increased usage of fruits, vegetables and starchy staples, a move to full nutrition labelling and marketing practices conducive to healthy food choices. [5]

The mechanisms for delivery of these targets largely related to processes within the National Health Service, as later official reviews of the strategy observed.[6] The government’s obesity targets not only failed to be achieved but in each subsequent year body weight trends moved in the opposite direction.

The failure of an NHS-focussed public health strategy brought about renewed emphasis on not just ‘policy’ but ‘delivery’: the question of appropriate structures to deliver change and clearer knowledge of what the desired changes actually were. Some areas of the UK approach, overall, deal with consumption knowledge and behaviours and some deal directly with components of the diet. What the British have called ‘joined up policy making’ – often more an aspiration than real – has been to establish multiple statutory (i.e. governmental) mechanisms working together, across government and from central to local, alongside establishing partnerships to promote overall nutritional goals. The formation of PPPs starts from this basis, albeit some of the motivation between in part, defensive, by elements of the food industry fearing public blame for ‘fattening foods’.

2.3.6. Food industry market structure

The economic dimension of the main component parts of the UK food industry are shown in Graph 1. Table 2 shows a more detailed picture of the UK food chain, including data on
greenhouse gas emissions and energy use. The previous government produced a strategy for the food and farming sectors and for food and the entire food supply chain, however, the position of the current government is yet to be determined.

The food and drink manufacturing sector is the single largest manufacturing industry in the UK, accounting for 14% of the total manufacturing sector, and is central to the food supply chain. This part of the supply chain includes the food and drink manufacturers (including alcoholic drinks), food retailers, the food service providers and the wholesale/distribution sector. These account for a total estimated gross value added of £73.4 billion (2007), as well as 18.8% of national part-time employment and 8.7% of national full-time employment (2008).

Graph 1. Gross Value of the agri-food sector in the UK in 2008

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100 Explanations to the data to be found in the source report: Department for Environment, Food and Rural Affairs, Department of Agriculture and Rural Development (Northern Ireland), Welsh Assembly Government, The Department for Rural Affairs and Heritage, The Scottish Government, Rural and Environment Research and Analysis Directorate, Agriculture in the United Kingdom, 2009
Overview of National cases

- Agriculture: £7.7 bn, 9%
- Non-Residential Catering: £22.1 bn, 26%
- Food and Drink Retailing: £22.9 bn, 27%
- Food and Drink Manufacturing: £22.8 bn, 27%
- Food and Drink Wholesaling: £9.5 bn, 11%

Source: Annual Business Inquiry (ONS) and Defra
2.3.7. National Obesity Policy

The national obesity policy of the UK is a composite of the obesity policies of four nations, each with devolved administrations. As noted the United Kingdom of Great Britain and Northern Ireland (UK) composes four nations with a UK Parliament in Westminster (London) and devolved parliaments and assemblies in Northern Ireland, Wales and Scotland.
Devolution began in 1998, with the creation of an elected parliament in Scotland. This was quickly followed by elected assemblies in Wales and Northern Ireland. Overall some elements of administration remain UK-wide (economic policy, social security) with some national, the scope of devolution varies between each of the three devolved administrations and there are also historical differences in legal structure. The Westminster Parliament additionally acts are the parliamentary body for England and there are also cross-border agreements (including on food safety) between Northern Ireland and the Republic of Ireland (ROI).

Among the various devolved powers, responsibilities for formulating and enacting public health policies were transferred to the devolved nations although specifically food policy (that is, related to agriculture) is UK-wide and as well as partly devolved. As a result, health policies in relation to obesity have diverged. This implies that the institutional complex are complex, having government levels at UK and national level as well as power elements which may also be local (i.e. at the level of the local authority). In practice, and despite variation of administration and legal function, long historical associations, the fluidity of information and personnel, and existence of UK media, often means that policy drivers are common. If obesity has been a concern of the UK Parliament the same is true of all the devolved bodies.[7] The result is that there is cornucopia of policy documents, targets, budgets and commitments.

In 2004 the Government for England – thereby covering over 4 in 5 of the UK population - published a public health strategy document (white paper) Choosing Health: Making healthy choices, closely followed by more detailed strategies, Choosing a Better Diet and Choosing Activity. In 2006, the National Institute for Health and Clinical Excellence (NICE), the public body which provides guidance, sets quality standards and manages a national database to improve people's health and prevent and treat ill health. Published its evidence and guidance on physical activity and obesity. The first was focused on communities and the second professional guidance to NHS staff. This was followed by a more detailed strategy, formulated in the light of the Government’s Foresight study of obesity. The cross-governmental obesity strategy for England Healthy Weight, Healthy Lives: A Cross-Government Strategy for England (January 2008) was introduced with a substantial budget, £372 million over three years, and with an initial focus on children and families. The introduction to the strategy highlighted the need for individuals to know more about healthy eating, lifestyle factors, and the causes and consequences of the rise in unhealthy weight and set out the ambition “to be the first major nation to reverse the rising tide of obesity and overweight in the population.” In terms of targets these were expressed in the desire to reduce the proportion of overweight and obese children to 2000 levels.

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107 Four commonly used methods to increase physical inactivity; brief interventions in primary care, exercise referral schemes, pedometer and community-based exercise programmes for walking and cycling. (Public Health Intervention Guidance No 2) National Institute for Clinical Excellence, London, 2006.
Scotland, which has long acknowledged a heritage of poor diet, particularly in poorer communities, gave particular emphasis to nutrition and physical activity. The Scottish Diet Action Plan was published in 1996 setting out targets for dietary improvement. Scotland's Physical Activity Task Force was launched in 2001 followed by a 2003 publication Let’s Make Scotland More Active: A strategy for physical activity. The unachieved targets were reviewed in 2003 and further commitments and strategy documents sought their achievement by 2010. In 2008, physical activity and obesity strategy was further reviewed in Healthy Eating, Active Living: An action plan to improve diet, increase physical activity and tackle obesity (2008-2011). This document supported the principles of the original Diet Action Plan, but suggests that a more pragmatic set of longer term dietary goals to replace the existing ones that expire in 2010 should be considered. This was further reflected in the publication of the Government's National Food and Drink policy in 2009 (Recipe for Success). The Scottish Government also produced under the Scotland Performs initiative, indicator number 19 for obesity: “to reduce the rate of increase in the proportion of children with their Body Mass Index outwith (NB ‘outside’) a healthy range by 2018.” A new strategy Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight, which incorporated this target was published in February, 2010.

In Northern Ireland, a 2005 framework document, Fit Futures, set out the need for ‘joined up’ healthy public policy, providing healthier choices in food available to young people (including their marketing), supporting healthier earlier years, healthier schools, and healthier communities and called for “a positive response by the local food industry”. An Implementation Plan was developed and published for consultation in 2007 with a programme board to oversee its implementation. A cross-sectoral Obesity Prevention Steering Group was established in 2008 to oversee the progress against the Fit Futures recommendations, and lead the development of an overarching policy to prevent obesity across the life course. To support the work of the Obesity Prevention Steering Group four policy advisory sub-groups were set up to deal with food and nutrition; physical activity; education, prevention and public information; and data and research.

In Wales policies on obesity are set by a number of strategy themes, such as a nutrition strategy for Wales nutritional standards of food and drink provided in schools in Wales.

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policies for promoting of breast feeding, and multiple policies on physical activities, sport, cycling, play, etc., culminating with *Creating an Active Wales* in 2010.\(^1\)\(^{21}\)

All UK policies have strong elements of partnership, thus implying support for Public Private Partnership, in some cases with a financial contribution by government. In the English strategy, for example, policy vehicles include the Department of Health, Food Standards Agency, the School Foods Trust, Local Authorities and the NHS. In Scotland local authorities are major strategic partner. The new Scottish strategy is also developed on a multiorganisational stakeholder basis, and as with England there is a special focus given to children. In Scotland and England, particular attention has been given to working with the food industry and the establishment of public private partnerships.

### 2.3.8. Current UK Obesity Policy and how it developed

In May 2010 the Labour Party, in power since 1997, was replaced in government by a coalition of Conservatives (the majority political grouping) and Liberal Democrats. The position of Secretary of State for Health was assumed by the Conservative health spokesman. Prior to the election, then in opposition, he had announced that it was his intention to sustain one element of the obesity strategy, Change4Life, and to build on it. However, indicating the focus was moving away from evidence-based nutritional advice (such as provided through SACN), he remarked: “It is not for us to dictate what is good food or what is bad food but to make sure the Change4Life message is part of a constant long term campaign to help people take responsibility for their own lives.”\(^1\)\(^{22}\)

This perspective resonates with that of the food industry. Conservative party policy was explicitly by Conservative party commissioned and business-led (Unilever financed) Public Health Commission, chaired by the chief executive of Unilever.\(^1\)\(^{23}\) the Conservative party, before the election committed a new Conservative government to increasing the role of business in prevention, extend media voluntary restrictions on marketing to children, support voluntary food reformulation efforts with regard to salt, saturated fats and sugar, encourage company voluntary reduction in portion sizes, particularly on processed foods, promote consistency and clarity of food information (and making the traffic lights approach voluntary rather than mandatory), and shift the nutrition programme elements of Food Standards Agency activities to the Department of Health (the Public Health Commission had argued that the nutrition policy should not be subject to political interference, implying the retention of slightly more ‘arms-length’ body such as the FSA.)

Although the focus on obesity prevention was to continue, the Change4Life health education (social marketing) programme, as with other government communications, was halted and food companies given a more central role in the funding of the programme.\(^1\)\(^{24}\) From 1


\(^{122}\) Speech at Tackling Obesity Conference 2010, Tuesday 23rd of March OEII Conference Centre, Westminster.

\(^{123}\) Public Health Commission, *We’re all in this together; improving the long-term health of the nation*, London: The Commission, 2009

\(^{124}\) Conservative Party A Healthier Nation, Policy Green Paper No. 12, 2010
October 2010 responsibility for nutrition policy transferred from the Food Standards Agency to the Department of Health in England and to the Assembly Government in Wales. The health departments in these countries henceforth became responsible for nutritional labelling, nutrition and health claims, dietetic food and food supplements, calorie information in catering establishments, food reformulation to reduce salt, saturated fat and sugar levels in food and reducing portion size (including catering and manufacturing), nutrition advice, surveys and nutrition research. However, the FSA nutrition remit in Scotland and Northern Ireland was still to be reflected in FSA websites (food.gov.uk/scotland/scotnut and food.gov.uk/northernireland/nutritionni/respectively.) In terms of detailed strategy regarding diet and physical activity the coalition government has yet to publish any detailed strategies on these areas.

2.3.9. Socio-economic reasons for obesity

The economic case for public health action was made in the first official inquiry into health which led to the first public health legislation in the nineteenth century. The importance of economic factors equally applies to obesity. The first attempt put costs on obesity in the UK were made in the report *Tackling Obesity in England* (2001). This National Audit Office (NAO) report provided an overview on the causes, prevalence, costs and the management of obesity in England. Subsequent studies from the House of Commons Select Committee and the 2007 report from the Government Office for Science (Foresight, Tackling Obesities: Future Choices Project Report) have become the principal cited sources for further discussion.

The National Obesity Observatory collected the various sources of information in October 2010. The costs to the NHS of overweight and obesity were estimated on a range from £991 million to £1,124 million in 2002 and the total impact on employment as much as £10 billion for the same time period. In 2006/07, obesity and obesity-related illness was estimated to have cost £148 million in inpatient stays in England. In Scotland, the total societal cost of obesity and overweight in 2007/08 was estimated to be between £600 million and £1.4 billion, the NHS cost may have contributed as much as £312 million. There are no independent estimates for Northern Ireland and Wales. Foresight provided an overview of obesity in the UK which included modelled estimates of future trends in levels of obesity and obesity-related diseases, and associated costs in terms of both the health service and of wider society. Estimates of the direct NHS costs of treating overweight and obesity, and related morbidity in England have ranged from £479.3 million in 1998 to £4.2 billion in 2007. Estimates of the indirect costs (those costs arising from the impact of obesity on the wider economy such as loss of productivity) from these studies ranged between £2.6 billion and £15.8 billion. Modelled projections suggest that indirect costs could be as much as £27 billion by 2015.

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125 House of Commons Select Committee on Health www.parliament.the-stationeryoffice.co.uk/pa/cm200304/cmselect/cmhealth/23/2309.htm
NORTH

DENMARK

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

Information on various interventions within the field of obesity prevention and health promotion is available. However, there is a need to make some reservations with regards to answering on accessibility as it is impossible to say whether there are interventions that have not been identified. Primary source of information has been the internet: databases for scientific articles, websites for ministries and private companies, newspaper archives and random searches through search-machines like google. Also personal network has been used for gathering information.

1.2. Different types of PPPs

If partnerships are being defined as: involving two partners & voluntary & formal & targeted at obesity, then partnerships in Denmark can generally be divided into: partnerships with a specific aim (health education or impact of healthy meals), partnerships with specific issues (answer to government wishes of involvement) and partnerships with international potential. The activities carried out in partnerships are quite diverse: public campaigns, codes of conduct, research on metabolism, development of a New Nordic Food concept etc.

1.2.1. Typical PPPs

In general, the objectives of the national strategy for nutrition and health seem well integrated into policies. Several types of collaborations exist, but most commonly it seems to be in a combination of either public authorities and private companies or between NGOs and private companies.

1.2.2. “Atypical” PPPs

In doubt of what is required to fall into this category, but the partnership between the private company Novo and the University of Copenhagen may be a candidate. The partnership consists in huge funding for research in metabolism and the funding comes from the world’s number one producer of insulin.

1.2.3. Best example cases

The criteria for selecting cases according to proposal from MSJ and BEMI are: sustainability embedded, adverse effects addressed and relevant stakeholders involved. However, evaluation of interventions are in some cases difficult to find/non-existent and, hence, criteria for selection are mentioned below:

6aDay: long-running, evaluated both of internal and external actors – and adjusted according to findings, well known in the public, has had actual impact on food habits

Started in 2001 and is still running, but has been adjusted according to findings in evaluations and research. The campaign is based on the formulation of mutual recommendations for
intake of fruit and vegetables, and, from there, to raise Danes’ awareness of integrating food and vegetables into their daily meals. The campaign has been distributed through mass media with effective and catchy messages. In 2006, 63% of the population could refer to the campaign unassisted/ 84% if assisted. Precise data on actual intake is however uncertain, but estimated at 404 gram per day compared to less than 300 gram per day before the campaign started (http://6omdagen.dk/dokumentation/tranberg/Aug2006rap.pdf)

Partners: Danish gardeners’ organization, FDB (retail), Cancer Association, Heart Foundation, National Board of Health, National Board of Food
Potential problem: reaching the part of the population not susceptible for health messages

**Code of responsible marketing communication:** possibility of impact is high, further dialogue among stakeholders initiated with initiative
Initiative was launched in January 2008. The initiative is aimed at limiting marketing and advertising of nutrient poor and energy dense food and beverages to children through television, internet and mobile phones (cinemas and family programs on television are not targeted). In general, the initiative has received much positive attention – also among NGO’s.
Partners: Danish Food and Drink Federation in The Confederation of Danish Industries, The Danish Chamber of Commerce, The Federation of Retail Grocers in Denmark, TV2 | DANMARK, Danish Brewers’ Association, Danish Newspaper Publishers' Association, Association of Danish Advertisers, the Association of Danish internet medias, Danish Association of Advertising and Relationship Agencies, Danish Magazine Publishers' Association
Potential problem: A number of NGOs and academic experts have voiced concern with regard to the procedures in evaluation of the initiative. The Forum behind the code of conduct are evaluating on an internal basis, whereas NGOs and experts are in favour of an external – and hence transparent – process.

### 2. Country context

#### 2.1. Background information

Population, total in 2010: 5.5 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 121
Unemployment rate, January 2010, %: 7.1
Healthy life years at birth, 2008, m/f: 62.3/60.7
Obesity rates among adults, 2008 (or nearest year available), %: 11.4

#### 2.1.1. Food production

2.700.000 ha of farmland with 57.831 farms, of which 10.6 % are larger than 100 ha (Ceja, 2002). This means that approximately 50% of Danish land is cultivated and agriculture is a large contributor to the Danish economy, exporting for more than 60 billion Danish Crowns (Danish Council for Agriculture, 2007), counting for almost 20% of the total Danish export.

#### 2.1.2. Danish Kitchen

Historically, agriculture has played an important role in the Danish society. Crops and dairy products are traditionally used food items and the changing seasons have had an important impact on meal patterns. The most important ingredients have been potatoes, cabbage and a
variety of root crops, with bread of rye as the main component of cold meals (Boyhus, 2000). However, traditional food patterns have been set aside and for decades meat has constituted a more important part of Danish meals with each Dane consuming more than 100 kilo meat per year (World Resource Institute, 2007). There are indications, though, that a change is underway as the consumption of meat is stabilizing for men and decreasing for women (Danish National Food Council, 2010). One reason may be the renewed focus on traditional food items, organic production methods and locally grown crops, also fueled by the uprising of the New Nordic Kitchen (Meyer, 2006)

Traditionally, family-meals have had a great significance. This pattern, where eating is an event within the social context of the family seems to be changing: even if most eating still takes place at home, modern eating tends to be more isolated and many engage in other activities while eating, such as watching television or reading. (Kjaernes, 2001). This change of eating habits seems to be widespread (National Board of Health, 2003), whereas the renewed focus on traditional food items and production methods are true only for parts of the population. In Denmark, too, socio economic disparities are visible in food choice and in the prevalence for overweight and obesity (Council of physical activity and nutrition, 2007)

2.1.3. The State

Denmark is a constitutional monarchy, in which the royal family has no executive powers. The country is a representative democracy, in which powers are separated into executive, legislative and judicial powers (Danish Constitution, 1953). The Government is appointed by the Parliament and must step back in case of a declaration of mistrust from the Parliament.

2.1.4. Government, Ministries & health

The Prime Minister appoints the ministers and there is no fixed number of ministries (Danish Constitution, 1953). Currently, decisions regarding obesity prevention and health promotion are taken by the ministry of agriculture and food, the ministry of finance and the ministry of the interior and health; the ministry of taxation plays a role with regards to decisions in health policies linked to taxation.

2.1.5. Regulation

The general trend in the Nordic countries is that national public authorities are generally regarded as trustworthy, while skepticism is more widespread towards the market and international institutions (Kjaernes, 2001). Whether this has had an impact on the regulatory mechanisms in Denmark is an open question, but in general the Danish Food Law prioritises food safety rather than regulation of the nutritional content of the food (Danish Ministry of Food, Agriculture and Fisheries, 2005). There is a trend of introducing self regulation as a regulatory means in public health, which has been criticised by consumer organisations (Council of Consumers, 2008), but it is preferred by the producers and retailers (Hedegaard, 2009).

The food law forms the overall framework regarding statutory legislation (Danish Ministry of Food, Agriculture and Fisheries, 2005). Furthermore, a number of laws and provisions regulate the area of obesity prevention and health promotion, for instance the additional tax on saturated fat and sugar (Danish Parliament, 2010). As for self regulatory measures, a number of stakeholders have committed themselves to for instance codes of conduct like the code of responsible marketing communication (Danish Industries, 2009).
2.2. Overweight and obesity

From a general point of view, obtaining reliable figures on overweight and obesity is difficult – on one hand, because overweight and obese persons tend to abstain from participating in studies, and on the other, because self reporting may be erroneous (Due, 2006). However, numbers drawn from Danish military drafting over the past 60 years show a significant increase in the number of overweight men (Danish Academy of technical sciences, 2007). Various studies confirm this rise as a general tendency, for instance a large-scale study published in 2009, in which 36% of the persons measured were overweight and 11.6% obese (Institute of Public Health, 2009). In case, these results are representative, more than 2 million Danes are overweight and approximately 300,000 are obese.

The uncertainty regarding precise numbers is also the case with regards to the number of overweight and obese children and adolescents. However, a prominent reason is the lack of a central registration of measurements carried out by family doctors and nurses at schools (Council of physical activity and nutrition, 2007). Furthermore, comparison of existing registrations must be carried out with caution as there are various definitions of overweight and obesity (Council of physical activity and nutrition, 2007). However, existing studies indicate an increase in the number of overweight children and adolescents in Denmark during the past 25 years. In 2003, 21% of girls from 6 to 8 years in Copenhagen were overweight, and also 21% of girls between 14 and 16 years. The same study shows that 15% of boys from 6 to 8 years were overweight, and also 14% of boys between 14 and 16 years. Studies from other parts of the country show results pointing in the same direction (Council of physical activity and nutrition, 2007).

According to some studies, Danish children have a lower prevalence of overweight than other countries (DG Sanco, 2007), but the fact that socio-economic status is an important determinant reflects a global trend (Council of physical activity and nutrition, 2007). Furthermore, studies show that children’s intake of added sugar is alarmingly high: 14% of total energy-intake (National Food Council, 2005) in the beginning of the century and almost unchanged during the past years (National Food Council, 2009).

A study presented at the International Congress on Obesity in July 2010 indicates that the total number of overweight and obese children has been decreasing slightly over the last decade (Rokholm, 2010). However, there are no data indicating that Danish children should differ from the global trend verified by other studies; that is, the overall decrease will probably consist in a decrease among the highest socio economic groups, whereas the number of overweight and obese children from less advantaged groups continues to increase (Stamakis et al, 2010).

2.3. National policies on nutrition and obesity

Despite the fact that the New Nordic Kitchen has sparked an interest in Nordic food culture and that the Nordic Council of Ministers has adopted the New Nordic Manifesto and has put effort into promoting Nordic food (Nordic Council of Ministers, 2005), the concept is absent in the Danish food and nutrition policies. Around year 2000, plans were made to establish an institution dedicated to Nordic food, but the plans were cancelled when the right-wing government took over in 2001 (Meyer, 2007). However, even if the traditional Danish food
culture has been absent in policies, nutritional disorders have been on the agenda, mostly in terms of increased costs in the health sector (Danish Government, 2005).

The increased awareness of the obesity problem has paved the way for a series of recommendations and action plans. The referential paper was published in 2003 by the National Board of Health and consists in a national Action Plan against obesity with 66 recommendations (National Board of Health, 2003). Actions were recommended to take place at three levels: private, community and public sector, and were proposed to take the form of either regulation, normative action or information. The National Board of Health spent seven million Danish Kroner for funding of projects from 2003 to 2005 and from 2005 to 2008, 73 million Danish Kroner were given to the municipalities for funding of projects targeted at children and adolescents. Another 57 million Danish Kroner were put into the area to sponsor projects from 2007 to 2010 (National Board of Health, 2008). Furthermore, a number of campaigns have been run in joint projects with partners among the NGOs and the private sector.

However, the National Board of Health has an advisory role, and, hence, cannot force through the recommendations put forward in 2003. Some recommendations have been followed, like implementing food policies for day care and schools and carrying out information campaigns (Danish Government, 2005). But, with regards to public policies like increasing standards with regards to mandatory number of lessons in home economics or introduction of bans on marketing and advertising of unhealthy food items the results have been meager. Private sector initiatives as codes of conduct in marketing and advertising have been introduced, but the repeated call for evidence before regulating an area indicates a barrier in the implementation of nutritional policies (Hedegaard, 2009). Increase of physical activity, on the other hand, has been implemented as a means of combating overweight (Danish Government, 2005).

Campaigns like 6aDay have been positively evaluated, but in order to increase the intake of fresh fruits and vegetables among the less advantaged groups in society, a number of stakeholders have asked for differentiated taxes (Danish Academy of technical sciences, 2007). Policy makers decided not to lower taxes on specific food items and introduced an additional tax on sugar and saturated fat in 2010 (Danish Parliament, 2010). Whether this tax will be accepted by the EU is yet unknown, and as for future public policies on nutrition and obesity, there is some uncertainty: the Commission for Prevention has put forward ten proposals for future implementation (Commission for Prevention, 2009) and the Government has launched their 2015-plan (Danish Government, 2010). However, forming a clear view of future action in the field of obesity prevention is difficult. Scientists and NGOs call for mutual action as the Danish approach to the problem has been too fragmented and consisted mainly in short term projects (Boersen Newspaper, 2010).

2.3.1. Retail structure

Generally, small specialised local stores are being replaced by supermarket chains, and in 2005 more than 80% of retail food sales were through supermarket chains (Institute of Food and Ressource Economics, 2006). The average Danish consumer spends approximately 11% of total spending on food, which is relatively low in so far as prices on food are high in Denmark compared to other European countries (Government Agency of Consumption, 2007).

2.3.2. Health-oriented non-govermnetal organisations (NGOs)
Especially the Cancer Association, the Heart Foundation, the Diabetes Association and the Consumer Council have been active in obesity prevention and health promotion.

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Estonia

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

Government authorities, consumer organisations, trade association and heart association were contacted by e-mail and internet searches were done. Limited response and search results
resulted in that only one initiative was identified. Reasons for limited accessibility were also language barrier.

Information about one PPP, a code of responsible advertising to children, was provided by the National Institute for Health Development, who also provided information about national policies on nutrition and obesity.

2. Country context

2.1. Background information

Population, total in 2010: 1.3 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 64
Unemployment rate, January 2010, %: 19.0
Healthy life years at birth, 2008, m/f: 52.7/57.2
Obesity rates among adults, 2008 (or nearest year available), %: 18.0

2.2. Overweight and obesity

Overweight and obesity has increased, especially among men, in Estonia. Based on health behavior surveys in the 1990s the prevalence of overweight (BMI 25-29.9) was 35% among adult Estonian men and 27% among women, and the prevalence of obesity (BMI>30) was 10% among men and 15% among women.\textsuperscript{128} Age and low level of education was associated with obesity. The health behavior survey in 2008 reported that the proportion of obese men has increased to 18% and women 19.5%. The proportion of overweight was 40.5% among men and 27% among women. The combined prevalence of overweight and obesity (BMI>25) was 59% among men and 47% among women in 2008.\textsuperscript{129}

Overweight and obesity has increased among adolescent males and it was 19.8% in 2008, among females the rate was 8.9%.\textsuperscript{130}

2.3. National policies on nutrition and obesity

In 2002, the Healthy Nutrition Action Plan was worked out as an recommendation from authorities covering the period 2002–2007. Areas of action are food and nutrition research and information, accessibility of food, local food for local consumption, food safety, and nutrition of specific population groups, overweight and chronic diseases.

Since February 2005, Estonia has had a national policy document dealing with nutrition and physical activity: the National Strategy for Prevention of Cardiovascular Diseases (CVH Strategy). The Strategy includes four priority areas: physical activity, nutrition, nonsmoking and dissemination of information and community development. It has been adopted for the period 2005–2020, although the first action plan is envisaged and confirmed only for the period 2005–2008. Its objective is to enhance healthy choices and lifestyles by developing a


health education system and reducing the availability of harmful substances. Under the administration of the Ministry of Social Affairs, the implementation of public health strategies is carried out through the National Institute for Health Development and financed by the state budget.

An advisory body under the Ministry of Social Affairs has a leading scientific and administrative role in the CVH Strategy and covers all sectors of the Strategy. It includes representatives of the Ministries of Agriculture, Education, Culture and Internal Affairs to ensure better interministerial coordination of action. Other governmental institutions and nongovernmental organizations are also involved in the implementation of the strategy.

To facilitate implementation of the Strategy at local level, health councils have been established in all counties. The responsibility of these councils is to plan, allocate resources, coordinate implementation and evaluate activities at county level. The councils have a specific budget for local action.

New nutrition recommendations and food-based dietary guidelines are worked out and introduced within the framework of the CVH Strategy. The development of the Health Promoting Networks is one of the actions carried out within CVD strategy.

Actions in the school settings include school meals for children in the first to ninth grades paid by the Government. In a kindergarten parents have to pay only partly for the 3 meals a day and there are subsidized meals for children from poor families paid by the municipalities. From September 2006, adolescents studying in vocational schools after graduating from primary school will also receive school meals paid by the Government. In 2008, Ministry of Social Affairs adopted updated regulation on health protection requirements for catering facilities in pre-school institutions, schools. By that regulation a school lunch covers 30-35% of the daily energy and nutrient needs and in kindergartens 85-90% of the daily energy and nutrient needs. Also brown bread is included to the daily school meal. School fruit scheme is introduced from 2009. Every year is held competition “The Best School Canteen” organised since 2006 to encourage the school canteen staff and improve the professionalism of the caterers.

The Estonian Health Insurance Fund contributes to the CVH Strategy and supports the CVD counselling cabinets in counties. Three levels are involved in this Project: family doctors, county heart centres and the Tallinn-Tartu lipid centres. The Project includes risk factor measurement, lifestyle counselling and supervision by medical staff.

Online source for dietary and nutritional information www.toitumine.ee was created in 2009. Public health information, including healthy diet and physical activity, is also available at www.terviseinfo.ee. As a supportive measure to the strategy, the Estonian Diet and Nutrition Database was created that maps dietary surveys, nutrition policies, and dietary interventions in Estonia. The database is available online www.nutridata.ee.

In 2008, the National Health Development Plan 2009-2020 was adopted by the Government. All other public health strategies (including Estonian National Strategy for the Prevention of CVD) have been integrated into it. The National Health Development Plan has been divided into five wider sections: social inclusion and equal opportunities; development of health of youth and children; healthy environment; healthy lifestyle and development of healthcare system. The Plan brings together vertical development plans and strategies from the field of
health. The Plan units a wide range of strategic documents from other fields which have already been implemented or are under development. Specific actions to be implemented with regards to this plan are removing energy-dense nutrient poor foods and beverages in school vending machines.

**FINLAND**

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

18 PPPs were identified using mainly Internet.

1.2. Different types of PPPs

1.2.1. Typical PPPs

Labelling, campaigns and education.

1.2.2. “Atypical” PPPs

Film program aimed at schools.

PPPs that use modern ICT. For example, Hyperfit, an interactive communicative tool – monitoring for mobile phones.

1.2.3. Best example cases

Heart symbol labelling of foods.

2. Country context

2.1. Background information

Population, total in 2010: 5.3 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 113
Unemployment rate, January 2010, %: 8.8
Healthy life years at birth, 2008, m/f: 58.6/59.4
Obesity rates among adults, 2008 (or nearest year available), %: 15.7

Finland is a modern industrialized welfare state and most Finns work in services, trade and manufacturing. The proportion of Finns working in agriculture is 4% of the labour force.  

2.1. Dietary habits

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131 www.stat.fi
The dietary habits of Finnish people have in the recent decades changed in a positive direction. The consumption of vegetables, fruit, berries and rye bread has increased. Low-fat and fat-free dairy products, vegetable oils and vegetable fat spreads are already part of the diet for the majority of Finns. Salt is used in smaller quantities. Less desirable changes include an increase in the consumption of meat and sweets. Larger consumption amounts of various sweet and acid beverages and particularly alcohol are not in line with health objectives, either. The changes in dietary habits are reflected in the intake of nutrients with the relative shares of energy nutrients already approaching the recommended values. The quality of fat and the intake of salt, however, still leave a lot to be desired. With the exception of vitamin D, the intake of vitamins and minerals can actually be considered abundant.

The health of the population has shown favourable changes, partly due to improved nutrition: annual cardiovascular mortality has decreased by about 80% since the 1970s and the prevalence of many cancerous diseases has decreased or the diseases have transferred to older age groups. New challenges include population weight increase and the health problems associated with it, such as type 2 diabetes. Inadequate exercise plays an important role in weight gain, but dietary changes also contribute to it. This is particularly true with younger people and with sugar-containing products and fast food. Dental caries is also on the increase again among young people.

2.2. Overweight and obesity

Obesity in the working age Finnish population is approximately 20% and overweight 60% (men 66% and women 49%). Obesity has increased especially among men:

- 1966-1972 BMI>30 among men 9.1% and women 17.8%
- 2000 BMI>30 among men 20.5% and women 21.5%

Concern about increase among the younger age groups (has doubled since 1977).
Survey from 1999:
- Boys (age 12-18) 15.3-19.0% overweight; 2.4-3.0 obese
- Girls (age 12-18) 9.0-12.6% overweight; 1.1-1.7 obese

The average BMI exceeds the upper limit of normal weight in all parts of Finland. Energy intake and BMI were smaller in cities compared to other areas. The proportion of population with abdominal obesity was highest in Western and Eastern Finland and lowest in the Southern and in the most Northern parts of Finland.

2.3. National policies on nutrition and obesity

2.3.1. The retail structure

In Finland the food retail is concentrated to two large groups: S-group 41% and K-group 34% (+ Tradeka 12% and other independent 13%). The number of retail outlets/shops was in 2007 3 922 (the number has decreased from being over 6 000 in the early 1990s):

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Overview of National cases

133 Hypermarkets
121 Department stores
540 Big supermarkets
446 Small supermarkets
1084 Shops 200-400 m2
1037 Small shops under 200 m2
561 Speciality shops

Sales in 2007 was 13 046 million euro.\(^\text{134}\)

In 2008 Finnish consumers shopped more at hypermarkets and Lidl – economic uncertainty makes people choose cheaper alternatives.

The Horeca register includes 21 743 kitchens and on average 153 meals were eaten per Finn in 2008. Approximately one in two Finns uses daily Horeca-services (eats or drinks).\(^\text{135}\)

2.3.2. National nutritional policy and obesity

Starting in the 1970s growing interest in nutrition policy in Finland. The Ministry of Social Affairs and Health appointed various committees (e.g. reduction of sugar consumption). The National Nutrition Council is an expert body (members are representatives of authorities handling nutrition issues, consumer, health promotion and catering organisations, food industry, trade and agricultural organisations) appointed by the Ministry of Agriculture and Forestry (since 1954) developed national recommendations and action plans in the 1980s. The recommendations for improving health and diet (1987) emphasized the relationships of fat, salt and dietary fibre to health. The subsequent action plan (1989) included recommendations for different sectors, for example, food pricing and taxes, food production, industry and retail, catering, and nutrition education.\(^\text{136}\) Nutrition recommendations have been renewed (1998, 2005) and actions plans (2003).

The renewed Finnish nutrition recommendations 2005 are based on the new Nordic Nutrition Recommendations, which were approved in 2004 by the Nordic Council of Ministers. The goal of the recommendations is to improve the diet of the Finnish people and public health. As the most important diet-related health problems are cardiovascular disease, osteoporosis, diabetes, obesity and dental caries, it is important that Finns:

- Have balance between energy intake and energy expenditure.
- Have a balanced nutrient intake.
- Increase the intake of carbohydrates with high fiber content.
- Decrease the intake of refined sugars.
- Decrease the intake of hard fat and increase the proportion of soft fats.
- Decrease the intake of salt (natrium).
- Have moderate alcohol consumption

Recommendations on physical activity are also included. The adult population should undertake a minimum of 30 minutes of daily physical activity of moderate intensity. For

\(^{134}\) A.C. Nielsen Finland Oy: 2007 food retailing. Available at: www.nielsen.com
\(^{135}\) www.nielsen.com
prevention of weight gain more physical activity, about 60 minutes, may be needed. For children and adolescents there should be a minimum of 60 minutes of physical activity every day. Recognize reasons for obesity: less physical activity, more energy from fatty and sweet snacks, and bigger packages.

Also issued Recommendations for special groups:
2004 pregnant and breastfeeding women
2008 school meals
2010 nutrition recommendations for elderly.
(2010) patients

In 1995 the Finnish National Nutrition Surveillance System was established at the National Public Health Institute to collect, interpret, evaluate and communicate data on the nutritional situation in Finland, and to assess the need for measures to promote nutrition and health policies. Five nutrition reports that present results from Finnish nutritional research have been published, the last one is from 2004.\(^{137}\) This report described changes in health and nutritional status of the Finnish population (largely based on FINDIET 2000 study). Additional special topics are beverages, working place and school meals, and programs and recommendations in the field of health and nutrition policy.

In 2009 the National Public Health Institute was merged with STAKES –knowledge for welfare and health to form the National Institute for Health and Welfare (THL). THL is a research and development institute under the Finnish Ministry of Social Affairs and Health.

The Finnish health promotion policy system comprises national, regional and local levels of government, a strong structure of NGOs, professional bodies and institutions and an increased attention to the role of the media and visibility of health in the media.\(^ {138}\)

The Finnish health care system is closest to those of other Nordic countries and the UK, in that it covers the whole population and its services are mainly produced by the public sector and financed through general taxation. The Finnish health care system can be described as one of the most decentralised in the world. Even the smallest of the 444 municipalities (local government authorities) are responsible for arranging and taking financial responsibility for a whole range of “municipal health services”. Municipally provided services include primary and specialist health care. In addition, municipalities are responsible for other basic services, such as nursing homes and other social services for the elderly, child day care, social assistance and basic education. Municipal taxes, state subsidies and user charges finance the municipal health services.\(^ {139}\)

The Finnish Centre for Health Promotion (FCHP) works in collaboration with actors in various related fields. The main aims of the Finnish Centre for Health Promotion are:
• to strengthen cooperation between NGOs and other actors in the sphere of health promotion;
• to advance and advocate for health promotion issues in legislation; and

\(^{138}\) http://www.euro.who.int/document/e78092.pdf
• to provide a centre of excellence for its members, including method development and the quality of materials.

The Association of Clinical and Public Health Nutritionists in Finland, RTY, is the educational and professional interest organisation for nutritionists in Finland.\textsuperscript{140} The association has issued a model for dietary treatment of obesity and published educational material on dietary treatment of obesity among children and adolescents. HyperFit electronic food and exercise diary. Leaflet “Weight management – eat wisely, loose weight permanently” – renewed in 2009.

**LATVIA**

1. Overview of PPP initiatives

Two PPPs were identified in Latvia.

2. Country context

2.1. Background information

Population, total in 2010: 2.2 million
GDP per capita in Purchasing Power Standards (EU-27 = 100), 2009: 52
Unemployment rate, January 2010, %: 20.1
Healthy life years at birth, 2008, m/f: 51.5/54.1
Obesity rates among adults, 2008 (or nearest year available), %: 16.9

2.2. Overweight and obesity

Studies show that 41\% of men aged 19 to 65 years were overweight and 9.5\% were obese, and 33\% of women were overweight and 17\% were obese. Self-reported data from 2006 shows that 32\% of men (15-64 years) and 28\% of women were overweight, and 12\% of men and 18\% of women were obese. Measured data among 7-17-year-old children from the Sports Medicine State Agency shows that 12.4\% of boys and 11.7\% of girls were overweight 2004-2008. Based on self-reported data 6.7\% of adolescents were overweight and 0.9\% were obese in 2005/2006.\textsuperscript{141}

2.3. National policies on nutrition and obesity

In 2003, the policy “Healthy Nutrition 2003-2013” was issued.

\textsuperscript{140} [http://www.rty.fi](http://www.rty.fi/)

LITHUANIA

1. Overview of PPP initiatives

One PPP was identified in Lithuania.

2. Country context

2.1. Background information

Population, total in 2010: 3.3 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 55
Unemployment rate, January 2010, %: 17.2
Healthy life years at birth, 2008, m/f: 54.6/59.3
Obesity rates among adults, 2008 (or nearest year available), %: 19.7

2.2. Overweight and obesity

The National Nutrition Survey of 2007 showed that 60% of men aged 19 to 65 years and 46% of women were overweight and 11% of men and 15% of women were obese. The prevalence of overweight was 10.5% among school-aged boys (11-15 years) and 4.5% among girls in 2006 according to health behavior survey.\textsuperscript{142}

2.3. National policies on nutrition and obesity

In 2003, the Lithuanian government issued a National Food and Nutrition Strategy and Action Plan for 2003-2010. In 2005, dietary guidelines for the Lithuanian population were issued by the Ministry of Health.\textsuperscript{143}

NORWAY

1. Overview of PPP initiatives

1.1. Assessment of accessibility of information on PPPs

SIIFO (National Institute for Consumer Research) are involved in quite a few food and health related projects where private stakeholders are represented. We therefore knew about some relevant public-private initiatives that were easily mapped. In the process of searching for new unknown private-public initiatives we used mainly the Internet; search on relevant key words and phrases in Google, websites for grocery chains, ministries, public health institutions and NGOs. We have also had some e-mail contact with key persons. Information on various initiatives directed at counteracting obesity and promoting health in Norway are relatively

easily available on the Internet. We found 9 private-public collaborating initiatives which were focused on nutrition and reducing obesity.

**Stakeholders:** Stakeholders involved in the PPPs we found in Norway were: health and family authorities (Directorate of Health, Ministry of Health and Care Services, Ministry of Children, Equality and Social Inclusion), The Consumer Council, Nordic Innovation Centre, research institutions with a focus on food and health (SIPO, Nofima, NILF), food and fast food producers and retailers (for example ICA, Bama, Norgesgruppen, Reitan, Stabburet), Federation of Norwegian Food and Drink Industry, Information office for bread and whole grain and representatives from kiosk-petrol stations and service chains. In the following we present two initiatives that might have best case potential.

1.2. Different types of PPPs

1.2.1. Best example cases

**The keyhole label:** The keyhole symbol that has been used in Sweden to label more healthy food since 1989 was introduced also in Norway and Denmark in 2009. Through this process, the criteria for food that can be labelled Keyhole were revised in 2009, and re-established by the Norwegian, Swedish and Danish food and health authorities jointly. Foods labelled with a Keyhole must be prepacked with the exception of fresh fish, fruit and vegetables. The keyhole label can not be used in foods that contain artificial sweeteners. Keyhole has a requirement for the content of fibre and a maximum content of fat, salt and sugar within 25 food groups. For some food groups, labelled products are also entitled to contain a minimum amount of whole grain, fruit or vegetables. The idea is that the Keyhole will make it easier for consumers to choose healthy food. It is voluntary for food producers to use the labelling. In Norway the Directorate for Health and Food Safety Authority together have regulatory oversight of the manufacturers who use the symbol on some of their products.

**Guidelines for marketing food and beverages to children and youth:**

The Norwegian Government’s *Handlingsplan for bedre kosthold i befolkningen 2007-2011. Oppskrift for et sunnere kosthold* (Plan of Action to Improve the Nations Diet 2007-2011. Recipe for a healthier diet) states that the prevalence of overweight and obesity is increasing due to a low level of physical activity and an unfavourable diet (Departementene 2007). Especially children and young people consume too much sugar and fat. In May 2007 the World Health Organisation passed a resolution to draw up international guidelines for the marketing of unhealthy food and diet to children and youth. Norway was appointed to lead this work (Folkehelseinstituttet 2010). In 2007 the Norwegian Consumer Council took an initiative for collaboration with trade and industry to develop guidelines or codes of conduct for a more responsible marketing of food and drink to children and young people, both in schools and in public. This regards especially energy-dense and nutrient-poor food and drink such as sweets and confectionery, carbonated soft drinks, crackers, cakes and snacks. The voluntary agreement regarding marketing guidelines was formally signed in September 2007.

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144 [http://www.ica.no/FrontServlet?s=mat_inspirasjon&state=nyckelhal_fettfibrer](http://www.ica.no/FrontServlet?s=mat_inspirasjon&state=nyckelhal_fettfibrer)
http://forbrukerportalen.no/Artikler/2007/Matbransjen%20rydder%20opp
Work on the guidelines has taken place under the auspices of Standard Norway. The Norwegian Directorate of Health, Ministry of Health and Care Services, Ministry of Children, Equality and Social inclusion, The Ombudsman for Children, National Institute of Consumer Research (SIFO), National Nutrition advisory board and the Norwegian Food Safety Authority participated in the development of the guidelines as observers. The Bureau for Legal Affairs in Marketing participated by giving advice, point of views and text suggestions under the development of the guidelines. So far the following representatives from the food industry have signed the voluntary codes of conduct: ANFO-Annonsørforeningen, COOP Norway, Forbrukerrådet, HSH, ICA Norge AB, Kraft Foods Norge AS, Kreativt Forum, McDonalds Norge AS, NBL, Næringsmiddelbedriftenes Landsforening, Nidar AS, Norgesgruppen ASA, Norske Sjokoladefabrikkers Forening, Orkla foods, Reitan Servicehandel, Ringnes AS, TINE BA, Setre, Kims, Stabburet, Bakers and Axellus.

The guidelines are as follows:

3.6 Activities in schools
Schools shall not be used as an arena for advertising. Marketers of food and beverages shall support the authorities’ efforts to avoid advertising in schools. Activities shall be in accordance with the requirements set out in the Education Act and the Act relating to independent schools. Any measures in schools shall be designed in consultation with the school concerned. Food and beverage manufacturers shall be cautious about influencing pupils’ diet in an undesirable direction by placing automatic vending machines in or actively selling products to school canteens. Automatic vending machines for energy-dense and nutrient-poor products shall not be offered to any schools below college level.

3.7 Sponsorship and PR campaigns at various events
No agreements should be entered into relating to PR, the distribution of samples, etc. at arrangements or events for children which the children attend alone without their parents or guardians. If any PR activities take place at arrangements intended solely for children, parents/guardians shall be informed in advance, or permission shall be obtained. If samples are to be distributed, this shall take place in an organised manner, in moderate quantities and with the concurrence of parents/guardians or other responsible persons.

3.8 Displays at retail outlets
When products are displayed at retail outlets, it is important to consider the effect of such displays. Business and industry should demonstrate caution in promoting energy-dense and nutrient-poor products to children and youth. In accordance with consumer preferences and authorities’ efforts, retailers should actively promote the sale of healthier products.

3.9 Sampling at retail outlets
Product samples should not be distributed to unaccompanied children.

3.10 Description of contents
Food manufacturers must ensure that correct, easily understandable and easily accessible information about the nutritional content of their products is provided by labelling them and/or using other appropriate channels of information. Marketing shall not be misleading cf. The Marketing Act, draft of new Marketing Act and regulation regarding food labelling. The presentation of product properties shall be precise and unlikely to mislead the consumer with respect to product size, content, nutritional content or health benefits.

3.11 Nutrition and health
Marketing should be based on the authorities’ recommendations for a balanced, varied diet and an active lifestyle. For example, marketing should not encourage or promote over-
consumption. Portion sizes should be adapted to the situation in which the product is to be used.

2. Country context

2.1. Background information

Population, total in 2010: 4.8 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 178
Unemployment rate, January 2010, %: 3.4
Healthy life years at birth, 2008, m/f: 70.0/68.8
Obesity rates among adults, 2008 (or nearest year available), %: 10.0

2.1.1. Societal organization

Norway’s population numbers roughly 4.8 million. Norway is a modern industrialized welfare state and most people work in services and industries (Roos et al. 2002). Only 2 percent of Norwegians worked in agriculture and fishing in 1994 (Statistics Norway 1995). The country is a representative democracy, in which powers are separated into executive, legislative and juridical powers. Norway can be said to have a “mixed economy” with high degree of state ownership in key industrial sectors (i.e. oil and gas).

2.1.2. National food landscape

Norwegian eating habits are characterised by homogeneity, simplicity, and strong references to norms about healthy and proper eating, with a strict division of everyday and leisure spheres. Compared with the other Nordic countries, Norwegian main meals tend to be modest and generally include fewer items, with a limited range of dishes (Kjærnes and Døving 2009). However, eating associated with leisure and items consumed outside of the regular meals are quite the opposite. Consumption levels are high for chocolate, sweetened soft drinks, salty snacks, ice cream and fruit (Kjærnes 2001). Norwegians consumption of ice cream and soft drinks is among the highest in Europe (Kjærnes and Døving 2009). In Norway it is common to bring a packed lunch (matpakke) to school and some workplaces. The packed lunch is commonly a whole wheat bread with margarine and thinly topped with cheese, brown cheese or meat spread. The packed lunch is a tradition from the interwar years, when Norwegian municipalities were poor and could not afford costly reforms like the introduction of school meals. Milk drinking is also central in the Norwegian diet, and developed much as a state led support to Norwegian small scale milk producers in the interwar years. Most schools have a “milk arrangement” where children receive a small milk to eat with their packed lunch (Kjærnes and Døving 2009). The portion of the total household budget that was used on food and alcohol free drinks bought in grocery stores decreased from 20 to 12% from 1979 to 2004, while expenditures related to eating out increased, such as restaurants, fast food and canteens. It has become more common for work places to have a canteen arrangement (Departementene 2007). Norwegians consume quite a lot of meat, estimated to an average of 77 kg per person in 2008, and spend three to four times as much on meat as on fish products. Sweet and soft drinks constitutes almost one fifth of food expenditures, more than is spent on fruit, vegetables and potatoes together (Helsedirektoratet 2010).

2.2. Overweight and obesity
In the 1960s, Norwegian women had a higher BMI than men; however women lost weight during the 1970s. Norwegian men, on the other hand, have steadily gained weight since the 1960s. Women have increased in weight since 1985. In 2000, 40 and 45 year old men in average weighed 5.0 kg more than in 1985. For women the difference was 5.8 kg. From 1995 the BMI of Norwegians went through a steep increase. Especially adult men under 60 years and adult women under 50 years gained weight in this period (Midthjell, K. et al 1999). In the period 2000-2003 health studies were conducted in the five counties of Oslo, Hedmark, Oppland, Troms and Finnnmark. In all groups, except from 30-year-old women from Oslo, the average BMI was above 25 kg/m2, which is the WHO definition of overweight (see table 2) (Folkehelseinsitutet 2010).

<table>
<thead>
<tr>
<th>Age</th>
<th>Men, KMI (kg/m2)</th>
<th>Women, KMI (kg/m2)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30 years</td>
<td>40/45</td>
</tr>
<tr>
<td>Oslo 2000-01</td>
<td>25,7</td>
<td>26,4</td>
</tr>
<tr>
<td>Hedmark 2000-01</td>
<td>26,7</td>
<td>27,5</td>
</tr>
<tr>
<td>Oppland 2001</td>
<td>27,0</td>
<td>27,2</td>
</tr>
<tr>
<td>Troms 2001-03</td>
<td>26,7</td>
<td>27,2</td>
</tr>
<tr>
<td>Finnmark 2002-03</td>
<td>27,0</td>
<td>27,3</td>
</tr>
</tbody>
</table>

Table 2: Average values for body mass index (BMI) for age groups 30, 40-45, 60 and 75 years in five counties.

Numbers from Statistics Norway, based on self–reported height and weight, shows that the percentage of obese persons increased from 4 to 6 % between 1973 to 1998, and to 10 % from 1998 to 2008. However the number of overweight or obese persons is lower in the self reported material than in studies based on actual measures of height and weight (Norwegian Directorate of Health 2010). Studies based on actual measurements in 2000- 2003 show that in the 40 - and 45-years old, between 14 and 22% of men and 13 to 20% of women were obese with BMI over 30. The share of adults with severe obesity (BMI >40) were between 0.2 to 1.5%. BMI was lower in Oslo than in the other four counties. On average, 40 and 45 year old men in Hedmark and Oppland weighed 86 kg and females 71.9 kg. Less than 1 percent was underweight (Folkehelseinsitutet 2010).

Another study shows that 40-year-olds with higher education have less obesity than groups with lower education. This is an expression of socio-economic differences. In Oslo, the adult population is heavier in eastern than in western districts, especially among women. Also 15 and 16-year-olds of both sexes are heavier in eastern than in western districts. Among immigrants in Oslo prevalence of overweight and obesity varies with ethnic background. The proportion of persons with BMI over 30 is highest among women from Turkey and lowest among men from Vietnam. Women from Sri Lanka and Pakistan have the highest waist-hip

147 http://www.fhi.no/eway/default.aspx?pid=233&trg=MainLeft_5648&MainArea_5661=5648:0:15,2917:1:0:0::0:0&MainLeft_5648=5544:44465::1:5647:30::0:0
ratio, according to a study among 3000 immigrants from developing countries (Kumar, BN et al. 2005).

Children and adolescents: Already in the mother’s womb the weight is influenced. According to Medical birth register the average birth weight has increased from 3450 to 3530 in the period 1968 to 2000. Children with a birth weight of at least 4 kg increased from 16.2 to 21.9%, and the number of children who weighed at least 4.5 kg is almost doubled from 2.9 to 4.7% (Norwegian Directorate of Health 2004). In the period 1993 to 2000 the portion of overweight among 13-year-olds increased from 8.4 to 12.6% among girls, and from 8.5 to 14% for boys, according to a national self reported diet survey called Ungkost (Helsedirektoratet 2010). Measures of weight and height among 7000 school children in Oslo in 2004 showed that 21% of both 8 and 12-year-olds were overweight (Departmentene 2007). Measures of weight and height among 3500 third graders in 2008 showed that 12-14% of 8-9-year-olds were overweight and 4% obese (Helsedirektoratet 2010).

New figures for age group 7-11 years show that 15-20% in Northern Europe and 30-35% in the Mediterranean countries are overweight (BMI>25). In the Nordic countries, the figures are 18% in Sweden and 15% in Denmark, compared with 17% for this age group in Norway (Juliusson et al. 2007). A new Swedish study of 10 year old girls in Gothenburg shows that the proportion of overweight and obesity has decreased: from 20 to 16 percent in the years 2000/2001 to 2004/2005. New studies are needed to confirm whether the trend is broken, if the percentage of obese children and adolescents are no longer rising, or falling (Lobstein and Frelut 2003, Sjöberg 2008).

Studies show a clear connection between socioeconomic factors and overweight (Grøholt 2008). Studies of 8-12 year-olds in Oslo in 2005 show that big difference between the eastern and western districts. In inner west and outer east, respectively 9 and 15% were overweight. In inner east and a new satellite town, respectively 29 and 26% were overweight (Vilimas 2005). There are also considerable differences in the occurrence of overweight among Norwegian and immigrant children (Departementene 2007). Among immigrant youth 15-16 year-old in Oslo the number of overweight varies from 4 to 12%. Immigrant youth from other western countries, Eastern Europe, The Middel East and North-Africa had higher prevalence of overweight (Kumar et al. 2004).

Norwegian Institute of Public Health concludes that both for the adult population and young people, there is insufficient information to assess whether the proportion of overweight continues to increase also the last few years, and whether the development is different for different counties in Norway (Folkehelseinstituttet 2010).

2.3. National policies on nutrition and obesity

Norway was one of the first industrialised countries to respond to the statement that all countries should formulate a nutrition policy as promoted at the World Food Conference in 1974. The initial White Paper (stortingsmelding) on nutrition was closely linked with policies of agricultural self-sufficiency and regional development. The following White Paper in 1982 shifted its focus more towards nutrition and health policies. In 1993 the role of nutrition in health policies was further emphasised. Traditionally, Norwegian authorities have regarded nutrition more as a problem of individual knowledge and behaviour than of food supply, but structural arrangements have been also addressed (Roos et al. 2002). Norway has a National Council for Nutrition (Nasjonalt råd for Enæring) under the auspices of the Directorate for
Health and Social Affairs. The National Council for Nutrition has a permanent administration and plays a central role in the implementation and co-ordination of food and nutrition policy. In 2005 the Council issued a national nutrition strategy plan for 2005-2009. In 2007 the government issued a Plan of Action to Improve the Nation’s Diet 2007-2011 on behalf of all the Ministries (Departementene 2007). The action plan 2007-2011 builds on WHO’s global strategy for nutrition, physical activity and health from 2004. The Norwegian action plan explicitly states the importance of a multidisciplinary action plan and co-operation between Ministries to improve nutrition. It is seen as an aim to improve the health of the population as a whole and reduce social differences. The proposed measures emphasises the need for structural arrangements that make it easier to choose healthy food, and stimulate healthy meals in kinder gardens, schools and welfare services to the elderly. Co-operation between state, private and voluntary sector is seen as fundamental for establishing viable measures. The action plan for diet (2007-2011) declare ambition and concrete quantitative targets:

Objectives for the nursing of infants:
- Percentage of infants to be fully breastfed at 4 months of age will increase from 44% to 70%
- Percentage of infants to be fully breastfed at 6 months of age will increase from 7% to 20%
- Percentage of infants to be fully breastfed at 12 months of age will increase from 36% to 50%

In addition, a 20% change in the following goals for the diet of the population:
- Increase the proportion who eat vegetables daily
- Increase the proportion who eat fruit daily
- Increase the percentage of people who eat fish for dinner at least once a week
- Increase the percentage of people who eat fish spread at least twice a week
- Increase the percentage of adolescents who eat breakfast daily
- Reduce the proportion of children and young people who eat sweets daily
- Reduce the proportion who drink soft drinks daily
- Reduce the proportion receiving more than 10% of energy intake from sugar
- Reduce the proportion receiving more than 10% of energy intake from saturated fat

The action plan further outlines concrete measures to be undertaken to reach the asserted aims, some of which are: information campaigns, strengthen dialogue and co-operation with and between food industry, NGOs and researchers, product development, economic incentives to eat healthier, marketing toward children and youth, product placement in stores etc. (Departementene 2007).

2.3.1. The retail structure and food industry

The grocery market in Norway is completely dominated by four retail chains; Coop Norge AS, ICA Norge AS, Norgesgruppen AS, Rema 1000 Norge AS. The three first chains are “umbrella chains” which comprise different store concepts; discount stores, supermarkets and hypermarkets. In 2009, Coop Norge AS had 24%, ICA Norge AS 15.7%, Norgesgruppen AS 40% and Rema 1000 Norge AS 20.3% of market shares. The Norwegian grocery market is dominated by discount stores with little selection, which comprise 50% of the total market. Approximately 10% are hypermarkets and 26% supermarket concepts which offer more variety. Approximately 12% are local stores, which can boast more or less variety

The structure of the Norwegian grocery market has been relatively stable the last years.

NGOs: National association for overweight people (Landsforeningen for overvektige), LHL - The Norwegian Heart and Lung Patient Organization (Landsforeningene for hjerte- og lungesyke), The Norwegian Diabetes Association (Norges diabetesforbund) and Norwegian association for obesity research (Norsk forening for fedmeforskning) are the most active NGOs in relation to obesity issues in Norway. From the organisations homepages, it seems the NGOs are more involved in financing research on obesity related diseases, dissemination of knowledge and treatment of obesity related diseases, than to participate directly in public/private initiatives which we are mapping in work package 4.

References


149 http://www.pht.no/prosjekt/dvh/fasit/fasit.html


**SWEDEN**

1. **Overview of PPP initiatives**

1.1. Assessment of accessibility of information on PPPs

Information on various initiatives directed at counteracting obesity and promoting health are available. There seems to be many initiatives in Sweden aimed at counteracting obesity though healthy diet and stimulating physical activity; however a minority of these are public/private initiatives. Rather they tend to be initiated either by private actors or public instances. We found 9 private-public collaborating initiatives which focused on nutrition. Internet has been used as the primary source of information: database for scientific articles (ISI Web of Knowledge), websites for grocery chains, ministries, research institutions and NGOs and searches on key phrases and words through search machines such as Google.

1.2. Different types of PPPs

1.2.1. Typical PPPs

Traditionally Swedish public/private initiatives directed at reducing overweight and obesity seem to be more oriented toward information campaigns (see mapped initiatives in appendix). Typical private/public initiatives have distributed health and nutrition information through issuing free magazines (for example Pharmacies Advice for life/ Milk mirror-mjölkspelgen), websides (for example Informedica) and interactive internet portals (for example Hälsstorget). There seems to have been little evaluation of the impact of these information campaigns. In the following we present three initiatives that have used more innovative ways of interacting with the populace and food producers/retailers to counteract trends of overweight and obesity,
and which also have in common that the success of their activities can be more easily evaluated.

1.2.3. Best example cases

**Viktklubb.se**: Viktklubb.se is an Internet-based weight club\[151\]. The initiative is a collaboration between the Obesity research unit at Karolinska Institute and the national newspaper Aftonbladet. The project was initiated because obesity care in Sweden today does not reach out to all who needs help. Estimates show that in the Stockholm area only 1-3 percent of all obese persons receive care. This means indicates a need for alternative forms of treatments. Through viktklubb.se the obesity unit at Karolinska Institute can help many by a relatively small operation, unlike the more usual cases where one cure few with major efforts. The weight club was started in April 2003. It offers services such as weight loss diary, day-to-day recipes, exercise programme, weight profile, chat forum, expert advice and weekly coach letters. There is a PhD project linked to viktklubb.se which aims to monitor and analyze members' weight loss and use of the virtual club in relation to sixty variables. Data is collected continuously. Currently there are data on 38 000 members followed for two years. In Sweden there is a national health policy where employers should stimulate physical movement and health among their employees. Employees may have their membership at the viktklubb.se paid by their employer. By 2010 350 000 Swedes have joined the Aftonbladet weight service. Since its inception, viktklubb.se has helped its members drop 600 tons, or 1.2 million packs of butter. A study of data collected at viktklubb.no shows that eighty-six percent of members are female, between 18-101 years. A sizable dropout rate has been observed, but among the completers, 16% changed from overweight or obese to normal weight (Jonasson et al. 2009). Professor Stephan Rössner at Karolinska Institute, who co-founded viktklubb.se, says that the project has been a success and that they have reached more people than they hoped for. viktklubb.se can be defined as a mixture of policy programme, research programme and Internet campaign. The initiative can be considered successful in the sense that it is a project that has helped many using small resources.

**The keyhole label**: In Sweden the Keyhole symbol of the National Food Administration (NFA) has existed since 1989\[152\]. In 2009 the system was introduced also in Norway and Denmark. Keyhole labelling is used for 25 different food groups. Labelled food is leaner and contains less fat, sugar and salt, but more fiber and whole grain foods than other products of the same type. Food producers using the label are responsible for regulatory compliance. Use of labelling is voluntary. NFA sets standards for food groups and has regulatory oversight of the manufacturers who use the symbol on some of their products. In Sweden keyhole labelling is used in three contexts: 1) On pre-packaged food directed at consumers and catering firms 2) On recipes aimed at consumers in stores. Special agreements on criteria are in this case made between the NFA and grocery chains such as ICA, Coop, Finax etc. 3) In Sweden the keyhole label has also been extended to restaurant meals (see the mapped initiative *Keyhole at restaurants/Food project* in appendix. Keyhole at restaurant is the Swedish partner of the EU project FOOD, Fighting Obesity through Offer and Demand\[153\]). The criteria for the keyhole symbol go hand in hand with new nutrition recommendations and the development of new food products. In 2009 stricter requirements for whole grain cereal and ready-made food

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\[151\] [http://ki.se/ki/jsp/polopoly.jsp?d=16986&l=sv](http://ki.se/ki/jsp/polopoly.jsp?d=16986&l=sv), [http://viktklubb.aftonbladet.se/cm/2.10/2.112](http://viktklubb.aftonbladet.se/cm/2.10/2.112)


were introduced, as well as for sugar and salt content in some food groups. The keyhole symbol helps consumers choose the healthier alternatives, both when they buy food in stores and eat at restaurants. The initiative can also be considered successful because it provides incentives for food manufacturers and grocery chains to develop and stock more nutritious and healthy food. The keyhole label can be described as a mixture of policy programme, research on food composition, voluntary label system for food producers and choice editing-and marketing in stores, which together establish codes of conduct for consumers’ food choices.

“Buddy with the body – five a day”: Recent research has demonstrated the health benefits of eating a diet rich in vegetables and fruit. In Europe, children’s consumption of fruit and vegetables is far below the current recommendations. In the Buddy with the body project, ICA and the Cancer Society collaborate with the Karolinska Institute to encourage school children to establish healthier eating habits early in life. Nine consecutive years Swedish school children in grades 2 and 5 have been invited to a fruit and vegetable lesson at their local ICA supermarket. During the autumn 2009 and spring 2010, 27 Swedish school classes received three visits each where staff from the Karolinska Institute and ICA held lectures and brought fruit and vegetables. The long-lived Swedish project sparked EU interest in 2009, and within a year the Buddy with the body project became part of a larger European study, ProGreens. The aim of the ProGreens project is to assess European schoolchildren’s consumption of fruit and vegetables, and to identify long-term strategies to increase school children's intake of fruits and vegetables. Twelve partners from eleven countries collaborate in the ProGreens project, which runs from August 2008 through July 2011. ICA’s teaching materials and inspirational posters from the Buddy with the body project have been translated into English and are used by the other countries. The Buddy with the body project can probably be described as a mixture of marketing and policy programme directed at schools. Coupled with the ProGreens study, it is also a research project. The adoption of the Buddy with the body method within a larger EU project might indicate that the initiative has best practice potential. The methodology adapted in initiative will probably be evaluated through the ProGreens project, where first results are expected autumn 2010.

2. Country context

2.1. Background information

Population, total in 2010: 9.3 million
GDP per capita in Purchasing Power Standards (EU-27 =100), 2009: 118
Unemployment rate, January 2010, %: 8.9
Healthy life years at birth, 2008, m/f: 69.2/68.7
Obesity rates among adults, 2008 (or nearest year available), %: 10.2

2.1.1. Societal organisation

There are 9 million inhabitants in Sweden. Sweden is a modern industrialized welfare state and most people work in services and industries (Roos et al. 2002). 3 percent of Swedes worked in agriculture, forestry and fishing in 1994, compared to 25 percent in 1950 (Statistics

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[http://www.progreens.org/index.html](http://www.progreens.org/index.html)
Sweden 1995). The country is a representative democracy, in which powers are separated into executive, legislative and juridical powers.

2.1.2. National food landscape

In Sweden it is common to serve mass catered, warm lunches in schools and at work places. The majority of Swedish school children have received subsidized warm lunches since the mid 1940s. School meals are seen as a mean to influence and improve children’s food habits and make them aware of the connection between food and health. As such warm meals at schools and workplaces are considered an important part of public health work (Roos et al. 2002). Since the 1980s, food habits in Sweden changed to the worse, but the last few years a certain improvement of this development can be identified. Between 1980 and 2006 the consumption of candy rose from 10 to 15 kg per person, and mineral water from 30 to 90 litres. The average energy intake increased with 4 percent, which certainly stimulated the growth of overweight among the Swedish populace (National Board of Health and Welfare 2009). In light of governmental recommendations, Swedes eat too little fruit, vegetables and fish. Less than one out of ten eat fruit and vegetables five times a day. Women and people with a high level of education generally tend to have better food habits than men and people with lower levels of education. Since 2002 the energy intake among the Swedish populace has decreased again. The last few years children’s food habits have also improved. More eat fruit and vegetables and the consumption of candy and mineral water decreased markedly between 2001 and 2005. However Swedish children still consume too much candy, mineral water, ice cream, snacks and pastries (National Board of Health and Welfare 2009).

2.2. Overweight and obesity

Numbers from Statistics Sweden (SCB) show that more than 50% of men and approximately 35% of women are overweight (BMI>25) or obese (BMI>30). Of these, around 10% of both genders are obese. During the 90s the number of overweight persons in Sweden increased in all socio-economic groups and educational levels, while obesity increased more among people with lower levels of education. However current medical research on overweight and obesity show that for the adult population overweight and obesity rates have remained relatively stable since 2000/2001 (Ministry of Health and Social Affairs 2008). However, obesity levels among certain subgroups remain alarmingly high (Sundquist et al. 2010).

A study compared two cross-sectional, nationwide random samples of persons aged 16 to 84 years, the first from 2000/01 (N= 5515 men, 5838 women) and the second from 2004/05 (N= 4681 men, 4821 women). Results showed that total mean BMI remained almost unchanged between 2000/01 and 2004/05 for both men and women. The prevalence of obesity increased slightly in both men and women (from 9.7 to 10.8% and from 9.6 to 10.2% respectively). Although the BMI and obesity rates were almost unchanged in the Swedish adult population in this period, the research concludes that obesity levels in Sweden remain unacceptably high, especially in certain subgroups: men aged 45-54 (14.3%), and 55-64 (16.5%), women aged 65-74 (15.9%) and 74-84 (16.8%), men and women of middle educational level (15.6% and 14.4% respectively), male former smokers (13.4%), and men from small towns or rural areas (13.1%) (Sundquist et al. 2010).

Another study which used longitudinal data over a 17 year period for a Swedish cohort aged 20-68 in 1980/1981 found that income is the main driving force behind obesity inequality, people with low economic resources tend to weigh more. Being single (as opposed to married
or cohabiting) was found to be an important factor counteracting obesity. This study thus suggests that policies directed at adjusting income inequality might be the most effective for reducing obesity inequality (Ljungvall et al. 2010).

Investigating the association between meal patterns and obesity among people living in the Vastra Gotaland region in Sweden, a study found that being obese was significantly associated with omitting breakfast or omitting lunch and eating at night. Obesity was thus associated with a meal pattern shifted to later in the day and significantly larger self-reported portions of main meals (Berg et al. 2009).

Analysing the sociodemographic factors associated with obesity among different ethnic groups (classified as Swedish, Middle Eastern and Other European) settled in two deprived neighbourhoods in Sweden found that one third of the sample (N=289) was obese. There were higher rates of obesity among Middle Eastern women than among Swedish women, and men of other European origin had higher BMI obesity than Swedish men. The study concludes that there is a need for prevention programmes targeting native and immigrant adults in deprived neighbourhoods in Sweden, and suggest that initiatives should focus on particular groups, such as immigrant women and those experiencing economic difficulties (Faskunger et al. 2009).

A study investigated cardiovascular risk factors in normal weight, overweight and obese men in Goteborg, Sweden, all aged 50 when examined (N=3251). Researchers found that over a 40 year period (from 1963 to 2003), there was a net increase in BMI from 24.8 to 26.4, with an increase in the prevalence of obesity from 6% to 13.8%. At the same time results showed that obese Swedish men who are now in their fifties have much lower levels of other health risk factors compared with obese men 40 years ago. The study suggests that this can contribute to explain why coronary heart disease death rates are falling despite increasing rates in obesity (Rosengren et al. 2009).

With regard to Swedish children studies show that rates of overweight and obesity among Swedish children are high; it is estimated that 15 - 20% are overweight or obese. Of these, approximately 2–8 % is obese (Ministry of Health and Social Affairs 2008). Nevertheless recent research indicates that overweight and obesity levels among Swedish children might be stabilizing or even levelling off.

Height and weigh data for 4-year-old children registered in the county of Vasterbotten in Sweden showed that overweight prevalence decreased between 2002 and 2008, for boys from 17.2% to 14.2% and for girls from 22.3% to 19.0%. Among girls, there was also a decrease in obesity prevalence from 5.7% to 3.1%. The results of this study indicate that the overweight and obesity epidemic among Swedish pre-school children may be levelling off (Bergstrom and Blomquist 2009).

Another study researching time trends in overweight, obesity and underweight among 10-year-old school children in eight areas with different socioeconomic status in Stockholm County. Among boys, the prevalence of overweight was 21.6% in 1999 and 20.5% in 2003. The prevalence of obesity was 3.2 and 3.8% respectively. Among girls, overweight decreased from 22.1 to 19.2% and obesity from 4.4 to 2.8% during the same time interval. The study indicates that rates of obesity, overweight and underweight are relatively stable in Stockholm County. However strong gradients, with more obesity and overweight in socioeconomically disadvantaged areas were observed in both genders in 2003 (Sundblom et al. 2008).
A study conducted among 10 year-old children in Goteborg, Sweden show that between 2000/01 and 2004/05 the prevalence of overweight and obesity in girls decreased from 19.6% to 15.9%. In boys, differences in the corresponding cohorts were nonsignificant: 17.1% versus 17.6% were overweight including obese. The study concludes that the obesity epidemic in 10-11 year olds may be easing off in urban Sweden, and possibly reversing among girls (Sjoberg et al. 2008).

However, a six-year follow up study on 296 Swedish 10-year-olds and a panel study among 16 year-olds, showed no difference in prevalence of overweight and obesity between 2001 and 2007 samples (Ekblom et al. 2009).

2.3. National policies on nutrition and obesity

In general Scandinavian health policies aim to improve the health of the population as whole and reduce social differences. Nutritional policies have been important in this respect (Roos et al. 2002). Nutritional policies in the Scandinavian countries have shifted from close alliance with agricultural politics to health politics (Jensen 1997, Kjærnes 1997). In Sweden The National Food Administration (NFA) (Livsmedelsverket) is responsible for nutrition recommendations, food control and legislation. The National Public Health Institute (Statens folkhälsoinstitut) is a state agency under the Ministry of Health and Social Affairs and is responsible for developing methods for intervention and evaluation, and for drafting national policy for health promotion (in relation to alcohol, drugs, diet, exercise, etc). The two authorities also support regional and local work. In addition there are several additional experts and reference groups (Roos et al. 2002). The Joint Expert Group advise governmental agencies in diet, exercise and health issues (Expertgruppen för kost-, motions- och hälsofrågor 1997). In 1995 the Swedish government issued the first official plan for nutrition. The initiatives proposed were among other centralized co-ordination and surveillance, strengthened education and training, support to local and regional initiatives, and a strengthening of consumer influence (NFA 1994). In 2000 a new national strategy plan for nutrition for 1999-2004 was launched (NFA 2004). Swedish nutrition plan for 1999 to 2004 presented a list of 11 aims and strategies, and acknowledged the importance of a multidisciplinary approach and stakeholder involvement. One of the central aims of the plan was to promote dialogue with central stakeholders and especially the food industry (Ibid.). Other stakeholders mentioned in the document are; retail and distribution, schools and mass catering, consumer organisations and national board for education. However the nutrition plan for 1999 - 2004 did not pinpoint aims in numbers and remained descriptive on the nutritional level (Lachat et al. 2005). A 2007 evaluation of the implementation of the 1999 – 2004 nutrition plan concluded that the implementation programme had just been started and an intensification of activities was need to reach the aims of the programme (Stockholms läns landsting 2010). The new action plan for overweight and obesity 2010 – 2013 declare ambitious and concrete aims: 1) to reduce the number of obese persons by half by 2013 2) to stagger the growth in obesity by 2010 3) to reduce the number of obese persons each year between 2011 and 2018 4) new cases of diabetes type 2 shall be reduced each year in the period 2010 – 2018 5) during the period 2010 -1018 the number of youth aged 18-24 that are overweight/obese shall be reduced by 10 percent 6) the growth in BMI shall be reduced by 2010, as compared to 2002 numbers. The action plan further identifies five prioritised working areas through which the aims will be followed up, and describes concrete implementation plans, responsible instances and intermediate aims ((Stockholms läns landsting 2010).
2.3.1. The retail structure and food industry

In Sweden, three national retail chains control over 90 percent of the market. This structure has been stable for some 30 years of so (Elg 2008). The largest retail group is ICA, which has a 45% market share. ICA is cooperation of independent stores which collaborate on purchasing, transport and marketing. KP is a centrally coordinated group of regional consumer cooperatives with 25% od market shares. Some 2 150 stores, most of them independent convenience stores are affiliated with DAGAB (24% market share). In addition to these groups, there are a number of independent chains that in some regions (primarily in the southwest) comprise a significant share of sales, but at the national level have a joint market share of only 6% (Asplund & Friberg 2002). An article discussing the relation between retail chains and food manufactures in Sweden, claim that the retail chains are the most powerful vis-à-vis the food producers. It is claimed that there is a growing rate of change, internationalisation of brands and multiplication of retail brands within the fast moving consumer goods area not only in Sweden, but in Europe as a whole (Elg 2008).

2.3.2. Health oriented non-governmental organizations (NGOs)

The Swedish Cancer Society, the Swedish Hearth-Lung Foundation and the Swedish Diabetes Foundation are some of the most active NGOs with regard to health promotion in Sweden. Reading the organisation’s homepages they generally tend to be more involved with collecting resources to finance medical research projects, building public opinion and disseminate results than to participate directly in executive public/private initiatives. In 2011 the Swedish Cancer Society will hand out 389 million SEK to fund Swedish cancer research, including research on overweight and obesity. The Hearth-Lung Foundation handed out 154 million SEK to health related research in 2009, and the Diabetes foundation annually support research on nutrition and diabetes with approximately 14 million SEK.

References


Overview of National cases


Conclusions

The following table summarizes the number of the PPPs which were identified:

<table>
<thead>
<tr>
<th>Region</th>
<th>Country</th>
<th>Number of PPPs</th>
<th>Number of PPPS selected to WP5</th>
</tr>
</thead>
<tbody>
<tr>
<td>South (N = 40)</td>
<td>Cyprus</td>
<td>2</td>
<td></td>
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<tr>
<td></td>
<td>Greece</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Italy</td>
<td>9</td>
<td></td>
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<tr>
<td></td>
<td>Malta</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Portugal</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Spain</td>
<td>12</td>
<td>2</td>
</tr>
<tr>
<td>Central and East (N = 76)</td>
<td>Austria</td>
<td>25</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Bulgaria</td>
<td>2</td>
<td></td>
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<tr>
<td></td>
<td>Czech Republic</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Germany</td>
<td>13</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Hungary</td>
<td>11</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Poland</td>
<td>8</td>
<td>2</td>
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<tr>
<td></td>
<td>Romania</td>
<td>5</td>
<td></td>
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<tr>
<td></td>
<td>Slovakia</td>
<td>5</td>
<td></td>
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<tr>
<td></td>
<td>Slovenia</td>
<td>4</td>
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<tr>
<td>West (N = 57)</td>
<td>Belgium</td>
<td>13</td>
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<td></td>
<td>France</td>
<td>14</td>
<td>2</td>
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<tr>
<td></td>
<td>Republic of Ireland</td>
<td>6</td>
<td>1</td>
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<td></td>
<td>Luxembourg</td>
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<tr>
<td></td>
<td>The Netherlands</td>
<td>14</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>UK</td>
<td>10</td>
<td>2</td>
</tr>
<tr>
<td>North (N = 63)</td>
<td>Denmark</td>
<td>24</td>
<td>1</td>
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<tr>
<td></td>
<td>Estonia</td>
<td>1</td>
<td></td>
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<tr>
<td></td>
<td>Finland</td>
<td>18</td>
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<td></td>
<td>Latvia</td>
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<tr>
<td></td>
<td>Lithunaia</td>
<td>1</td>
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<td></td>
<td>Norway</td>
<td>9</td>
<td>1</td>
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<tr>
<td></td>
<td>Sweden</td>
<td>8</td>
<td>2</td>
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<tr>
<td>TOTAL</td>
<td></td>
<td>236</td>
<td>24</td>
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</tbody>
</table>

We identified totally 236 initiatives, the numbers varied from 0 to 25 for each country (the highest numbers were found in countries in West, Central and North). However, for some countries that have many PPPs, for example, UK it was only a selection of all PPPs that were included. In addition, information was collected by several partners with various backgrounds. Therefore, we cannot based on this study conclude exactly how many PPPs initiatives to counteract obesity and overweight there are in EU and Norway. We can only suggest that there seems to be more PPPs in the Anglo-American zone and the Nordic zone than in the Mediterranean zone and the Eastern European zone.
The most common type of PPP was education aimed at children in kindergarten or school. We have also identified policy programmes, research programmes, labels, programmes directed at work places, codes of conduct and campaigns.

There were several issues that had to be taken into account when selecting the cases for further analysis in WP5 (Figure 1). The accessibility of information varied and this has been taken into account when selecting the cases. In addition, the cases that have been selected have to show some results and/or evaluation. We have also made an attempt to get different types of PPPs and from different zones.

<table>
<thead>
<tr>
<th>Children</th>
<th>Kindergarten</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Schools</strong></td>
<td><strong>XXI generation</strong> (Portugal)</td>
<td><strong>Moving kids</strong> (Spain)</td>
</tr>
<tr>
<td>EPODE (France)</td>
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<td></td>
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<tr>
<td>PAIDEIATROFI (Greece)</td>
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<td>THAO (Spain)</td>
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<tr>
<td>Keep fit (Poland)</td>
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<td>Incredible ed (Ireland)</td>
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<tr>
<td>NutriKids (Hungary)</td>
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<tr>
<td><strong>Campaigns</strong></td>
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<tr>
<td>No But (Hungary)</td>
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<tr>
<td><strong>Labelling</strong></td>
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<tr>
<td>Key hole (Norway, Sweden)</td>
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<td>Key-hole restaurants (Sweden)</td>
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<td>Heart symbol (Finland)</td>
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<td>Labels in schools (Austria)</td>
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<tr>
<td><strong>Drinking</strong></td>
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<td>I prefer water (Poland)</td>
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<tr>
<td>Clever drinking (Austria)</td>
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<tr>
<td><strong>Workplace</strong></td>
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<tr>
<td>Food at work (France)</td>
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<tr>
<td><strong>General</strong></td>
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<tr>
<td>6aday (Denmark)</td>
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<td>FSA catering commitment (UK)</td>
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<td>Balans day (Netherlands)</td>
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<td>Cooking for parents (Hungary)</td>
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<tr>
<td>Change4life (UK)</td>
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</tbody>
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Figure 1. Suggestions for best practice cases to be studied further in WP5 (N=24)