

French
National
Nutrition
and Health
Program
2011
2015



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Introduction

In this early part of the 21st century, improving the nutritional status of the population constitutes a major challenge for public health policies in France, Europe, and around the world. Good nutrition contributes to protecting health. Advances in research have made clear that an inadequate nutritional intake and insufficient physical activity play a determining role in the onset of many cancers and cardiovascular diseases, which represent more than 55% of the 550,000 deaths occurring each year in France. Nutritional factors can also put people at risk of or protect against diabetes, obesity, osteoporosis and various deficiencies.

The French National Nutrition and Health Program (PNNS) was initiated in 2001 and extended in 2006. It has provided a frame of reference and produced many incentive tools and mechanisms to support actions. It has mobilised ministries; local elected officials, health professionals, people working in sports, fitness and education, social workers, the business community and volunteers. Several of the initial objectives have been achieved, either in part or in full. These include reducing the prevalence of overweight and obesity among children, reducing the consumption of sugar and salt, and encouraging adults to eat more fruit. However, these improvements were not achieved consistently across all population groups and health inequalities between social classes have increased in the area of nutrition¹. The report submitted by France's General Inspectorate of Social Affairs (IGAS) and the General Council of Agriculture, Food and Rural Areas² (CGAAER) emphasised that renewing the PNNS in its current format "*was not advisable, given the difficulties identified between its role as frame of reference and its responsibilities in terms of operational performance, but also within its governance system and in the coordination between this program and the other plans, programs and sectoral policies.*"

The French President wanted an official Obesity Plan (PO) for France, to deal with the growing number of severely affected subjects. In 2010³, the French Parliament instituted a five-year government program relating to nutrition and health (Public Health Code, article L. 3231-1) and a government strategy regarding food (article L. 230-1 of the Rural Code).

The PNNS deals with nutrition as a determining factor in health. The Obesity Plan (PO) ties in with the PNNS and completes it through the organisation of obesity detection, patient treatment and care, and a significant research component. The PNNS and the PO are presented together.

French Food Strategy (PNA) was launched in September 2010⁴. Article L. 230-1 of the French Rural Code stipulates that the national food strategy sets out the actions that must be implemented to ensure:

- food security, or ensuring that everyone, and in particular the most destitute population groups, has access to suitable foods in adequate quantities;
- the safety of agricultural products and foods;
- the health of animals and plants that are likely to be eaten by people or animals;
- education and information about taste, varied and balanced diets, the specific needs of certain population groups, hygiene rules, knowledge of products and their seasonal availability, the origins of agricultural raw materials and production methods and the impact of agricultural activities on the environment;
- that marketing claims are truthful and there are rules for informing consumers;
- that agricultural products and the food supply taste good and are of good nutritional quality;
- that the production and distribution methods used for food and agricultural products respect the environment and limit waste;

1 - See key figures in appendix

2 - JOURDAIN MENNINGER Danièle, LECOQ Gilles, GUEDJ Jérôme, BOUTET Pierre, DANIEL Jean-Baptiste, MATHIEU Gérard ; Inspection générale des affaires sociales; Conseil général de l'alimentation, de l'agriculture et des espaces ruraux : Evaluation du programme national nutrition santé PNNS2 2006-2010, mai 2010 [General Inspectorate of Social Affairs (IGAS) and the National Council for Food, Agriculture, and Rural Affairs (CGAAER): Evaluation of the National Nutrition and Health Program PNNS2 2006-2010, May 2010]

3 - Through law n°2012-874 dated 27th, July 2010 on the modernisation of agriculture and fishing.

4 - <http://www.alimentation.gouv.fr>

- that local products and traditions are preserved and promoted;
- that local food systems are developed and geographical proximity between food producers and processors is encouraged;
- that institutional and corporate caterers use local agricultural products;
- that French food and France’s culinary heritage are preserved, through measures that include the creation of a national culinary heritage register.

“That the actions implemented to educate and inform people about how to achieve a balanced and varied diet and about the nutritional quality of the food supply follow the recommendations set out in the French national nutrition and health program, defined in article L. 3231-1 of the French public health code.”

The measures that are included in the PNA to promote healthy eating are part of the nutritional prevention strategy of the PNNS. To this end, they mobilise the various stakeholders (producers, manufacturers, retailers, restaurant owners, associations and organisations) working in the food industry. Because general practitioners are in direct contact with each family, they have a very specific role to play in nutritional prevention that is adapted to each person’s lifestyle, as well as in detecting and managing nutrition-related conditions, including overweight and obesity.

Since the PNNS also involves the ministries in charge of national education, sports, consumer affairs, social cohesion, and higher education and research, there is a strong interministerial aspect to the program.

Moreover, a specific version of the actions included in the PNNS and PO will be established for the French overseas departments.

The following document includes:

- “The nutrition objectives set in 2010 by the French High Council for Public Health (HCSP)”;
- “The measures planned in the PNNS to achieve the target figures set by the HCSP, and its main actions broken down into four focus areas and a transversal component.”

Issues, principles, methodology and objectives of the PNNS

To improve the health of the entire French population by taking action on one of its major determining factors, nutrition.

The nutritional public health objectives set by the French High Council for Public Health (HCSP)

The HCSP's responsibilities include "contributing to defining public health objectives over several years, evaluating how well the national public health objectives are achieved, and contributing to their monitoring on a yearly basis." In its April 2010 report entitled "Objectifs de santé publique : évaluation des objectifs de la loi du 9 août 2004. Propositions"⁵ (Public health objectives: an evaluation of the objectives of the law dated 9th August 2004. Proposals), the HCSP defined objectives aimed at guiding and evaluating the nutrition policy, in terms of improving the health of the population and reducing its exposure to various risks. The issue of health inequalities between social classes is present in all of the themes covered in the public health policy and, consequently, it received special attention. These nutritional objectives form the structure of the strategic orientations and are used as a basis for defining the actions planned as part of the French National Nutrition and Health Program (PNNS) and the Obesity Plan (PO). Within the field of nutrition, these quantified objectives have been grouped into four focus areas. Other objectives relating to levels of exposure that have consequences on an individual's nutritional status (alcohol consumption) or to health problems where nutrition plays a determining role (hypertension, dyslipidemia, etc.) have also been defined.

1 – Reduce obesity and overweight among the population

- Stabilise the prevalence of obesity and reduce overweight in adults
- Reduce the prevalence of obesity and overweight among children and adolescents

2 – Increase physical activity and decrease sedentary behaviour in all age groups

- Increase physical activity among adults
- Increase physical activity and combat sedentary behaviour among children and adolescents

3 – Improve eating habits and nutritional intake, especially among high-risk population groups

- Increase fruit and vegetable consumption
- Reduce salt intake
- Increase calcium intake among high-risk groups
- Fight against iron deficiency in women living in poverty
- Improve the folate status of women of childbearing age
- Promote breastfeeding

4 – Reduce the prevalence of nutrition-related health conditions

- Undernutrition, eating disorders

The detailed and quantified nutritional health objectives set by the French High Council for Public Health (HCSP) are outlined below within their corresponding focus area.

5 - <http://www.hcsp.fr/docspdf/avisrapports/hcspr20100317ObjectifsSP.pdf> (pages 114 to 131)

Steering of the PNNS and PO

To achieve the set objectives, the PNNS and PO harness the skills and resources of other sectors, plans and programs that are implemented and managed by several French ministries. These include the Ministry of Food (National Food Strategy – PNA), but also the Ministry of Education (Health Education Program 2011-2015), the Ministry of Consumer Affairs, the Ministry of Sports, the Ministry of Social Cohesion, and the Ministry of Higher Education and Research. An inter-ministerial support committee under the aegis of the Ministry of Health coordinates the PNNS and PO to provide the global management that is necessary for ensuring that the actions undertaken to achieve the set objectives are coherent and efficient.

The programs tie in with the other public health programs implemented by the Ministry of Health, such as the Cancer Plan; the plan to improve the living conditions of people suffering from chronic illnesses; the healthy youth plan; and the national health and environment action plan (PNSE).

Implementation of the PNNS and PO is monitored by the programs' respective presidents with the support of a committee composed of the ministries, agencies and organisations that contribute to the PNNS, as well as civil society and experts from the scientific field. A status report covering the implementation and orientation of the planned actions is established on a regular basis, along with how the various plans associated with the PNNS tie in together. A progress report covering the actions that fall under the responsibility of the various ministries, agencies and organisations is presented before this committee on a regular basis.

At the national level, the PNNS:

- Ensures the coordination and coherence of interventions and monitors their implementation;
- Provides the scientific material necessary for implementing the actions;
- Proposes ways to encourage involvement from the numerous institutional and private stakeholders and associations whose actions contribute to achieving the set objectives;
- Guides and supports the actions of all involved parties.

At the regional level:

- The regional health agencies ("ARS or Agence Régionale de Santé" in French), implement the public health initiatives developed within the framework of the PNNS, in conjunction with all concerned parties. To this end, they also implement the actions that contribute to reducing nutrition-related health inequalities between social classes.
- Based on the skills of the ARS, the regional prefect coordinates the actions of the local government departments that contribute to implementing the PNNS. Part of the prefect's responsibilities is to ensure that the actions conducted within the Regional Committee for Food (CRALIM) are consistent with the regional version of the PNNS.

The PNNS 2011-2015: elaborated through extensive cooperation and dialogue

The PNNS 2011-2015 was elaborated based on the experience acquired by the numerous professionals and organisations that are partners in the PNNS. For the last 10 years, these partners have contributed to developing the nutritional policy and have implemented programs and actions within this area, thereby contributing to the improvements observed within the population over the last few years.

Headed by Professor Dominique Turck, the committee in charge of elaborating the PNNS 2011-2015 was made up of representatives of the ministries involved in the nutritional policy, health agencies, the president of the PNNS (Professor Serge Hercberg), and the president of the PO (Professor Arnaud Basdevant). The committee met on four occasions between July and November 2010, to analyse all of the suggestions that emerged from a very large consultation process organised between June and November 2010. From this process, the orientations, objectives and major actions selected for the PNNS 2011-2015 emerged.

The following were consulted as part of this process:

- the PNNS2 Steering Committee, during the July, September and October 2010 sessions. It put forward proposals from the various organisations and experts participating in the committee;
- the French Society of Public Health (SFSP) which, through its website and at the request of the French Department of Health (DGS), asked professionals and individuals in the field to make suggestions based on their own experience. A summary of this consultation has been produced;
- the SFSP coordinated a think tank of 31 learned societies that gather experts in the numerous disciplines involved in the field of nutrition⁶. This work, which was formalised during a two-day conference in September 2010, resulted in a report containing proposals backed by scientific arguments (<http://www.sfsp.fr/publications/file/RapportfinalpropositionsPNNS5-11-010.pdf>);
- the health agencies and the French National Research Agency (ANR), the French network of WHO Healthy Cities and Eco-Mayors;
- the national old age pension fund, the national family benefits fund, and the national solidarity fund for autonomy;
- the managers of public health plans with a nutrition component;
- the National Health Conference, before which the project was presented in November 2010.

6 - (*For English translations, please refer to the glossary appended to this document) 1. Association des Chercheurs en Activités Physiques et Sportives (ACAPS), 2. Association des Educateurs Médico-Sportifs (ADEMS), 3. ANCREC – Coordination des réseaux diabète, 4. Association des Epidémiologistes de Terrain (EPITER), 5. Association des Médecins Inspecteurs de Santé Publique (AMISP), 6. Association Française d'Etudes et de Recherches sur l'Obésité (AFERO), 7. Association Française de Pédiatrie Ambulatoire (AFPA), 8. Association Française des Diététiciens Nutritionnistes (AFDN), 9. Association Française des Epidémiologistes de Langue Française (ADELF), 10. Association Francophone en Activités Physiques Adaptées (AFAPA), 11. Association Francophone pour la Recherche sur les Activités Physiques et Sportives (AFRAPS), 12. Association Nationale de Prévention en Alcoologie et Addictologie (ANPAA), 13. Association pour la Prévention et la prise en charge de l'Obésité en Pédiatrie (APOP), 14. Collège des Enseignants de Nutrition (CEN), 15. Collège National des Cardiologues Français (CNCF), 16. Collège Universitaire des Enseignants en Santé Publique (CUESP), 17. Coordination nationale des Réseaux de prévention et prise en charge de l'obésité pédiatrique (CNRéPPOP), 18. Fédération Française de Cardiologie (FFC), 19. Fédération Nationale des comités d'Education pour la Santé (FNES), 20. Ligue nationale de lutte contre le cancer, 21. Nouvelle Société Française d'Athérosclérose (NSFA), 22. Société Française de Cardiologie (SFC), 23. Société Française de Gériatrie et de Gérontologie (SFGG), 24. Société Française de Nutrition (SFN), 25. Société Française de Pédiatrie (SFP), 26. Société Française de Santé Publique (SFSP), 27. Société Française des Professionnels en Activités Physiques Adaptées (SFP-APA), 28. Société Française de Recherche et de Médecine du Sommeil (SFRMS), 29. Société Française Sport et Santé (SF2S), 30. Société Francophone du Diabète (SFD), 31. Société Francophone Nutrition Clinique et Métabolisme (SFNEP).

During a symposium held in Paris on 15th November 2010 and gathering 400 professionals, the major orientations derived from this consultation process were presented, based on 6 main themes (Communication, information, education (strategies and tools); Improvement of the food supply and the physical environment; Territorialisation, mutualisation, local authorities; Detection, treatment and care, health and medico-social establishments (obesity and undernutrition); Monitoring, evaluation, research; Training of professionals). Other suggestions were also gathered during the symposium and in the days following.

The suggestions that emerged from this process were then assessed by the government authorities, and the focus areas, measures and actions for the PNNS 2011-2015 were decided upon. These are presented hereafter.

The general principles of the PNNS

1. The word "nutrition" must be understood as encompassing all matters relating to food (nutrients; foods; social, cultural, economic, sensory and cognitive factors that determine eating behaviours) and physical activity.
2. The PNNS takes into account the biological, symbolic and social aspects of eating and physical activity.
3. The orientations developed and the messages promoted as part of the PNNS are based on scientific expertise organised by the government authorities.
4. The purpose of the actions implemented by the PNNS is to promote eating and lifestyle habits that protect health and reduce exposure to the risk factors associated with chronic diseases. All of these actions and initiatives were designed and developed to take into account the issue of health inequalities between social classes.
5. The PNNS places great importance on ensuring that the various measures, actions and regulations are coherent, complementary and synergistic in order to achieve the set objectives. Incentive measures that are adapted to the different types of stakeholders are valued. Regulatory measures may be implemented if necessary, in order to overcome nutrition-related health inequalities between social classes effectively.
6. The strategies and actions that are set up and coordinated as part of the action plans developed by the government authorities and which have an impact on the nutritional status of the population must be coherent and free of contradictions, whether these are explicit or caused by omissions.
7. The dietary recommendations included in the PNNS aim to promote physical activity and eating habits that are conducive to an optimal nutritional and health status. The messages in the PNNS do not forbid the consumption of any type of food or drink available on the market. To achieve better health, the nutritional recommendations promote certain categories of food and drink and recommend limiting the consumption of other categories.
8. Living conditions, but also the food and physical environment are factors that have a strong influence on behaviours. The PNNS must contribute to creating a global nutritional environment that facilitates positive choices for the health of consumers.
9. The PNNS promotes and organises dialogue with the program partners at the national, regional and local levels.
10. When the PNNS logo appears on documents, tools, promotional materials or action descriptions, in accordance with the regulations, this serves as a guarantee of their validity with regards to the PNNS objectives.
11. Stigmatising people based on their eating habits or a particular nutritional status is forbidden by the PNNS.
12. The PNNS includes a regular assessment of its target figures and, wherever possible, the actions or measures it implements (effectiveness indicators or process evaluation).

Strategic levers

The PNNS actions that allow attainment of the objectives set by the HCSP are defined within two themes (food and physical activity) according to five strategic levers:

- Information, communication and education to provide everyone with guidance regarding eating habits and physical activity;
- Improvement of the food and physical environment to facilitate the adoption of habits that are beneficial to everyone's health;
- Organisation of the system for detecting and managing nutritional disorders;
- Training of professionals whose work influences people's eating habits and physical activity;
- Monitoring and evaluation to ensure operational management of the program.

STRATEGIC FOCUS OF THE PROGRAM

FOCUS AREA 1 – Reduce nutrition-related health inequalities between social classes through specific actions within general preventive measures

The measures included in this focus area are aimed at achieving the objectives set by French High Council for Public Health (HCSP) in April 2010 with regards to nutrition and to cardiovascular and metabolic diseases. **These are outlined below, where SO stands for “specific objective”.**

NUTRITIONAL OBJECTIVES

General objective 3 – Improve eating habits and nutritional intake, especially among high-risk population groups

- **General sub-objective 3-1: increase fruit and vegetable consumption**

SO 3-1-1: within 5 years, increase the fruit and vegetable consumption of the general adult population, so that:

- at least 70% of adults eat at least 3.5 servings of fruit and vegetables per day;
- at least 50% of adults eat at least 5 servings of fruit and vegetables per day.

SO 3-1-2: within 5 years, increase the fruit and vegetable consumption of adults living in poverty, so that:

- the number of adults declaring that they eat fruit and vegetables at least 3 times a day is doubled;
- the number of adults declaring that they eat fruit and vegetables at least 5 times a day is increased fivefold.

SO 3-1-3: within 5 years, increase the fruit and vegetable consumption of children and adolescents aged 3 to 17, so that:

- at least 50% eat at least 3.5 servings of fruit and vegetables per day;
- at least 25% eat at least 5 servings of fruit and vegetables per day.

- **General sub-objective 3-2: reduce salt intake**

SO 3-2-1: within 5 years, reduce the average salt intake of the population to:

- 8 g/day for adult men;
- 6.5 g/day for adult women and children.

- **General sub-objective 3-3: improve the macronutrient ratios in non-alcoholic energy intake**

SO 3-3-1: within 5 years, reduce the average contribution of total fats to the non-alcoholic energy intake of adults and children to 36.5%

SO 3-3-2: within 5 years, reduce the average ratio of saturated fatty acids in total fat intake to:

- 36% for adults; - 37% for children.

SO 3-3-3: in both adults and children, increase the ratio of complex carbohydrate and fibre intake and reduce the ratio of simple carbohydrates from sugary foods in the total energy intake

SO 3-3-3-1: within 5 years, increase the proportion of people with complex carbohydrate intakes \geq 27.5% of the total non-alcoholic energy intake:

- by 20% for adults; - by 35% for children

SO 3-3-3-2: within 5 years, increase the proportion of people with a simple carbohydrate intake from sugary foods $<$ 12.5% of the total non-alcoholic energy intake:

- by 7% for adults; -by 20% for children.

SO 3-3-3-3: double the proportion of adults with a fibre intake $>$ 25 g/day

SO 3-3-3-4: within 5 years, reduce by at least 25% the proportion of children drinking more than half a glass of sugar-sweetened beverages per day

- **General sub-objective 3-4: increase calcium intake in high-risk groups**

SO 3-4-1: reduce by at least 10% the proportion of young women, adolescents and elderly people with a calcium intake from food that is below the EAR (Estimated Average Requirement)

- **General sub-objective 3-5: fight against iron deficiency in women living in poverty**

SO 3-5-1: within 5 years, reduce by a third the incidence of iron deficiency anaemia among women of childbearing age (15 to 49 years old) who are living in poverty

- **General sub-objective 3-6: improve the folate status of women of childbearing age**

SO 3-6-1: within 5 years, reduce by at least 30% the proportion of women of childbearing age (15 to 49 years old) at risk of folate deficiency (plasma folate levels < 3 ng/mL)

SO 3-6-2: within 5 years, reduce by at least 20% the proportion of women with folate levels below the EAR

SO 3-6-3: within 5 years, increase by at least 50% the number of units of folic acid tablets (0.4 mg) prescribed for a planned pregnancy

- **General sub-objective 3-7: promote breastfeeding**

SO 3-7-1: within 5 years, increase by at least 15% the percentage of children breastfed from birth

SO 3-7-2: within 5 years, increase by at least 25% the proportion of children that are breastfed exclusively from birth

SO 3-7-3: within 5 years, extend the median duration of breastfeeding by 2 weeks

SO 3-7-4: within 5 years, postpone the median age for introducing foods other than milk (whether mother's milk or formula) by one month

General objective 1 – Reduce obesity and overweight among the population

- **General sub-objective 1-1: stabilise the prevalence of obesity and reduce overweight among adults**

SO 1-1-1: within 5 years, stabilise the prevalence of obesity among adults

SO 1-1-2: within 5 years, reduce by at least 10% the prevalence of overweight among adults

SO 1-1-3: within 5 years, stabilise the prevalence of obesity among women living in poverty

SO 1-1-4: within 5 years, reduce by at least 15% the prevalence of morbid obesity

- **General sub-objective 1-2: reduce the prevalence of obesity and overweight among children and adolescents**

SO 1-2-1: within 5 years, reduce by an average of 15% the overall prevalence of overweight and obesity among children and adolescents aged 3 to 17

SO 1.2.2: within 5 years, reduce by an average of 15% the prevalence of overweight and obesity among children and adolescents aged 3 to 17 from disadvantaged homes

OBJECTIVES RELATING TO CARDIOVASCULAR AND METABOLIC DISEASES

General objective 2 – Reduce hypercholesterolemia and arterial hypertension

SO 2-1: within 5 years, reduce by 5% average cholesterolemia (LDL-cholesterol) among the adult population

SO 2-2: within 5 years, increase the proportion of hypercholesterolemia sufferers who are treated and stabilised

SO 2-3: within 5 years, increase the proportion of patients with high blood pressure who are treated and stabilised

Since the PNNS was introduced in 2001, numerous preventive actions have been developed to avoid the appearance of risk factors or health conditions caused by an inadequate diet. By drawing on the principles of health promotion, these actions aim to create a synergy between:

- initiatives aimed at giving individuals the means to make informed choices with regards to food and physical activity, through the design, dissemination and implementation of campaigns, tools and programs that inform and educate people about nutrition (based on the PNNS definition of nutrition);
- initiatives aimed at making the environment more conducive to exercising the right choices when it comes to food and physical activity.

This approach is consistent with that outlined in the National Food Strategy (PNA).

Article L 1411-1 of the French Public Health Code stipulates that the public health policy must aim to “reduce health inequalities through health promotion, and through developing access to health care and diagnosis throughout the country.”

The HCSP report dated April 2010 mentions: “health inequalities between social classes have tended to increase” and “result in a 7-year difference between the life expectancy of 35-year old blue collar workers and that of white collar workers of the same age, even though both of these categories are employed, housed and socially integrated.” These inequalities are “systematic, socially constructed and therefore unfair and modifiable.”

There has been no decrease in nutrition-related health inequalities between social classes since 2001 when the PNNS was first introduced. On the extreme end of the scale, there are people in situations of poverty who receive food aid. Their situation is in itself different depending on whether the aid is recent, long-standing, permanent, or temporary. People who are in a difficult socioeconomic situation without being in a situation that leads them to requesting food aid, reveal a nutritional status that is less satisfactory than that of people with a higher socio-economic level.

Eating habits and behaviour with regards to physical activity are socially determined, and not only “individual”. Initiatives to reduce nutrition-related health inequalities between social classes should therefore target both proximal causes (individual behaviour) and fundamental causes (the context surrounding the behaviour).

Measure 1. Take specific actions to reduce nutrition-related health inequalities between social classes

Nutrition-related health inequalities between social classes mainly stem from differences in income. However, other factors play a determining role in these inequalities: the marital status (separated, single parent family, etc.), employment status (job insecurity, unemployment, forced part-time work, student, young worker), level of education, cultural origins, migration status, immediate environment of an individual, and the isolation of certain elderly people are all factors and constraints that must be considered in order to identify the various population groups in the gradient of social inequalities and propose suitable actions.

Reducing nutrition-related health inequalities between social classes is part of the general aims of the interventions included in the PNNS. This objective also requires specific actions. The difficulties and constraints which the different socio-economic groups must face vary from one group to another. As a consequence, local community actions must be adapted specifically to the various contexts. Inequalities can be reduced by encouraging people to purchase foods that are of benefit to their health, improving access to such foods and facilitating their choice, as well as informing the public about which foods to eat in limited quantities in order to protect their health. The same applies to the physical activity aspect of nutrition. These actions must be developed by taking into account the findings and propositions that have emerged from the various studies conducted on this subject⁷ as well as the elements mentioned in the report released by the French General Inspectorate of Social Affairs (IGAS) and the General Council of Agriculture, Food and Rural Areas (CGAER) in April 2010⁸.

Numerous institutional and professional organisations work directly to limit health inequalities between social classes: community groups (community social action centres – known as CCAS, urban health workshops known in French as ASV or ateliers santé-ville, leisure centres without accommodation, etc.), the regional council (mother and infant protection service known as PMI), social workers, associations (sports clubs, food aid, etc.). These must be identified so that action can be coordinated in order to be consistent.

ACTIONS

1. First: identify the inequalities and mobilise the stakeholders by:

(1.1) Completing the available data and analyses regarding health inequalities between social classes, by finalising the collective assessment of the specific issue of nutrition-related health inequalities between social classes, entrusted to the French Institute of Health and Medical Research (INSERM) and initiated in 2010.

2. Develop specific education and information actions by:

(2.1) Raising awareness of the nutritional health issue among social workers (employees of the family benefit and old-age pension funds), by providing them with relevant documents (information sheets, brochures) to broach the subject when speaking with benefit recipients;

(2.2) Designing and disseminating nutrition messages and tools in a format that is suitable for the various audiences affected by nutrition-related health inequalities between social classes (TV, free newspapers).

3. Specifically encourage the accessibility of foods of good nutritional quality with the aim of reducing health inequalities between social classes, by:

(3.1) Continuing the analyses aimed at improving the way consumers are informed about healthy eating, in order to make their choices easier;

(3.2) Continuing to analyse the impact of variations in food prices, taking into account the impact on individual health (in terms of nutritional quality), the environment, society, the economy;

7 - See for instance the special report in issue n° 73 of ADSP, the HCSP's quarterly publication, entitled Les inégalités sociales de santé [Health inequalities between social classes]. Published by La Documentation française, December 2010
8 - <http://lesrapports.ladocumentationfrancaise.fr/BRP/104000214/0000.pdf>

(3.3) Evaluating how public funds and food consumption (fruit, vegetables, fish, dairy products, etc.) are impacted by various welfare organisations providing food vouchers to households experiencing financial hardship.

4. Train local community stakeholders in nutrition by:

(4.1) Having the French Association of Nutritionist-Dieticians (AFDN) provide a training module to the organisations responsible for training social workers;

(4.2) Encouraging staff members of local authorities to go through training in conjunction with the National Centre of Territorial Civil Service (CNFPT).

5. Increase the amount of human, material and financial resources available by:

(5.1) Making suitable PNNS logo-bearing tools available to the teams working among the target populations;

(5.2) Encouraging access to resource persons as part of civic service.

Measure 2. Extend the nutritional prevention strategy to the food industry

Improving the environment with the aim of making healthy eating choices accessible to all is a fundamental public health strategy that is an essential complement to communication, information and nutritional education campaigns.

Since 2007, businesses in the food industry have the possibility of voluntarily signing a charter for nutritional progress with the French government, on the basis of an application presented to an ad hoc committee and evaluated using a standard frame of reference.

By late May 2011, 26 of the 42 applications submitted were accepted. This strategy demonstrated its feasibility and its impact on improving the nutritional quality of the products in question that were released on the market and on the terms governing their sale. Several sectors of the food industry, including major companies, SMEs and joint trade associations, approved applications. This innovative procedure is being carefully analysed on an international level.

There remains a gap, however, between dietary intake consumed by the population and the recommendations set by the PNNS, as well as the public health objectives, particularly where salt is concerned. The conclusions of the European Council on 8th June 2010 "ask the Member States to take or reinforce measures to reduce salt intake in order to improve the health of the population."

For this "preventive" measure, the PNNS will rely in particular on the PNA actions whose objectives are:

- To make good quality food accessible to all (Focus Area I);
- To improve the food supply (Focus Area II);
- and on complementary actions.

ACTIONS

6. Make good quality food accessible to all (Focus Area 1 of the PNA)

I.1 Improve the eating habits of people experiencing financial hardship

I.1.1 Increase quantities and encourage a more balanced diet

I.1.1.1 by mobilising more donations and unsold food items for food aid

i.1.1.2 by reorganising food aid

i.1.1.3 by supporting food aid distribution with social actions

i.1.1.4 by ensuring fair distribution of food aid across the entire country throughout the year

i.1.1.5 by removing the obstacles that prevent associations from properly distributing food

I.1.2 Encourage initiatives that link measures stopping food waste and measures helping the destitute

I.2 Adopt good eating habits in schools and extracurricular facilities

I.2.1 Make the distribution of fruit widespread in schools, in addition to the fruit served at the canteen

I.2.2 Make school canteen meals balanced and enjoyable for young people

i.1.2.2.1 by compelling school canteens to follow the rules of good nutrition

i.1.2.2.2 by developing the "plaisir et cantine" (enjoyment and canteen) campaign in secondary schools

i.1.2.2.3 by encouraging students to learn good eating habits and facilitate their discovery of unprocessed food products at social prices

i.1.2.2.4 by developing nutritional education in universities

i.1.2.2.5 by providing guidance and **special training courses** to managers of school catering services

I.3 Ensure better eating in health and medico-social establishments

I.3.1 Improve patient comfort

I.3.1.1 by improving the well-being of weakened elderly people through **a range of approved foods** that are adapted to their needs and combine nutrition and enjoyment

i.3.1.2 by encouraging health and medico-social establishments to make **practical improvements to their menus and the conditions in which meals are taken**

i.3.1.3 by evaluating the “**baskets of fresh fruit and vegetables in hospitals**” programme

I.3.2 Provide families with guidance and advice to help maintain the convivial aspect of meal times when a child has a disease requiring him or her to be monitored and **to follow a specific diet outside of the healthcare establishment**

I.4 Improve the diet of elderly people

I.4.1 Adapt the diet of elderly people to take into account new requirements

i.4.1.1 by improving compliance with the **rules of good nutrition** in nursing homes and care facilities

I.4.2 Help the elderly to remain independent for as long time as possible

i.4.2.1 by improving **meal delivery services to their homes**

i.4.2.2 by enabling elderly people in remote areas to receive “**farmers’ market baskets**”

i.4.2.3 by increasing available information regarding nutrition for people over 55

I.5 Improve the food supply in prisons and detention centres and encourage reintegration through food

I.5.1 Encourage the **cooks of the various establishments to share their practices** with one another to improve the catering service

I.5.2 Use food as a means to support **professional reintegration** by developing training courses in food-related professions

I.5.3 Provide youths under judicial protection with guidance and training in trades relating to the fields of agriculture and the environment, the agri-food industry, food and forest industries, and rural services, in accordance with the framework agreement established in May 2009 between the French Ministry of Justice’s Department for the Judicial Protection of Minors (DPJJ) and its Department of Prison Administration (DAP), and the Teaching and Research Department (DGER) of the Ministry of Agriculture, Food, Fisheries, Rural Affairs and Town and Country Planning

7. Improve the food supply (Focus Area II of the PNA)

II.1 Encourage the widespread implementation of voluntary initiatives and public/private partnerships that enable innovations to improve the quality of ingredients

II.1.1 Set up a food observatory to improve the monitoring of food quality

II.1.2 Incite professionals from the industry in question to formulate suggestions for improving the quality of their products via collective quality standards agreements

II.1.3 In order to facilitate these changes, encourage innovation in the fields of agricultural production, fishing and food, in particular where SMEs (small and medium enterprises) are concerned

II.1.4 Improve access to basic products

II.1.5 Improve or maintain the organoleptic aspect of the food supply

II.1.6 Reduce salt intake via the food supply

II.1.7 Evaluate opportunities for developing and enhancing the agricultural production methods that can improve the nutritional quality of food products

II.1.8 Create a strategic committee of players in the food processing industry

II.2 Develop fruit and vegetable varieties with high environmental, nutritional and organoleptic value

II.2.1 Modify the selection criteria for new varieties so that they include environmental, nutritional and organoleptic value

II.2.2 Improve information about varieties available commercially

II.3 Bring producers and consumers closer together

II.3.1 Develop short/local distribution channels for agricultural produce and fish and seafood

II.3.2 Make it easier for consumers in public institutional catering facilities to have access to food products from those channels

II.4 Improve the safety of the foods that are made available to consumers

II.4.1 Impose food hygiene training for all professionals in the catering industry

II.4.2 Help small businesses and on-farm food processors to incorporate food safety into the management of their business

COMPLEMENTARY ACTIONS

Actions that are complementary to those of the PNA outlined above are proposed to achieve the 3rd nutritional objective of the HCSP detailed above: "Improve eating habits and nutritional intake, especially among high-risk population groups."

8. Develop and promote voluntary charters of commitment to nutritional progress for a food supply that adheres to the PNNS objectives, by:

(8.1) Developing the standard frame of reference for the individual voluntary charters of commitment to nutritional progress; promoting the charters among relevant players among the business community, the media, professional intermediaries, the general public; and developing a framework that allows signatories to advertise their commitment;

(8.2) Helping SMEs (small and medium enterprises) to create charters.

9. Develop a system of reference to more health-conscious cooking that is in keeping with the PNA and aimed at healthcare professionals, social workers and young people.

Measure 3. Implement the actions mentioned in the Health Education Program 2011-2015 that have an impact on public health and complement this program

ACTION

10. As part of the Health Education Program 2011-2015, improve nutritional education in schools by:

(10.1) Developing nutrition-related education based on the school curriculums in particular, especially in CE2 and 5^{ème} (year 4 and year 8);

(10.2) Promoting and disseminating reference tools for nutritional education in primary schools, including tools for analysing food advertising, sensory education tools, and tools for cooking workshops;

(10.3) Developing parents' awareness, based on the newly updated resource kit;

(10.4) Distributing a circular about food intake at school (primary school, junior high school and senior high school).

Measure 4. Develop actions aimed at educating and informing about nutrition

The nutritional recommendations in the PNNS are not known, perceived and understood in the same way by everyone. It is possible to run into a series of obstacles when it comes to applying them. Making the shift from knowing the recommendations to actually applying them remains a challenge for large sections of the population (especially the most disadvantaged).

There are many health conditions related to nutrition. It is crucial to develop actions for informing professionals - particularly those in the health care sector - but also elected representatives and the general population.

Scientific data highlights the fact that food advertising on television contributes to encouraging people to eat more products with a high sugar, fat and salt content. Exposing children and vulnerable populations to advertising has an impact on preferences and food choices, snacking, knowledge, and nutritional status.

To increase nutritional education in schools, the goal is to opt for fun tools, to inform, to educate and to guide young consumers towards nutritionally suitable food choices.

ACTIONS

11. Develop updated communication tools regarding the nutritional recommendations in the PNNS, as well as tools that are adapted to specific audiences; inform people about the relationships between nutrition and disease by:

(11.1) Updating the nutritional recommendations; increasing communication about them so that they are adopted and applied (including lesser known recommendations such as starchy foods), using an approach that takes into account the specific characteristics of the different target groups; developing information about portion sizes; informing people about alcohol consumption; promoting iodised and fluoridated salt to limit salt intake;

(11.2) Increasing information about sedentary behaviour (particularly screen time); including awareness-raising information about the links between sleep and weight gain in the published PNNS and PO documents aimed at professionals and the general public;

(11.3) Informing health professionals about the links between nutrition and disease, whilst providing nutritional recommendations to support the treatment of chronic organ disease; raising awareness among professionals about food allergies;

(11.4) Taking into account the main conclusions of studies performed on the subject of body image, with a view to developing concrete measures for a better representation of body diversity;

(11.5) Developing government-approved information about the proper use of food supplements;

(11.6) Communicating about the reports on weight loss produced by ANSES, the French national agency responsible for food, environmental and occupational health safety, and AFSSAPS, the French health products safety agency.

Placing restrictions on home shopping services that promote products and devices that have an effect on nutritional status (see Obesity Plan).

12. Increase public health messages and lessen the effects of advertising pressure by:

(12.1) Continuing to explore ways to reduce the advertising pressure exerted on children to encourage the consumption of fatty/sugary/salty foods;

(12.2) Improving the health messages that are included in advertising that emanates from food industry;

(12.3) Raising awareness among producers of television shows regarding the relationship between nutrition and health.

Measure 5. Promote breastfeeding

Breastfeeding is a personal practice that is linked to the history and culture of each society and a choice each mother must make. It is a practice that has scientifically proven benefits for the health of the breastfed child and its mother in the short, medium and long term. The decision to breastfeed is a personal choice that is dependent on the knowledge, availability, traditions and means of each woman, as well as her general attitude towards breastfeeding.

ACTION

13. Implement some measures from the breastfeeding action plan to:

(13.1) Communicate with mothers, inform them and raise their awareness regarding feeding methods for newborns, whilst including an objective view of breastfeeding (including the benefits and the necessary conditions) to allow mothers to make an informed decision;

(13.2) Ensure that maternity wards really do provide women with personalised and objective information for making their decision. Establishments that meet these conditions must state so in the certification process.

FOCUS AREA 2 – Develop the practice of physical and sporting activities and limit sedentary behaviour

The measures included in this focus area are aimed at achieving the objectives set by the French High Council for Public Health (HCSP) in April 2010 with regards to nutrition and to cardiovascular and metabolic diseases. These are outlined below:

NUTRITIONAL OBJECTIVES

General objective 2 – Increase physical activity and decrease sedentary behaviour in all age groups

- **General sub-objective 2-1: increase physical activity among adults**

SO 2-1-1: within 5 years, increase the proportion of adults with a physical activity level* categorised as:

- “high” by at least 20% among men and at least 25% among women;
- “moderate” by at least 20%.

* : according to the International Physical Activity Questionnaire (IPAQ)

- **General sub-objective 2-2: increase physical activity and combat sedentary behaviour among children and adolescents**

SO 2-2-1: within 5 years, ensure that at least 50% of children and adolescents aged 3 to 17 practise some type of high-intensity physical activity three times a week for at least one hour.

SO 2-2-2: within 5 years, reduce by at least 10% the average amount of time children and adolescents aged 3 to 17 spend in front of a screen on a daily basis.

General objective 1 – Reduce obesity and overweight within the population

- **General sub-objective 1-1: stabilise the prevalence of obesity and reduce overweight among adults**

SO 1-1-1: within 5 years, stabilise the prevalence of obesity among adults.

SO 1-1-2: within 5 years, reduce by at least 10% the prevalence of overweight among adults.

SO 1-1-3: within 5 years, stabilise the prevalence of obesity among women living in poverty.

SO 1-1-4: within 5 years, reduce by at least 15% the prevalence of morbid obesity.

- **General sub-objective 1-2: reduce the prevalence of obesity and overweight among children and adolescents**

SO 1-2-1: within 5 years, reduce by an average of 15% the overall prevalence of overweight and obesity among children and adolescents aged 3 to 17.

SO 1.2.2: within 5 years, reduce by an average of 15% the prevalence of overweight and obesity among children and adolescents aged 3 to 17 from disadvantaged homes.

General objective 2 – Reduce hypercholesterolemia and arterial hypertension

SO 2-1: within 5 years, reduce by 5% average cholesterolemia (LDL-cholesterol) among the adult population.

SO 2-2: within 5 years, increase the proportion of hypercholesterolemia sufferers who are treated and stabilised.

SO 2-3: within 5 years, increase the proportion of patients with high blood pressure who are treated and stabilised.

In a society that encourages a more sedentary lifestyle, the collective expert report on physical activity issued by the French National Institute of Health and Medical Research (INSERM) and the report entitled "Retrouver sa liberté de mouvement" (Regaining freedom of movement) drafted by Professor Toussaint in 2008, revealed that the "moving" component of nutrition is crucial to achieving energy balance at all ages. Physical activity instils social and educational values and has a positive effect on health, whether it is performed as part of one's daily outings and activities, or under supervision in a sporting facility. It is also an additional form of therapy for patients undergoing medical treatment. In light of this, numerous initiatives have already been developed to encourage people to put the PNNS guideline of "At least 30 minutes of physical activity per day" into practice. It is, however, necessary to boost the health education and promotion policy with actions in this area, to take into account the objectives set by the HCSP.

Two levels of physical and sporting activities must be developed:

- daily physical activity for all, when going from A to B, working, or as part of leisure activities, supplemented with regular supervised physical activity;
- adapted physical activity for people who are especially vulnerable, including disadvantaged population groups, people with disabilities or suffering from chronic illnesses, and the elderly.

Measure 1. Promote, develop and increase the daily amount of physical activity practiced by everyone

Two measures are recommended in reports at an international level to encourage citizens to practise a physical activity: information and improvement of the physical environment.

ACTIONS

14. Promote an environment that is conducive to practising a physical activity and limit sedentary behaviour by:

(14.1) Promoting and encouraging active modes of transport by incorporating active travel options in transport networks (in association with PNSE2, the second National Environment and Health Plan);

(14.2) Organising events aimed at the general public to promote physical and sporting activities as factors that contribute to health and well-being.

15. Promote resources aimed at increasing physical activity by:

(15.1) Increasing communication with the public regarding the practice of a physical and sporting activity, while taking into account each group's specific circumstances and raising awareness among employers, works councils and local authorities (among others) regarding the benefits of physical activity;

(15.2) Raising awareness among healthcare and welfare workers and teachers, who are in contact with children and adolescents, regarding the health benefits of physical and sporting activity.

Measure 2. Promote sports and adapted physical activity (APA) among the disabled, disadvantaged, and elderly, as well as people suffering from chronic diseases

16. Improve access to physical and sporting activities for people with disabilities (physical, mental, psychological, or sensory) by:

(16.1) Using the PNNS portal to better communicate with professionals and the general public regarding the health benefits associated with the practice of physical and sporting activities by people with disabilities;

(16.2) Supporting each department's centre for the disabled (MDPH) so that access to a regular physical or sporting activity is included within the personalised compensation plans put together by the departmental committees;

(16.3) Assisting specialised centres and sporting associations with implementing physical and sporting activities for people with a physical, mental, psychological or sensory disability;

(16.4) Assisting sporting federations with developing the range of sporting and physical activities available to this population group, and the owners of sporting facilities with installing the equipment necessary to facilitate access for people with disabilities.

17. Improve access to physical and sporting activities for disadvantaged population groups by:

(17.1) Increasing the importance of urban policy places on the promotion of physical and sporting activity as a determining factor for health;

(17.2) Developing physical and sporting activities in disadvantaged neighbourhoods;

(17.3) Developing physical and sporting activities as a means of supporting the education of youths under judicial protection. The "Challenge Michelet", which is an annual sporting event aimed at young people under judicial protection or receiving support as part of the urban policy and delinquency prevention initiatives, participates in this development.

18. Promote adapted physical and sporting activity among people over 50 and those experiencing a loss of independence by:

(18.1) Creating and distributing a directory of sports associations that offer activities for people aged over 50;

(18.2) Developing the range of physical activities in accommodation facilities for dependent elderly people (EHPAD) and retirement homes;

(18.3) Harmonising programs for preventing falls due to physical and sporting activities and setting up a clearly identified national plan.

19. Promote adapted physical and sporting activity in sports clubs among individuals suffering from chronic diseases by:

(19.1) Creating a guide aimed at assisting clubs with setting up a range of physical and sporting activities aimed at individuals suffering from chronic illnesses, once current experiments have been evaluated;

(19.2) Creating a reference guide of best practices, aimed at sports clubs wanting to set up a range of physical and sporting activities for individuals suffering from chronic illnesses;

(19.3) Providing financial support to the sporting federations and their regional and departmental committees, to encourage them to develop the range of activities available to this population group.

FOCUS AREA 3 – Organise detection and management of nutrition-related health conditions in patients; reduce the prevalence of undernutrition

The measures included in this focus area are aimed at achieving the nutritional objectives set by the French High Council for Public Health (HCSP) in April 2010 and outlined below:

NUTRITIONAL OBJECTIVES

General objective 4 – Reduce the prevalence of nutrition-related health conditions

SO 4-1: reduce the prevalence of eating disorders among adolescents.

SO 4-2: within 5 years, reduce the percentage of undernourished elderly people within the general population, living at home or in institutions:

- by at least 15% for people over 60;
- by at least 30% for people over 80.

SO 4-3: within 5 years, reduce the percentage of undernourished hospitalised individuals by at least 20%.

Based on the recommendations of available practices, detecting and managing nutrition-related health conditions (obesity and undernutrition) requires a rational organisation of the care and treatment, from the first contact with the primary care physician through to the hospitals and the follow-up care and rehabilitation (SSR). The role each of these plays in the care pathway must be clear. Where obesity is concerned, this theme is one of the focus areas of the PO, covered separately.

Undernutrition affects the elderly, but also children and adults. All of the major chronic diseases (chronic organic diseases affecting the lungs, kidneys, heart or liver; cancers; Alzheimer's; eating disorders) can indeed lead to undernourishment resulting in an increase in morbidity and mortality and a decline in quality of life. Undernutrition can also represent a loss of opportunity for sick people. It generates considerable health costs. Undernutrition is an issue that affects a variety of public health plans, including the quality of life plan for people suffering from chronic illnesses, the Alzheimer's plan, the cancer plan, the mental health plan, etc.

Systematic detection of undernutrition and nutritional disorders, whether in hospitals, ambulatory care facilities or other health care facilities, is particularly important in terms of both prevention and care. This detection makes it possible to offer coordinated treatment and care and ensure regular follow-up in a public or private health establishment, during hospital care at home, or in a medico-social establishment (accommodation facilities for dependent elderly people, retirement homes, etc.).

This detection - the details of which are defined by the French National Health Authority (HAS) - forms part of the Indicators for Improving Healthcare Quality and Safety (IPAQSS). Its measurement is documented in the indicators that are evaluated each year.

Measure 1. Organise detection of nutritional disorders and patient management

ACTIONS

20. Ensuring nutrition is given better consideration in ambulatory care by:

- (20.1) Publishing an online tool to help general practitioners familiarise themselves with the PNNS;
- (20.2) Analysing the relevance of defining a "doctor specialised in nutrition" title and a corresponding skill set;
- (20.3) Defining therapeutic education programs for patients in health care establishments and ambulatory care facilities;
- (20.4) Analysing the care requirements of patients suffering from a severe nutrition-related condition and suggesting ways to organise this care.

Organising the nutrition care pathway at the national level (see Obesity Plan).

21. Ensuring nutrition is given better consideration in establishments by:

- (21.1) Including an official process relating to nutritional status (from diagnosis to corrective measures) within the requirements for establishment certification;
- (21.2) Evaluating the impact of the Nutrition Support Teams (NST), called Unités Transversales de Nutrition or UTN in French;
- (21.3) Implementing IPAQSS indicators for nutrition (and extending them to hospital care at home).

Measure 2. Preventing and detecting undernutrition

Raising awareness about undernutrition (the elderly, people with health conditions, including children, disadvantaged population groups, etc.) among health care professionals and care assistants is a priority objective. In addition to this, relevant approved tools will be made available and official measures implemented to ensure a food intake that is sufficient in terms of both quantity and quality.

ACTIONS

22. Raise awareness among health care professionals by:

- (22.1) Updating the online undernutrition training tool and promoting training courses on undernutrition;
- (22.2) Designing practical tools for detecting and managing undernutrition, and analysing the terms of their availability.

23. Improve the nutrition of elderly people by:

- (23.1) Developing communication and information campaigns aimed at families, home care workers and professionals;
- (23.2) Raising awareness of undernutrition detection, treatment and care among residents of accommodation facilities for dependent elderly people;
- (23.3) Promoting oral health among the elderly.

Drawing up nutritional recommendations for home-delivered meals, in line with the PNA (I.4.2.1).

24. Detect undernutrition in ambulatory care by:

- (24.1) Promoting the use of the MNA (Mini Nutritional Assessment) in its abridged form among general practitioners.

25. Detect undernutrition in patients suffering from acute and chronic diseases by:

- (25.1) Creating a practical guide to improve information gathering and the traceability of the nutritional assessment.

Setting up a system for monitoring nutritional status and dietary supervision (see action 26.1).

Measure 3. Manage undernutrition

The conditions for effective management of undernutrition include general measures to make it easier for the health system to take it into account; the particular characteristics of the various types of undernourished patients require specific interventions.

ACTIONS

26. Facilitate the treatment and care of undernutrition in patients by:

- (26.1) Drawing up specific nutritional support protocols for patients that are recognised as undernourished;
- (26.2) Developing therapeutic education programs on undernutrition within the ambulatory care setting;
- (26.3) Including nutritional support in the personalised care plan of cancer patients;
- (26.4) Informing and involving patients and their loved ones to ensure they remain committed to the treatment plan, in conjunction with patient associations.

27. Improve the treatment and care of undernutrition in elderly people by:

- (27.1) Developing training courses for home care workers, care workers and professionals in contact with elderly people in their homes, staff from home nursing agencies;
- (27.2) Studying opportunities for developing treatment and care at home in order to reduce the strain on the hospital system.

Measure 4. Prevent and manage the nutritional disorders of disabled people

Severe disabilities that are mental, neurological, neurotraumatological or traumatic in origin lead to significant nutritional vulnerability. The 2005 Disability Act (N° 2005-102) imposes equal rights and opportunities for disabled people. But the social impoverishment and inequalities that result from the disability are factors for nutritional disorders (undernutrition or overweight), which are likely to worsen the disability, but also have an impact on autonomy and quality of life and increase morbidity and mortality. The detection, treatment and prevention of nutritional disorders in disabled people are major elements in the overall integrated medico-social treatment and care of the disability.

ACTION

28. Develop actions for the diagnosis, prevention and monitoring of the nutritional status of disabled people

(28.1) Analyse the needs, obstacles and difficulties that are specific to detection and prevention actions that take into account the various types of disabilities, and to the general monitoring of the nutritional status of disabled people, in the medico-social sector and in ambulatory care. Proposals for suitable actions will be developed based on this analysis.

FOCUS AREA 4 – Promote the PNNS as the reference for nutrition-related actions and stakeholder involvement

The measures included in this focus area are aimed at achieving all of objectives set by the French High Council for Public Health (HCSP) in April 2010 with regards to nutrition and to cardiovascular and metabolic diseases, presented in the three previous focus areas.

The PNNS proposes a consistent framework for intervention as an incentive for the many stakeholders involved in nutrition. The scope of the PNNS is very broad. To enable the stakeholders to promote their own actions, the program must benefit from good overall exposure and promotion.

Since its launch, the PNNS has implemented various mechanisms, tools and procedures to incite the various stakeholders to commit to health through nutrition, within the consistent framework defined by the public authorities. These mechanisms must be promoted.

Numerous businesses and sectors are committing to making nutritional improvements to the food products they manufacture and sell. These commitments are validated by a commission set up by the public authorities and deserve greater exposure and a better explanation of their relevance (see Focus Area 1, action 8).

Measure 1. Promote the PNNS as the leading reference for “nutrition and health”

The PNNS implements numerous actions in various fields. If these actions are to improve health in the area of nutrition, they absolutely must be complementary. Everyone must be able to track their progress.

ACTION

29. Set up a communication strategy for the PNNS by:

(29.1) Creating a specific institutional web-portal for information regarding the PNNS, its principles, its actions, its major partners that are approved sources of information: www.pnns.gouv.fr (which can redirect to various approved sources);

(29.2) Promoting the www.mangerbouger.fr website as a leading online reference tool for information about “nutrition and health”;

(29.3) Informing the media, relevant professionals, elected representatives and the general public regularly regarding PNNS accomplishments;

(29.4) Increasing the prominence of the PNNS logo and its variants;

(29.5) Actively taking part in topical debates to highlight the messages of the PNNS.

Measure 2. Develop charters of commitment for local authorities that actively support the PNNS

At the decentralised level, commitment and political support are essential to ensuring the development and long-term viability of the actions and programs developed by professionals from the local authorities and various associations. To this end, the PNNS proposes charters of commitment. Coordination between the various institutional partners that apply the PNNS within the different regions of France must make it possible to ensure the actions are synergistic and effective.

ACTIONS

30. Develop the "Active PNNS Cities" charter by:

- (30.1) Increasing the nationwide coordination of the cities that are actively taking part in the PNNS, by improving the "[reseauillesactivespnns](#)" website;
- (30.2) Encouraging the cities that are taking nutrition-related actions to become "Active PNNS Cities";
- (30.3) Setting up dynamic interactions between active PNNS cities at the regional level.

31. Develop the "Active PNNS Departments" charter by:

- (31.1) Developing ties between the "active PNNS departments" and other departments

32. Developing an "Active PNNS Region" charter and synergy between the interventions of the various local authorities by:

- (32.1) Creating a charter in association with elected officials and technical representatives of the regional councils;
- (32.2) Creating a framework that takes into account the diversity of regional contexts and aims to harmonise and develop synergies between the actions of the various regional stakeholders.

Measure 3. Develop charters of commitment aimed at private and public companies for the benefit of employees

Employees spend several hours a day at their place of work. They also eat there and must commute to get there. Consequently, businesses can contribute to promoting a healthy diet.

ACTION

33. Develop the "Active PNNS Businesses" charter by:

(33.1) Proposing a charter for businesses with more than 50 employees initially, then subsequently forming a committee responsible for monitoring the implementation of this charter and suggesting changes when necessary;

(33.2) Creating a database that compiles the actions taken by businesses that have signed the charter. This database will be developed and incorporated into the PNNS Internet portal;

(33.3) Organising a national conference every two years as an opportunity for representatives of "Active PNNS Businesses" to meet and share best practices.

Measure 4. Promote and raise awareness of PNNS-approved actions and documents

A procedure for attributing the PNNS logo to the actions, tools and documents produced by the various organisations actively involved in the program (associations, businesses, local authorities, etc.) was set up in 2004.

It is essential to promote and share the wealth of experience generated by the evaluated experiments conducted by the numerous stakeholders in the field of nutrition. By finding ways to support the adoption of these best practices, this should lead to an improvement in the quality of the actions conducted for the benefit of the different population groups.

ACTIONS

34. Revise the conditions for attributing the PNNS logo and encourage its attribution by:

(34.1) Developing a communication strategy to promote the logo attribution procedure and make it known among the stakeholders that are likely to want to use it (leaders of associations in particular), the organisations funding the nutrition-related actions (the regional health agencies, for instance) and potential users (including teachers);

(34.2) Improving the database that is available on the mangerbouger.fr website and lists the actions, tools and documents that bear the logo. The database will be enhanced and rendered more functional;

(34.3) Revising the specifications for PNNS logo attribution;

(34.4) Creating a forum where tools and documents bearing the PNNS logo can be presented for promotional purposes.

35. Creating local, regional and national events to promote actions conducted as part of the PNNS and stakeholders actively involved in the program, by:

(35.1) Transforming the "mouv'eat" week, which is prepared through meetings at the interregional level, into a "local authorities for nutrition" week to promote the various local authorities that are actively applying the PNNS;

(35.2) Organising a conference of "Active PNNS regional and local authorities" every two years to allow sharing of best practices gleaned from achievements.

36. Organise sharing of validated PNNS tools and practices by:

(36.1) Assisting with the dissemination and adoption of the evaluated programs and actions that are considered especially beneficial.

TRANSVERSAL COMPONENTS : Training, monitoring, evaluation and research

The measures included in this focus area are aimed at achieving all of objectives set by the French High Council for Public Health (HCSP) in April 2010 with regards to nutrition and to cardiovascular and metabolic diseases, presented in the first three focus areas.

Initial and ongoing training of professionals on the subject of “nutrition and public health” contributes to the development, maintenance and consistency required by the PNNS.

Monitoring and evaluation are fundamental elements for constantly refocusing intervention strategies, and for improving the relevance and effectiveness of the implemented actions.

New questions are emerging in fields relating to fundamental biology, but also epidemiology, human and social sciences, and clinical research. The PNNS draws on research to decide on the focal points of future actions.

Measure 1. Contribute to guiding training in nutrition and public health

To protect public health, it is crucial to maintain a certain level of skill and ensure that the knowledge of professionals working in the field of nutrition is current.

Training includes both initial training and continuing professional development, which must be consistent with the objectives and orientations of the PNNS.

ACTIONS

37. Develop training courses about PNNS implementation, by:

(37.1) Holding training courses/discussions about the implementation of the PNNS and practices at the regional level;

(37.2) Continuing to train PNNS-approved trainers;

(37.3) Setting up PNNS training courses aimed at the media.

38. Develop nutrition training tools by:

(38.1) Developing an online module about obesity detection and management, aimed at professionals;

(38.2) Making PNNS training modules available in different formats suitable for teachers, registered childminders, company employees;

(38.2) Proposing "PNNS" labelling for continued professional development training modules produced by various organisations, and promoting these modules;

(38.4) Continuing the "PNNS summaries" series;

(38.5) Releasing an updated compilation of the "nutrition guides" produced for professionals by the National Institute for Prevention and Health Education (INPES).

39. Improve initial and continuing education courses for professionals by:

(39.1) Reviewing the content and details of the initial training aimed at doctors, pharmacists, dentists, midwives, dieticians, and paramedical professionals in the field of nutrition, with a view to updating these in association with the college of teachers of nutrition (called Collège des Enseignants de Nutrition in French or CEN);

(39.2) Adapting the initial training of dieticians, to bring it in line with current practices in the European Union;

(39.3) Suggesting changes to the degree courses for professionals in the field of physical activity and the training of social workers, to include nutritional health;

(39.4) Supporting the creation of a healthy cooking training institute.

Measure 2. Maintain the national nutrition monitoring tools and create the necessary new tools

Renewing a variety of nationwide studies initiated in the late 1990s and during the 2000s will provide reliable data regarding the evolution of the situation.

ACTIONS

40. Conduct the studies among the population by:

Conducting major nationwide surveys and studies among the general population:

- (40.1) The second French Nutrition and Health Survey (ENNS 2);
- (40.2) The third National Individual Survey on Food Consumption (INCA 3);
- (40.3) A urine sodium study conducted among the general population;
- (40.4) Continuing to collect available data in the "Baromètres nutrition" [nutrition barometers] studies conducted by the National Institute for Prevention and Health Education (INPES);

Conducting nationwide surveys and studies among specific population groups:

- (40.5) A second ABENA study on the Diet and Nutritional Status of Food Aid Recipients (ABENA 2);
- (40.6) The EPIFANE study (epidemiology of the diet and nutritional status of children in France);
- (40.7) The ANAIS study (the diet, nutritional status and mental health of institutionalised elderly people);
- (40.8) The regional compilation of the body mass index of a sample of children in Year 1, for monitoring purposes;
- (40.9) Incorporating "PNNS-compatible" indicators in studies that contain a nutrition-health element (physical activity included);
- (40.10) Taking social inequalities into account in the gathering of monitoring data.

41. Ensuring monitoring of the nutritional quality of foods by:

- (41.1) Continuing the analyses conducted by the French Observatory of Food Quality (OQALI) on the nutritional quality of food products, in keeping with the French Food Strategy (PNA);
- (41.2) Having the OQALI study the direct impact of the voluntary charters of commitment to nutritional progress.

Measure 3. Clarify the challenges, benefits, requirements and methods of the evaluation

Evaluating the actions and programs against the set objectives and planned processes is a factor for progress. The conditions for carrying out this evaluation must be specified to improve its quality.

ACTION

42. Develop a standardised methodology for evaluating nutrition-related actions by:

- (42.1) Setting up a workgroup tasked with the question of evaluating nutrition-related actions and organising a national symposium;
- (42.2) Publishing an online document to standardise the methods for evaluating nutrition projects;
- (42.3) Analysing the potential benefits of national cohorts as a tool for nutritional monitoring;
- (42.4) Pre-testing and assessing prevention campaigns.

Measure 4. Contribute to guiding the course of research in nutrition and public health

Research in nutrition draws on the work of the French National Research Agency (ANR), hospital-based clinical research programs (PHRC), research institutes, various foundations, etc.

ACTION

43. Encourage multidisciplinary research in nutrition by:

(43.1) Formalising proposals to the research organisations, in line with the orientations of the PNNS, regarding the biological, environmental, cultural, economic and social factors, relating to the consequences of practices and behaviour on the nutritional status of an individual as well as evaluating assessment strategies among the population.

Measure 5. Promote French expertise at the European and international levels

France has many experts in nutrition. Their presence within international scientific bodies and expert committees must be promoted and increased. Exchanges between European experts in the field of nutrition must be encouraged.

ACTION

44. Develop and promote French expertise in nutrition at the international level by:

(44.1) Building a database of French experts in the field of nutrition;

(44.2) Promoting this database among European and international bodies.

Measure 6. Evaluate the PNNS and the Obesity Plan (PO)

Evaluating achievement of the set objectives at the national, regional or local level, and evaluating the processes implemented, contributes to improving the quality of interventions, developing the most efficient methods, adapting interventions, and setting quantitative objectives that are relevant and realistic.

ACTION

45. Referral to the IGAS (halfway through the PNNS and at the end of the program) and the HCSP (at the end of the program) for assessment of the PNNS and the Obesity Plan (whose research component will be assessed by the AERES – the French Evaluation Agency for Research and Higher Education).

Appendices

Key Figures

PREVALENCE OF OVERWEIGHT AND OBESITY AMONG CHILDREN

1- Prevalence of overweight and obesity among children (aged 3 to 17) in metropolitan France:

- Overweight: 14.3%
- Obesity: 3.5%

(Source: ENNS, 2006-2007, measured data)

2- Trends in the prevalence of overweight and obesity among children and adolescents in the 2000s in metropolitan France (various studies)

	Overweight		Obesity	
	Start	End	Start	End
InVS-DESCO (7-9 years old) 2000-2007	2000: 14.3%	2007: 13%	2000: 3.8%	2007: 2.8%
INCA1-INCA2 (3-14 years old) 1998-2006	1998: 11.6%	2006: 11.6%	1998: 3.5%	2006: 2.9%
DREES (Grande section ≈ Year 1) 1999-2006	1999: 14.4%	2006: 12.1%	1999: 3.4%	2006: 3.1%
DREES (CM2 ≈ Year 6) 2002-2005	2002: 15.8%	2005: 16%	2002: 4.1%	2005: 3.7%

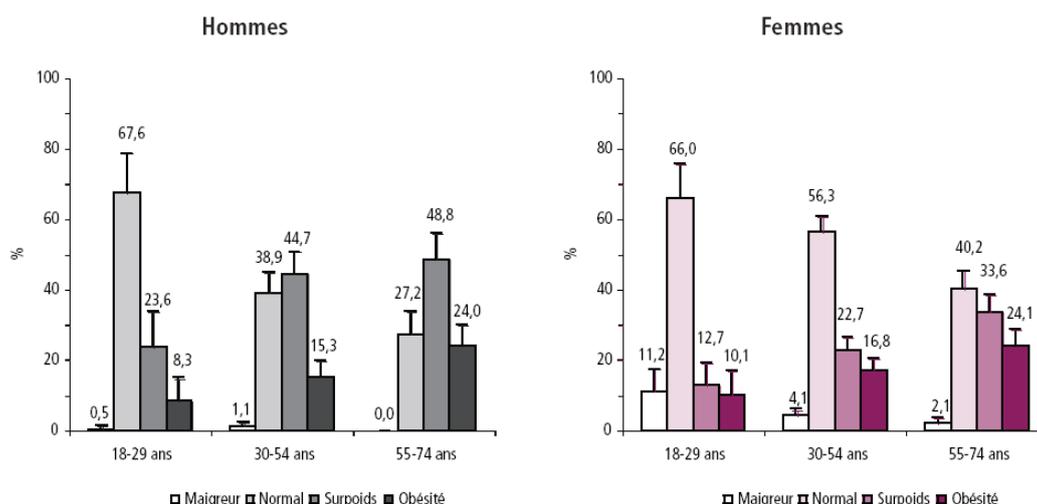
PREVALENCE OF OVERWEIGHT AND OBESITY AMONG ADULTS

1- Prevalence of overweight and obesity among adults (aged 18 to 74) in metropolitan France (overseas territories excluded)

- Overweight: 41% among men and 23.8% among women
- Obesity: 16.1% among men and 17.6% among women

(Source: ENNS, 2006-2007, measured data)

Distribution of men and women 18 to 74 years old, according to age and BMI, (WHO references) ENNS study, 2006



Hommes = Men Femmes = Women

18-29 ans = 18-29 years old
 30-54 ans = 30-54 years old
 55-74 ans = 55-74 years old

Maigreur = Thin
 Normal = Normal
 Surpoids = Overweight
 Obésité = Obese

2- Prevalence of obesity and overweight (adults) in French overseas communities

	Overweight		Obesity	
	Men	Women	Men	Women
Mayotte (15 years and over) Source: Nutriway 2006	24.8%	25.7%	7.6%	32.3%
Reunion Island (18 years and over) Source: Reconsal 2002	38%	33%	8%	20%
Martinique (16 years and over) Source: Escal 2003-2004	38%	29%	14%	26%
Guadeloupe (aged 25 to 74) Source: Consant 2007	37%	34%	14%	31%

PHYSICAL ACTIVITY AND SEDENTARY BEHAVIOUR

1- Physical activity (Source: ENNS, 2006-2007)

- % of adult subjects (aged 18 to 74) who engage in the equivalent of at least 30 minutes per day of **at least moderate-intensity physical activity (IPAQ)**:
 - Among men: 64% of which 30% engage in high-intensity physical activity
 - Among women: 63% of which 24% engage in high-intensity physical activity
- % of subjects (aged 11 to 14) who engage in the equivalent of at least 30 minutes per day of at least moderate-intensity physical activity (IPAQ):
 - Among boys: 65% of which 46% engage in high-intensity physical activity
 - Among girls: 55% of which 30% engage in high-intensity physical activity
- % of subjects (aged 15 to 17) who engage in the equivalent of at least 30 minutes per day of at least moderate-intensity physical activity (IPAQ):
 - Among boys: 78% of which 42% engage in high-intensity physical activity
 - Among girls: 65% of which 19% engage in high-intensity physical activity

2- Sedentary behaviour (Source: ENNS, 2006-2007)

- % of subjects spending more than three hours per day in front of a screen (television, computer), regardless of the type of day (work or rest)
 - Among adults (aged 18 to 74)
 - Men: 59%
 - Women: 48%
 - Among children (aged 3 to 17)
 - Boys: 41%
 - Girls: 38%
- Average screen time per day (television, computer, video games)
 - Among adults (aged 18 to 74): 3 h 21

(Source: ENNS, 2006-2007)

- Among children

	Time
ENNS (3 to 17 years old) (2006-2007)	3 h
INCA2 (3 to 17 years old) (2006-2007)	2 h 50
DREES (Grande section ≈ Year 1) 2005-2006	3 h or more
DREES (CM2 ≈ Year 6) 2007-2008	
DREES (Troisième ≈ Year 10) 2008-2009	

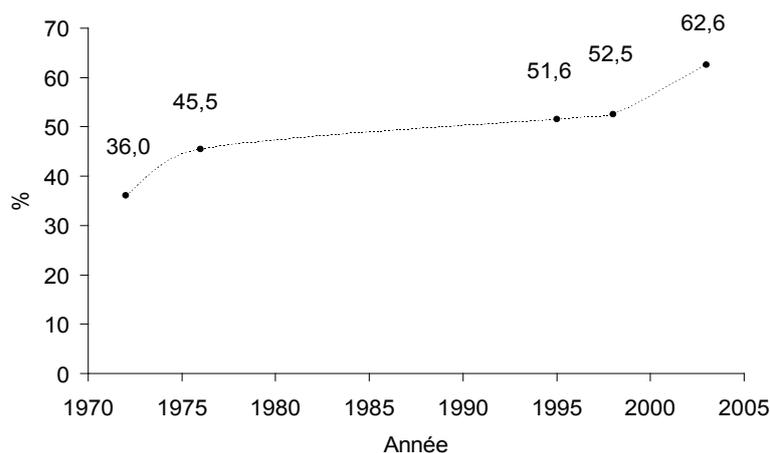
BREASTFEEDING

1- Prevalence of breastfeeding initiation

- In 2003, 62.6% of infants in maternity wards were breastfed. 56.3% of these were exclusively breastfed and 6.3% were partially breastfed.

(Source: *Enquêtes nationales périnatales (ENP) [national perinatal surveys]*)

Trends in the prevalence of breastfeeding initiation (exclusive and partial) in maternity wards in France, from 1972 to 2003



(Source: *Enquêtes nationales périnatales (ENP) [national perinatal surveys]*)

2- Duration of breastfeeding

- In 1998, the average duration of breastfeeding was 10 weeks.
- Breastfeeding up to the age of 4 months occurs in barely 5% of cases in France.

(Source: *Prof. Dominique Turck. Propositions d'actions pour la promotion de l'allaitement maternel [Suggested actions to promote breastfeeding]. June 2010: 40 p.)*

UNDERNUTRITION

1- Prevalence of undernutrition in short-term care facilities

- Children: 20%
- Adults: 45%
- The elderly: 60%

(Source: *Énergie 4+, a study conducted by AP-HP (health and social security services and Paris hospitals), 2003*)

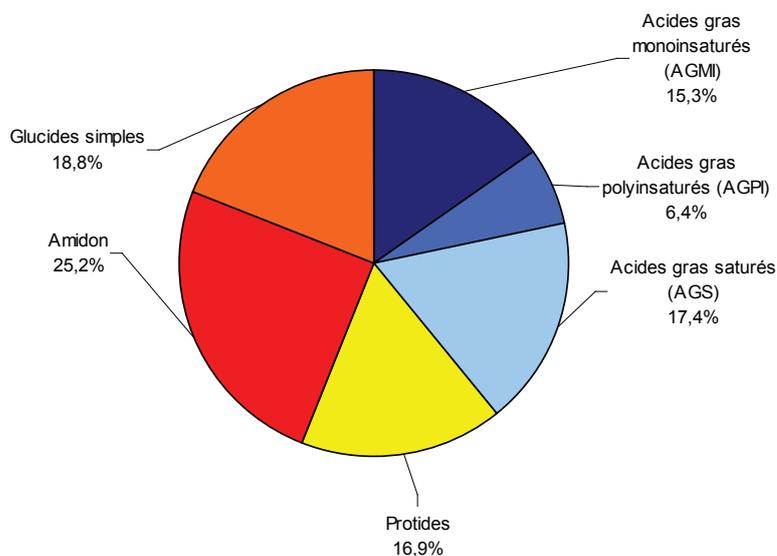
2- Prevalence of undernutrition, overweight and obesity in retirement homes

- Undernourished: 45%
- Overweight: 13%
- Obese: 16%

(Source: *J.-C. Desport et al., nutrition clinique et métabolisme [clinical nutrition and metabolism], May 2010*)

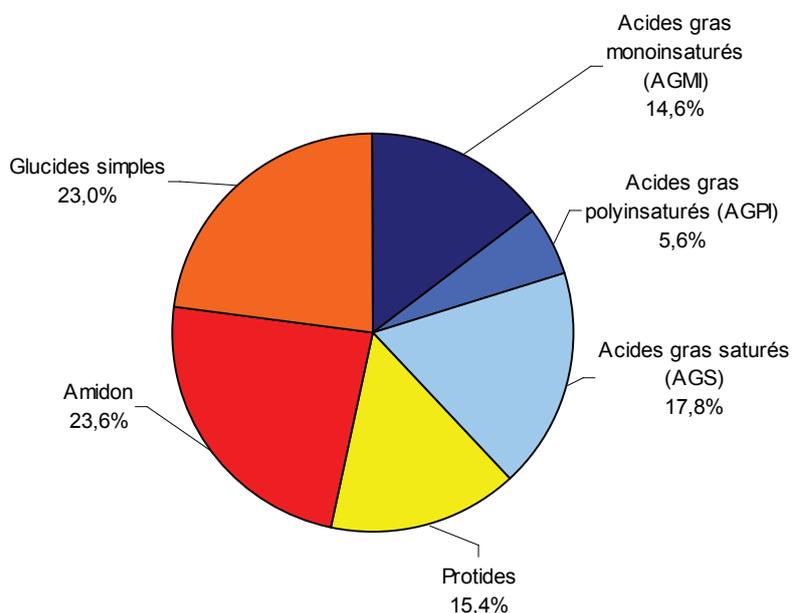
FOOD CONSUMPTION

1- Contribution of macronutrient to non-alcoholic energy intake among adults (aged 18 to 79)



Source: INCA2, 2006-2007

2- Contribution of macronutrient to non-alcoholic energy intake among children and adolescents (aged 3 to 17)



Source: INCA2, 2006-2007

- Glucides simples = Simple carbohydrates
- Amidon = Starches
- Glucides = Carbohydrates
- Protides = Proteins
- Lipides = Lipids
- Acides gras saturés = Saturated fatty acids
- Acides gras poly insaturés = Polyunsaturated fatty acids
- Acides gras mono insaturés = Monounsaturated fatty acids

3- Daily salt intake (excluding salt added during cooking and eating)

- Among adults (aged 18 to 79): 7.7 g
 - Men: 8.7 g
 - Women: 6.7 g

(Source: INCA2, 2006-2007)

- Among children and adolescents (aged 3 to 17): 5.4 g
 - Boys: 5.8 g
 - Girls: 5 g

(Source: INCA2, 2006-2007)

4- Daily fibre intake

- Among adults (aged 18 to 79): 17.5 g

(Source: INCA2, 2006-2007)

- Among children and adolescents (aged 3 to 17): 12.6 g

(Source: INCA2, 2006-2007)

5- Daily alcohol intake

- Among adults (aged 18 to 79): 13 g

(Source: INCA2, 2006-2007)

6- Proportion of people with a calcium intake that is below the Estimated Average Requirement (EAR)

- Adolescents (aged 11 to 17): 68%
- Women (aged 18 to 29): 36%
- The elderly (aged over 60): 50%

(Source: INCA2, 2006-2007)

7- Iron deficiency anaemia (haemoglobin < 12 g/dL and ferritin levels < 15 mg/L)

- Adults (aged 18 to 74): 3.2%
- Women of childbearing age (15- to 49-year olds): 5.7%

(Source: ENNS, 2006-2007)

8- Risk of folate deficiency (< 3 ng/L: 7%)

- Women of childbearing age (15- to 49-year olds): 7%

(Source: ENNS, 2006-2007)

9- Vitamin D in adults (aged 18 to 74)

- Moderate deficiency (5 and 10 ng/mL): 4.4%
- Risk of deficiency (10 and 20 ng/mL): 36.7%

(Source: ENNS, 2006-2007)

10- Adult subjects (aged 18 to74) whose food consumption meets the nutritional recommendations set out in the PNNS (expressed as a %)

Food groups	Guideline	Indicator	Women	Men	Adults
Fruit and vegetables	At least 5 per day	% consuming at least 5 portions per day	43	43	43
Bread, cereals, potatoes, pulses	At each meal and according to appetite	% consuming 3 to 6 portions per day	38	60	49
Milk and dairy products	18-54 years old: 3 servings per day	% of 18- to 54-year olds consuming 2.5 to 3.5 portions per day (and 2.5 to 4.5 among 55- to 74-year olds)	27	31	29
	55 years and over: 3 to 4 per day				
Meat, poultry, fish and seafood, eggs	1 to 2 per day	% consuming 1 to 2 portions per day	54	51	52
	Fish: at least twice a week	% consuming at least 2 portions of fish per week	32	28	30
Added fats	Limit intake	% consuming less than 16% of the non-alcoholic daily energy intake as added fats	89	93	91
	Opt for vegetable fats and oils	Average proportion of added fats from vegetable sources	55	50	53
Sugary foods	Limit intake	% consuming less than 12.5% of the non-alcoholic energy intake as total simple carbohydrates from sugary foods	74	73	74
Drinks	Water in unlimited quantities	% of subjects consuming more than 1 L of water (including coffee, tea, etc.) and less than 250 ml of sweet drinks	72	67	69
	Limit consumption of sweet drinks				
	Alcohol consumption must not exceed 2 glasses per day for women and 3 for men	% of women consuming less than 20 g of alcohol per day and % of men consuming less than 30 g of alcohol per day	91	77	83
Salt	Limit intake	% consuming less than 8 g of salt per day	74	34	54

(Source: ENNS, 2006-2007)

11- Child subjects (aged 3 to 18) whose food consumption meets the nutritional recommendations set out in the PNNS (expressed as a %)

Food groups	Guideline	Indicator	Girls	Boys	Children
Fruit and vegetables	At least 5 per day	% consuming at least 5 portions per day	19	20	20
Bread, cereals, potatoes, pulses	At each meal and according to appetite	% consuming 3 to 6 portions per day	28	38	33
Milk and dairy products	3 to 4 per day	% consuming 2.5 to 4.5 portions per day	40	45	43
Meat, poultry, fish and seafood, eggs	1 to 2 servings per day	% consuming 1 to 2 portions per day	45	49	47
	Fish: at least twice a week	% consuming at least 2 portions of fish per week	26	30	28
Added fats	Limit intake	% consuming less than 16% of the non-alcoholic daily energy intake as added fats	97	97	97
	Opt for vegetable fats and oils	Average proportion of added fats from vegetable sources	42	44	43
Sugary foods	Limit intake	% consuming less than 12.5% of the non-alcoholic energy intake as total simple carbohydrates from sugary foods	47	43	45
Drinks	Water in unlimited quantities	% of subjects consuming more than 1 L of water (including coffee, tea, etc.) and less than 250 ml of sweet drinks	24	24	24
	Limit consumption of sweet drinks				
Salt	Limit intake	% consuming less than 8 g of salt per day	82	72	77

(Source: ENNS, 2006-2007)

12- State of food consumption among adults (aged 18 to 79) in 2007

<ul style="list-style-type: none"> • An adult consumes an average of 2,744 g of food and drink daily: <ul style="list-style-type: none"> > 2,582 g for a woman; > 2,922 g for a man. • Women consume the most fresh dairy products, fish and fruit. • Processed foods tend to be consumed more by 18- to 34-year olds and unprocessed and traditional foods by 55- to 79-year olds. • Seafood, fruit, vegetables, cakes and pastries are consumed more by individuals with a higher level of education. • Oils and vegetables are preferentially consumed in the South; butter, potatoes, and sugary foods in the North; milk and fresh dairy products in the West; cheese in the East. 	<ul style="list-style-type: none"> • Fruit, vegetables, ice cream are consumed more in the summer; mixed dishes, soups and pulses are consumed more in the winter. • Breakfast cereals, milk, and sugary foods tend to be consumed for breakfast; and cooked pork meats, savoury tarts and pizzas for dinner. • Sugary foods, alcoholic beverages, and shellfish are consumed more on weekends and outside of the home.
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(Source: INCA2, 2006-2007)

13- Changes in the food consumption of adults (aged 18 to 79) between 1999 and 2007

- Increase in the consumption of fruit and vegetables, pasta and rice, ice cream and chocolate
 - Decrease in the consumption of milk, cheese, meat, cakes and sweet biscuits
- (Source: INCA2, 2006-2007)

14- State of food consumption among children and adolescents (aged 3 to 17) in 2007

<ul style="list-style-type: none"> • A child consumes an average of 1,760 g of food and drink daily: <ul style="list-style-type: none"> > 1,650 g for a girl; > 1,863 g for a boy. • Cereals, starchy foods and animal products are consumed more by boys. • Apart from milk, fresh dairy products and cooked and stewed fruit, consumption of the food groups increases along with the child's age. • Fruit, vegetables, stewed fruit, oils, fresh dairy products, cheese, water, pastries and cakes are consumed more by children whose guardian has a high level of education. • Oil, fruits and vegetables, meat, poultry and water are consumed more in the South; pastries and cakes, hot drinks, and cold non-alcoholic beverages in the North. 	<ul style="list-style-type: none"> • Fruit, vegetables, ice cream and water are consumed more in the summer; mixed dishes, soups, pulses, pastries and cakes in the winter. • Breakfast cereals, milk, and sugary foods tend to be consumed more for breakfast; sweet breads and buns (such as brioches, croissants and pains au chocolat), biscuits, pastries, cakes and chocolate for an afternoon snack; cooked pork meats, savoury tarts and pizzas for dinner. • Ice cream, sweet breads and buns, biscuits, cold non-alcoholic beverages, and sandwiches are consumed more outside of the home.
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(Source: INCA2, 2006-2007)

15- Changes in the food consumption of children and adolescents (aged 3 to 17) between 1999 and 2007

- Strong increase in the consumption of stewed fruit
- Stabilisation in the consumption of fruit and vegetables
- Decrease in the consumption of bread, potatoes, milk, meat and poultry, and sugary foods among children aged 3 to 14
- Decrease in the consumption of meat and poultry among 15- to 17-year olds

(Source: INCA2, 2006-2007)

NUTRITION-RELATED DISEASES

1- Cause of morbidity

- Leading cause of morbidity
 - Among men: Cancer (33% of deaths)
 - Among women: Diseases of the circulatory system (31% of deaths)
- 2nd cause of morbidity
 - Among men: Diseases of the circulatory system (26% of deaths)
 - Among women: Cancer (23% of deaths)

(Source: La situation du cancer en France en 2010, Collection Rapports & synthèses, ouvrage collectif édité par l'INCa, Boulogne-Billancourt, novembre 2010, 288 p. [The State of Cancer in France in 2010, Collection of reports and summaries, composite work published by the French National Cancer Institute - INCa, Boulogne-Billancourt, November 2010, 288 p.])

2- Decrease in mortality

- **From cancer between 1980 and 2005**
 - Among men: -1.1%
 - Among women: - 0.9%

(Source: La situation du cancer en France en 2010, Collection Rapports & synthèses, ouvrage collectif édité par l'INCa, Boulogne-Billancourt, novembre 2010 [The State of Cancer in France in 2010, Collection of reports and summaries, composite work published by the French National Cancer Institute - INCa, Boulogne-Billancourt, November 2010])

- **From cardiovascular diseases between 1990 and 2005: - 35%**

(Source: Haut Conseil de la Santé Publique, Objectifs de santé publique, évaluation des objectifs de la loi du 9 août 2004, propositions. Collection : Avis et rapports. Avril 2010. 284 p. [High Council of Public Health, Public health objectives, evaluation of the objectives of the law dated 9th August 2004, proposals. Collection: Opinions and Reports. April 2010. 284 p.])

3- Cancers in 2010

- **Incidence: 357,500 new cases (203,000 among men and 154,500 among women)**
- **Annual increase in the rate of cancer incidence**
 - Among men: + 1.2%
 - Among women: + 1.4%
- **Number of deaths: 146,500**
- **The three most common types of cancer and the number of new cases**
 - Among men:
 - 1- Prostate: 71,500
 - 2- Lung: 27,000
 - 3- Bowel: 21,000
 - Among women:
 - 1- Breast: 52,500
 - 2- Bowel: 19,000
 - 3- Lung: 10,000

(Source: La situation du cancer en France en 2010, Collection Rapports & synthèses, ouvrage collectif édité par l'INCa, Boulogne-Billancourt, novembre 2010, 288 p. [The State of Cancer in France in 2010, Collection of reports and summaries, composite work published by the French National Cancer Institute - INCa, Boulogne-Billancourt, November 2010, 288 p.])

4- Cardiovascular diseases and risk factors

Number of deaths: 145,250 including

- 38,011 from ischemic heart disease (27% of cardiovascular deaths)
- 32,186 from cerebrovascular disease (22% of cardiovascular deaths)

(Source: French Centre of Epidemiology on Medical Causes of Death (CépiDc), 2006-2008 data)

5- Nutritional risk factors for cardiovascular diseases

	Definitions	Adults (aged 18 to 74)
Arterial hypertension	Systolic blood pressure \geq 140 mmHg and/or Diastolic blood pressure \geq 90 mmHg and/or Treatment with medication for controlling blood pressure	31% Men : 34.1% Women : 27.8% (15.7% are treated)
Dyslipidaemia	Triglyceride levels \geq 1.7 mmol/L and/or LDL cholesterol levels \geq 4.1 mmol/L and/or HDL cholesterol levels \leq 1.0 mmol/L and/or Treatment using lipid-lowering medications	43.9% (12.5% are treated)
Fasting hyperglycaemia	Fasting blood sugar \geq 7.0 mmol/L and/or Treatment using oral anti-diabetic medications	4.7% (3.4% are treated)

(Source: ENNS, 2006-2007)

- **Hypercholesterolemia with high levels of LDL (LDL \geq 4,1 mmol/L): 36.5%**

(Source: MONICA, 2007)

6- Diabetes

- **Prevalence of pharmacologically-treated diabetes in France (2007): 3.95%**, ie. 2.5 million treated diabetics, of which 600,000 are treated with insulin
- **Prevalence rate by age group**
 - 0-44 years: 0.4%
 - 45-64 years: 5.8%
 - 65-74 years: 13.3%
 - 75 and over: 13.4%
- **Highest prevalences in French overseas regions:**
 - Reunion Island: 7.8%
 - Guadeloupe: 7.3%
 - Martinique: 6.8%

(Source: Kusnik-Joinville O., Weill A., Ricordeau Ph., al. "Diabète traité en France en 2007 : un taux de prévalence proche de 4 % et des disparités géographiques croissants" [Treated diabetes in France in 2007: a prevalence rate of near 4% and growing geographical disparities]. InVS [French Institute for Public Health Surveillance]. Weekly Epidemiological Bulletin (BEH) n°43, 12 November 2008. p. 408-413.)

TRENDS IN THE PROMINENCE OF THE PNNS NUTRITIONAL TOOLS AND MESSAGES



The PNNS tools are increasingly recognised*

	2005	2009
PNNS logo	19%	25%
At least one of the nutrition guides	17%	24%
The mangerbouger.fr website	13%**	62%

*: in 2006



Trends in the frequency of mention of the recommendations between 2006 and 2009*

PNNS recommendations	Frequency of mention	
	In 2006	In 2009
At least 30 minutes of physical activity per day	91%	91%
1 to 2 servings of meat, fish or eggs per day	71%	66%
At least 5 servings of fruit and vegetables per day	47%	75%
3 servings of dairy products per day	29%	40%
3 servings of starchy foods per day	12%	19%

*Source: Survey conducted regularly since 2005 to measure the evolution of the prominence of various indicators (the PNNS logo, the nutrition guides, the mangerbouger.fr website, and the nutritional recommendations set out in the PNNS), quantitative quota-based survey conducted face-to-face among a representative sample of the population aged 15 years and over (1000<n<2000), National Institute for Prevention and Health Education (INPES)

List of abbreviations

ACAPS Association des Chercheurs en Activités Physiques et Sportives French Association of Researchers in Physical and Sporting Activities	ANR Agence nationale de recherche French National Research Agency
ADEL Association Française des Épidémiologistes de Langue Française French Association of French-speaking Epidemiologists	ANSES Agence nationale de sécurité sanitaire de l'alimentation, de l'environnement et du travail National Agency responsible for Food, Environmental and Occupational Health Safety
ADEMS Association des Éducateurs Médico-Sportifs Adapted Physical Activity Coaches French Association	APOP Association pour la Prévention et la prise en charge de l'Obésité en Pédiatrie French Association for Prevention and Management of Obesity in Paediatrics
AFAPA Association Francophone en Activités Physiques Adaptées Francophone Adapted Physical Activity Association	ARS Agence régionale de santé Regional Health Agency
AFDN Association Française des Diététiciens Nutritionnistes Nutritionist-Dieticians French Association	CEN Collège des Enseignants de Nutrition Nutrition Teachers French College
AFERO Association Française d'Études et de Recherches sur l'Obésité French Association for Obesity studies and researches	CGAAER Conseil général de l'alimentation, de l'agriculture et des espaces ruraux General Council of Agriculture, Food and Rural Areas
AFPA Association Française de Pédiatrie Ambulatoire French Association of Ambulatory Paediatrics	CNCF Collège National des Cardiologues Français French Cardiologists National College
AFRAPS Association Francophone pour la Recherche sur les Activités Physiques et Sportives Francophone Research Association for Physical and Sporting Activities	CNFPT Centre national de la fonction publique territoriale National Centre of territorial civil services
AFSSAPS Agence française de sécurité sanitaire des produits de santé French Health Products Safety Agency Named ANSM since 2012 Agence nationale de sécurité du médicament et des produits de santé French Health Products Safety Agency	CNRÉPPOP Coordination nationale des Réseaux de prévention et prise en charge de l'obésité pédiatrique National Committee of Networks for the Prevention and Management of Paediatric Obesity
AMISP Association des Médecins Inspecteurs de Santé Publique French Association of Public Health Physicians	CRALIM Comité Régional de l'Alimentation Regional Committee for Food
ANCRED Coordination des réseaux diabète Coordination of Diabetes Networks French National Association	CUESP Collège Universitaire des Enseignants en Santé Publique Public Health Teachers French College
ANPAA Association Nationale de Prévention en Alcoologie et Addictologie Prevention in Alcoholology and Addictology National Association	DAP Direction de l'administration pénitentiaire Department of Prison Administration
	DGER Direction Générale de l'Enseignement et de la Recherche Teaching and Research Department
	DGMIC Direction Générale des Médias et des Industries culturelles Directorate-General of the Media and Cultural Industries

DGS Direction générale de la santé Health Department	MDPH Maison départementale des personnes handicapées Local office for handicap
DPJJ Direction de la Protection judiciaire de la Jeunesse Department for the Judicial Protection of Minors	NSFA Nouvelle Société Française d'Athérosclérose Atherosclerosis New French Society
DREES Direction de la recherche, des études, de l'évaluation et des statistiques Department of statistics for the ministry of Social affairs and health	Ligue nationale de lutte contre le cancer French National League Against Cancer
ENNS Etude nationale nutrition santé National study on nutrition and health	OQALI Observatoire de la qualité de l'alimentation Food quality observatory
EPITER Association des Épidémiologistes de Terrain French Association of Field Epidemiologists	PHRC Programme hospitalier de recherche clinique Hospital program for clinical research
FFC Fédération Française de Cardiologie Cardiology French Federation	PNA Programme national d'alimentation National Food Strategy
FNES Fédération Nationale des comités d'Éducation pour la Santé Health Education Committees French Federation	PNNS Programme national nutrition santé French National Nutrition and Health Programme
HAS Haute Autorité de Santé French National Health Authority	PNSE Plan national santé environnement National Environment and Health Plan
HCSP Haut conseil de santé publique High committee on public health	PO Plan obésité Obesity Plan
IGAS Inspection Générale des Affaires Sociales French General Inspectorate of Social Affairs	SFC Société Française de Cardiologie Cardiology French Society
INCA Institut National du cancer National cancer institute	SFGG Société Française de Gériatrie et de Gériologie Geriatrics and Gerontology French Society
INPES Institut national de prévention et d'éducation pour la santé National Institute for Prevention and Health Education	SFN Société Française de nutrition French Nutrition Society
INSERM Institut national de la santé et de la recherche médicale National Institute for health and medical research	SFP Société Française de Pédiatrie French Society of Paediatrics
InVS Institut de veille sanitaire Public Health Surveillance French Institute	SFRMS Société Française de Recherche et de Médecine du Sommeil French Society of Sleep Research and Medicine
IPAQSS Indicateurs Pour l'Amélioration de la Qualité et de la Sécurité des Soins Indicators for air quality improvement	SFSP Société française de santé publique French Society of Public Health

More information:

www.sante.gouv.fr