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**GREEN PAPER**

**"Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases"**

## TABLE OF CONTENTS

I.	State of play at European Level .....	3
II.	Health and Wealth.....	4
III.	The Consultation Procedure.....	4
IV.	Structures and Tools at Community Level .....	5
IV.1.	European Platform for Action on Diet, Physical Activity and Health.....	5
IV.2.	European Network on Nutrition and Physical Activity .....	6
IV.3.	Health across EU policies .....	6
IV.4.	The Public Health Action Programme .....	7
IV.5.	European Food Safety Authority (EFSA).....	7
V.	Areas for Action.....	7
V.1.	Consumer information, advertising and marketing.....	7
V.2.	Consumer education.....	8
V.3.	A focus on children and young people.....	8
V.4.	Food availability, physical activity and health education at the work place.....	9
V.5.	Building overweight and obesity prevention and treatment into health services.....	9
V.6.	Addressing the obesogenic environment .....	10
V.7.	Socio-economic inequalities .....	10
V.8.	Fostering an integrated and comprehensive approach towards the promotion of healthy diets and physical activity .....	10
V.9.	Recommendations for nutrient intakes and for the development of food-based dietary guidelines .....	11
V.10.	Cooperation beyond the European Union.....	11
V.11.	Other issues .....	12
VI.	Next steps.....	12
	Annex 1: Figures and Tables.....	13
	Annex 2: Relationship between diet, physical activity and health.....	17
	Annex 3: References .....	20

## GREEN PAPER

### “Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases”

#### I. STATE OF PLAY AT EUROPEAN LEVEL

- I.1. Unhealthy diets and lack of physical activity are the leading causes of avoidable illness and premature death in Europe, and the rising prevalence of obesity across Europe is a major public health concern (*cf annex 2 for background information*).
- I.2. The Council has invited the Commission to contribute to promoting healthy lifestyles<sup>(i)</sup>, and to study ways of promoting better nutrition within the European Union, if necessary by presenting appropriate proposals to that end<sup>2</sup>. The Council has also called upon Member States and the Commission to conceive and implement initiatives aimed at promoting healthy diets and physical activity<sup>3</sup>.
- I.3. The Community has a clear competence in this area: Article 152 of the Treaty requires that a high level of human health protection be ensured in the definition and implementation of all Community policies and activities. A number of areas of Community policy are relevant to nutrition and physical activity, and the Council has confirmed the need to mainstream nutrition and physical activity into relevant policies at the European level<sup>4</sup>.
- I.4. Action at national level may usefully be complemented at the Community level. Without limiting the scope for actions which Member States may wish to initiate, Community action may exploit synergies and economies of scale, facilitate Europe-wide action, pool resources, disseminate best practice and thereby contribute to the overall impact of Member State initiatives.
- I.5. The Council underlined that the multi-causal character of the obesity epidemic calls for multi-stakeholder approaches<sup>5</sup> - for which the European Platform for Action on Diet, Physical Activity and Health (*cf section IV.1*) is a prominent example - and for action at local, regional, national and European levels<sup>6</sup>. The Council also welcomed the Commission's intention to present this Green Paper and to present in 2006 the results of the public consultation exercise initiated with the Green Paper<sup>7</sup>.
- I.6. The European Economic and Social Committee underlined that action at Community level can reinforce the effect of initiatives taken by national authorities, the private sector and NGOs<sup>8</sup>.
- I.7. A number of Member States are already implementing national strategies or action plans in the field of diet, physical activity and health<sup>9</sup>. Community action may support and complement these activities, promote their coordination, and help to identify and disseminate good practice, so that other countries can benefit from experience gained.

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<sup>(i)</sup> References are grouped in Annex 3 at the end of the document

## **II. HEALTH AND WEALTH**

- II.1. Apart from the human suffering it causes, the economic consequences of the increasing incidence of obesity are of particular importance. It is estimated that in the European Union, obesity accounts for up to 7% of health care costs<sup>10</sup>, and this amount will further increase given the rising obesity trends. Although detailed data are not available for all EU countries, studies underline the high economic cost of obesity: A report prepared by the United Kingdom's National Audit Office in 2001 estimated that obesity in England alone accounted for 18 million days of sickness absence and 30,000 premature deaths, corresponding to an annual direct health care cost of at least GBP 500 million. The wider costs to the economy, which include lower productivity and lost output, were estimated at a further GBP 2 billion per year<sup>11</sup>. The 2004 report from the United Kingdom's Chief Medical Officer on the impact of physical activity and its relationship to health estimated the cost of physical inactivity at GBP 8.2 billion annually (including both the health care cost and the wider cost to the economy, such as days lost from work)<sup>12</sup>. In Ireland, the direct cost of treating obesity was estimated at some €70 million in 2002<sup>13</sup>. In the USA, the CDC estimated obesity-attributable health care costs at \$75 billion<sup>14</sup>. At an individual level, studies estimate that the average obese adult in the United States incurs annual medical expenditures that are 37% higher than an average person of normal weight<sup>15</sup>. These direct costs do not take into account reduced productivity due to disability and premature mortality.
- II.2. An analysis made by the Swedish Institute of Public Health concludes that in the EU, 4.5% of disability-adjusted lifeyears (DALYs) are lost due to poor nutrition, with an additional 3.7% and 1.4% due to obesity and physical inactivity – a total of 9.6%, compared with 9% due to smoking<sup>16</sup>.
- II.3. A recent report by the Netherlands Institute for Public Health and the Environment, RIVM, examined unfavourable dietary composition and health loss. One of the conclusions is that an excessive intake of the 'wrong' type of fats, such as saturated and trans fatty acids, increases the likelihood of developing cardiovascular disease by 25%, while eating fish once or twice a week will reduce this risk by 25%. In the Netherlands, every year, 38,000 cases of cardiovascular disease among adults aged 20 and above can be attributed to an unfavourable composition of the diet<sup>17</sup>.
- II.4. Tackling overweight and obesity therefore is not only important in public health terms, but will also reduce the long-term costs to health services and stabilise economies by enabling citizens to lead productive lives well into old age. This Green Paper will serve to determine if, by complementing Member States' activities, action at Community level may contribute to reducing health risks, curbing health care spending, and improving the competitiveness of Member States' economies.

## **III. THE CONSULTATION PROCEDURE**

- III.1. As announced in the Communication "Healthier, safer, more confident citizens, a Health and Consumer Strategy"<sup>18</sup>, the Commission is preparing a series of Community strategies to tackle the most important health determinants, including nutrition and obesity. In this context, the present Green paper aims at opening a broad-based consultation process and at launching an in-depth discussion, involving the EU

institutions, Member States and the civil society, aiming at identifying the possible contribution at Community level of promoting healthy diets and physical activity.

- III.2. The Commission calls on all interested organisations to submit responses to the issues raised in this Green Paper, no later than 15 March 2006, to the following address (preferably by e-mail):

European Commission  
Directorate-General Health and Consumer Protection  
Unit C4 – Health Determinants  
E-mail: [SANCO-C4-NUTRITIONGREENPAPER@cec.eu.int](mailto:SANCO-C4-NUTRITIONGREENPAPER@cec.eu.int)  
Postal address: L-2920 Luxembourg  
Fax: (+ 352) 4301.34975

These responses should not be scientific papers, but concrete and evidence-based proposals for policy building mainly at EU level. In particular, responses are expected from economic operators on issues within their specific area of interest (e. g. advertising and marketing, labelling...), patient associations and health and consumer protection NGOs.

- III.3. Unless respondents make a declaration to the contrary, the Commission services will assume that they do not object to having their responses, or parts thereof, published on the Commission's website and/or quoted in reports analysing the outcome of the consultation process<sup>19</sup>.
- III.4. Given the multifactorial nature of diseases linked to unhealthy dietary habits and physical inactivity, and the multi-stakeholder response needed to address them, this Green Paper includes certain issues that fall primarily under the competence of EU Member States (e. g. education, town planning); it should also contribute to determine where the EU could nevertheless provide added value, e.g. by supporting networking amongst stakeholders and disseminating good practice.

#### **IV. STRUCTURES AND TOOLS AT COMMUNITY LEVEL**

##### **IV.1. European Platform for Action on Diet, Physical Activity and Health**

- IV.1.1. In order to establish a common forum for action the European Platform for Action on Diet, Physical Activity and Health was launched in March 2005. The Platform brings together all relevant players active at European level that are willing to enter into binding and verifiable commitments aimed at halting and reversing current overweight and obesity trends. The objective of the Platform is to catalyse voluntary action across the EU by business, civil society and the public sector. Members of the Platform include the key EU-level representatives of the food, retail, catering, and advertising industries, consumer organisations and health NGOs.
- IV.1.2. The platform is to provide an example of coordinated but autonomous action by different parts of society. It is designed to stimulate other initiatives at national, regional or local level, and to cooperate with similar fora at national level. At the same time, the Platform can create input for integrating the responses to the obesity challenge into a wide range of EU policies. The Commission regards the Platform as

the most promising means of non-legislative action, as it is uniquely placed to build trust between key stakeholders. First results from the Platform are encouraging: involvement of other Community policies is strong, Platform members are planning far-reaching commitments for 2006, and a joint meeting with US stakeholders will contribute to exchanging good practice. Moreover, agreement has been secured by Sports Ministers to offer support to the Platform. A first evaluation of the outcomes of the Platform will take place mid-2006<sup>20</sup>.

## **IV.2. European Network on Nutrition and Physical Activity**

IV.2.1. A network on Nutrition and Physical Activity composed of experts nominated by the Member States, the WHO and consumer and health NGOs has been established by the Commission services in 2003 to advise the Commission on the development of Community activities to improve nutrition, to reduce and prevent diet-related diseases, to promote physical activity and to fight overweight and obesity. The Network will be closely involved in analysing the feedback to the present Green Paper.

## **IV.3. Health across EU policies**

IV.3.1. Preventing overweight and obesity implies an integrated approach to fostering health, an approach which combines the promotion of healthy lifestyles with actions aimed at addressing social and economic inequalities and the physical environment, and with a commitment to pursue health objectives through other Community policies. Such an approach would need to cut across a number of Community policies (e. g. agricultural, fishery, education, sport, consumer, enterprise, research, social, internal market, environment and audio-visual policies), and to be actively supported by them.

IV.3.2. At Commission level, a number of mechanisms are currently operating in order to ensure that health is taken into consideration in other Community policy areas:

- on major policy proposals from other Commission services, the Health and Consumer Protection Directorate-General is systematically consulted;
- the inter-service group on health discusses health-related issues between all concerned Commission services;
- the Commission's impact assessment procedure, which has been established as a tool to improve the quality and coherence of the policy development process and which includes the assessment of health impacts.

Questions on which the Commission invites contributions include:

- What are the concrete contributions which Community policies, if any, should make towards the promotion of healthy diets and physical activity, and towards creating environments which make healthy choices easy choices?
- Which kind of Community or national measures could contribute towards improving the attractiveness, availability, accessibility and affordability of fruits and vegetables?
- On which areas related to nutrition, physical activity, the development of tools for the analysis of related disorders, and consumer behaviour is more research needed?

#### **IV.4. The Public Health Action Programme**

- IV.4.1. The importance of nutrition, physical activity and obesity is reflected in the Public Health Action Programme<sup>21</sup> and its annual Work Plans. Under the health information strand, the Programme supports activities aimed at collecting more solid data on the epidemiology of obesity, and on behavioural issues<sup>22</sup>. The Programme is putting in place a comparable set of indicators for health status, including in the area of dietary intake, physical activity and obesity.
- IV.4.2. Under the health determinants strand, the Programme is supporting pan-European projects aimed at promoting healthy nutrition habits and physical activity, including cross cutting and integrative approaches which foster the integration of approaches on lifestyles, integrate environmental and socio-economic considerations, focus on key target groups and key settings and link work on different health determinants<sup>23</sup>.
- IV.4.3. The Commission's proposal for a new Health and Consumer protection programme<sup>24</sup> puts a strong focus on promotion and prevention, including in the area of nutrition and physical activity, and foresees a new action strand on the prevention of specific diseases.

Questions on which the Commission invites contributions include:

- How can the availability and comparability of data on obesity be improved, in particular with a view to determining the precise geographical and socio-economic distribution of this condition?
- How can the programme contribute to raising the awareness of the potential which healthy dietary habits and physical activity have for reducing the risk for chronic diseases amongst decision makers, health professionals, the media and the public at large?
- Which are the most appropriate dissemination channels for the existing evidence?

#### **IV.5. European Food Safety Authority (EFSA)**

- IV.5.1. The European Food Safety Authority can make an important contribution to underpinning proposed actions on nutrition (e. g. on recommended nutrient intakes, or on communication strategies aimed at health professionals, food chain operators and the general public on the impact of nutrition on health) with scientific advice and assistance (*on the role of EFSA in the establishment of food-based dietary guidelines, cf section V.9 below*).

### **V. AREAS FOR ACTION**

#### **V.1. Consumer information, advertising and marketing**

- V.1.1. Consumer policy aims to empower people to make informed choices regarding their diet. Information about the nutritional content of products is an important element in this respect. Clear, consistent nutrition information about foods can, along with relevant consumer education, act as the foundation of informed dietary choice. With this objective, the Commission has submitted a proposal for a regulation to harmonise the rules on nutrition on health claims<sup>25</sup>. This includes the principle of setting nutrient

profiles, in order to prevent foods high in certain nutrients (such as salt, fat, saturated fat and sugars) making claims about their potential nutrition or health benefits. The Commission is also considering amendments to the current rules on nutrition labelling.

- V.1.2. As far as advertising and marketing is concerned, it has to be ensured that consumers are not misled, and that especially the credulity and lacking media literacy of vulnerable consumers and, in particular children, are not exploited. This regards in particular advertising for foods high in fat, salt and sugars, such as energy-dense snacks and sugar-sweetened soft drinks, and the marketing of such products in schools<sup>26</sup>. Industry self regulation could be the means of choice in this field, as it has a number of advantages over regulation in terms of speed and flexibility. However, other options would need to be considered should self-regulation fail to deliver satisfactory results.

Questions on which the Commission invites contributions include:

- When providing nutrition information to the consumer, what are the major nutrients, and categories of products, to be considered and why?
- Which kind of education is required in order to enable consumers to fully understand the information given on food labels, and who should provide it?
- Are voluntary codes (“self-regulation”) an adequate tool for limiting the advertising and marketing of energy-dense and micronutrient-poor foods? What would be the alternatives to be considered if self-regulation fails?
- How can effectiveness in self-regulation be defined, implemented and monitored? Which measures should be taken towards ensuring that the credulity and lacking media literacy of vulnerable consumers are not exploited by advertising, marketing and promotion activities?

## V.2. Consumer education

- V.2.1. Improving public knowledge on the relationship between diet and health, energy intake and output, on diets that lower risk of chronic diseases, and on healthy choices of food items, is a prerequisite for the success of any nutrition policy, whether at national or Community level. Consistent, coherent, simple and clear messages need to be developed, and disseminated through multiple channels and in forms appropriate to local culture, age and gender. Consumer education will also contribute to creating media literacy, and enable consumers to better understand nutrition labelling.

Questions on which the Commission, in view of identifying best practices, invites contributions include:

- How can consumers best be enabled to make informed choices and take effective action?
- What contributions can public-private partnerships make toward consumer education?
- In the field of nutrition and physical activity, which should be the key messages to give to consumers, how and by whom should they be delivered?

## V.3. A focus on children and young people

- V.3.1. Important lifestyle choices pre-determining health risks at adult age are made during childhood and adolescence; it is therefore vital that children be guided towards healthy

behaviours. Schools are a key setting for health-promoting interventions, and can contribute to the protection of children's health by promoting healthy diets and physical activity. There is also growing evidence that a healthy diet also improves concentration and learning ability. Moreover, schools have the potential to encourage children to undertake daily physical activity<sup>27</sup>. Relevant measures could be considered at the appropriate level.

- V.3.2. In order to avoid that children are exposed to conflicting messages, health education efforts by parents and in schools need to be supported by efforts from the media, health services, civil society and relevant sectors of industry (positive role models...) (*for marketing towards children, cf section V.1*).

Questions on which the Commission, in view of identifying best practices, invites contributions include:

- What are good examples for improving the nutritional value of school meals, and how can parents be informed on how to improve the nutritional value of home meals?
- What is good practice for the provision of physical activity in schools on a regular basis?
- What is good practice for fostering healthy dietary choices at schools, especially as regards the excessive intake of energy-dense snacks and sugar-sweetened soft drinks?
- How can the media, health services, civil society and relevant sectors of industry support health education efforts made by schools? What role can public-private partnerships play in this regard?

#### **V.4. Food availability, physical activity and health education at the work place**

- V.4.1. Work places are a setting which has a strong potential to promote healthy diets and physical activity. Canteens that offer healthy choices, and employers who foster environments which facilitate the practice of physical activity (e. g. provision of showers and changing rooms) can make important contributions towards health promotion at the workplace.

Questions on which the Commission, in view of identifying best practices, invites contributions include:

- How can employers succeed in offering healthy choices at workplace canteens, and in improving the nutritional value of canteen meals?
- What measures would encourage and facilitate the practice of physical activity during breaks, and on the way to and from work?

#### **V.5. Building overweight and obesity prevention and treatment into health services**

- V.5.1. Health services and health professionals have a strong potential for improving patients' understanding of the relations between diet, physical activity and health, and for inducing necessary lifestyle changes. Patients could receive important stimuli for such changes if health professionals included in routine contacts practical advice to patients and families on the benefits of optimal diets and increased levels of physical activity. Obesity treatment options need also to be addressed<sup>28</sup>.

Questions on which the Commission invites contributions include:

- Which measures, and at what level, are needed to ensure a stronger integration aiming at promoting healthy diets and physical activity into health services?

## **V.6. Addressing the obesogenic environment**

- V.6.1. Physical activity can be integrated into daily routine (e. g. walking or cycling instead of using motorized transport in order to get to school or work). Transport and urban planning policies can ensure that walking, cycling and other forms of exercise are easy and safe, and address non-motorised modes of transportation. The provision of safe cycling and walking paths to schools could be one means to address the particular worrying trends for overweight and obesity in children.

Questions on which the Commission invites contributions include:

- In which ways can public policies contribute to ensure that physical activity be “built into” daily routines?
- Which measures are needed to foster the development of environments that are conducive to physical activity?

## **V.7. Socio-economic inequalities**

- V.7.1. Food choice is determined by both individual preferences and socio-economic factors<sup>29</sup>. Social position, income and education are determinants of diet and physical activity. Certain neighbourhoods could discourage physical activity, lack recreation facilities and affect the disadvantaged more than those who can afford or have access to transportation. Lower levels of education and poorer access to relevant information reduce the capacity to make informed choices.

Questions on which the Commission invites contributions include:

- Which measures, and at what level, would promote healthy diets and physical activity towards population groups and households belonging to certain socio-economic categories, and enable these groups to adopt healthier lifestyles?
- How can the “clustering of unhealthy habits” that has frequently been demonstrated for certain socio-economic groups be addressed?

## **V.8. Fostering an integrated and comprehensive approach towards the promotion of healthy diets and physical activity**

- V.8.1. A coherent and comprehensive approach aimed at making the healthy choices available, affordable and attractive involves taking account of mainstreaming nutrition and physical activity into all relevant policies at local, regional, national and European levels, creating the necessary supporting environments, and developing and applying appropriate tools for assessing the impact of other policies on nutritional health and physical activity<sup>30</sup>.
- V.8.2. The prevalence of chronic conditions related to diet and physical activity can vary greatly between men and women, age groups, and between socio-economic strata. Moreover, dietary habits, as well as physical activity behaviours, are often embedded

in local and regional traditions. Therefore, approaches aimed at promoting healthy diets and physical activity need to be sensitive to gender, socio-economic and cultural differences, and to include a life-course perspective.

Questions on which the Commission invites contributions include:

- Which are the most important elements of an integrated and comprehensive approach towards the promotion of healthy diets and physical activity?
- Which role at national and at Community level?

## **V.9. Recommendations for nutrient intakes and for the development of food-based dietary guidelines**

V.9.1 The WHO/FAO Report<sup>31</sup> provides general recommendations on population nutrient intake and physical activity goals in relation to the prevention of major non-communicable diseases.

V.9.2. The Eurodiet project<sup>32</sup> has proposed quantified population goals for nutrients, and underlines the need for these to be translated into food-based dietary guidelines (FBDGs). FBDGs need to be based on customary dietary patterns, and take socio-economic and cultural factors into account.

V.9.3. The Commission has asked the European Food Safety Authority (EFSA) to update the advice on energy, macronutrients and dietary fibre. Following on from this, EFSA will also advise on population reference intakes of micronutrients in the diet and, if considered appropriate, other essential substances with a nutritional or physiological effect in the context of a balanced diet. Moreover, EFSA will provide advice on the translation of nutrient based dietary advice into guidance on the contribution of different foods to an overall diet that would help to maintain good health through optimal nutrition.

Questions on which the Commission invites contributions include:

- In which way could social and cultural variations and different regional and national dietary habits be taken into account in food-based dietary guidelines at a European level?
- How can the gaps between proposed nutrient targets and actual consumption patterns be overcome?
- How can dietary guidelines be communicated to consumers?
- In which way could nutrient profile scoring systems such as developed recently in UK contribute to such developments<sup>33</sup>?

## **V.10. Cooperation beyond the European Union**

V.10.1. Some reflection is currently taking place at international level as regards the global involvement of Codex Alimentarius<sup>34</sup> in the field of nutrition. In line with the request in the WHO Global Strategy on Diet, Physical Activity and Health, the EU supports the view that general consideration should be given to how nutrition issues should be integrated into Codex work, while retaining the current mandate of Codex.

- V.10.2. Nutrition, diet and physical activity should be the subject of close cooperation between regulators and stakeholders in the EU and in other countries where rising levels of overweight and obesity are of concern<sup>35</sup>.

Questions on which the Commission invites contributions include:

- Under which conditions should the Community engage in exchanging experience and identifying best practice between the EU and non-EU countries? If so, through which means?

**V.11. Other issues**

Questions on which the Commission invites contributions include:

- Are there issues not addressed in the present Green paper which need consideration when looking at the European dimension of the promotion of diet, physical activity and health?
- Which of the issues addressed in the present Green paper should receive first priority, and which may be considered less pressing?

**VI. NEXT STEPS**

- VI.1. The Commission services will carefully analyze all contributions received in reply to the consultation process launched by the present Green Paper. It is expected that a report summarizing the contributions will be published on the Commission's website by June 2006.
- VI.2. In the light of the results of the consultation process, the Commission will reflect upon the most appropriate follow-up, and will consider any measures that may need to be proposed, as well as the instruments for their implementation. Impact assessment will be carried out as appropriate, depending on the type of instrument chosen.

## ANNEX 1

Figures

and Tables

<b>Table 1</b>		
<b>Prevalence estimates of diabetes mellitus</b>		
	<b>estimate 2003</b>	<b>estimate 2025</b>
<b>Country</b>	prevalence (%)	prevalence (%)
Austria	9.6	11.9
Belgium	4.2	5.2
Cyprus	5.1	6.3
Czech Republic	9.5	11.7
Denmark	6.9	8.3
Estonia	9.7	11.0
Finland	7.2	10.0
France	6.2	7.3
Germany	10.2	11.9
Greece	6.1	7.3
Hungary	9.7	11.2
Ireland	3.4	4.1
Italy	6.6	7.9
Latvia	9.9	11.1
Lithuania	9.4	10.8
Luxembourg	3.8	4.4
Malta	9.2	11.6
Netherlands	3.7	5.1
Poland	9.0	11.0
Portugal	7.8	9.5
Slovakia	8.7	10.7
Slovenia	9.6	12.0
Spain	9.9	10.1
Sweden	7.3	8.6
United Kingdom	3.9	4.7
<i>source: Diabetes Atlas, 2<sup>nd</sup> edition, International Diabetes Foundation 2003</i>		

Fig. 2: Deaths in 2000 attributable to selected risk factors (European region)  
(source: World Health Report 2002)

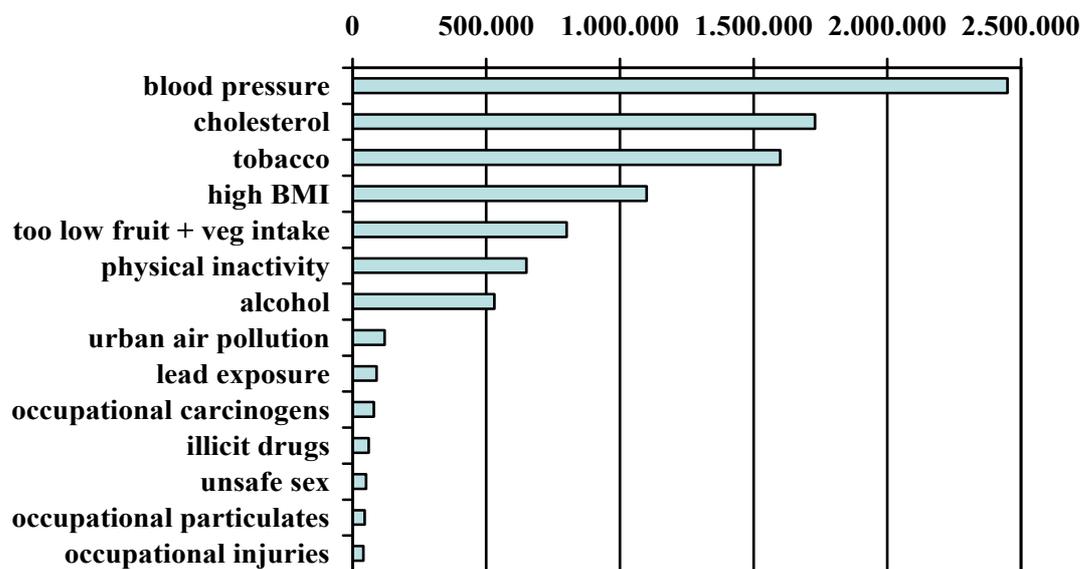


Table 2 - Overweight and obesity among adults in the European Union							
		Males			Females		
Country	Year of Data Collection	%BMI <sup>1</sup> 25-29.9	%BMI $\geq$ 30	%Com-bined BMI $\geq$ 25	%BMI 25-29.9	%BMI $\geq$ 30	%Combined BMI $\geq$ 25
Austria	1999	40	10	50	27	14	41
Belgium	1994-7	49	14	63	28	13	41
Cyprus	1999-2000	46	26.6	72.6	34.3	23.7	58
Czech Republic	1997/8	48.5	24.7	73.2	31.4	26.2	57.6
Denmark	1992	39.7	12.5	52.2	26	11.3	37.3
England <sup>2</sup>	2003	43.2	22.2	65.4	32.6	23.	55.6
Estonia ( <i>self reported</i> )	1994-8	35.5	9.9	45.4	26.9	15.3	42.2
Finland	1997	48	19.8	67.8	33	19.4	52.4
France ( <i>self reported</i> )	2003	37.4	11.4	48.8	23.7	11.3	35
Germany	2002	52.9	22.5	75.4	35.6	23.3	58.9
Greece	1994-8	51.1	27.5	78.6	36.6	38.1	74.7
Hungary	1992-4	41.9	21	62.9	27.9	21.2	49.1
Ireland	1997-99	46.3	20.1	66.4	32.5	15.9	48.4
Italy ( <i>self reported</i> )	1999	41	9.5	50.5	25.7	9.9	35.6
Latvia	1997	41	9.5	50.5	33	17.4	50.4
Lithuania	1997	41.9	11.4	53.3	32.7	18.3	51
Luxembourg		45.6	15.3	60.9	30.7	13.9	44.6
Malta	1984	46	22	68	32	35	67
Netherlands	1998-2002	43.5	10.4	53.9	28.5	10.1	38.6

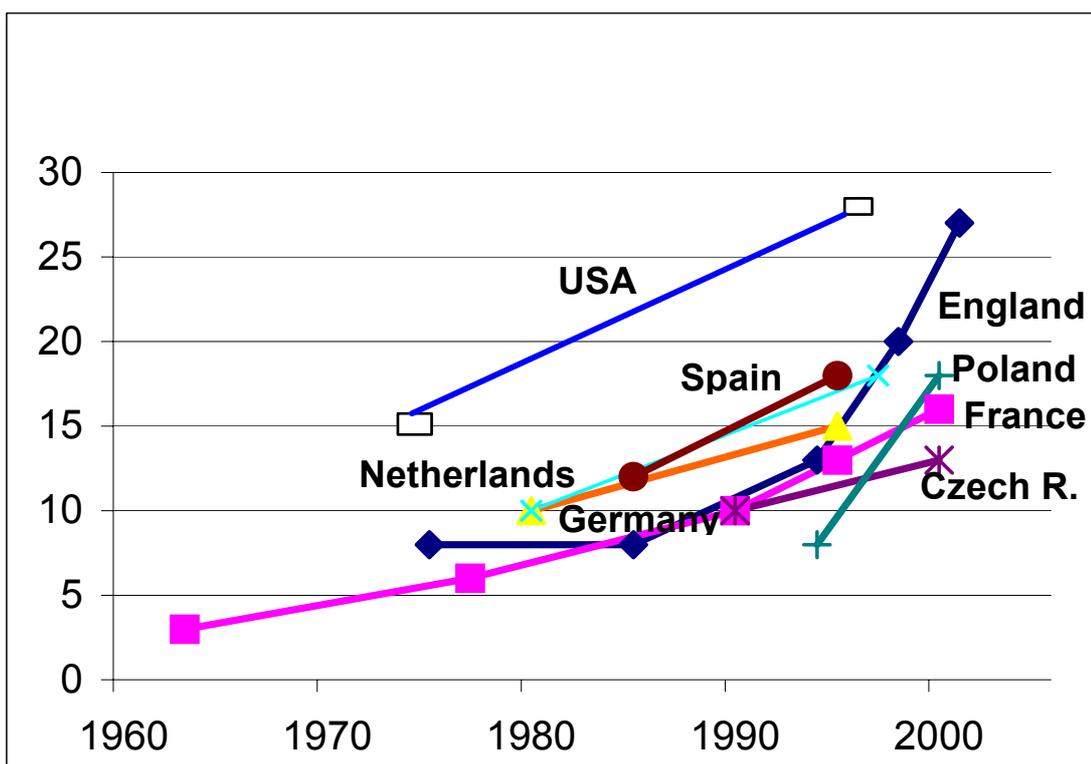
<sup>1</sup> BMI = Body Mass Index: a person's weight in kg divided by (height in metres)<sup>2</sup>; persons with a BMI between 25 and 30 are considered overweight, persons with a BMI >30 are considered obese

<sup>2</sup> Data from Health Survey for England, which does not include data for Scotland, Wales and Northern Ireland

Poland (self report)	1996	n/a	10.3	n/a	n/a	12.4	n/a
Portugal (urban)	Published 2003	n/a	13.9	n/a	n/a	26.1	n/a
Slovakia	1992-9	49.7	19.3	69	32.1	18.9	51
Slovenia (self reported)	2001	50	16.5	66.5	30.9	13.8	44.7
Spain	1990-4	47.4	11.5	58.9	31.6	15.3	46.9
Sweden (adjusted)	1996-7	41.2	10	51.2	29.8	11.9	41.7

*Age range and year of data in surveys may differ. With the limited data available, prevalences are not standardised. Self reported surveys may underestimate true prevalence. Sources and references are from the IOTF database (© International Obesity Task Force, London – March 2005)*

Fig. 2: Rising prevalence of overweight in children aged 5-11 (source: IOTF)



## ANNEX 2 - Relationship between diet, physical activity and health

1. The relationship between diet, physical activity and health has been scientifically established, in particular regarding the role of lifestyles as determinants of chronic non-communicable diseases and conditions such as obesity, heart disease, type 2 diabetes, hypertension, cancer and osteoporosis<sup>36</sup>.
2. Particularly alarming is the increase in the prevalence of **diabetes** (*cf table 1, Annex 1*). Type-2-diabetes, which accounts for over 90% of diabetes cases worldwide, is related to obesity, a sedentary lifestyle and diets high in fat and saturated fatty acids. Both prevention and treatment of type-2 diabetes need to focus on lifestyle changes (weight loss, physical activity, diets low in fat and saturated fatty acids)<sup>37</sup>.
3. **Cardiovascular diseases** (CVD) are together with cancer the most important causes of death and disease in Europe. Stopping smoking, increasing physical activity levels and adopting healthier diets are the most important factors in the primary prevention of CVD. The key recommendations for CVD prevention are maintenance of normal body weight, moderate physical activity of 30 minutes or more every day and avoidance of excess consumption of saturated fatty acids and salt.
4. Dietary factors are estimated to account for approximately 30% of all **cancers** in industrialized countries<sup>38</sup>, making diet second only to tobacco as a theoretically preventable cause of cancer. Consumption of adequate amounts of fruits and vegetables, and physical activity, appear to be protective against certain cancers. Body weight and physical inactivity together are estimated to account for approximately one-fifth to one-third of several of the most common cancers<sup>39</sup>.
5. **Osteoporosis** is a disease in which the density of bones is reduced, increasing the risk of fracture. Around the world, it affects one in three women and one in five men over the age of fifty. Although genetic factors will determine whether an individual is at heightened risk of osteoporosis, lifestyle factors can influence the acquisition of bone mass in youth and the rate of bone loss later in life. The joint WHO/FAO expert consultation<sup>40</sup> concludes that dietary and lifestyle recommendations developed for the prevention of other chronic diseases may prove helpful to reduce osteoporosis risk.
6. The *World Health Report 2002*<sup>41</sup> describes in detail how a few **major risk factors** account for a significant proportion of all deaths and diseases in most countries (*cf figure 1, Annex 1*). Six out of the seven most important risk factors for premature death (blood pressure, cholesterol, Body Mass Index, inadequate fruit and vegetable intake, physical inactivity, excessive alcohol consumption) relate to diet and physical activity (the odd one out being tobacco). Unhealthy diets and lack of physical activity are therefore the leading causes of avoidable illness and premature death in Europe.
7. The **underlying determinants** of the risk factors for the major chronic diseases portrayed above are largely the same. Dietary risk factors include shifts in the diet structure towards diets with a higher energy density (calories per gramme) and with a greater role for fat and added sugars in foods; increased saturated fat intake (mostly from animal sources) and excess intake of hydrogenated fats; reduced intakes of complex carbohydrates and dietary fibre; reduced fruit and vegetable intakes; and

increasing portion sizes of food items. Other important lifestyle-related risk factors, apart from smoking and excessive alcohol consumption, include reduced levels of physical activity. Of particular concern is the increasingly unhealthy diet and physical inactivity of adolescents and children.

8. As relatively few risk factors cause the majority of the chronic disease burden, the related morbidity and mortality is to a great extent preventable. It is estimated that up to 80% of cases of coronary heart disease, 90% of type 2 diabetes cases, and one-third of cancers can theoretically be avoided if the whole population followed current guidelines on diet, alcohol, physical activity and smoking. Addressing lifestyle factors such as nutrition and physical activity therefore has an enormous potential for the prevention of severe morbidity and mortality.
9. **Obesity** (BMI<sup>42</sup> >30) is a risk factor for many serious illnesses including heart disease, hypertension, stroke, type-2-diabetes, respiratory disease, arthritis and certain types of cancer. The rising prevalence of obesity across Europe (*cf. Annex 1, table 2*), particularly among young people (*cf. Annex 1, fig. 2*), has alarmed health experts, the media and the population at large, and is a major public health concern.
10. Evidence from population surveys suggests that obesity levels in the EU have risen by between 10-40% over the past decade, and current data suggest that the range of obesity prevalence in EU countries is from 10% to 27% in men and up to 38% in women<sup>43</sup>. In some EU countries more than half the adult population is overweight<sup>44</sup> (BMI >25), and in parts of Europe<sup>45</sup> the combination of reported overweight and obesity in men exceeds the 67% prevalence found in the USA's most recent survey<sup>46</sup>. Despite efforts by individuals the loss of health to the population as a whole due to unhealthy diets and inactivity is extraordinarily high: a small increase in Body Mass Index (BMI), e. g. from 28 to 29, will increase the risk of morbidity by around 10 %<sup>47</sup>.
11. The number of EU children affected by overweight and obesity is estimated to be rising by more than 400,000 a year, adding to the 14 million-plus of the EU population who are already overweight (including at least 3 million obese children); across the entire EU25, overweight affects almost 1 in 4 children<sup>48</sup>. Spain, Portugal and Italy report overweight and obesity levels exceeding 30% among children aged 7-11. The rates of the increase in childhood overweight and obesity vary, with England and Poland showing the steepest increases<sup>49</sup>.
12. The factors underlying the onset of obesity are widely known (high intake of energy dense micronutrient poor foods or sedentary lifestyles are the most convincing factors determining obesity risk; high intake of sugars sweetened soft drinks and fruit juices, heavy marketing of energy dense foods or adverse socioeconomic conditions are also probable determining factors. High intake of non starch polysaccharides and regular physical activity are convincing factors lowering obesity risk; breastfeeding and home or school environments supporting healthy food choices for children are also probable lowering factors). It should however be borne in mind that for some people it is going to be harder to maintain a healthy weight than for others because they are genetically disposed to storing fat, or because they have genetic dysfunctions which make it difficult for them to control the feeling of hunger. In fact, even if some scientists<sup>50</sup> estimate that 40-70% of the variation in fat mass between individuals is determined by genetic factors, environmental factors remain important and determine the expression

of these genes in individuals; addressing the “obesogenic environment” (*cf section V.6*) therefore has a strong potential to curb obesity<sup>51</sup>.

13. While the effects of diet and **physical activity** on health often interact, particularly in relation to obesity, there are additional health benefits from physical activity that are independent of nutrition and diet. Likewise, there are significant nutritional risks that are unrelated to obesity.
14. Weight gain in an individual is the result of an excess of energy consumed as food over energy expenditure. There is a strong tendency for excess weight to continue to accumulate from childhood through to middle age. It is therefore important to achieve an optimum body weight throughout life through proper diet and daily physical activity. In addition to promoting overall feelings of wellbeing and apart from weight management aspects, physical exercise has also independent positive effects on the prevention of diseases such as cardiovascular disease, type II diabetes, osteoporosis and depression, and contributes to maintaining muscular strength in older age.
15. To maintain cardiovascular health, the recommended daily amount of exercise is at least 30 minutes for most of the days of the week. There is no general agreement on the level of physical activity needed to prevent weight gain, but a total of one hour on most days of the week is probably needed. However, all physical activity increases energy consumption and contributes to weight management<sup>52</sup>.
16. A 2003 Eurobarometer survey<sup>53</sup> showed that around 60 % of Europeans (EU 15) had no vigorous physical activity at all in a typical week, and more than 40 % did not even have moderate physical activity in a typical week. Europe-wide, only about one third of schoolchildren appear to be meeting recognised physical activity guidelines<sup>54</sup>. Exercising seems to be more common among people who claim they eat healthily and do not smoke, which is in line with the generally observed “clustering of good habits”.
17. The **WHO Global Strategy on diet, physical activity and health** was adopted by the World Health Assembly in May 2004<sup>55</sup> as an outcome of a global consultation process and consensus-building exercise. The Global Strategy underlines the importance of achieving a balanced diet reducing the consumption of fats, free sugars and salt, of increasing the intake of fruits, vegetables, legumes, grains and nuts, and of performing moderate physical activity during at least 30 minutes a day.
18. The Community has actively supported the WHO Global Strategy process since its beginning. The Global Strategy can serve as an extremely valuable input in the development of a comprehensive Community action on nutrition and physical activity, and active use should be made of the scientific evidence underpinning it<sup>56</sup> when building the rationale for a broad Community strategy in this area.

## ANNEX 3 – References

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- 2 Council Resolution of 14 December 2000 on health and nutrition (2001/C 20/01) - Official Journal of the  
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- 3 Council conclusions on obesity, nutrition and physical activity (adopted on 03.06.2005)  
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- 4 Council conclusions on obesity, op. cit.
- 5 actions which include e. g. the food industry, the advertising industry, the retailers, the caterers, NGOs  
and consumer organisations, local, regional and national Governments, schools and the media
- 6 Council conclusions on obesity, op. cit.
- 7 Council conclusions on obesity, op. cit.
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[http://eescopinions.esc.eu.int/EESCopinionDocument.aspx?identifier=ces\soc\soc201\ces1070-2005\\_ac.doc&language=EN](http://eescopinions.esc.eu.int/EESCopinionDocument.aspx?identifier=ces\soc\soc201\ces1070-2005_ac.doc&language=EN)
- 9 Member States launched in recent years a number of initiatives to promote healthy nutrition and physical  
activity. Some Member States like Ireland (<http://www.healthpromotion.ie/topics/obesity/>) and Spain  
(<http://www.msc.es/home.jsp>) established National Strategies to counter obesity, involving Public  
Administrations, independent experts, the food industry, the physical activity sector, NGOs etc. in multi-  
sectorial actions aimed at promoting healthier diets and physical activity. France launched in 2001 a four  
year national healthy nutrition plan (<http://www.sante.gouv.fr/>), covering a wide range of measures at the  
inter-sectorial level, with the objective to reduce the prevalence of obesity and overweight. More recently,  
in March 2005 the Slovenian Parliament approved a National Nutrition Policy Programme for 2005–2010  
(<http://www2.gov.si/mz/mz-splet.nsf>). The Netherlands integrated obesity as one of the priorities of its  
national health care prevention policy (<http://www.minvws.nl/>). Nutrition and physical activity are also  
mentioned as an important area for public health action in the United Kingdom's White Paper Choosing  
health: making healthier choices easier, released in November 2004  
([http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/Publicatio-nsPolicyAndGuidanceArticle/fs/en?CONTENT\\_ID=4094550&chk=aN5Cor](http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/Publicatio-nsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4094550&chk=aN5Cor)). Germany established a  
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Health, 1997; quoted from: Food and health in Europe: a new basis for action. WHO Regional  
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increasing fish consumption from the average consumption (1998) of 2 to 3 times per month to 1 or 2  
times per week. It should be noted that in the Netherlands, consumption of fish (per capita consumption:  
20.5 kg/head/year) is at the mid point for EU25; Austria, Germany, Ireland, the United Kingdom, Belgium  
and Luxemburg and all of the new Member States apart from Malta, Cyprus and Estonia are below the  
Dutch level of consumption. Three Member States (Hungary, Slovakia and Slovenia) are at only one third  
of the Dutch consumption level. <http://www.rivm.nl/bibliotheek/rapporten/270555008.html>

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19 A report on the contributions received will be published on the Commission's website at the following  
address:  
20 [http://europa.eu.int/comm/health/ph\\_determinants/life\\_style/nutrition/green\\_paper/consultation\\_en.htm](http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/green_paper/consultation_en.htm)  
Further information on the work of the Platform is available at the following internet  
21 address: [http://europa.eu.int/comm/health/ph\\_determinants/life\\_style/nutrition/platform/platform\\_en.htm](http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/platform/platform_en.htm)  
More information on the scope of the Public Health Action Programme, the conditions for participation in  
the calls launched under the Programme, and on projects financed so far can be found at the following  
22 internet address: [http://europa.eu.int/comm/health/ph\\_programme/programme\\_en.htm](http://europa.eu.int/comm/health/ph_programme/programme_en.htm).  
i. a. the Working Party 'Lifestyle and other Health Determinants' aims at improving the availability of  
comparable information on nutritional habits and physical activity levels in Europe. Its Scientific  
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Numerous Commission financed projects in particular under the former Cancer, Health Promotion and  
Health Monitoring Programmes have developed activities in the field of nutrition, physical activity and  
health. An overview of these initiatives is set out in the *Status report on the European Commission's work*  
*in the field of nutrition in Europe, 2002*  
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<http://www.foodstandards.gov.uk/multimedia/pdfs/foodpromotiontochildren1.pdf>  
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role of sport in the context of education and as a means of restoring the balance"  
<http://europa.eu.int/comm/sport/documents/lotpaderborn.pdf>  
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physical activity, behaviour therapy (acquiring new habits that promote weight loss), drug therapy (to be  
used in high BMI patients or patients with obesity-related conditions together with appropriate lifestyle  
modifications and under regular medical control), and surgery (in extremely high BMI patients or patients  
with severe obesity-related conditions, used to modify the stomach and/or intestines to reduce the amount  
of food that can be eaten)  
29 Food and health in Europe: a new basis for action, WHO regional publications. European series No. 96,  
2004  
30 Information and communication technologies can play an important role in health promotion by providing  
sound and high-quality information on lifestyle and diet. This can be done, for example, through personal  
devices highlighting individualised health information that can give feedback, guidelines, forewarning,  
and can help to avoid acute events resulting from unhealthy lifestyles. A number of Community supported  
projects have developed information systems relating to health and diet, such as VEPSY UPDATED  
(<http://www.vepsy.com/index.htm>) and MYHEART  
(<http://www.hitech-projects.com/euprojects/myheart/>)  
31 Diet, Nutrition and the Prevention of Chronic Diseases, *op. cit.* The recommendations include: Achieve  
energy balance for weight control; Substantially increase levels of physical activity across the life span;  
Reduce energy intake from fat and shift consumption from saturated fats and trans-fatty acids towards  
unsaturated fats; Increase consumption of fruit and vegetables as well as legumes, whole grains and nuts;  
Reduce the intake of "free" sugars; Reduce salt (sodium) consumption from all sources and ensure that  
salt is iodized.  
32 EURODIET core report, *op. cit.*  
([http://europa.eu.int/comm/health/ph\\_determinants/life\\_style/nutrition/report01\\_en.pdf](http://europa.eu.int/comm/health/ph_determinants/life_style/nutrition/report01_en.pdf))  
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(FAO) and the World Health Organisation (WHO) to develop food standards, guidelines and related texts  
such as codes of practice under the Joint FAO/WHO Food Standards Programme. The main purposes of  
this Programme are protecting health of the consumers and ensuring fair trade practices in the food trade,

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and promoting coordination of all food standards work undertaken by international governmental and non-governmental organizations. [http://www.codexalimentarius.net/web/index\\_en.jsp](http://www.codexalimentarius.net/web/index_en.jsp)

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