



Food and  
Agriculture  
Organization  
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United Nations



# Food-based dietary guidelines

Summary report of a Workshop held on 18-20 May 2009 in Budapest, Hungary

Organised by the European Food Information Council in conjunction with the Food and Agriculture Organization of the United Nations' (FAO) Regional Office for Europe and Central Asia (REU) and the EU-funded EURRECA project (European micronutrient recommendations across Europe).

## **Foreword**

A workshop on food-based dietary guidelines (FBDG), organised by the European Food Information Council (EUFIC) in conjunction with the Food and Agricultural Organization of the United Nations' (FAO) Regional Office for Europe and Central Asia (REU) and the EU-funded EURRECA (European micronutrient recommendations across Europe) project, was held in Budapest on 18-20 May 2009.

The aim of the workshop was to exchange information about the FBDG status in the Central and Eastern European countries (CEEC), to discuss their experiences and compare lessons learned with regards to the development, implementation, communication, monitoring and evaluation of FBDG.

Fourteen countries (Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Serbia, Slovak Republic, Slovenia) participated in the workshop.

This report contains the proceedings and summarises the outcome of the workshop.

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## Introduction

This workshop on food-based dietary guidelines was organised by the European Food Information Council in conjunction with the Food and Agricultural Organization of the United Nations (Regional Office for Europe and Central Asia) and the EURRECA project (European micronutrient recommendations across Europe).

The workshop was held on the 18-20 May, 2009 at the regional FAO-offices in Budapest. The workshop was divided into three sessions:

- Session 1: Development of FBDG
- Session 2: Implementation and communication of FBDG
- Session 3: Evaluation and monitoring of FBDG.

For each session there were one or two speakers invited to share their expertise on the area with the participants.

Prior to the workshop the country participants were asked to complete a questionnaire, containing questions on the development, implementation/communication, monitoring/evaluation of FBDG. This questionnaire was based on the questionnaire the European Food Safety Authority (EFSA) used to gather information when preparing scientific advice on FBDG for the European Commission (containing only questions on the development of FBDG).<sup>1</sup> For questions on implementation/communication, and evaluation/monitoring, the International Life Sciences Institute Europe (ILSI Europe) summary report of the workshop on FBDG held in 2004 was used as basis for questions.<sup>2</sup> All 14 countries returned the completed questionnaire. This information was summarised and presented at the workshop. The workshop participants were also asked to prepare a poster, summarising the FBDG situation in their country and bring it to the workshop.

Each of the three sessions enclosed a break-out group discussion where participants were divided into three smaller groups and asked to discuss pre-set questions. The questions were drafted so that they would encourage the participants to draw upon their own national experiences and share them with each other. After the discussions each break-out group presented their conclusions in plenary. Ensuing those presentations further discussions across the groups were encouraged.

Twenty-six people attended the workshop. This included the participants, organisers (EUFIC, FAO, EURRECA) and speakers. The 14 country participants came from government agencies, such as Ministries or Public Health Institutes, in Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Serbia, Slovak Republic and Slovenia. The five invited speakers came from academia, FAO Headquarters, national Governmental Agency (safefood) and on behalf of a European Agency (EFSA).

The workshop was officially opened by Dr. Mária Kadleciková, Regional representative for Europe and Central Asia at the FAO Regional Office for Europe and Central Asia in Budapest. Hereafter Dr. Milan Kovač, Food safety and consumer protection consultant at the FAO Regional Office for Europe and Central Asia in Budapest presented the work of the FAO in the region. Ensuing Dr. Josephine Wills

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<sup>1</sup> Public consultation of the Scientific Panel on Dietetic Products, Nutrition and Allergies on a draft Opinion related to Food Based Dietary Guidelines:  
[http://www.efsa.europa.eu/EFSA/efsa\\_locale-1178620753812\\_1211902045161.htm](http://www.efsa.europa.eu/EFSA/efsa_locale-1178620753812_1211902045161.htm)

<sup>2</sup> ILSI Europe. National Food Based Dietary Guidelines: Experiences, Implications and Future Directions. 28-30 April, 2004.

introduced EUFIC to the participants, explaining that EUFIC is an organisation communicating science-based food information to health and nutrition professionals, educators and journalists in a way that promotes consumer understanding. Dr. Monique Raats from the University of Surrey completed the introduction of the workshop by presenting the European Commission-funded project EURRECA to the participants. She explained that EURRECA is a Network of Excellence seeking to develop quality-assured, harmonised nutrient recommendations across Europe.

### ***Objectives***

The following objectives were set up for the workshop by EUFIC; FAO and EURRECA:

- Exchanging information about food-based dietary guideline-situations (status, implementation, evaluation) in the participating countries
- Discuss experiences and compare lessons learned in the development, implementation, communication, monitoring and evaluation of food-based dietary guidelines in the participating countries
- Develop a contact list in the participating countries for the FAO
- Gather as much information as possible on the process of development, implementation, communication and evaluation of FBDG in those countries and on the actors involved to complement the questionnaire's feedback

# Session 1: Development and status of food-based dietary guidelines

## ***Presentations and discussions***

### Presentation: Relevance and formats of Food-Based Dietary Guidelines

*Professor Jürgen S. König*

Department of Nutritional Sciences, University of Vienna, Austria

In his presentation Prof. Jürgen S. König provided an overview of the history of FBDG. He highlighted that nowadays, non diet-related aspects linked to healthy lifestyle, such as physical activity, are included in FBDG. Ensuing he touched upon the key concepts of FBDG, stressing how important it is for dietary guidelines to reflect food patterns rather than nutrient goals. In addition, FBDG need to be flexible, practical, comprehensible, and culturally acceptable to fit the population at large. To achieve this, testing of the FBDG is of greatest importance. Hereafter, Prof. König went through the EFSA stepwise guide<sup>3</sup> to developing FBDG, highlighting its importance.<sup>4</sup> He ended his presentation by showing a wide range of FBDG examples from around the world and concluded that FBDG meet the key recommendations in most cases. However, cultural diversity within countries are often not paid adequate attention to. In order to be able to deliver the messages to the public Prof. König also emphasised that marketing instruments such as mass media need to be used.

#### **Key Recommendations:**

- Limit the number of FBDG to one general guideline for the whole population.
- Test the guidelines before they are disseminated.
- Make sure that the guidelines are culturally acceptable.
- Avoid guidelines that encourage radical changes to current dietary practice. Minimise the changes for the consumers.
- Make sure that the guidelines are updated regularly as society changes.
- Create a graphical representation of your FBDG.

#### **Discussion**

The presentation was followed by a brief question and answer session between Prof. König and the participants.

Firstly, the suitability of the pyramid as visual aid was discussed. Prof. König mentioned that the pyramid is not necessarily the most suitable visual aid for FBDG. However, it is a convenient tool as it is easy to adjust to national needs, which probably explains its wide use. On the question to what extent there should be cooperation with industry on promoting healthy eating etc., Prof. König concluded that it is necessary to collaborate with industry considering a lot can be learnt from them.

<sup>3</sup> Public consultation of the Scientific Panel on Dietetic Products, Nutrition and Allergies on a draft Opinion related to Food Based Dietary Guidelines:

[http://www.efsa.europa.eu/EFSA/efsa\\_locale-1178620753812\\_1211902045161.htm](http://www.efsa.europa.eu/EFSA/efsa_locale-1178620753812_1211902045161.htm)

<sup>4</sup> The EFSA step-wise guide was presented in more depth by Dr. Karin Hulshof on the last day of the workshop.

Food groups were also briefly discussed. The discussion focussed on whether food groups actually reflect what the population eats, or if they mirror what people should eat. Prof. König stated there is no use in presenting ideal food groups instead of realistic ones. Using food groups that are not built upon the real situation hampers the success of FBDG.

The last part of the discussion focussed on the importance of involving multidisciplinary groups in the development of FBDG, as they are more likely to reach good results than a group of experts and professionals from only one discipline.

#### Presentation: Nutrition labels and Dietary guidelines - Consumer Education Tools

*Dr. Janice Albert*

Food and Agriculture Organization of the United Nations

Dr. Janice Albert focussed her presentation on three different aspects of nutrition labels and dietary guidelines: purposes of FBDG and nutrition labels, trends in national and international nutrition labelling and educational and communication challenges. In the first part of her presentation Dr. Albert drew attention to the fact the nutrition labelling and FBDG are seeking to solve the same public health problems such as obesity, hypertension, diabetes etc. using similar solutions (energy balance, increase intake of fruit and vegetables etc.). However, whilst FBDG focus upon the total diet and give qualitative and easily understood advice, the information on labels tend to focus on individual foods, and requires a certain degree of nutrition awareness in order to be able to use the information correctly.

Moving on to the second part of her presentation Dr. Albert underlined that nutrition labelling already is mandatory in 13 countries around the world (Australia, New Zealand, Canada, USA, Argentina, Brazil, Chile, Paraguay, Uruguay, Hong Kong, Malaysia, Thailand and Israel). In addition, the EU is considering mandatory nutrition labelling, although a high number of food products already carry some kind of nutrition information on food labels on a voluntary basis in Europe, such as Guideline Daily Amounts, Traffic Lights, health logos etc. Dr. Albert also presented some of the results from the last Codex Committee on Food Labelling meeting. She stated that in 2008 the Committee began considering the expansion of the list of nutrients, new formats and the implications of mandatory labelling standards. In 2009 there was general support for including saturated fat, sodium/salt and total sugar in the list of nutrients. Whether to include trans fatty acids, dietary fibre and added sugar will be discussed again in 2010. In 2011 the Committee plans to review the implications of mandatory policies.

In the third and last part of her presentation Dr. Albert focussed upon educational and communication challenges stating that there is need for further research on questions like 'how well do consumers understand FBDG and nutrition labels?' and 'do FBDG and nutrition labels affect consumer behaviour and health?'. There has been some research already, but not enough to convince policy makers to invest. Furthermore, sufficient resources are required to be able to communicate and educate people about these messages, so for labels and FBDG to be efficient, policy makers need to invest money in the dissemination and communication. As a significant amount of products today cross borders there is also a need for a harmonised approach to avoid confusion.

**Key Recommendations:**

- Policy makers need to invest in this area. Make sure to have resources for dissemination and communication of FBDG.

**Discussion**

In the plenary there was some discussion on the complexity of FBDG. Since FBDG should be easy for the public to read and understand, it was acknowledged that not all information can be fit into them. Food labels will allow other nutrition information to be out there for nutritionists and consumers.

There was also a brief discussion on health logos and the similarities they have with FBDG in the sense that they do not require the consumer to go through complicated nutrition information in order to know whether the product they are buying is a healthier option. It was said that it would be interesting to know how closely aligned the health logo criteria in different countries are with the FBDG.



## ***Summary of questionnaire results – Part 1 (Development)***

On the basis of the questionnaire sent out to the workshop participants prior to the workshop it was seen that 13 out of the 14 participating countries in the workshop had developed FBDG. Most countries' FBDG were accompanied by a visual aid, most commonly a pyramid.

The most common messages included in the FBDG were 'eat a varied diet' and 'eat fruit and vegetables'. As for diet-related health problems, FBDG in those countries focussed on cardiovascular disease, overweight/obesity, type 2 diabetes and hypertension. The most common macro-nutrients addressed are protein, fat, carbohydrates, saturated fatty acids and dietary fibre, as well as energy. The most common micronutrients are calcium, iron, vitamin C, vitamin B6 and vitamin E.

About half of the countries had based their FBDG upon the CINDI (WHO) guidelines, whereas the other half had developed FBDG specifically for their country. Only half of the FBDG were endorsed by the government.

All countries involved stakeholders in the development of FBDG. However, only one conducted consumer research as part of the development. The majority of the countries had one guideline for the general population or for adults. In the development of their FBDG they had most frequently experienced problems with lack of reliable data, lack of local expertise and insufficient financing. Four countries indicated that they had revised their FBDG once or twice.

## ***Findings of the break-out groups***

During the workshop, break-out discussions were organised where the 14 country participants were divided into three smaller working groups. The groups were asked to discuss pre-set questions. The questions required participants to have a look at each other's FBDG-posters. This exercise encouraged participants to learn more about the FBDG situations in the other countries and stimulated discussion. As part of the break-out sessions the groups were also asked to prepare a PowerPoint-presentation with their conclusions which they presented in plenary.

In the following, the combined conclusions of the three groups are presented.

### **Questions (Status and Development of FBDG):**

- 1. What are the main similarities and differences between the different countries' FBDG?**
- 2. Why do you think there are similarities and differences?**
- 3. What are the key challenges in the developing process?**
- 4. What are the key factors for a successful development of FBDG?**

### **1. What are the main similarities and differences between the different countries' FBDG?**

#### *Similarities*

Most countries have FBDG. Almost all of them also have a visual aid, most commonly the pyramid. FBDG tend to have the same messages. FBDG are mainly intended for the general population and are based upon nutrition-health relationships.

#### *Differences*

Most differences relate to the messages included in the FBDG. Water/fluid, physical activity, BMI, sweets/sugars were included in some FBDG but not in others. Some FBDG displayed qualitative and some quantitative messages. The number of messages also differs from guideline to guideline.

The body responsible for the development of FBDG is different in different countries. In addition, some countries have only one general guideline while others have numerous, adapted to different population groups. Finally, FBDG differ on whether consumer research has been conducted or not and on the stakeholders included in the process.

### **2. Why are there similarities and differences?**

Similarities and differences may occur due to differences in who is responsible for the development of the FBDG (is it the government? has the responsibility been delegated? etc.); the extent to which stakeholders have been involved in the process, and the type of stakeholders involved (depends on the country's culture); disease prevalence; national traditions and habits. Differences may also emerge depending on whether a country has conducted consumer research or not (this is directly linked to availability of sufficient financial resources and local expertise). Similarities can also occur when countries have the same goals and/or have based their FBDG on International recommendations (e.g. WHO).

### **3. What are the key challenges in the development process?**

- To develop simple messages that the general public can understand. Scientific messages are often too complicated

- To ensure successful collaboration between different actors involved (governmental, economic, consumer groups, etc.)
- The fact that many consumers (especially adolescents and children) want foods that are tasty, particularly those high in fat, sugar and salt
- To ensure that the FBDG fit all population groups
  - Healthy people vs. patients
  - Different gender and age groups
  - Sub-groups with different dietary habits (e.g. vegetarian)
- To set aside sufficient economic resources
  - For example, to conduct consumer research as part of the development of FBDG
- To develop evidence-based FBDG
  - To make sure that there are reliable data on food consumption, national health status, nutrient intake etc.
- Choosing the most effective communication method
- Choosing the appropriate evaluation method

#### 4. Key factors for successful development:

- Messages tailored to the target group
  - For example, easily understood messages for children etc.
- Make sure that the messages are positive (makes it more acceptable), e.g. do not say DO NOT!
- Provide information on how to give taste to a meal without using too much salt (e.g. use vinegar, herbs and spices etc.)
- Base FBDG upon reliable data and combine different data sources (one should not limit oneself to for example only dietary surveys)
- Test the FBDG before they are finalised
- Involve stakeholders in the development process
- Make sure that there are sufficient human and economic resources
- To have governmental support during the developing phase
- Intersectoral collaboration in the development of FBDG

#### Plenary discussion

Fluid/water recommendations were discussed. One participant stated that the fact that bottled water has become so popular poses certain problems considering bottled water does not necessarily contain the same minerals as tap water. Should tap water be replaced largely by bottled water, one should start thinking about whether our diet would provide a sufficient amount of calcium and magnesium. It was argued that water primarily is a source of hydration, and not minerals. Hence, whether the increase in intake of bottled water is seen as a setback depends on whether water is seen as a source of minerals or not. Distilled water was discussed and found not to be a problem.

Hereafter the discussion focussed upon whether physical activity should be included in FBDG as people might rely on physical activity for burning calories and thereby compensating for extra food intake instead of thinking twice about what they eat. The counterargument was that physical activity messages complement nutrition messages and that including physical activity in FBDG therefore is a good way to put more focus on food and what one should eat. Furthermore, evidence shows that the calorie-intake has gone down over the years. However, the levels of physical activity have also gone down drastically, which has resulted in a growing overweight and obesity rate. Hence, to change behaviour it may be necessary to include activities related to foods and eating, such as physical activity, in FBDG.

For the future, it was reflected upon whether we will see a growing need of physical activity experts in the development of FBDG, seeking to develop more complex physical activity messages that better seek to help the population improve their health. Finally, for the choice of wording, physical activity was said to be a good choice considering it is not associated with going to the gym which makes it accessible to a larger part of the population.

## **Session 2: Implementation and communication of FBDG**

### ***Presentations and discussions***

Presentation: Communicating Food-Based Dietary Guidelines: A balancing act

*Dr Cliodhna Foley-Nolan*

Safefood - Irish Food Safety Promotion Board

Initially, Dr. Cliodhna Foley-Nolan spoke about the FBDG as a tool to help the population eat healthily. Generally, as people do not spend much time in the supermarket looking at labels before buying food products, FBDG are valuable in providing advice.

Hereafter, Dr. Foley-Nolan presented the FBDG situation in Ireland. She stated that the guidelines from 1991 were a relatively good inheritance as they were based upon guidance from the Department of Health and the US model. The pyramid was taken on in 1993. Over the years there have been minor revisions taken on board. An official revision came in 2006. A FBDG advisory group was set up composed of professionals from a wide range of disciplines and expertise, which was key to achieve the best possible end results.

The building blocks for revising the Irish FBDG were data on nutrition recommendations, dietary intake (revealing vitamin D deficiencies, too low fibre intake, too high salt intake and a high amount of snacking between meals), obesity, diabetes and cardiovascular statistics.

Dr. Foley-Nolan highlighted the importance of performing consumer research. Before taking any key decisions on how to revise the Irish FBDG consumer research was conducted to get the consumers' point of view. Firstly, consumers were asked to provide feedback on the pyramid (their understanding and attitudes towards it). Secondly, parents were surveyed about what they felt could be done to tackle childhood obesity. Thirdly, research on people's understanding of different descriptors of portion size was conducted.

Data from the consumer research on the rationale for a healthy diet was presented. Most people stressed that a healthy diet is important to feel well. However, there was a distinction between men and women and different age groups. Most women stated that the rationale for a healthy diet was to look well, young people generally also highlighted the importance of appearance, while older people focussed on health. Dr. Foley-Nolan pointed out the relevance of considering people's needs when working out how to communicate FBDG messages to the different population groups.

Dr. Foley-Nolan also presented the 'Little Steps Campaign'. This consumer research was carried out to see how parents dealt with childhood obesity. The data, gathered in 812 face-to-face interviews with parents and children aged 1-17, showed that home and parents are key determinants of children's health. Children take after parents' eating and lifestyle habits. Parents are aware of this problem of childhood obesity, and concerned, but that does not necessarily result in action.

Consumer research was also conducted on portion sizes in supermarkets. Roughly 1000 persons were surveyed on their perception of a portion. Portion size is a

problematic area and this was an attempt to come closer to a solution by seeking to understand what consumers see as a portion.

Another exercise looking at nutrition analysis of foods consumed was performed, looking at sample persons' 4-day menus. One conclusion was that low-fat, instead of full-fat, milk and dairy products should be recommended to everyone over the age of 5 years, to ensure a correct calcium intake without exceeding the allowed fat intake from dairy.

Based on all this information the Irish FBDG could be revised. The revised version has been modified three times. There have been two written consultations with stakeholders and the general public, and one workshop.

Dr. Foley-Nolan concluded her presentation by listing three things that were learnt from the revision process: 1) that it is necessary to compromise between ideal nutrition and realistic FBDG, 2) that working in a multidisciplinary setting is a key success factor, and 3) that consultations are necessary, preferably on a recurrent basis, to ensure successful revisions of FBDG.

**Key Recommendations:**

- Work in a multidisciplinary group - it is a key factor for success.
- Conduct consumer research as part of developing the communication of FBDG.
- In order to be successful, compromise between ideal nutrition and FBDG. FBDG must be acceptable to the public.

**Discussion**

Portion sizes were discussed after Dr. Foley-Nolan's presentation. Concerns were raised regarding the inconsistency between how industry and consumers define 'portion'. The US model Recommended Amount Commonly Consumed (RACC) was brought up as a solution to solve those differences. However, RACC poses the problem of too large amounts being consumed.

Translation of FBDG into meals was also discussed. People generally have quite good knowledge about food group-recommendations, but the translation into mixed meals are blurred. The importance of having practical examples that people can relate to was highlighted. This was found to be especially important for encouraging schools and catering services to use the guidelines.

Another topic discussed was what can be done with a limited budget. Focus groups is a rather cost-effective solution. Staff could also be trained on how to conduct focus groups. Carrying out research with the help of market research agencies, although expensive, does give a lot of insight, bringing a complete picture of the situation. Another solution could be using qualified universities to do the research.

## ***Summary of questionnaires – Part 2 (Communication and Implementation)***

All countries, except one, that have FBDG communicate and disseminate them. Usually, the Ministry of Health, Institute or Centre for Public Health or Food or Nutrition Institute is responsible for developing the FBDG communication plan.

Consumer research is not widely used in the development of the communication of FBDG with only three countries having done that.

The communication of FBDG most frequently took place in health service buildings and schools, and was carried out by school staff, doctors and dietitians. The most used communication tools were leaflets/brochures, websites, articles, TV, and radio. The messages tended to be communicated recurrently.

The most common barrier identified by the countries to implement and communicate FBDG was an insufficient budget.

## ***Findings of the break-out groups***

The three working groups (where the 14 participants were allocated) were asked to discuss the questions in the box below. The combined feedback and conclusions from the three working groups is summarised as follows.

### **Questions (Implementation and Communication of FBDG):**

- 1. Discuss the advantages and the disadvantages of different methods of communication.**
- 2. How do you make the communication of FBDG messages sustainable?**
- 3. How do you work with the different groups that are disseminating FBDG?**
- 4. What examples of success are there?**
- 5. What are the key factors of success?**
- 6. What are the lessons to avoid failure?**

### **1. Discuss the advantages and the disadvantages of methods of communication.**

- *Websites* - Inexpensive to produce and maintain and can reach a wide audience, including young people. On the downside, not everyone has access to the Internet, especially in rural areas, and face-to-face interaction is not possible.
- *Mass media* - Allows very large outreach. However, it is expensive, unless there are possibilities/agreements of using it for free or at a very low cost, such as having a journalist write about one's topic because it's hot news. In the latter example, the risk will be lack of control over the message. In the case of a TV spot, the credibility of the messages is lower than when health professionals communicate it to the public. This is due to lower trust of the sender. Besides, conflictual messages are often communicated on TV, which contribute to confusion among the public. Again, interaction with the audience is not possible, although this can partially be compensated by setting up a phone line for people to ask questions in connection to TV slot.
- *Leaflets* - Leaflets were seen as expensive by the participants. They require organised dissemination, and once printed off, it is difficult and expensive to make changes to them. Design is key for their impact and message should be tailored to the target group.
- *Communicators/disseminators (health professionals)* - The advantage of using health professionals as communicators/disseminators is that they are perceived as independent and credible, which is a prerequisite for people taking on a health message. On the other hand, health professionals are not experts in communication.
- *Development of the message* - A multidisciplinary group should be involved to ensure the best possible messages and highest efficacy.
- *Vary the use of communication methods* - Different communication methods have different strengths and some may be better than other to reach different target groups.
- *Parents can be influenced via their children (e.g. schools)*
- *Launch of FBDG should be done via a press conference* - This allows experts to convey health messages both to mass media and public at large.

### **2. How do you make the communication of FBDG messages sustainable?**

- By ensuring that communication is repeated (recurrent frequency of exposure)



- Mass media - regular slot (e.g. each September - programme is run at school)
- By regular work with health professionals to ensure that they keep disseminating the messages
- By making the messages positive
- By ensuring sufficient budget (so that repetition is possible)
- By using different communication media so that everyone can be reached
- By ensuring the cost of foods that people are encouraged to consume are affordable to everyone
- By checking with consumers whether the messages are well-received
- By involving stakeholders in the implementation - if everyone agrees with messages there will be consistency which increases chances for sustainability
- By applying for external grants (that would for example allow to develop websites and/or produce leaflets)
- By including FBDG messages in schoolchildren's and professional schools' curricula, and in guidelines for caterers

### 3. How do you work with different groups that are disseminating FBDG?

- *Doctors' surgeries/consultations* - Here, leaflets can be disseminated cheaply. However, healthy people do not go here so if one only works with the doctors' surgeries/consultations, information will only reach part of the population.
- *Health promotion groups* - Can be used for communicating with groups like the elderly, where face-to-face communication is more effective.
- *Women's magazines* - Can help but also disseminate conflicting messages (i.e. often provide information on dieting etc).
- *Schools, canteen providers; Community networks etc.*

The communication should be based on tangible achievable objectives and tailored to the different target groups (e.g. health professionals, catering professionals, mothers etc.). For example, provide training for teachers, workshops for doctors and nurses; work with different age-groups of children at different school levels.

### 4. Examples of success:

- Change in eating habits:
  - Lots of people consume low-fat dairy products since they have been introduced in the market
  - People consume margarine and vegetable oil instead of butter
  - Pork fat levels are decreasing
  - An increasing number of people are eating more fruits and vegetables
  - In one of the participating countries: Promotion of fish has increased the consumption of fish among young people (however not among the elderly)
- New/increased focus on the issue:
  - There are interviews on TV that focus on nutrition messages
  - FBDG/nutrition is included in the school curricula
  - Messages communicated have become more specific (specific messages have been to be more successful in changing behaviour)
  - Caterers and food professionals receive training on FBDG
  - Journalists report on food-related issues, including FBDG
  - TV slots are allocated to nutrition
  - Children books (fairy tales) teach them about healthy eating
  - In one country: Lunch boxes are provided at schools each September to encourage children to bring healthy lunches to school

- Collection of best examples of kindergarten games for teachers that are then used in the kindergartens to put focus on healthy eating
- Campaigns promoting fruit and vegetable consumption in schools (e.g. providing them for free); similar campaigns with milk (for free)
- Lessons to learn from the industry

Industry is successful in communicating messages to the public (using a variety of tools): public authorities could learn a great deal from this!

#### **5. Key factors of success:**

- Involvement of all actors (multidisciplinary approach) in the development of the communication strategy will ensure better end-results. For example, in order to reduce a specific nutrient consumption (e.g. fat) industry, retail, and consumers should be involved. Higher consumer awareness drives companies to respond with new products and reformulations.
- Support from government in promotion of healthy lifestyle. Governments should be encouraged to put nutrition messages higher on their agendas. Governments and government professionals are trusted by the public to be unbiased, which place them in the right position to deliver messages.
- A written communication strategy at national level (policy document). This can help provide consistency, which is important for communication to be effective.
- Messages tailored to target audience. Women should be considered a key target audience as they are mostly responsible for preparing food at home.
- Consistent funding.
- FBDG should be evidence-based (e.g. strong relationship between non-communicable diseases and healthy dietary pattern and lifestyle).
- Education of children/young people at schools (next generation).

#### **6. Lessons to avoid failure**

- Be flexible in tailoring messages for different population groups. Not all population groups respond equally good to the same kind of message
- Appropriate budget and continuous funding
- Usage of different types of media
- Work with stakeholders
- Consider taste preferences (e.g. sweet, salty), i.e. FBDG have to take into consideration reality and not be too idealistic
- Consider the economic context
- Test messages (e.g. in focus groups)
- Positive in the communication rather than negative
- Clear and consistent communication. Different messages issued from same recommendations may be interpreted differently by different organisations

#### **Plenary discussion**

The importance of all communication aspects was discussed, such as for example culture, which needs to be considered when one seeks to communicate on how to eat and drink healthily.

## Session 3: Monitoring and evaluation of FBDG

### ***Presentations and discussions***

Presentation: Evaluation and monitoring in the literature

*Dr Monique Raats*

Consumer Behaviour and Health Research Centre, University of Surrey

Dr. Monique Raats presented how the British FBDG pictorial was developed in the beginning of the 1990s. Different formats were field-tested among both health professionals and consumers, and the research showed different preferences for those groups.<sup>5</sup> This exemplifies the importance of testing with different target audiences, as the results would have been different should the consumers not have been consulted, which in turn might have had resulted in negative implications on the communication of the food guide to the consumers. Other challenges faced in the implementation of FBDG were highlighted; namely how to achieve increased awareness around healthy eating and motivate behavioural change (i.e. get FBDG to move from the provision of information to messages targeting behaviour change); how to address all segments of the population; how to maintain consistency among the messages and how to translate the FBDG into other languages or dialects.<sup>6</sup> To find out if those things are brought about it is necessary to monitor and evaluate FBDG. Dr. Raats stated that national governments should evaluate FBDG implementation regularly and that intermediate success indicators should be used to track deviations from the right direction. The World Health Organization (WHO) and the Food and Agriculture Organisation (FAO) could coordinate a common mode of monitoring to help assess the contribution of stakeholders to FBDG implementation. Furthermore, Food and Health Organisations should be watchdogs to ensure that governments regularly perform the monitoring.<sup>7</sup>

Dr. Raats also presented two different ways of evaluating outcomes. The first one is to monitor implementation or indicators of 'activity'. This entails for example monitoring the number and content of leaflets and booklets which are distributed/sold/requested over time, the number and content of advertising campaigns and their impact, performing surveys (with consumers or health professionals) on awareness and knowledge about FBDG. The other one is to evaluate the effects by looking at changes in food sales/purchases, food consumption and health status. However, it is of course difficult to gauge the relative role of FBDG as apposed to other efforts in effecting change.

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<sup>5</sup> Gatenby, S.J., Hunt, P. And Rayner, M. (1995). The National Food Guide: development of dietetic criteria and nutritional characteristics. *Journal of Human Nutrition and Dietetics*. 8: 323-53.

Hunt, P., Rayner, M. and Gatenby, S.J. (1995a). A National Food Guide for the UK. Background and development. *Journal of Human Nutrition and Dietetics*. 8: 315-22

Hunt, P., Gatenby, S.J. and Rayner, M. (1995b). The format for the National Food Guide: performance and preference studies. *Journal of Human Nutrition and Dietetics*. 8: 335-53

<sup>6</sup> Schneeman, B.O. (2003). Evolution of Dietary Guidelines. *J Am Dietet Ass*. 103 (12 Suppl. 2): S5-9

<sup>7</sup> Keller, I. and Lang, T. (2007) Food-based dietary guidelines and implementation: lessons from four countries – Chile, Germany, New Zealand and South Africa. *Public Health Nutrition*. 11: 867-874

Finally, an example of monitoring tool used in The Netherlands was presented.<sup>8</sup> The tool puts the current dietary pattern into a pie chart and compares this pie chart with the ideal dietary pattern pie chart based on FBDG. This allows us to easily perform comparisons over time and to see any improvement or deviation trend from the ideal dietary pattern.

**Key Recommendations:**

- Monitor and evaluate your FBDG regularly.
- Develop intermediate success indicators to follow the impact of the FBDG over time.
- Make sure to feed evaluation information back into the FBDG.

Presentation: Differing perspectives on evaluation of FBDG

*Dr Cliodhna Foley-Nolan*

Safefood - Irish Food Safety Promotion Board

Dr. Cliodhna Foley-Nolan shared the experiences of evaluating and monitoring FBDG in Ireland. Evaluating FBDG is complex, as changes in health outcomes are long-term (it may be decades before health changes are seen), and a multiplicity of approaches are necessary for a successful evaluation.

In Ireland market research is carried out as part of the evaluation of FBDG to look at their effectiveness, trends and attitudes, reported intentions vs. reported behaviour, consumers' perception about the credibility of information sources etc. Currently, two different kinds of research are carried out by *Safefood* in Ireland. The Omnibus market research, in which face-to-face interviews with 1000 adults are conducted four times a year; and Safetrak, which is an in-depth study carried out once a year. Market research costs will vary from economy to economy but may well be less expensive and more expedient than academic research as should be considered as an option.

Ireland is also using focus groups in the evaluation of FBDG. Group discussions are held about three times a year (on topics like beef, imported foods, smoothies, soft drinks and teenagers sports nutrition). Furthermore, lifestyle/attitude/nutrition surveys have been carried out (Slán 1992, 2002, 2007), based upon food frequency questionnaires, anthropometric methods and physical examinations. In addition a food consumption surveys (based on a 4-day weighed food diary) has been carried out (IUNA). Although the latter is a very important part of the FBDG evaluation, it is very labour-intense and costly.

In conclusion, different methodologies all have advantages and disadvantages. Therefore, the use of multiple methodologies (to ensure capturing the entire picture) is the key to success in evaluating FBDG. Finally, research should be repeated to see developments in the right direction.

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<sup>8</sup> Wilson-van den Hooven, E.C., Raaij, J.M.A., Ocké, M.C., Rossum, C.T.M., Verhagen, H. (2008) Visualisation of the nutrient situation in the Netherlands: an instrument. <http://www.rivm.nl/bibliotheek/rapporten/350060002.pdf>

**Key Recommendations:**

- Use multiple approaches in the evaluation of your FBDG to capture the whole picture. All methodologies have advantages and disadvantages.
- Conduct ongoing research in order to regularly evaluate your FBDG.

**Discussion**

The participants engaged in a discussion on the methodology used to evaluate FBDG. Four- and seven-day dietary records and 24h recalls were discussed. It was said that 7-day dietary records are very costly to carry out and it is difficult to get a balanced sample. This is due to the fact that it is difficult to find people to participate as it is time-consuming, and the sample therefore tends to end up being composed of people interested in health and diet, which is not representative. Furthermore, it is difficult to get complete records and sometimes the quality of the data may be compromised (risk of underreporting). Twenty four hours dietary recalls, in which the burden on the respondent is lighter, were also discussed. By conducting 24h dietary recalls with one repetition, it is possible to calculate a person's average food consumption. However, in 24h recalls, there is the risk of people changing their diet during the 24h because they know they need to report everything they consume. Even when people accurately report what they consume there is a risk that the recall is made on a day that is not specifically representative. There is an agreement in many, but not all, European countries about using this methodology.

It was concluded that both methods have strengths and weaknesses.

### ***Summary of questionnaires – Part 3 (Monitoring and evaluation)***

Six countries had evaluated and monitored their FBDG, and four out of these six stated their monitoring and evaluation happens on a regular basis. The monitoring and evaluation was mostly done by the Ministry of Health, a Public Health Authority, Statistical Office or Institute for Food/Nutrition Sciences. Predominantly the countries collect data on changes on food/nutrient consumption as part of their evaluation and monitoring (5 out of 6 countries). About half of the countries that evaluate and monitor their FBDG also collect data on changes in health status (4 countries), food sales and food composition (2 countries). Some countries also collect survey data on awareness/knowledge/usage of FBDG among consumers (3 countries) and health professionals (1 country). A couple of countries collected data on the extent to which FBDG are incorporated in school children's curricula (2 countries) and on the number, content, impact of leaflets/booklets that incorporate FBDG (2 countries). One country collects data on the number, content, and impact of advertising campaigns that incorporate FBDG. Also, one country collects data on the number, content, impact of websites that incorporate FBDG. One country collects data on the extent to which FBDG are used by actors like caterers (i.e. catering guidelines for schools).

## ***Findings of the break-out groups***

The three working groups were asked to discuss the questions in the box below. The combined feedback and conclusions from the three working groups is summarised as follows.

### **Questions (Monitoring and Evaluation of FBDG):**

- 1. What are the key constraints and opportunities for evaluation and monitoring?**
- 2. How would success be defined?**
- 3. What are the key factors of successes?**
- 4. What examples are there of monitored and evaluated success?**
- 5. Was the population awareness/understanding evaluated?**
- 6. Were behaviour changes in the population evaluated?**
- 7. What tools were used?**
- 8. What are the lessons to avoid failure?**

### **1. Key constraints and opportunities:**

In general, the budget was found to be a key constraint/opportunity for successful evaluation/monitoring. Feeding the information received from evaluation studies back into FBDG activities and campaigns is seen as key for success.

Some country-specific monitoring and evaluation experiences were shared.

### **2. How would success be defined?**

- By the execution of a campaign
- By looking at the degree of understanding and awareness of FBDG messages among the general public/different organisations/industry
- By looking at the perceived credibility of messages. This is important for the motivation towards behavioural change
- By achieving (small) behavioural changes in the population (e.g. grilling instead of frying, no longer adding salt without first tasting the food, using better fat)
- By reporting a reduction of non-communicable diseases. This is a long-term success indicator
- By physiological changes in health status sustained over time measured by changes of biomarkers of health status
- By performing regular surveys, i.e. getting regular and updated information to assess how dietary patterns and physical activity/exercise levels change
- By reporting positive changes in household data from national statistical offices
- A high(er) amount of website visits. This can be used as an intermediate/short term success indicator
- When different organisations communicate the same message (consistency and sustainability in communication of messages)
- By reporting on high levels of consumer awareness of health issues related to nutrition and lifestyle

When discussing this question, advice were given on the following:

- For the organisation of the evaluation:
  - A baseline is needed
  - Scientific monitoring at national level should be conducted (food consumption, food composition tables, etc.). This brings the

necessary insight into national problems, which can be used to design messages to address those problems.

- Set realistic objectives. The objectives should be revised as the situation changes
- Design and methodology need to be chosen carefully to measure the intended outcome

### **3. What are the key factors of successes?**

- A large enough representative survey and data collection
- Properly designed surveys (good methodology)
- Sufficient budget
- Regular monitoring (recurrent questions)
- Appropriate use of the survey results
- Use different data sources in the analysis in order to get valid results (triangulation)
- Being able to establish a link between FBDG and changes in dietary behaviour or nutritional status
- Increased awareness, knowledge and understanding of FBDG

### **4. What examples are there of monitored and evaluated success?**

- Booklets for teaching FBDG were handed out in schools. A survey done both before and after with school-children showed increased knowledge after the booklets were handed out
- Increased amount of healthy meals in schools
- Improved choice of beverages in schools' vending machines
- Slight improvement in nutritional status (based on records), BMI, energy and vitamin C intake (Slovakia). The link between this and FBDG is unclear, but will be considered in future studies
- From health behaviour studies on food intake one can see changes in the use of fat according to goals set in FBDG (Estonia)

### **5. What tools were used?**

Among the participating countries there have been no studies on the awareness and understanding of FBDG. However, food behaviour studies have been carried out: food frequency questionnaire as part of a wide study on nutritional status (including 24 h recall, anthropometric measures, BMI, blood cholesterol, blood pressure, physical activity).

### **6. What are the lessons to avoid failure?**

- Engage all stakeholders from the beginning, in order to avoid rejection of the messages/campaign/intervention later on
- Make healthy foods attractive and tasty, ensure a more pleasant school canteen environment and more time to eat for schoolchildren
- Ensure a supportive environment for behavioural change
- Ensure sufficient budget for healthy school meals
- Introduce canteens at work/at schools. This is a better environment to influence the diet compared to vouchers to eat outside
- Shared responsibility (e.g. food industry, government etc.)
  - Changes that consumers can make at individual level are the easiest to communicate but the impact may be small
  - Systematic changes in the food supply are more difficult to achieve but can possibly obtain a greater impact
- Prepare a long-term evaluation programme (differences do not happen overnight) that is science-based and transparent, that will allow to track trends



- In early phases (ideally in the development of FBDG), foresee the monitoring and evaluation to ensure budget is secured for this
- Use and build upon experiences from other countries
- Involve appropriate experts in the design of the evaluation
- Analyse the data from different viewpoints (triangulation)
- Provide training on methods and approaches to evaluate and monitor FBDG;
- Ensure a feedback loop between evaluation and revision of FBDG
- Evaluation and monitoring need to be proportionate to the importance of the issues

**To keep in mind!**

Data gathered during studies that are not focussing directly on FBDG can sometimes be used to evaluate the efficacy of nutrition messages and FBDG.

**Plenary discussion**

Considering other surveys, not directly focussed on FBDG, to gather data for evaluating FBDG was discussed. This requires awareness of ongoing surveys but has the potential benefit of avoiding funding a new survey. Other projects, for example EU projects, can also be worth looking into. The participants were encouraged to establish contact with the national contact point for EU funding. By doing this, they can be informed of upcoming or ongoing projects via which it might be possible to receive funding or that are gathering relevant data. If no ongoing or recent surveys provide the information needed to evaluate the FBDG, it is also possible to try to add FBDG questions to another survey, and thereby cost-effectively gather information that can be used for the evaluation. The importance of feeding the evaluation information back into the FBDG was once more stressed.

A brief discussion on what would be the follow-up of this workshop ensued. The participants were asked whether they would prefer a workshop only among European countries or rather with countries from all over the world. It was stated that the composition of the group should depend on the objectives of the workshop. If the objective is to exchange information and learn about each others' countries, a mix of countries from around the world is suitable; if the purpose is to look for solutions to specific problems, then it is essential that participating countries share dietary patterns and are able to understand each other. Otherwise too much time is used on explanations. On the other hand, it was stated that countries, despite their differences in diets etc., often have more in common than they think in terms of issues and challenges.

Finally, the usefulness of a transnational network of people working on FBDG was highlighted. Through such a network it should be possible to contact each other for advice, queries and encouragement. Different countries often are at different stages of the evaluation phase, which means they have different experiences to share.

## Session 4

### ***Presentations and discussions***

Presentation: The work of NDA Panel related to Food-Based Dietary Guidelines

*Dr. Karin Hulshof*

Member of EFSA's NDA Panel

Dr. Karin Hulshof presented the European Food Safety Authority's (EFSA) stepwise guide to developing FBDG, extracted from EFSA's Scientific draft Opinion on FBDG.<sup>9</sup>

- The first step is to identify general diet-health relationships. It is important for the individual country to gather up-to-date information on this point.
- Secondly, one should identify country-specific diet-related problems. Each country should review diet-health patterns, disease and mortality in the country and identify nutrition problems.
- Thirdly, an identification of critical nutrients is important. Countries should prioritise nutrients that are not consumed in accordance with recommendations and for which there is evidence of important health-relationship.
- Fourthly, critical foods should be identified, by looking at main dietary sources of key nutrients and foods whose intake might explain differences between those who achieve nutrient recommendations and those who do not.
- Fifthly, it is essential to identify critical food consumption patterns.
- According to the sixth step it is of great importance to test and optimise FBDG by confirming whether applying them will result in achieving the recommendations and avoiding unwanted side effects.
- Finally, graphical translation(s) (pictorial) of FBDG should be developed. This will facilitate the communication to consumer.

Dr. Hulshof also stressed that once FBDG have been established they have to be implemented and monitored in order to become effective. Since implementation was out of the remit of the NDA Panel, only some indications about possible implementation strategies were indicated by EFSA.

In her presentation, she also presented some of the results from a questionnaire that was sent out to gather information on existing FBDG in EU Member States. Hereafter, she discussed the difficulty in setting European FBDG. Even though the hierarchy of disease burden is comparable in Europe there are country-specific diet-related health issues that need to be taken into consideration.

#### **Key Recommendations:**

(From the EFSA stepwise guide)

- Identify diet-health relationships;
- Identify country specific diet-health related problems;
- Identify critical nutrients;
- Identify critical foods;
- Identify critical food consumption patterns;
- Test and optimise FBDG;
- Develop graphical translation.

<sup>9</sup> Public consultation of the Scientific Panel on Dietetic Products, Nutrition and Allergies on a draft Opinion related to Food-Based Dietary Guidelines:

[http://www.efsa.europa.eu/EFSA/efsa\\_locale-1178620753812\\_1211902045161.htm](http://www.efsa.europa.eu/EFSA/efsa_locale-1178620753812_1211902045161.htm)

**Discussion**

EFSA was congratulated on carrying out this type of work. It was stated that it will be interesting to see whether this work will contribute to a harmonisation of the FBDG process. It was commented on whether, and to what extent, this would be feasible. It was concluded that it would be very useful and helpful to develop steps similar to the development-steps of EFSA for the communication/implementation and monitoring/evaluation of FBDG, especially for the monitoring/evaluation since it is clear that a lot of countries do not evaluate their FBDG. Such steps would have to take into consideration the range of ways in which different countries have approached this, but also seek to capture common ways of thinking and transform those into steps. This would be helpful in helping countries to communicate and evaluate their FBDG.

## ***Findings of the break-out groups***

Break-out session 4 was structured differently to break-out sessions 1-3. Participants were divided into two groups and instead of presenting the participants with pre-set questions for them to discuss, they were presented with a hypothetical case study on the implementation of FBDG for adolescents (14-18 years). The case study was based around the general principles of social marketing. As background information, the participants were told that evidence showed that adolescents were not meeting FBDG targets, and that they frequently purchased foods outside their home and school. The participants were asked to first discuss the case study without taking into consideration budget constraints, and then to imagine the project with a limited budget (for prioritisation of actions). Finally, each group was asked to prepare a short presentation with their conclusions and present it in plenary immediately after the discussions. The combined feedback and conclusions from the two working groups is summarised as follows.

### **The groups identified the following adolescents' diet and lifestyle problems:**

Overweight was mentioned as becoming an increasing problem among adolescents, with levels of physical activity decreasing, sedentary lifestyle activities increasing, and adolescents eating significant amounts of energy-dense foods, contributing to negative health effects. Dyslipidemia, anaemia and the risk of osteoporosis are problems seen among teenagers. Typical of this age group is also the problem of alcohol and smoking. Eating disorders (e.g. bulimia, anorexia, obesity) in this age group are also escalating. In general, adolescence is an age where both boys and girls are concerned about their weight and body image.

Another identified problem is that during adolescence, adolescents pass from having parental control over food to autonomy in food choice, and when they make their own choices they tend to be unhealthy. Hence, the less parental balance, the more unhealthy adolescents tend to be. This is related to the irregular meal patterns of that population group (not having breakfast, skipping lunch etc.).

The overall objectives of FBDG for this group were identified as reducing the prevalence of obesity, overweight and diet and lifestyle related diseases.

### **Desired results and timeframe to achieve those results:**

- Improved lifestyle
- Increased level of physical activity (short term - 2y)
- Decreased sedentary activities (screen time) (short/medium term - 5y)
- Improved diet
- Decreased portion sizes, intake of soft drinks and sweets, revised choice in fast food restaurants
- Improved snacking patterns (reduce frequency and improve quality)
- Increased intake of fruit and vegetables, low fat food and drinks, red meat consumption, milk and dairy
- Raised awareness and understanding of diet-health link
- Improved perception of healthy body image

Not all desired outcomes are accompanied by a timeframe. This was due to lack of time to discuss everything in detail.

### **It was agreed that the following messages should be conveyed to adolescents:**

- Consume soft drinks and sweets in moderation

- The message needs to take into consideration desires, and not only needs, of adolescents. It is important to communicate the message in a way that encourages adolescent to listen.
- Eat more fruits and vegetables (to resonate with adolescents, the message should link to body image and a healthy weight, since this is important for adolescents)
  - Currently, 20% of adolescents do not eat fruit and vegetables daily. The objective should be to increase the consumption of fruit and vegetables among the 80% that eat fruit and vegetables daily, and to understand the reasons why the remaining 20% do not eat fruit and vegetables on a daily basis.
- Be more physically active (The message should present options for physical activity to encourage adolescents to engage in more physical activity, i.e. messages could be locally based and presented in cooperation with sports clubs etc. It is key to make it easy for adolescents to engage in physical activity!)
- Eat breakfast!
- Provide facts about alcohol so that adolescents can see the negative impact of alcohol on performance. Craft message carefully!

#### **Diet-related problems in target group**

The reasons why teenagers do not consume fruits and vegetables were discussed. The main reasons were that, for adolescents, taste is more important than health, fruit and vegetables are too expensive (perceived value for money - fruits and vegetables do not provide you with high amounts of energy or fill you), availability (not least in schools) and family eating habits.

The reason behind teenagers consuming too many soft drinks was also discussed. Once again it was said that, for teenagers, taste is more important than health. Furthermore, marketing, availability and peer-pressure were highlighted as reasons for high consumption of soft drinks.

#### **Analysing the environment**

It was said that the following groups had to change their behaviour in order to reach the overall objectives:

- Adolescents (including peers)
  - There has to be different strategies for boys and girls.
- Families
  - There has to be specific strategies for lower socio-economic and ethnic groups.
- Media

#### **Social marketing strategies**

- Channels to use in the communication of health messages: websites, radio, music, (teenage) magazines, sports, TV, computer games, school curriculum, journalists, social networks (Facebook), Youtube
- Make use of celebrities. Idols can be used to influence teenagers by endorsing health messages
- Try to get all stakeholders, for example web designers, advertisers, food industry, retail, government, teachers, NGO, doctors, on board
  - Fast food chains, or other places where teenagers gather should be used. Fast food chains are capable of getting healthy nutrition messages out.
  - Sports clubs can also be partners in communicating messages to adolescents.

- School canteens (in countries that have this) can communicate on what healthy eating is. Students should be asked about the food choice in canteens - what do they want to eat?
  - Add nutrition to the school curriculum
  - Work with schools to ensure healthier choices in the school vending machines. Decrease the number of vending machines selling soft drinks. It is recommended that every school has a policy regulating vending machines
  - Increase the availability of fruits and vegetables in schools
  - Teach adolescents how to cook
  - Teach adolescents how to read labels
  - Teach adolescents to be critical to advertising
  - Work with the families of the adolescents
  - Introduce a fat-tax, e.g. a tax on foods that are high on sugar and fat
  - Introduce new products (e.g. appealing healthy products with fruits and vegetables)
  - Get retailers to increase the amount of healthy messages
  - Seek to introduce/implement/enforce legislation around advertising to children
- For messages to be effective they should attempt to be “cool” as in principle, teenagers oppose being told what to do!
  - Adolescents should feel they own the messages. Make nutrition cool!

#### **FBDG with a limited budget**

It was agreed that with a limited budget one would have to prioritise activities. Hence, the FBDG messages to be communicated should be:

- Eat a varied diet
- Engage in physical activity
- Drink water
- Ensure healthy eating, healthy bodyweight, healthy lifestyle

In order to increase funds it was suggested to be in close contact with government since it may be able to provide subsidies for certain activities, such as for example school catering. Also, public-private partnerships should be looked into. Furthermore, it was proposed to use the Internet to communicate messages since this would be a less costly alternative to reach a large number of people. Another idea would be to contact celebrities and ask them to give up some time to record a video (with healthy messages) that is put on YouTube. Finally, brands could provide healthy eating messages on packs, so that adolescents see them while food shopping.

#### **Plenary discussion**

It was concluded that there were remarkable similarities in the presentations of the two groups, with several of the things highlighted being identical. Hereafter, seeing that the workshop was coming to an end, the discussion focussed on the workshop as such. The participants shared their view on what had worked well during the workshop and what could have worked better regarding structure, content, what was learnt etc.

## **Feedback**

The feedback from the participants was very positive. The workshop was seen as useful in terms of creating awareness of the FBDG situation in other countries. The structure of the course was furthermore enjoyed by the participants. To divide the large group into smaller ones for discussions was appreciated, and the fact that the workshop was following the structure of the questionnaire was seen as positive as it brought consistency to the process. Furthermore, the proportion between keynote speakers and working in groups were in general thought to be good. However, it was said that two and a half day is not enough to discuss all aspects. Some participants expressed that they would have liked more time to study the other countries' posters. To make this possible, the posters were sent electronically to the participants after the workshop.

One participant, that also took part in the workshop on FBDG arranged by ILSI Europe five years ago, congratulated the participating countries on the progress that had been made on their work on FBDG.

## **Conclusions**

The vast majority of the participating countries had, during the time of the workshop, FBDG. The levels of development were however varied. Most participants with FBDG communicated and disseminated their FBDG. Constraints were however reported on the accomplishment of (effective) communication and dissemination. They were similar in all countries and were related to lack of financial resources and lack of local expertise. It was also reported on the lack of use of consumer research in the development of communication of FBDG. Consumer research was as a matter of fact very rarely used in any of the phases. This was thoroughly discussed in the workshop, and as a future plan for strengthening the national FBDG, the countries were eager to look into the possibilities of cost-effective consumer research in order to improve their FBDG. A smaller number of countries reported that they monitored and evaluated their FBDG. The problems hampering the development of such evaluative measures were the lack of satisfactory financial and human resources. Yet, it was highlighted during the workshop that terminology can mask FBDG evaluations. In addition to this, the participants were given some practical advice on how to keep evaluation costs down.

It is hoped that the participants took on board what they learnt from discussing different FBDG situations with the other participants and the speakers, and that this will be useful in their practical work.