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Safeguarding children and young people from obesity and type 2 diabetes

Report[1]
Social, Health and Family Affairs Committee
Rapporteur: Mr Mike HANCOCK, United Kingdom, Alliance of Liberals and Democrats for Europe (ALDE)

Summary

There has been a dramatic increase in obesity and type 2 diabetes affecting children and young people in the last decade. These life-shortening conditions – which can lead to other illnesses and which negatively affect sufferers' quality of life – also place a considerable burden on health-care systems. Member states need to respond urgently to this public health crisis.

It is essential to focus on the causes and to ensure that the rights of children and young people to health and a healthy environment are fully respected. In particular, measures need to be taken to promote healthy nutritional habits and a healthy lifestyle (in the family, at school and in the community), as well as a healthy (natural and built) environment.

In addition, governments should make sure that children and young people at risk of obesity and/or of various complications linked to this condition have genuine access to medical advice and suitable care and treatment.

1. 2011 - Second part-session

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A. Draft resolution[2]

1. The Parliamentary Assembly stresses the fundamental importance of safeguarding the health and well-being of children and young people and regrets the recent rise, in Europe and elsewhere, in obesity and type 2 diabetes affecting them. Obesity and type 2 diabetes, an acquired metabolic disorder, are preventable, life-shortening conditions which can lead to other illnesses (including cardiovascular diseases and cancer); they negatively affect sufferers' quality of life and place a considerable burden on health-care systems. The Assembly thus considers that member states need to respond urgently to this public health crisis.

2. The Assembly therefore welcomes the Global Strategy on Diet, Physical Activity and Health of the World Health Organisation (WHO) as a reference framework for member states' initiatives to decrease risk factors and to promote healthy lifestyles and environments. It calls on member states to implement the European Charter on counteracting obesity adopted at the WHO European Ministerial Conference on Counteracting Obesity, held in Istanbul (Turkey) from 15 to 17 November 2006.

3. The Assembly invites member states to consider the prevention of obesity from the perspective of the right of children and young people to health and a healthy environment in the framework of the United Nations Convention on the Rights of the Child, which calls on states parties to recognise the right of children to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health (Article 24).

4. The Assembly calls on member states to take urgent action to protect children and young people from the onset and the consequences of obesity and type 2 diabetes, in particular measures to promote healthy nutritional habits, a healthy lifestyle and a healthy environment. The measures designed should take due account of the principle of respect of the child's best interest.

5. With a view to promoting healthy nutritional habits, the Assembly recommends that member states:

5.1. take measures to improve food content, from the earliest age, through:

5.1.1. the promotion of breastfeeding, from birth to the age of six months;

5.1.2. healthier food processing and the elimination of synthetic trans-fats, preservation additives and other chemicals in foodstuffs;

5.1.3. the improvement of school meals and the minimisation of the consumption of unhealthy food and drinks;

5.2. ensure access to and availability of healthier food, including fruit and vegetables, to children and young people, as far as possible making healthier food choices affordable;

5.3. regulate food marketing (including food labelling, nutritional information and advertising) to reduce its pressure on children and young people and to limit advertising, particularly television advertising, aimed at children that promotes high-energy, low-nutrient food or food products with high sugar, salt or fat content;

5.4. inform children and young people, as well as their parents and carers, about the benefits of healthy eating habits, as well as the dangers and the long-term consequences of nutritionally unbalanced fast-food consumption and the risks of poor health due to induced obesity;

5.5. reconsider their fiscal policies related to food and consider introducing taxes on foods that are high in synthetic trans-fats, salt and sugar, using generated revenues to lower the cost of healthy foods, particularly for low-income population groups or investing them in the health system to enable treatment of people who suffer from obesity and type 2 diabetes.

6. With a view to promoting healthy lifestyles, the Assembly recommends that member states take measures to improve the well-being of children and young people in all areas of life, approaching public health-related issues in a holistic way. In so doing, member states are invited to:

6.1. raise awareness among children and young people on their development needs, enabling them to identify food as nutrition, not as a substitute for the satisfaction of other needs or discomforts; educate them about ways and means of managing stress and dealing with negative emotions, such as sadness and anger, as these are well-known triggers for excess food consumption;

6.2. promote a more active lifestyle, educating children and young people accordingly;

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2. Draft resolution adopted unanimously by the committee on 22 March 2011.

6.3. provide children and young people with opportunities for individual accomplishments in both formal educational settings and through their social life, thus developing their personal autonomy and their feeling of self-worth;

6.4. support schools in their efforts to encourage healthy eating habits and physical exercise, and ensure that schools are properly funded to be able to carry out this task successfully; ensure the widest possible dissemination and implementation of Committee of Ministers Resolution ResAP(2005)3 on healthy eating in schools, paying particular attention to the quality of school meals, while making healthier school meals affordable for all children and young people;

6.5. implement Committee of Ministers Recommendation Rec(2003)6 on improving physical education and sport for children and young people in all European countries, *inter alia* by improving access to sports facilities for children and the young (in socially disadvantaged areas in particular) and by running campaigns promoting a more active lifestyle;

6.6. ensure the full participation in society of children and young people, including those who are suffering from obesity/overweight and type 2 diabetes, and take a firm stand against discriminatory measures affecting persons suffering from obesity.

7. With a view to promoting a healthy environment, the Assembly recommends that member states:

7.1. develop specific policies and initiatives to support a health-promoting natural and built environment;

7.2. take specific measures to improve urban mobility, for instance by promoting cycling and walking through better urban design and transport policies.

8. The Assembly calls on member states to provide children and young people with appropriate treatment in response to obesity and type 2 diabetes and to make sure that persons at risk of obesity and/or of various complications linked to this condition have genuine access to medical advice and suitable care and treatment. Member states should improve, in particular, the early intervention and management of obesity and type 2 diabetes affecting children and young people.

9. The Assembly recommends taking urgent action in order to strengthen member states' capacity to undertake research and find solutions to these problems, including by substantially improving data collection and analysis (for example with regard to children with type 2 diabetes). The Assembly also calls on the specialised international organisations to provide adequate support to research initiatives aimed at reversing the development of obesity and type 2 diabetes epidemics in children and young people.

10. The Assembly considers participation of children and young people in the design of public health programmes intended for them as an important condition for their successful implementation, and thus recommends ensuring their full participation in all action undertaken in Council of Europe member states.

B. Draft recommendation[3]

1. The Parliamentary Assembly, referring to its Resolution ... (2011) on safeguarding children and young people from obesity and type 2 diabetes, draws the Committee of Ministers' attention to the dangers posed by the dramatic rise in the rates of obesity and type 2 diabetes in Europe, particularly among children and young people.

2. The Assembly fears that member states will face a dramatic increase in public health expenditure in the next 15 to 20 years to cover the costs of illnesses related to obesity if no countermeasures are taken now.

3. A general policy to prevent children and young people becoming overweight and obese, and to assist those affected, should thus now be drawn up and implemented in all Council of Europe member states.

4. The Assembly therefore recommends that the Committee of Ministers draft a set of guidelines to encourage member and observer states to adopt and implement co-ordinated strategies involving relevant sectors, such as public health, education, youth and sport, on preventing and treating obesity and type 2 diabetes among children and young people.

3. Draft recommendation adopted unanimously by the committee on 22 March 2011.

C. Explanatory memorandum by Mr Hancock, rapporteur

1. Introduction

1.1. Childhood obesity and type 2 diabetes: the origins and risks

1. Excess weight and obesity contribute to a large proportion of noncommunicable diseases, shortening life expectancy and adversely affecting the quality of life. According to the World Health Organization (WHO), more than one million deaths every year in the European region are due to diseases related to excess body weight.[4] An energy imbalance in the population has been triggered by a dramatic reduction of physical activity and changing dietary patterns, including increased consumption of energy-dense nutrient-poor food and beverages (containing high proportions of saturated as well as total fat, salt, and sugars) in combination with insufficient consumption of fruit and vegetables.[5]

2. Childhood obesity has increased rapidly in virtually all Council of Europe member states. This is a relatively recent phenomenon, with little evidence of any change in the prevalence of childhood obesity before the early 1980s, and signs of a rapid increase in prevalence during the 1990s and early 2000s.

3. Type 2 diabetes, an acquired disorder affecting a person's metabolism, which accounts for over 90% of diabetes cases worldwide, is directly related to obesity, a sedentary lifestyle and diets high in fat and saturated fatty acids. Prevention and treatment of both, obesity and type 2 diabetes, thus need to focus on lifestyle changes.[6]

4. Obesity has a striking and unacceptable impact on children. An obese child faces a lifetime of increased risk of various diseases, including cardiovascular disease, diabetes, liver disease and certain forms of cancer. Even during childhood, obesity increases the risk of these diseases and is a significant cause of psychological distress.

5. As indicated by the World Health Organization, many countries have made progress in raising awareness and an increasing number have launched policies and action plans in recent years. In 2009, a first preliminary glance showed a levelling-off of obesity rates in children in some countries as a result of concrete action. However the socio-economic gradient in childhood obesity is still high.[7]

6. The epidemic's rapid growth is linked to the global increase in the availability and accessibility of food and the reduced opportunities to use physical energy. Food has never been so affordable, and products high in fats and sugar are the cheapest. In addition, some of the biggest players in the food production and distribution and catering industries fail to comply with WHO recommendations that they should limit the salt, sugar and fat contents of their products, reduce the size of individual portions, provide nutritional advice and encourage or support physical activities.

7. The latest studies show that if nothing is done to counter the rise in obesity and type 2 diabetes among children and young people, member states will be facing a dramatic increase in public health expenditure in the next fifteen to twenty years to cover the costs of related illnesses, including cardiovascular diseases and cancers linked to obesity. In France, it is estimated that if nothing is done to prevent it, the financial costs of obesity could reach 7% of public health expenditure in 2020. In financial terms, for health insurance alone this may reach €250 billion.[8]

8. A few years ago, the Parliamentary Assembly adopted Recommendation 1786 (2007) "Towards responsible food consumption", which stressed that responsible consumption necessarily entails healthy eating. The Assembly focused on the importance of improving information and nutritional education, the value of guidelines for good nutrition and finally the need to target consumers' consciences to persuade them to

4. European Charter on counteracting obesity, WHO, 16 November 2006, EUR/06/5062700/8.
5. Ibid.
6. European Commission Green Paper on "Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases" (COM(2005)637 final).
7. McPherson K., Brown M., Marsh T. and Byatt T., "Obesity: Recent Trends in Children Aged 2-11 and 12-19", and its companion paper, Brown M., Byatt T., Marsh T., and McPherson K., "Obesity Trends for Children Aged 2-11 – Analysis from the Health Survey for England 1993-2007".
8. "Prévention et traitement de l'obésité: l'état de la recherché, Rapport sur les perspectives offertes par les recherches sur la prévention et le traitement de l'obésité" (minutes of the public hearing held on 4 March 2009), Mr Jean-Claude Etienne and Ms Brigitte Bout, Senators, 1770 National Assembly, France, p. 6.

choose responsibly. However, the recommended measures have had a limited effect. There is now an urgent need for the authorities and citizens to respond to this rise in obesity and type 2 diabetes, especially among children and young people. This report aims to provide the tools needed to tackle the problem at its roots.

9. I believe that further comprehensive and consolidated action, led by all Council of Europe member states, is needed. In line with the United Nations Convention on the Rights of the Child, all children living in Europe have the right to live and grow in an environment that allows them to reach their highest attainable level of health – and this includes safeguarding them from obesity and type 2 diabetes.[9]

1.2. Obesity epidemic in Europe: children and young people as a vulnerable group

10. According to European Union data, one quarter of European schoolchildren are now overweight or obese – a figure which is growing by 400 000 each year. Furthermore, 3 million schoolchildren in the European Union are now classed as obese – a figure that is increasing by 85 000 every year.[10]

11. The International Obesity Task Force reports that the levels of excess weight and obesity among children in southern Europe are higher than their northern European counterparts as the traditional Mediterranean diet gives way to more processed foods rich in fat, sugar and salt. The Mediterranean islands of Crete, Malta and Sicily, as well as Gibraltar, Italy, Portugal and Spain, report excess weight and obesity levels exceeding 30% among children aged 7 to 11.[11]

12. In addition, Cyprus, England, Greece, Ireland and Sweden report levels above 20%, while France, Switzerland, Poland, the Czech Republic, Hungary, Germany, Denmark, Netherlands and even Bulgaria report excess weight levels of 10-20% among this age group. For teenagers (aged 13 to 17), seven countries indicate excess weight and obesity levels above 20% with Crete peaking at 35%. Childhood excess weight and obesity is seen to be accelerating rapidly in some countries. Rates of increase vary, with England and Poland showing the steepest increases,[12] reaching some 27% of the population in the United Kingdom.[13] This is very worrying.

13. This data was confirmed by the recent replies to the questionnaire of the Social, Health and Family Affairs Committee (see appendix). I would like to thank all 29 countries which replied. The analysis of these replies gave us an opportunity to analyse the situation of childhood obesity in Council of Europe member states.[14]

14. Almost all countries who answered the questionnaire believe that over the last ten years they have experienced a rise in type 2 diabetes in children. Some countries do not have the necessary data to prove this rise, but their paediatricians feel that more and more children come to them with type 2 diabetes. Only the Czech Republic and Estonia felt that the number of children with type 2 diabetes had remained stable during the last ten years. None of the countries thought that the number of children with diabetes type 2 was decreasing.

15. I would like to stress that children suffering from obesity are not only medically compromised, they are socially and psychologically disadvantaged. In fact, obese children are stigmatised and discriminated by their peers, often develop low self-esteem and a negative body image, leading sometimes to depression, with implications in terms of increases in health-care expenditure.

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9. The Committee of Ministers set up an expert committee on child-friendly health care aimed at assisting member states in identifying children's health needs and applying particular standards for children-oriented care and in developing child-friendly health care. Portugal will host the 9th Ministerial Conference of European Health Ministers in late 2011 on child-friendly health care and I would like to contribute to this conference by tackling in particular the issue of prevention of obesity and type 2 diabetes and promotion of healthy nutritional habits among children and young people.

10. European Commission, Directorate-General on Health and Consumer Protection, Nutrition & Obesity Prevention, 2006.

11. International Obesity Task Force, "European Union Platform on Diet, Physical Activity and Health", prepared in collaboration with the European Association for the Study of Obesity, 15 March 2005, p. 3.

12. Ibid., p. 3.

13. Wang, Y. and Lobstein, T., Worldwide trends in childhood overweight and obesity, *International Journal of Pediatric Obesity*, 2006/1, pp. 11-25.

14. See document AS/Soc/Inf (2011) 3, available from the committee's secretariat.

16. Moreover, scientific research argues that there is a link between endocrinal disruption caused by obesity and the subsequent excessive production of oestrogen and, as a result, precocious puberty. Research shows there are links between obesity and early sexual maturity of girls. Psychological maturity comes two to three years after physical maturity, which creates discrepancies in child development. This can be dangerous and have severe consequences on the life of the child.

17. Obesity both results from and causes social gaps. Socially vulnerable groups are more affected by obesity because they live in neighbourhoods that do not facilitate active transportation and leisure, they have less access to education and information about lifestyles and health, and the cheaper food options available to them are nutrient poor and energy dense.

18. The impact of inequalities is a major concern for children's health and may be immediate, leading to poor health outcomes across a range of indicators and behaviour during childhood and adolescence. These may reduce young people's ability to participate fully in many aspects of life and affect, for example, school attendance and academic achievement, social functioning, sports participation and uptake of employment opportunities.

19. I strongly believe that achieving higher standards of nutrition and physical activity to improve the well-being and protect the health of European citizens, in particular that of children and young people, must be a major public health priority.

2. Prevention

2.1. Policy options and recommendations

20. As mentioned above, excess weight and obesity are largely preventable through modification of pre-identified risk factors. The best long-term approach to tackling overweight and obesity is prevention starting from childhood. Action therefore needs to take a life-course approach, starting with maternal health and leading on from infancy.

21. Given the complexity of the issues of excess weight and obesity, there is a need for a comprehensive, multi-sectoral approach that targets the underlying conditions that influence the ability of individuals to make healthier choices.

22. Most of the proposals that I am putting on the table are not new: improving the quality of school lunch programmes; encouraging children to get more exercise; increasing access to nutritious food in underserved urban areas; targeted parental education programmes.

23. However, making healthy choices requires both demand for and availability of healthy alternatives. With regard to children and young people's health, there should be a focus on measures to ensure the provision of healthy options in environments in which children and young people are likely to be found, this includes schools and sport and leisure centres.

24. This will be supported by creating the demand for healthy foods through health and nutrition education. Furthermore, the role of parents and those responsible for the care of children should not be ignored, and policies should also aim to facilitate improved knowledge and ease of choice for these groups.

25. To improve dietary habits and increase physical activity among vulnerable groups, measures should primarily be directed at the lower socio-economic gradient of the population where conditions for healthy dietary habits and physical activity are most lacking, thus making the choice for a healthy lifestyle more difficult. Evidence has shown that people make healthy choices more often if the surrounding environment is supportive.

26. As stressed by WHO, governments and national parliaments should ensure consistency and sustainability through regulatory action, including legislation. Other important tools include policy reformulation, fiscal and public investment policies, health impact assessment, campaigns to raise awareness and provide consumer information, capacity building and partnership, research, planning and monitoring.[15]

15. European Charter on counteracting obesity, WHO, 16 November 2006, EUR/06/5062700/8.

27. In their replies to the questionnaire on obesity and type 2 diabetes, member states reported on the government programmes in place which are aimed at keeping childhood obesity under control and the evidence of improvements due to government schemes. The following measures were highlighted:

– the Czech Republic, Bulgaria and Portugal made references to the implementation at national level of the WHO programme "Health for All in the 21st century";

– government action plans have been established in Belgium, Canada, Poland, Portugal, Slovakia, Sweden, and Switzerland;

– specific guidelines were developed in Canada and Norway;

– intersectoral committees and co-ordination councils were established in Malta, Poland and Portugal;

– appropriate data gathering programmes were put into place in Estonia, Georgia, and Italy;

– establishment of a monitoring system, including availability of indicators and benchmarks, was reported by Switzerland;

– measures to raise awareness of the general public on obesity and associated risks and to encourage healthy eating were taken and reported by France, Germany, Liechtenstein, Malta, "the former Yugoslav Republic of Macedonia" and the United Kingdom.

28. It seems there is goodwill on the governments' side to improve the situation. But is the health of our children really getting better?

29. I therefore urge all Council of Europe member states to take action to tackle child obesity in the following areas, following the main WHO and Council of Europe recommendations and in line with relevant European Union legislation.

2.2. Promotion of healthy nutritional habits

2.2.1. Food environment

30. The food environment can be understood as the combination of multiple factors which influence what and where people eat. There are different influences at different levels, including:

– the legislative and policy framework;

– the physical availability of and access to foods at home/work/school and in shops;

– social factors such as cultural traditions, social norms and role models.

31. In brief, I believe that our food choices are dictated by a number of factors that are to a greater or lesser extent modifiable.

32. Recent trends in food consumption reveal that high-calorie foods have become less expensive. Highly processed and fast foods are more readily accessible, whilst nutrient-dense foods such as fruit and vegetables have become relatively more expensive.

33. There has also been a move away from more traditional regional diets, to a converging energy-dense, nutrient-poor diet across Europe where fruit and vegetable consumption has stagnated. This has been the case, for example, in southern Europe in recent years where there has been a concomitant change in diet and levels of physical activity.

34. In my view, policy makers looking to address the food environment in Europe should consider policies to impact upon food production, food manufacturing, food trade, the labelling and marketing of food products and beverages, social welfare and health inequalities.

35. However, the public health evidence indicates that we are unlikely to succeed in tackling obesity if we focus only on the child and not on the child's prevailing environment, and if we only stigmatise behaviour.

36. Therefore, broad policy options to protect and promote public health need to be led by governments and must include formal engagements with a wide range of actors including the food industry and civil society.

37. I would start by urging member states to take measures to incite manufacturers and distributors of food and drink products to review both the composition of some of these products, in terms of quality and safety standards, and their activities to promote the consumption of those foods that are deemed to be fairly or extremely unhealthy.

38. I am also totally convinced that it is important to make sure that schools are preserved as a commercial free setting.

2.2.2. Food content

2.2.2.1. Breastfeeding

39. According to WHO, breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants; it is also an integral part of the reproductive process with important implications for the health of mothers. Exclusive breastfeeding for six months is the optimal way of feeding infants. Thereafter, it is recommended that infants should receive complementary foods with continued breastfeeding up to two years of age or beyond. The member states policies to promote breastfeeding are discussed below under the relevant family policies.[16]

2.2.2.2. Abolishing the use of synthetic trans-fats

40. The replies to the questionnaire have revealed an increased awareness in our member states about the dangers of synthetic trans-fats.[17] In reaction, some countries referred to the introduction of regulative measures to limit trans-fatty acids to 1% (Bulgaria, Estonia, Norway, Slovakia, "the former Yugoslav Republic of Macedonia") or to 2% (Hungary, United Kingdom, Liechtenstein) of the total energy value of food intake. There were, however, very few examples of government action to abolish the use of trans-fatty acids altogether.[18]

41. Some Nordic countries, such as Finland and Sweden, reported small amounts of trans-fatty acids (less than 0.4%) due to the use of the interesterification as the hardening method for vegetable oils since the 1990s, a method that does not produce trans-fatty acids. More research may be needed, however, into the effect of the products that are created using the interesterification method on the health of the consumer.

42. Co-operation with industry is essential and had proved successful in the Netherlands, where a "Dutch Task Force for the Improvement of the Fatty Acid Composition" had been set up.

2.2.2.3. Early exposure to chemicals and preservation additives

43. Early-life exposure to chemicals during development may also be contributing to the obesity epidemic. The exposure to chemicals is dangerous, especially if this happens during pregnancy. I am of the opinion that there is an outstanding need to further investigate the link between early exposure to chemicals and childhood obesity.

44. Evidence has been steadily accumulating that certain hormone-mimicking pollutants, ubiquitous in the food chain, have two previously unsuspected effects.[19] They act upon genes in the developing foetus and the newborn to turn more precursor cells into fat cells. They may also alter the metabolic rate, so that the body hoards calories rather than burning them. Diabetes and obesity may be predetermined during pregnancy when chemical substances disrupt endocrinal functions of the foetus.

45. A 2007 study under the European Registration, Evaluation, Authorization and Restriction of Chemicals (REACH) Regulation identified 3 000 chemical substances that were found to disrupt the endocrinal system, but only six out of 3 000 are currently being assessed. There is a need to develop high speed mechanisms to assess the effect of chemical substances on the human body, and specific measures to avoid exposure to them.

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16. See footnote 14.

17. Azerbaijan stressed that the consumption of synthetic trans-fats is among the factors leading to atherosclerosis, blood-vessel diseases, decrease of the sensitiveness of the pancreas cells with regard to insulin, chronic inflammatory processes and obesity. Similar views were expressed by other countries.

18. In Belgium, the "green" political party (*Ecolo-Groen*) recently introduced a draft bill in the House of Representatives to ban the commercialisation of foodstuffs containing a certain amount of trans-fats.

19. Sargis, R. M., Johnson, D. N., Choudhury, R. A. and Brady, M.J., "Environmental Endocrine Disruptors Promote Adipogenesis in the 3T3-L1 Cell Line through Glucocorticoid Receptor Activation", *Obesity* (2010) 18 7, 1283–1288. doi:10.1038/oby.2009.419.

2.2.2.4. Reformulation of food products

46. Governments should promote the reformulation of mainstream food products in order to reduce the amount of salt, added sugar, saturated fat and trans-fatty acids and promote the availability of healthier product ranges. This should be achieved by establishing formal engagements with food manufacturers.[20]

47. Recommendations provided by WHO should be implemented in such a way as to ensure that foods with less salt, fats and sugars are available and accessible for all citizens, including vulnerable groups; these measures should be supported by public awareness campaigns and other mechanisms such as front of pack labelling. Member states should also further develop and/or improve the existing national food-based dietary guidelines to take into consideration the need to overcome the obesity epidemic.

48. European legislation concerning hygiene can be acted upon to oversee food distribution. Sometimes such rules can, however, be counterproductive. This is the case with regard to the distribution of fruit in schools, which is sometimes not done for hygiene reasons.

2.2.3. Food marketing

2.2.3.1. Marketing and advertising

49. Many factors influence the diffusion of the obesity epidemic: food advertising is certainly a significant factor. Various independent bodies have drawn attention to the risk of excess weight and obesity facing children in Europe and have recommended a total review of the advertising, particularly television advertising, of food products for children.

50. Several studies indicate that food advertising is associated with preferences among children towards advertised products.[21] There is a connection between heavy marketing of energy-dense foods and fast-food outlets and an increased risk for weight gain and obesity. Several reviews have shown evidence of the impact of food marketing to children on awareness, influence on food preferences, attitudes, purchase requests and consumption.

51. As regards children's exposure to advertising, available data for France, Germany, Italy, Spain and the United Kingdom show that, in children's airtime, one food commercial is broadcast every five minutes. This means 33 000 commercials per year. About 60% of food advertising is programmed between 4 p.m. and 9 p.m. and about 40% of television advertising of soft drinks, confectionary, snacks, fast food and cereals is in children's airtime.[22]

52. Television is the easiest way for marketers to reach a large number of children. It gives marketers access to children at much earlier ages than print media. Internet and mobile telephones have given marketers even more access to the private sphere of children. A great number of fast-food companies also use the presence of toys in fast-food marketing in order to attract children. There was a discussion in the Spanish Parliament to prevent the distribution of plastic toys in food packaging. In the United States, there were initiatives[23] this year to ban the use of toys in food packaging aimed at children.

53. I strongly believe that children's programmes and the time between those programmes should be free from television advertising and teleshopping.

54. Moreover, I recently learnt that children in the United Kingdom are being paid up to £25 a week to promote sugary soft drinks and other products through social networking sites and playground chat. Firms are turning to these controversial tactics after moves to crack down on television advertising of unhealthy products. Some websites recruit thousands of children from seven upwards to take part in surveys that are used by big business to shape products and policy.[24]

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20. See also Assembly Doc. 9604, report on functional food: serving the interests of the consumer or the food industry?, rapporteur: Mr Bill Etherington (United Kingdom, Socialist Group).
21. In the European Union, 96% of respondents to a Eurobarometer study consider that food advertising and promotion influences children's eating habits: 28% consider that this influence is preponderant, 53% consider that it plays an important role while only 15% consider that advertising media have little influence in this area. See replies to the question 4.1.2 "What influences children's eating habits?" and 4.1.3, "The influence of food advertising and promotion on the choice of what children eat", in Health and food, Special Eurobarometer, European Commission, November 2006, pp. 45 and 47.
22. European Parliament study on The Effect of Advertising and Marketing Practices on Child Obesity, 2007.
23. http://food.change.org/blog/view/victory_san_francisco_bans_toys_in_unhealthy_kids_meals.
24. "Child 'mini-marketers' paid by junk food firms to secretly push products among themselves", *Mail online*, 15 February 2010.

55. I agree with some commentators that outlawing such promotions through websites would be difficult, because of the difficulty in proving that most sites are explicitly aimed at children.

56. Parents should guide the eating habits of their children and schools should support parents in this. Schools should encourage healthful eating habits and exercise and need to be properly funded to be able to carry out this task successfully.

57. An International Obesity Taskforce workinggroup has developed a set of underlying principles to guide national and transnational action to substantially reduce commercial promotions that target children, known as the Sydney Principles.[25] The taskforce stressed that protection of children from commercial exploitation is a societal responsibility. Children are particularly vulnerable to commercial exploitation, and regulations need to be sufficiently powerful to provide them with a high level of protection. Child protection is the responsibility of every section of society – parents, governments, civil society and the private sector.

58. Only legally enforceable regulations (both at European Union and national level) have sufficient authority to ensure a high level of protection for children from targeted marketing and the negative impact that this has on their diets. Industry self-regulation is not designed to achieve this goal. Regulations need to encompass all types of commercial targeting of children (namely television advertising, printed media, sponsorships, competitions, loyalty schemes, product placements, relationship marketing, Internet) and be sufficiently flexible to include new marketing methods as they develop. Regulations need to ensure that childhood settings such as schools, childcare, and early childhood education facilities are free from commercial promotions that specifically target children, as well as from vending machines with unhealthy foods.

59. Statutory regulations on the marketing of foods that are high in fats, synthetic trans-fats, salt and sugars should be considered, exploring models that are already in place in some member states. These schemes will make use of strict criteria to establish which foods products are permissible and which are not. I take the view that both surreptitious advertising and product placement of unhealthy foods must be banned.

60. Governments should implement strict regulations on the use of health and nutrient claims on food products. Strict independent criteria (nutrient profiles) should be developed to identify which products contribute to a healthy diet and may be permitted to use such claims. This is important in order to avoid misleading consumers as to the public health profile of a product.

2.2.3.2. Front-of-pack labelling

61. Under European Union legislation nutrition labelling is optional, although it becomes compulsory when a nutrition or health claim is made (for example “helps lower cholesterol”) or when vitamins or minerals are voluntarily added to foods. The European Union Directive 2000/13/EC the approximation of the laws of member states relating to the labelling, presentation and advertising of foodstuffs[26] has been mentioned as one of the reference elements for the labelling decisions by the European Union member states. The nutrition labelling on food is regulated by Directive 90/496/EEC. The European Union example shows that it is close to impossible to have unified nutrition labelling for all countries. But it is also unnecessary. The most important factor is that if the product makes a health claim for children and young people it should be able to prove it in a transparent way to consumers.

62. A health-friendly regulation would ensure that consumers are provided with clear, evidence-based information on all food products, including alcoholic beverages, and would help consumers to make an easy, at-a-glance choice between healthier and less healthy products.

63. I strongly support the recommendation that energy, saturated fats, sugar and salt be included on the front-of-pack label. It is particularly important that these elements be highlighted, as a reduction in their intake will significantly reduce the risk of cardiovascular disease and obesity.

64. In the replies to the questionnaire, a number of practices were mentioned. Some countries referred to the current use of the Guideline Daily Amounts (GDAs) indicators, while others preferred to be cautious in this respect. Estonia and the Czech Republic considered GDAs misleading. It was felt that as the Guideline Daily Amounts calculations are considered to be based on calories needed by a 40-year-old, moderately active,

25. International Association for the Study of Obesity, The Sydney Principles: guiding principles for achieving a substantial level of protection for children against the commercial promotion of foods and beverages, 2007.
26. http://ec.europa.eu/food/food/labellingnutrition/foodlabelling/comm_legisl_en.htm.

woman with a need of a total of 2 000 kilocalories a day, even unhealthy products can seem to be healthy when calculations are made in such a way. This is not appropriate information with regard to the needs of children and young people.

65. Member states generally supported references to the fruit and vegetables contained in packaged meals, such as the "five a day" symbol in Estonia. Other forms of labelling, indicating the level of fat, salt and sugar, seem to be effective in protecting the health of the consumer, such as the "the Heart Symbol" in Finland and the "Nordic Keyhole" symbol in Iceland.

66. Some research suggests that consumers find the multiple colour coding "traffic light system" the easiest to understand. This makes it clear to consumers whether a product contains low, medium or high levels of a certain nutrient, and helps them to make choices both within and across food categories.

67. At the same time, member states report that both the GDA and traffic light[27] systems have a drawback in that they can appear on any food and may make unhealthy products look healthy, such as, for example, cola drinks which contain no fat and no sodium, but are nevertheless not healthy.

68. In theory, using the traffic light system, the consumers choosing more products marked in green prefer a healthy lifestyle. However, the choice is difficult when a product is marked with several colours and cannot be compared to another product of this kind. Besides, this system of marking can lead to dietary errors as consumers can switch to an unbalanced diet, focusing on certain products marked with green, and this way bring about deficiency of certain ingredients (marked with red or amber) or overdose others (marked with green).

69. I am nevertheless convinced that one tool to help reduce the prevalence of obesity is to help consumers identify healthy foods and healthier options – this is relevant for reducing childhood obesity as parents and carers need to be provided with the necessary support to make healthy choices. Nutrition labelling is a crucial element in a wider strategy as mentioned by the WHO Second Action Plan on Nutrition and is a strong support tool aiding the implementation of nutrition education.

2.2.4. Fast food danger

70. If children eat fast food, also commonly referred to as "junk food",[28] every day, they get used to it. As a result, countries will need to deal with this in a curative way, and not only preventively.[29]

71. Furthermore, low-income groups, compared to the rich, do not eat as well, pay more for what they get in relative terms, and have restricted access to healthy options. Indeed, obesity often occurs within low-income families. The economic aspect is decisive when it comes to taking decisions on food purchases. Today it is less expensive to eat fast food than proper meals. Unfortunately, this is often the case in school canteens. Paradoxically, it seems that in places of detention the meals are healthier than in hospitals or schools. I am absolutely convinced that "cheap" in the short term will mean "very costly" in the long run, if nothing is done to change that. The state needs to step in.

2.2.5. Fiscal policies related to food

72. Given that junk food does not contribute to a healthy diet, governments should consider introducing taxes on foods that are high in fats – in particular synthetic trans-fats –, salt and sugar. At the same time, price incentives to promote the consumption of fruit, vegetables, and other healthy foods should be considered.

73. Pricing interventions have been shown to produce meaningful changes in patterns of food consumption and a reduction in diet-related diseases, particularly when a multi-nutrient approach is taken.[30] I take the view that taxation targeting foods that are high in synthetic trans-fats, salt and sugar could be offset by using revenues to lower the cost of healthy foods, particularly for low-income population groups. If, however, subsidies for healthy foodstuffs are already in place, governments might consider investing the revenues in the health system.

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27. The traffic lights system is used to indicate the quantity of a specific ingredient, marking with green a low content, with yellow a moderate, and with red a high content.
28. In his documentary *Supersize me* in 2004, while examining the influence of the fast-food industry, Morgan Spurlock personally explored the dramatic consequences on his health of a diet of solely McDonald's food for one month.
29. For example, the Russian Federation reported an intensified use of imported foods which uses preservation additives, including fast food.
30. Roehr, B., "Taxing junk food improves health outcomes", *British Medical Journal*, BMJ 2010;340:c1370.

2.3. Promotion of a healthy lifestyle

2.3.1. Individual

74. Member states should raise awareness of children and young people regarding their development needs, enabling children to identify food as nutrition, not as a substitute for the satisfaction of other needs or discomforts.[31] It has been established that emotional states, such as sadness and anger, have the greatest potential to drive a loss of control leading to conditioned hypereating.[32]

75. Such emotional states intensify the drive to eat, where eating becomes a form of "self-medication" with people taking food to calm themselves down. Moreover, when emotions amplify reward,[33] the drive for reward becomes even harder to control.[34] It is therefore necessary to provide psychological support, accompanying children in distress to ensure that they do not find refuge in an addiction to food.

76. It is widely recognised that the problem is not confined to the intake of calories, but is also due to the fact that there has been an increase in sedentary lifestyles. The lack of physical activity among children and young people contributes significantly to the high prevalence of obesity in Europe. I would therefore draw attention to the urgent need to do away with the sedentary lifestyle of modern societies, educating children and young people accordingly.

77. Findings concerning the amount and intensity of physical activity are remarkably consistent across studies and from one European country to another. These findings indicate that two thirds of young Europeans do not take part in sufficient or appropriate physical activity and that physical activity levels clearly decline with age.[35] As obesity results from an imbalance of energy intake/energy expenditure, an increase in sedentary lifestyles forms one part of the equation. It is thus important that young people are encouraged to participate in physical activity, so as to establish healthy lifestyle patterns throughout the life course, but also so that they can profit from the other benefits of physical activity: a better self-image, quality of life, self-reported health status and improved relationships with family and peers.

78. I also believe that there is a need to explore the relationship between increased television and computer use and obesity, as these constitute the major sedentary types of behaviour among young people.[36]

79. It is also very important to provide children and young people with opportunities for individual accomplishments in both formal educational settings and through their social life, thus developing their personal autonomy and the feeling of self-worth, and the capacity to take informed decisions with regard to their lives. An accomplished child will not seek satisfaction in food and will be less dependent on high sugar/high fat stimuli. Moreover, sports achievements are highly beneficial to child development and should therefore be highly encouraged.

80. The actions of professionals promoting healthy eating among children and young people through cooking their own food have been very much appreciated (Jamie Oliver[37] (United Kingdom) and Cyril Lignac[38](France)). Some of these programmes, accessible through the Internet and television, are a great support to children, helping them to acquire some essential life skills in an accessible manner. The acquisition of personal autonomy should also be regarded in terms of being able to feed oneself correctly, of cooking one's own food, on reaching adolescence. Such professionals should therefore be supported in their endeavours.

2.3.2. Family

81. The well-being of children and young people starts with the family. I want to emphasise the damage that societies will be faced with if we do not take into account the dietary situation. Unfortunately, it is very easy for parents not to live up to their responsibilities. I would therefore like to recall that there is no greater

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31. See also the Assembly report "Teenagers in distress: a social and health-based approach to youth malaise", rapporteur: Mr Miroslav Ouzký (Czech Republic, EDG), Doc. 9986.
32. Kessler, D. A., *The end of overeating*, , MD, Penguin Books, ISBN: 978-0-141-04781-2, p. 150.
33. Food in this case.
34. *The end of overeating*, op. cit., p. 151.
35. WHO – Europe, *The challenge of obesity in the WHO European Region and the strategies for response*, 2007.
36. Ibid.
37. www.jamieoliver.com.
38. www.cyrillignac.com.

responsibility than to safeguard our children's future. The complacency of parents who allow children to consume much more than necessary for a child's healthy development is regretful. It was found that a child may consume up to 6 000 calories on Christmas Day alone. Overfeeding may also be considered as a risk factor and a form of abuse, and should be prevented.

82. The first step that should be taken when a baby is born is to make sure that the mother is encouraged to breastfeed (see paragraph 39). Exclusive breastfeeding should be encouraged from birth to six months of age. Maternity-leave provisions should correspond to these recommendations, and the correct social and employment policy framework to facilitate such practices should be put into place. It is important to implement the breastfeeding breaks which are in most national legislations to protect lactating women and offering lactation support and separate rooms to allow mothers to continue breastfeeding when back at work.

83. Health professionals should ensure that pregnant women (and their partners) are provided with the necessary information and advice on the importance of good nutrition during pregnancy, including a wider approach to public health and pregnancy (the negative impact of alcohol and tobacco consumption should also be emphasised).

84. In the European Union, more than seven out of ten respondents to the Eurobarometer study on health and food[39] believe that parents and guardians have the most influence over what their children eat. This proportion varies from 58% in Italy to 84% in Finland. A third of European Union citizens (34%) believe that the most effective way of improving children's diets would be to provide more information to parents.[40]

85. Small children do not find energy-dense foods and beverages by themselves. Therefore parents, grandparents, other relatives and kindergarten personnel should make efforts to postpone the introduction of high fat, sugar and salt products.

2.3.3. School

86. The role of formal education in combating obesity is crucial. Pre-school and school policies should be designed in a way that takes full account of the need to prevent obesity and type 2 diabetes among children and young people. Education on healthy eating, and general awareness-raising about the nutrition value of various food products are essential. The important role attributed to schools in improving children's diets is noteworthy: the education of children at schools is the diet improvement measure that is most frequently mentioned (in second place after the provision of information to parents).[41]

87. Some countries report having achieved substantial results by looking at the functioning of the school in its entirety, by adopting the so-called "whole-school approach". The "Nutrition-friendly schools initiative" in Croatia and the "Healthy kids" campaign[42] in Australia are good examples.

88. The Government of Canada worked together with WHO to develop the WHO School Policy Framework,[43] which was released in November 2008. The Framework focuses on the promotion of healthy eating and physical activity through environmental, behavioural and educational changes. The framework aims to provide guidance to member states on how to develop and implement a sustainable national and/or sub-national school policy to promote and support healthy eating and physical activity.

89. The positive experience of international co-operation and exchange of best practices through the European Network of Health Promoting Schools has also proved successful and should be encouraged.

90. I would also recommend that governments promote eating a healthy breakfast at home and promote the concept of bringing healthy meals and snacks prepared at home to school through campaigns and advertisements.

2.3.3.1. School meals

91. Member states should continue taking measures to implement Resolution ResAP(2005)3 on healthy eating in schools,[44] paying particular attention to the quality of school meals, improving their nutritional value and decreasing the content of trans-fatty acids, salt and sugar, and increasing the consumption of fruit and vegetables, while making the healthier school meals affordable for all children and young people.

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39. Health and food, Special Eurobarometer, European Commission, November 2006, p. 45.
40. Ibid., p. 48.
41. Ibid., pp. 48-49.
42. www.healthykids.nsw.gov.au.
43. www.who.int/dietphysicalactivity/schools/en/index.html.

92. In the replies to the committee's questionnaire, the quality of school meals was reported to be regulated by law in a number of member states, aiming at preventing obesity (Ukraine), promoting healthier food consumption (Malta), including the increase in the consumption of fruit and vegetables (Hungary, Portugal), and limiting the consumption of unhealthy food and drinks.[45]

93. In the United Kingdom, a School Meals Review Panel was established to improve nutritional value of school meals following a recent campaign by celebrity chef Jamie Oliver which highlighted the poor standards of meals. The panel is composed of health and nutrition experts and also requires parental participation to ensure that the improvements introduced in schools are also carried out at home.[46]

94. Fruit and vegetables should be presented as attractive and tasty food. Furthermore, governments should consider making a commitment to providing free fruit and vegetables in schools, particularly in those schools located in deprived areas. The sale of healthy foods in the school environment (school shops, canteens and food vendors) should also be promoted, while the marketing and sale of junk food in school environments should be eliminated.

2.3.3.2. Compulsory physical activity and funding for the promotion of sport in schools

95. More physical activity in schools is the measure most frequently quoted as being the most effective measure in reducing the prevalence of childhood obesity in Europe.[47]

96. In their replies to the questionnaire, Canada, Malta and Sweden reported on their initiatives to increase physical activity and to promote the practice of sports in and out of school with children and young people.

97. Member states should take action to implement Committee of Ministers Recommendation Rec(2003)6 on improving physical education and sport for children and young people in all European countries. In particular, states should study ways in which the provision of physical education and sport can be improved for all children and young people, including those with disabilities; and should investigate and consider whether, in the light of the findings of recent international surveys, there is a need at national level to:

– redefine the role and purpose that physical education and sport should fulfil within the school curriculum;

– consider the need to improve the quality of physical education and sport available for children and young people in schools and ensure the necessary time, for example three hours of physical education classes for each child each week, to achieve the goals set;

– promote the ideal of one hour of physical activity each day for children and young people, including both physical education and sport in the school environment and recreational sport outside of school;

– examine the following areas: the curriculum, the status of physical education as a subject, the financial resources available, the availability and condition of facilities, gender and disability issues;

– take action, in the light of their findings, to improve the motivation and status of physical education teachers in order to attract and keep young people in the profession;

– improve the quality of training and retraining for those teaching physical education and sport, in order to increase the number of well-trained physical education teachers in European countries and to revise and improve their training programmes where possible;

– introduce campaigns which strive for a more active lifestyle for children and young people, while also taking steps to improve recreational facilities and sports programmes in the community.

98. These efforts should, however, take due account of the situation of each child. It is to be noted that it may prove very difficult to tell a child who is seriously obese to start doing sport. They may have heart attacks since their body is unable to take the strain.

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44. Resolution adopted on 14 September 2005 by the Committee of Ministers in its composition restricted to the Representatives of the Council of Europe states which are members of the Partial Agreement in the Social and Public Health Field.

45. See footnote 14.

46. European Dairy Association's response on the European Union Commission Green Paper "Promoting healthy diets and physical activity: a European dimension for the prevention of overweight, obesity and chronic diseases" (COM(2005)637 final), 15 March 2006, p. 5.

47. Health and food, Special Eurobarometer, European Commission, November 2006, p. 52.

99. Moreover, governments should support local education services in the establishment of schemes to promote active transportation to school, including cycling and walking.

2.3.3.3. School-based medical follow-up

100. Even though studies show that eating is not always linked to hunger, that it may often cover other needs, wants and desires, food consumption and physical exercise are the main areas in which one can act. Needless to say, all measures require adequate medical follow-up. The introduction of appropriate paediatric routines and other medical follow-up in schools would facilitate the prevention of obesity and type 2 diabetes.

2.3.4. Community

101. Inclusion and participation of children and the young in the design of measures to prevent obesity and type 2 diabetes should be further supported through the child and youth policies in all Council of Europe member states. Full participation in society of children and young people, including those who are suffering from obesity/excess weight and type 2 diabetes, should become a priority for public policymaking.

102. Education to prevent obesity and type 2 diabetes needs, in the current environment, to be a life-long endeavour.[48] Local communities and local public authorities should promote and facilitate children and young people's access to sports facilities and public areas for physical activity. Such places should be safe for children and young people and contribute to their full inclusion in society. Moreover, public authorities should make access to sports facilities easier, in particular, for the poorer categories of population, since these are sometimes reserved for the high revenue population.

2.4. Promotion of a healthy environment

103. I am of the opinion that children's obesity clearly shows the strength of environmental influences and the failure of the traditional prevention strategies based only on health promotion. Modern societies are "obesogenic" environments: they lead to overconsumption of food and to widespread sedentary lifestyles, which increase the risk of obesity.

104. A health-enhancing environment that provides opportunities for physical activity and makes healthy food options readily available would contribute significantly to the reduction of childhood obesity. Policy makers need to explore mechanisms to impact upon the "drivers" that influence people's consumption and activity levels. Changes to the surrounding environment are of particular importance for children who are in less of a position to make individual lifestyle choices.

105. Local authorities therefore potentially have a major role to play in creating the environment and opportunities for physical activity, active living and a healthy diet, and they should be supported in their efforts to change the current situation.[49]

2.4.1. Built environment

106. As with the food environment, the built environment contributes significantly to the obesity epidemic and government policies and initiatives need to identify ways to support a health-promoting natural and built environment. These actions should include improved urban planning and transport systems to support active transportation such as walking and cycling and improved safety in urban areas to promote active transportation. These are particularly important measures for low-income areas which are less likely to support physical activity. The importance of green spaces for promoting physical activity should not be ignored.

107. With particular reference to children and young people, policy makers need to consider measures to improve the provision of sports and recreational facilities in schools and communities. Building sufficient physical activity into the school curriculum is one way to encourage physical activity, but informal and extracurricular activities should also be supported. Furthermore, encouraging active transportation to school via cycling/walking schemes should be supported.

48. "Optimal child growth and critical periods for the prevention of childhood obesity", presentation by Margherita Caroli, Dept. Prevention and Public Health, AUSL BR1, Brindisi (Italy), at Life Skills Workshop, 17 February 2006.
49. European Charter on counteracting obesity, WHO, 16 November 2006, EUR/06/5062700/8.

108. Member states should promote the implementation of the Committee of Ministers Recommendation CM/Rec(2009)8 on achieving full participation through Universal Design[50] and of the relevant articles of the United Nations Convention on the Rights of People with Disabilities, to ensure that the built environment is fully accessible to everyone, including children who are severely obese, to foster their participation in culture, sports and leisure activities.

2.4.2. Urban mobility

109. Transport policy has the potential to improve health by encouraging active travel for families, and the young in particular. Unfortunately, the urban environment is not always conducive to this choice, with fast-moving traffic, insufficient cycle lanes or pedestrian walkways, and air pollution discouraging people from choosing active transportation solutions, such as walking and cycling.[51]

110. I believe that governments should implement improvements to the urban environment, which work to "lock in" travel behaviour change, thereby making sustainable transport choices the more attractive, healthier, safer and smarter choice. Governments should also employ "soft measures" such as travel behaviour change programmes, which aim to work with people's perceptions, provide appropriate information, and overcome barriers to bring about a change in travel behaviour towards more sustainable, "smarter" choices. Redesigning residential neighbourhoods is a powerful way to facilitate a shift in mode choice.

111. Road-user charging can also play an important role in sustainable urban transport policy, by helping to change how and how much we travel and encourage greater use of public transport.

3. Treatment

3.1. Early intervention and management of obesity and type 2 diabetes

112. The role of the health system is extremely important when dealing with people at high risk and those already overweight and obese, by designing and promoting prevention measures and by providing diagnosis, screening and treatment.[52]

113. It is absolutely clear that children should not be subject to heavy medication or surgical practices, such as the introduction of gastric circles or bypass surgery. Such practices may be life-threatening for a child. It is therefore essential to prevent obesity, ensuring that a child or young person does not reach a stage where there is a need for such extreme measures to be applied. Early intervention and management of obesity and type 2 diabetes are, indeed, crucial.

114. I strongly support the WHO stand on the role of health-care services in the prevention and treatment of obesity, as highlighted in the Global Strategy on Diet, Physical Activity and Health and the recent report on population-based prevention strategies for childhood obesity.[53]

115. Routine contacts with health-service staff should include practical advice to patients and families on the benefits of a healthy diet and increased level of physical activity, combined with support to help patients initiate and maintain healthy behaviour. Governments should consider incentives to encourage such preventive services and identify opportunities for prevention within existing clinical services, including an improved financing structure to encourage and enable health professionals to dedicate more time to prevention.

116. Health-care providers, especially for primary health care, but also other services (such as social services) can play an important role. Routine enquiries as to key dietary habits and physical activity, combined with imparting simple information and encouraging skill building to change behaviour, taking a life-course

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50. Universal Design is a strategy which aims to make the design and composition of different environments, products, communication, information technology and services accessible and understandable to, as well as usable by, everyone, to the greatest extent in the most independent and natural manner possible, preferably without the need for adaptation or specialised solutions. See also the report on "Achieving full participation through Universal Design".

51. A number of countries report on the domestic actions to promote cycling, such as for instance the Czech Republic Government Resolution of 7 July 2004 on the National Strategy of the Development of the Cycling Transport in the Czech Republic (The National Cycling Strategy).

52. European Charter on counteracting obesity, WHO, 16 November 2006, EUR/06/5062700/8.

53. Population-based prevention strategies for childhood obesity, report of the WHO Forum and Technical meeting, WHO, 2009.

approach, can reach a large part of the population and be cost effective. Training of health professionals, dissemination of appropriate guidelines, and availability of incentives are key underlying factors in implementing these courses of action.[54]

3.2. Rehabilitation of children and the young with obesity and type 2 diabetes

117. The design of rehabilitation programmes should take into account children's needs and interests. It is important to ensure that children enjoy what they are doing. More often than not, such programmes do not take into account this factor. Participation of children in the design of such programmes is therefore a substantial success factor.

118. Some countries report on the rehabilitation practices by which children are taken to rehabilitation clinics where they can learn how to cook and how to change their lifestyle. Unfortunately, once the children come back home, the old habits often re-emerge. Appropriate support and follow-up at home is thus crucial for treatment to succeed.

3.3. Strengthening member states' capacity to research and find solutions

119. Specific action must be taken in order to strengthen member states' capacity to research and find solutions, including a substantial improvement in data collection and analysis. I found that a staggering 16 out of 28 countries who answered the questionnaire do not gather any statistics on the number of children with type 2 diabetes, for instance.

120. Member states should thus set up mechanisms enabling them to collect data on children with type 2 diabetes. Countries where such mechanisms exist should be invited to share their experience and give advice on how to overcome obstacles. Countries encountering difficulties in gathering the data should be able to get assistance and advice. The specialised international organisations should provide adequate support to research initiatives aimed at reversing the development of the obesity and type 2 diabetes epidemics.

4. Conclusions and recommendations

121. The Assembly should recommend that member states take a number of measures as outlined in the draft resolution and draft recommendation in order to promote healthy nutritional habits, a healthy lifestyle and a healthy environment, with a view to safeguarding our children from obesity and type 2 diabetes.

54. Global Strategy on diet, physical activity and health, WHO, item 45, p. 9.

Appendix – Questionnaire on the prevention of obesity and type 2 diabetes and promotion of healthy nutritional habits among children and the young

Questions posed to member states:

1. How is the nutritional information of food in your country labelled?

2. Do you think food labelling could be clearer in such a way as to aid consumers in understanding whether the choices they make are healthy and nutritious (for example, Guideline Daily Amounts (GDA) or traffic light systems)?

3. What is your country's position on synthetic trans fats? Are you in talks with food companies to try and abolish these?

4. How many (and what percentage of) young people[55] in your country are obese or overweight?

5. How many (and what percentage of) young people in your country have type 2 diabetes?

6. Has your country experienced a rise in type 2 diabetes in children over the last ten years and, if so, is the increase in childhood obesity recognised as a serious contributing factor? Do you have any statistical evidence which demonstrates this?

7. What visible action is your government taking to try and keep childhood obesity under control? Is there any evidence of improvements due to government schemes?

8. What advertising regulations on unhealthy food and drink are there in your country? For example, has any television advertising been banned when children's programmes are being shown?

9. What is your country's stance on breastfeeding? If it is actively encouraged, is that because it is recognised to have a beneficial effect on the weight of children in later life?

10. Does any organisation in your country collect and record information on the height and weight of school-age children? If this information is given to parents, does it/do you think it would, have a positive effect on obesity levels?

11. Do you think shock tactics in general (such as putting pictures of cancerous lungs on cigarette packets to put people off smoking) are most effective in preventing obesity, or do you think softer measures are more appropriate with this sensitive issue?

12. What is being done in your country to educate people about type 2 diabetes and possible preventative measures?

13. In your country, are school meals under regulation and, if so, has there been success in trying to make these meals healthier and more nutritious for children?

14. On average, how many hours of compulsory physical activity do children participate in at school each week?

15. How much funding is given to the promotion of sport in schools by the government?

55. Those up to the age of 18.