NAO
National Audit Office
MALTA

A review of the implementation of Sustainable Development Goal 2: Addressing pre-obesity and obesity

July 2023

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Report by the Auditor General
July 2023

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List of Abbreviations

BMI	body mass index
CDC	Center for Disease Control and Prevention
COSI	Childhood Obesity Surveillance Initiative
EHIS	European Health Interview Survey
ERA	Environment and Resources Authority
ESF	European Social Fund
FEAD	Fund for European Aid to the Most Deprived
EU	European Union
GLP-1	glucagon-like peptide 1
HBSC	Health Behaviour in School-aged Children
HPDP	Health Promotion and Disease Prevention Directorate
IM	Infrastructure Malta
INTOSAI	International Organization of Supreme Audit Institutions
ISAM	IDI's SDG Audit Model
ISCED	International Standard Classification of Education
ITS	Institute of Tourism Studies
MAFA	Ministry for Agriculture, Fisheries, Food and Animal Rights
MDH	Mater Dei Hospital
MEYR	Ministry for Education, Sport, Youth, Research and Innovation
MFAA	Ministry for Active Ageing
MFE	Ministry for Finance and Employment
MFH	Ministry for Health
MHAL	Ministry for the National Heritage, the Arts and Local Government
MHSR	Ministry for Home Affairs, Security, Reforms and Equality
MSPC	Ministry for Social Policy and Children's Rights
MTIP	Ministry for Transport, Infrastructure and Capital Projects
NAO	National Audit Office
NGO	non-governmental organisation
PA	Planning Authority
SDG	Sustainable Development Goal
SPED	Strategic Plan for Environment and Development
TM	Transport Malta
UN	United Nations
WHO	World Health Organization

Executive Summary

1. The Sustainable Development Goals (SDGs), adopted by all United Nations Member States in 2015, reflect the global drive to eradicate poverty, safeguard the environment and promote peace and prosperity among all by 2030. The SDGs recognise that ending poverty and other deprivations requires concurrent improvements in health and education, reductions in inequality, and spurring of economic growth. SDG 2, as defined by the 2030 Agenda for Sustainable Development, aims to 'end hunger, achieve food security and improved nutrition and promote sustainable agriculture'. Within the European Union (EU), the attainment of healthy diets and productive and sustainable agricultural systems are the key challenges associated with SDG 2. SDG target 2.2 aims to 'end all forms of malnutrition'. According to the World Health Organization, malnutrition refers to deficiencies or excesses in nutrient intake, imbalance of essential nutrients or impaired nutrient utilisation. The double burden of malnutrition consists of undernutrition, pre-obesity and obesity on one hand, and diet-related noncommunicable diseases on the other.

2. Unlike many areas of the world, where hunger is a widespread issue, the EU's prominent nutritional issue is overweight. Overweight (comprising pre-obesity and obesity) is recognised as harmful to health and well-being, and negatively impacting health and social systems and public spending, as well as economic productivity and growth. The high prevalence of adult and childhood pre-obesity and obesity in Malta, the associated additional cost burdens on public expenditure, and the impact of obesity on morbidity, quality of life, mental wellbeing and life expectancy underlie the decision to focus this review on the Government's efforts aimed at reducing the prevalence of pre-obesity and obesity. This review, which focuses on SDG target 2.2, and more specifically the reduction of overweight, be it in terms of pre-obesity or obesity, is consistent with the role assigned to supreme audit institutions in respect of the successful realisation of the SDGs – that of conducting reviews that measure progress on particular goals.

3. This review sought to conclude whether progress has been registered in reducing the pre-obese and obese prevalence rates; whether Government has undertaken sufficient and effective efforts to address pre-obesity and obesity, and if the needs of vulnerable groups have been addressed; whether there is sufficient communication, coordination and cooperation within Government to address this issue; and whether Government managed to create a positive and enabling environment for non-Government stakeholders to contribute in efforts aimed at addressing pre-obesity and obesity.

4. To assess whether progress has been registered in reducing the proportion of the population that is pre-obese, obese and overweight, the National Audit Office (NAO) considered trends in prevalence over recent years and whether the targets set in 2012 in the Healthy Weight for Life Strategy were reached by 2020 – the implementation period deadline. The data reviewed either indicates no progress, or,

in most cases, provides evidence of regression. Statistics for the period 2013 to 2019 corresponding to children aged seven indicate stable rates for the obesity indicator (17.0 per cent to 17.1 per cent) and an increasing trend in pre-obesity (16.0 per cent to 18.3 per cent) and overweight (33.0 per cent to 35.4 per cent). In the case of adolescents aged 11, 13 and 15, data for the period 2014 to 2018 indicate an increasing trend for all three indicators. The pre-obesity prevalence rate increased from 20.0 to 22.4 per cent, while the obesity rate increased from 7.3 to 8.9 per cent and that of overweight from 27.3 to 31.2 per cent. A similar increase for all three indicators is noted for adults aged 15+ for the period 2014 to 2019. The 2019 pre-obese, obese and overweight prevalence rates were 35.7, 28.1 and 63.8 per cent, respectively, up from those of 2014, which stood at 34.4, 25.2 and 59.6 per cent, respectively.

5. The NAO's overall assessment in terms of the achievement of the targets set is negative, with only one of the four targets, that relating to adolescents, having been met. The target relating to adolescents was set as the maintenance of the proportion of 13-year-olds who are obese below 15 per cent. The data sourced by the NAO indicates that 7.4 per cent of 13-year-olds were obese in 2018, and therefore, the obesity prevalence rate among adolescents was effectively halved in the period 2006 to 2018, far exceeding the target set. However, when considering the overweight indicator as opposed to the obesity indicator for adolescents, a bleaker picture emerges. The percentage of adolescent boys and girls classified as overweight increased from 31 per cent in 2006 (both genders) to 38 and 35 per cent in 2018, respectively. In the case of the adult pre-obesity target, the envisioned reduction in prevalence from 36 to 33 per cent was not secured and instead the rate of pre-obese adults remained constant, with adult pre-obesity prevalence reported at 35.7 per cent in 2019. As regards the adult obesity target and the child overweight target, not only were the envisioned reductions (from 22 to 18 per cent for adult obesity and 32 to 27 per cent for child overweight) not realised, but prevalence increased substantially when compared to the rates at the start of the implementation period. Adult obesity registered an increase of around six percentage points, with 28.1 per cent of the population aged 15+ being classified as obese in 2019. The child overweight indicator rate increased to 33 per cent in 2019 and 35.4 per cent in 2022 (preliminary results).

6. In considering the lack of progress registered, the NAO takes cognisance that the failure to reduce pre-obesity and obesity prevalence rates is not unique to Malta. Moreover, this Office acknowledges the complex nature of overweight, the pervasive and strong presence of an obesogenic environment that is not entirely within the control of the Government, as well as the element of personal responsibility and choice.

7. As to whether the Government's efforts to address pre-obesity and obesity were sufficient and effective, the NAO acknowledges the investment and efforts undertaken by the Government, including legislative changes, policy developments, as well as implemented projects, measures and initiatives. Evidence of this was provided by the stakeholders this Office consulted with during the course of this review, and were included in the records of work of the Advisory Council and in the information made available by the Strategy Development and Implementation Unit, within the Office of the Superintendent of Public Health, Health Regulation Department in relation to the implementation progress of the Healthy Weight for Life Strategy. The Office commends the work undertaken by the Advisory Council

on Healthy Lifestyles to identify, consult with and secure the cooperation of relevant stakeholders, analyse the potential impact of different measures, explore funding source/s and lobby for change. The assessment of the implementation progress for the 89 areas for action included in the Healthy Weight for Life Strategy provided evidence of substantial resources and efforts invested and progress registered in specific areas, such as actions related to the promotion of healthy eating in life stages and within specific settings, the promotion of physical activity in schools and for the general population, including spatial planning efforts, the reorientation of health services, the development of community and specific services, and other initiatives, including structural action, economic instruments and research initiatives and prevalence surveillance mechanisms. Stakeholders also highlighted various positive efforts that have helped improve the physical and food environment.

8. However, current statistics for pre-obesity and obesity in themselves provide enough evidence that these efforts are not sufficiently comprehensive and effective. The latest statistics show 35.4 per cent, 31.2 per cent and 63.8 per cent of the child, adolescent and adult population being overweight. The assessment of implementation of the Strategy also identified areas of unknown or no progress. Moreover, in reviewing the log of implementation efforts, the NAO noted several instances where the identified implemented actions were at best tokenistic or tangential in their address of the respective area for action, or limited in scope, and in a few cases could be argued to be unrelated. Sustained high prevalence rates of overweight and the individual and national implications of obesity motivate some stakeholders' concerns that the gravity of the situation, in terms of scope and severity, is not being fully acknowledged by the Government or the public and that action taken is not commensurate to the scale of the problem.

9. The analysis of data relating to food consumption patterns and physical activity indicated high prevalence of behaviours that may impact health outcomes negatively and contribute to overweight, and the need for further efforts to motivate, enable and sustain healthier food consumption and more active lifestyles. More specifically, statistics indicate sub-optimal consumption of fruit and vegetables, more pronounced with respect to vegetables among all age categories, regular consumption of soft drinks by a considerable percentage of the population, this being highest among adolescents, over-consumption of sweets among adolescents, inconsistent daily breakfast consumption for most adolescents and a substantial proportion of children, and physical activity levels below minimum recommended levels for most adolescents and adults.

10. The NAO acknowledges feedback from stakeholders highlighting gaps in funding, human resources and service provision, as well as a current state of affairs where the address of obesity is not an overarching priority across the different sectors of the Government. While various funding allocations were acknowledged, concerns regarding the sufficiency of funding were expressed by stakeholders. More specifically, stakeholders questioned whether tackling overweight was prioritised when allocating funding, noted that the funds allocated for the obesity vote and for the provision of weight management programmes are consistently substantially lower than the requested amount, and considered the healthcare vote and staff complement allocated for health promotion and the prevention of non-communicable diseases to be very limited. Providers of weight management programmes indicated experiencing capacity shortages and struggling to find suitable candidates to recruit, in view of

supply issues and funding limitations. The omission of medication that can assist weight loss as part of the Government formulary list of medication was considered to hinder the medical treatment of patients with complex obesity. Attention was drawn to the fact that with respect to the various weight management programmes offered by the public health sector, no visibility on the long-term outcome is available, as follow-up studies that determine whether weight loss was maintained at specific time intervals after programme termination are not undertaken. Stakeholders spoke of insufficient cooperation and commitment from non-health stakeholders and sectors, weak communication and coordination between sectors, and poor policy integration. Current efforts from non-health stakeholders and sectors were not considered sufficient to create an enabling environment that facilitates healthy choices, with specific emphasis placed on the built environment. Also of concern to the NAO is the limited legislative changes implemented, far reduced in scope than those originally intended in the original private member's bill tabled to address obesity.

11. This Office advocates for strengthened political will to make the address of overweight a national priority across sectors, and for the allocation of appropriate resources and funding, as well as the undertaking of sufficient efforts commensurate with the gravity of the situation at hand. The NAO encourages Government to consider the multiple suggestions put forward by the many stakeholders consulted in this review, to inform future plans and actions to create an enabling environment that facilitates healthy choices with respect to physical activity and food consumption. Suggestions put forward included recommendations for policy and legislative changes, further fiscal measures, health education and health promotion initiatives, improvements to available weight management programmes and efforts relating to food labelling, food reformulation, portion size regulation, aisle placement changes, pesticide use control, physical activity opportunities and spatial planning.

12. The NAO is of the opinion that while the Government has undertaken several measures that positively address the vulnerabilities of particular groups, more varied and sustained efforts are required to effectively reach all vulnerable groups. The review of the Advisory Council's meeting minutes indicated that the Council considered the specific needs of vulnerable groups, with vulnerability mainly considered in terms of one's financial means, and assessed the impact of planned interventions in this respect. Various implemented targeted interventions were identified by stakeholders and by the NAO. On the other hand, disaggregated statistics and the feedback sourced from stakeholders provide insight into the systemic disadvantages of specific demographic groups, which insight can further direct Government in the design of future efforts. The NAO also noted that while some targeted efforts were envisaged in the Healthy Weight for Life Strategy, most areas for actions included generic interventions intended for specific age groups or settings, with no provisions specifically designed for particular socio-economic groups. This Office commends the Advisory Council's favourable disposition to further target vulnerable groups in future interventions and advises Government to consider the several suggestions for targeted interventions put forward by stakeholders in planning future action.

13. In assessing whether there is sufficient communication, coordination and cooperation within Government in its efforts to reduce pre-obesity and obesity, this Office considered strategic level issues and aspects relating to service provision. At the strategic level, the NAO considered the adequacy of the governance structure and the strategy implementation framework, as well as whether a whole-

of-government approach and policy coherence has been secured. At the service provision level, the extent of cooperation and overlap between different weight management services as well as educational campaigns was considered.

14. The NAO is of the opinion that the Advisory Council provides an adequate framework for enabling communication, coordination and cooperation within Government and for promoting a whole-of-government approach to addressing pre-obesity and obesity. In this respect, while the NAO is not opposed to the consideration of other alternative governance structures as suggested by stakeholders, this Office is of the opinion that strengthening the Council – possibly through the inclusion of other key ministries, the allocation of a supporting staff complement, additional resources and a separate research body – could help secure more impactful outputs and positive outcomes in terms of the set targets. Additionally, the NAO recognises the need for the Council to further widen its consultative processes to include more stakeholders from other sectors, public and private, and to introduce a more robust monitoring and implementation framework. This Office is of the opinion that status updates submitted by stakeholders regarding the Strategy implementation progress ought to be assessed by the Ministry for Health (MFH) with greater rigour. Moreover, it is suggested that, to facilitate implementation, the next strategy should clearly outline the areas of responsibilities of different ministries and stakeholders and concrete expected outputs specified for the short-, medium- and long-term, to allow for strengthened implementation ownership and more valid and effective monitoring.

15. The NAO notes the efforts undertaken to promote whole-of-government cooperation and a health-in-all-policies approach to tackling overweight, evident in terms of the inter-ministerial and multi-sectoral approach promoted in the Healthy Weight for Life Strategy and other health strategies; the cross-sectoral measures developed and the collaboration encouraged by the Advisory Council; as well as through the health considerations integrated in non-health policies and initiatives. On the other hand, this Office acknowledges the concerns raised by stakeholders regarding elements of incoherence in the wider policy framework, with economic considerations at times superseding or even conflicting with health-related priorities. The NAO advocates for additional efforts to further develop and nurture a health-in-all-policies approach to policy-making across Government. This Office also acknowledges the concerns raised by stakeholders relating to policy implementation shortcomings and inconsistencies between policy frameworks and major projects design, and advocates for strengthened political will to prioritise health considerations.

16. The NAO recognises the need for further cooperation across ministries and entities at the level of policy implementation and service provision to address the silo mentality identified by a few participants within the MFH and across Government. In view of the complexity of overweight, this Office advocates for coordinated efforts by all sectors to ensure lack of replication and enhanced endeavours through more synergistic and impactful activities and initiatives. The MFH alone cannot be held responsible for addressing overweight as most of the factors within our obesogenic environment that contribute, sustain or exacerbate overweight are not within the control of this Ministry. While health entities can educate the public as to the benefits of a healthy lifestyle and advocate for policies and initiatives

that promote healthy lifestyles across all sectors, their influence in creating an enabling environment is limited.

17. In relation to service provision, the NAO recognises that there is unclear differentiation between the weight management programmes offered by the Primary HealthCare and the Health Promotion and Disease Prevention Directorate, and that further efforts are required to identify distinct roles and areas of cooperation. In response to concerns raised regarding dwindling communication and cooperation within the sector over recent years, the NAO advocates for enhanced efforts in this regard to ensure the optimised utilisation of resources, knowledge sharing and ultimately better outcomes for patients. This Office supports the consideration of the various recommendations put forward by stakeholders to improve cooperation within the healthcare sector, including the introduction of integrated health patient records, a comprehensive database of available services, established information dissemination channels and educational seminars for professionals. In terms of the fragmented educational campaigns, the NAO recognises the validity of coordinating efforts for a unified, consistent message.

18. The final aspect of review considered by the NAO related to whether the Government provided an enabling and positive environment for other non-governmental actors, including business stakeholders, non-governmental organisations, academics, professionals in the field and affected groups, to contribute to efforts aimed at reducing the prevalence of pre-obesity and obesity. The NAO is of the understanding that the first step in providing an enabling and positive environment that is conducive to the contribution of other stakeholders is the consideration of stakeholders when designing policy and action. This Office's review of the Healthy Weight for Life Strategy, the records of work of the Advisory Council and focus group discussions suggests that this consideration is central to Government's approach to tackling overweight, and recommends for these considerations to be sustained in the future. More specifically, the Government has considered how stakeholders influence behaviours that contribute to excess weight in the population, the potential contribution of different stakeholders in addressing this issue, possible areas of collaboration and envisaged pushback to intended actions.

19. The NAO also considered the extent to which the Government consulted with various non-governmental stakeholders in the design of legislation, policy, initiatives and services. This Office recognises the various efforts undertaken by the Advisory Council to consult and foster cooperation with actors external to the Government; however, contends that there is scope for wider and more impactful consultative practices. In this respect, the NAO supports the Council's resolution to undertake further consultation with other stakeholders going forward, to secure additional feedback and areas of agreement and cooperation from different sectors. With respect to policy consultation, the NAO commends the wide-ranging consultation undertaken in the process of drafting and finalising the Healthy Weight for Life Strategy. Nevertheless, in view of the feedback of certain stakeholders regarding their lack of involvement, this Office is of the opinion that there is scope for improvement in terms of the breadth of stakeholders to be consulted when drafting the upcoming strategy. The scope for wider consultative practices also applies more broadly to legislative drafting, policy formulation and service design, delivery and evaluation across sectors, to allow for a more inclusive, comprehensive and grassroots

approach to governance. This Office specifically supports proposals for wider and more meaningful communication with patient representatives and professionals who practice or conduct research in the field, in the private and public sector, and employers and private sector stakeholders.

20. Finally, the NAO considered the extent to which positive developments, including areas of cooperation for implemented actions, have been secured with non-governmental stakeholders. The NAO commends the progress registered, albeit limited, in private sector settings and with non-governmental stakeholders. Specifically, this Office notes the positive developments relating to healthcare practitioners working in the private sector, sports non-profit organisations, food reformulation of local products, and within school and workplace settings. The NAO acknowledges that there is ample scope for additional collaboration with non-governmental stakeholders, to capitalise on all available resources, overcome capacity shortages and ensure a holistic approach towards tackling overweight. This Office supports the view expressed by several stakeholders that businesses should be more broadly and intensely consulted to explore areas of cooperation and be incentivised and supported to offer healthier products and services and work environments. Business could substantially aid Government's efforts should they find it profitable to subscribe to the agenda to address overweight. The NAO advises Government to consider the various proposals put forward by stakeholders for increased collaboration with non-governmental organisations, academics, business operators, including employers, and professional associations and health care professionals operating in the private sector.

Chapter 1| Pre-obesity and obesity: The Maltese context

1.1 Sustainable Development Goal 2: A focus on Target 2.2 – Tackling obesity

1.1.1 Sustainable development is commonly defined as development that meets the needs of the present without compromising the ability of future generations to meet their own needs. In effect, sustainable development goes beyond a sole concern for the environment, with focus also placed on the balance between economic and social progress in efforts to achieve sustainability. This concept was translated in the setup of the Sustainable Development Goals (SDGs), which reflect the global drive to eradicate poverty, safeguard the environment and promote peace and prosperity among all. The SDGs recognise that ending poverty and other deprivations requires concurrent improvements in health and education, reductions in inequality, and spurring of economic growth – all while preserving the physical environment. The SDGs were adopted by all United Nations (UN) Member States in 2015 and the targets were set to be reached by 2030.

1.1.2 SDG 2, as defined by the 2030 Agenda for Sustainable Development, aims to 'end hunger, achieve food security and improved nutrition and promote sustainable agriculture'. Within the European Union (EU), the attainment of healthy diets and productive and sustainable agricultural systems are the key challenges associated with SDG 2. Unlike many areas of the world, where hunger is a widespread issue, the EU's prominent nutritional issue is overweight. In 2019, 53 per cent of adults living in the EU were considered overweight, of which 36 per cent were pre-obese and 17 per cent obese. Obesity is recognised to harm health and well-being, negatively impact health and social systems and public spending, as well as economic productivity and growth.

1.1.3 The SDG target 2.2 aims to end all forms of malnutrition by 2030. Malnutrition is not restricted to undernourishment, stunting and wasting, but also includes the other end of the spectrum, that is, obesity. These aspects of malnutrition are captured in the standard indicators for SDG 2.2 at the international level, including the prevalence of obesity. In the case of adults, this is defined as the percentage of the adult population that has a body mass index (BMI) of 30kg/m2 or higher, based on measured height and weight. In the case of children under five years of age, this is defined as those children with a weight to height ratio greater than two standard deviations above the World Health Organization (WHO) Child Growth Standards median.

1.1.4 The often-cited interconnectedness of SDGs also applies to obesity, with interlinkage with many other SDGs, including SDG 10 (reduction of inequalities), SDG11 (sustainable urbanisation) and SDG12 (sustainable consumption and production), highlighted. However, most relevant in this respect is the connection with SDG3, which focuses on good health and wellbeing and includes a target for the reduction of one third premature mortality from non-communicable diseases through prevention and

treatment and the promotion of mental health and wellbeing (Target 3.3). Good health and wellbeing are essential components of sustainable development, conducive to the promotion of economic prosperity and the reduction of poverty and inequality.

1.2 Malta's rating with respect to Sustainable Development Goal 2

1.2.1 The 2022 SDG Index and Dashboards Report, which measures countries' progress towards the achievement of all SDGs, ranked Malta 33rd out of 163 countries. In 2021, Malta ranked 33rd out of 165 countries. These reports, and progress registered therein, are not comparable year-on-year in view of changes in the indicators and refinements in the methodology of the indicator frameworks and the data collection processes. Instead, the Index provides a unique snapshot of the progress registered in that particular year. Notwithstanding this, the Index helps gauge Malta's performance in terms of the achievement of the targets and allows for comparisons with other countries.

1.2.2 In the 2021 and 2022 SDG Index and Dashboards Reports (Figure 1 and Figure 2, respectively), SDG2 was rated as a major challenge for Malta, although a moderately improving trend was reported. This rating and trend has been consistent since 2017. SDG2 includes indicators for undernourishment, prevalence of stunting and wasting in children under five years of age, human trophic level, cereal yield, sustainable nitrogen management index and exports of hazardous pesticides, as well as prevalence of obesity in the adult population. Malta performs poorly on the obesity indicator and the sustainable nitrogen management index.

Figure 1 | Malta's achievement of SDG2 - SDG Index Country Profile, 2021

SDG2 – Zero Hunger	Value	Year	Rating	Trend
Prevalence of undernourishment (%)	2.5	2018	●	↑
Prevalence of stunting in children under 5 years of age (%)	2.6	2018	●	↑
Prevalence of wasting in children under 5 years of age (%)	0.7	2018	●	↑
Prevalence of obesity, BMI ≥30 (% of adult population)	28.9	2016	●	↓
Human trophic level (best 2-3 worst)	2.3	2017	●	→
Cereal yield (tonnes per hectare of harvested land)	4.9	2018	●	↑
Sustainable nitrogen management index (best 0-1.41 worst)	0.9	2015	●	↓
Exports of hazardous pesticides (tonnes per million population)	2.3	2018	●	●

● Achieved; ● Challenges remain; ● Significant challenges; ● Major challenges

↑ On track or maintaining achievement; → Stagnating; ↓ Decreasing

● Information unavailable

■ Overall SDG 2 Rating: Major challenges; ↗ Overall SDG2 Trend: Moderately improving

Figure 2 | Malta's achievement of SDG2 - SDG Index Country Profile, 2022

SDG2 – Zero Hunger	Value	Year	Rating	Trend
Prevalence of undernourishment (%)	2.5	2019	●	↑
Prevalence of stunting in children under 5 years of age (%)	2.6	2019	●	↑
Prevalence of wasting in children under 5 years of age (%)	0.7	2019	●	↑
Prevalence of obesity, BMI ≥30 (% of adult population)	28.9	2016	●	↓
Human trophic level (best 2-3 worst)	2.3	2017	●	→
Cereal yield (tonnes per hectare of harvested land)	4.9	2018	●	↑
Sustainable nitrogen management index (best 0-1.41 worst)	0.9	2015	●	↓
Exports of hazardous pesticides (tonnes per million population)	0.0	2019	●	●

● Achieved; ● Challenges remain; ● Significant challenges; ● Major challenges

↑ On track or maintaining achievement; → Stagnating; ↓ Decreasing

● Information unavailable

■ Overall SDG 2 Rating: Major challenges; ↗ Overall SDG2 Trend: Moderately improving

1.2.3 Specifically with respect to obesity, the SDG Index and Dashboards Reports have so far only reported the prevalence of obesity in the adult population. In the case of Malta, in 2021 and 2022, 28.9 per cent of the adult population were reported as having a BMI of 30 or higher. These values were based on 2016 data and were cited consistently in the yearly reports for the period 2018-2022. Earlier data for this indicator was reported in the 2017 report, which indicated a 26.6 per cent prevalence rate. For this reason the 2021 and 2022 reports indicate a worsening trend, while all reports for Malta (2017-2022) systematically present obesity as a major challenge.

1.3 The measurement framework

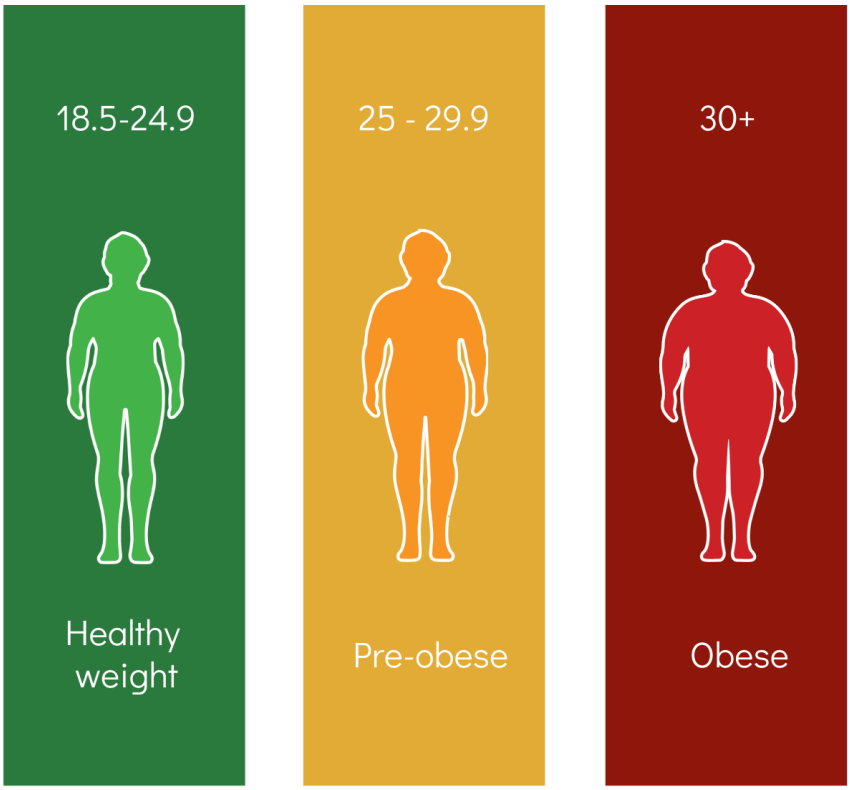
1.3.1 Different tools are used within the local setting to measure overweight. The European Health Interview Survey (EHIS) is one such tool, conducted every five years and targeting the population of persons 15 years and older. Another is the Health Behaviour in School-aged Children (HBSC), which is conducted every four years and focuses on 11-, 13- and 15-year-olds. Third is the WHO European Childhood Obesity Surveillance Initiative (COSI), which focuses on 7- to 9-year-olds. For round one (2008) and round two (2010) of COSI Malta sampled 6-year-olds, while 7-year-olds were sampled for subsequent rounds. These three tools are the main sources of data for pre-obesity and obesity figures. There is therefore some overlap in the target population of the HBSC and the EHIS in terms of 15-year-olds, and some gaps, with certain age groups not captured in any of these studies. Unlike the HBSC and the EHIS, the COSI is not self-reported but involves an anthropometric assessment, which means that the 7- to 9-year-olds that participate in this process are measured directly. This aspect of assessment assumes relevance when one considers that there is a certain element of bias when it comes to self-reported weight and height, due to overreporting and underreporting of measurements. Despite such biases, self-reported data is still beneficial to observe trends over time.

1.3.2 Excess adiposity is assessed in these studies through BMI measurements. The BMI is a measure of a person's weight relative to their height. While the BMI is not a perfect measure of adiposity, as it does not distinguish between fat and other tissue, it has been found to be a practical and valid measure for

adiposity in clinical and surveillance settings. The BMI does not require specialised skills or equipment and the measurement procedure is non-invasive and is not resource or time intensive. It is calculated as a person's weight (in kilograms) divided by the square of his or her height (in metres).

1.3.3 In the case of adults, persons with a BMI greater than or equal to 25 are considered overweight, those with a BMI of 30 or higher are considered obese, and those with a BMI ranging from 25 (inclusive) to 30 (exclusive) are considered pre-obese. Overweight is therefore the summation of pre-obese and obese. This definition also applies for the other data sources.

Adult BMI thresholds

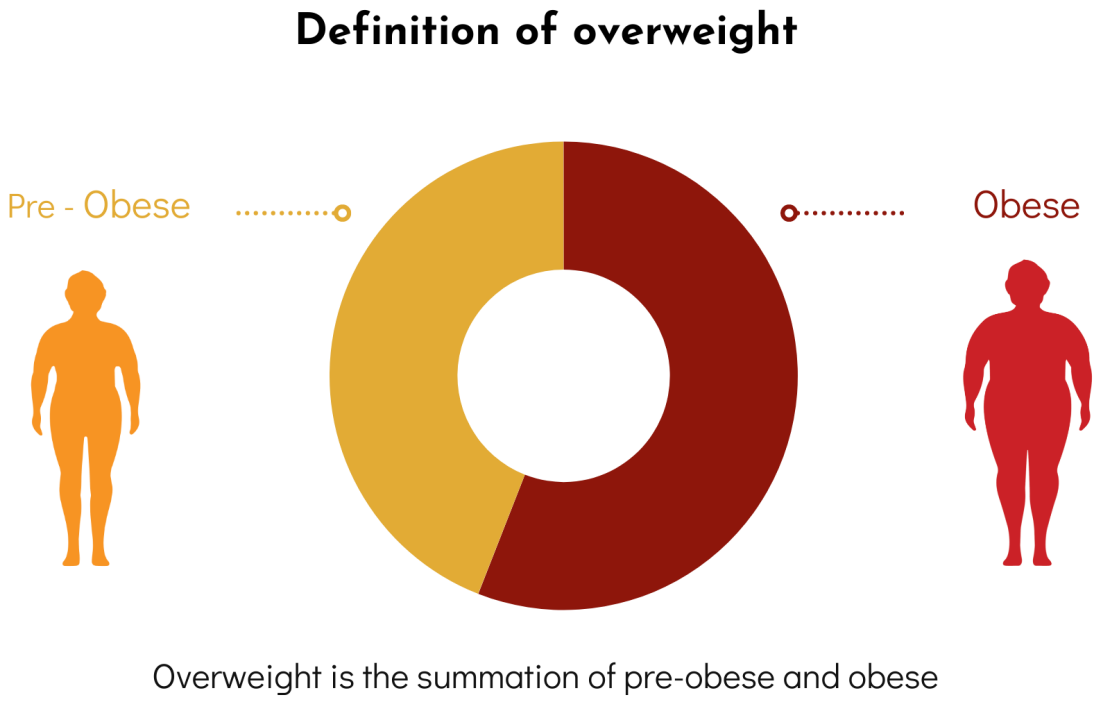


1.3.4 In the case of children and adolescents, one single cut-off point for overweight and obesity is not suitable because of developmental differences by age and between genders. In such age groups, two approaches to defining pre-obesity and obesity are widely used – a distributional approach and the application of international age- and gender- specific BMI thresholds. The Center for Disease Control and Prevention (CDC) and the WHO criteria use the distributional approach. The CDC defines children with BMIs equal to or greater than the 85th and 95th percentile values of the US national growth charts for the corresponding age and sex, as overweight and obese, respectively. The WHO defines children aged 5 to 19 years as overweight and obese if their BMI z-score[1] is one standard deviation and two standard deviations above the WHO Growth Reference median for the corresponding age and sex respectively. The other approach determines children as overweight and obese on the basis of

[1] A z-score, also known as a standard score, is a statistical measure that represents the number of standard deviations an individual data point is away from the mean of a distribution. It is used to standardise data and compare individual observations to the overall distribution.

age- and gender- specific BMI thresholds corresponding to adult reference levels projected backwards onto children based on a large international sample of children and youth from six countries. These thresholds have been sanctioned by the International Obesity Task Force.

1.3.5 Aside from COSI, HBSC and EHIS, ad hoc studies undertaken by researchers and policy-mandated reviews, such as that carried out on preschool children by the Office of the Superintendence of Public Health and the Ministry for Education, Sport, Youth, Research and Innovation (MEYR), also provide information about the prevalence of pre-obesity and obesity within the local setting.



1.4 Malta's prevalence rates

1.4.1 Statistics from the EHIS, HBSC and COSI studies show that Malta has alarming levels of overweight (Figure 3 refers), especially among adults, with increasing trends over time in prevalence rates.

Figure 3 | Malta's latest prevalence rates

Population group	Data Source	Pre-obese (%)	Obese (%)	Overweight (%)
7-year-olds	COSI, 2022 (preliminary figures)	18.3	17.1	35.4
11-, 13-, 15-year-olds	HBSC, 2018	22.4	8.9	31.2
15-year-olds and over	EHIS, 2019	35.7	28.1	63.8

1.4.2 The third wave of data collection of the EHIS, which provides harmonised statistics across the EU member states in relation to respondents' health status, lifestyle and their use of healthcare services, indicates distressing results for Malta. In 2019, Malta recorded the highest obesity rates among persons of age 15 years and over, equal to 28.1 per cent of the population, substantially higher than the EU average of 16.0 per cent. Malta also recorded the highest proportion of overweight, with 63.8 per cent of the population aged 15 years and over classified as either pre-obese or obese. This

is again substantially higher than the EU average of 51.2 per cent. Disaggregating these rates by gender clearly indicates that men are at a disadvantage. More specifically, 30.2 and 25.9 per cent of men and women, in comparison to an EU average of 16.3 and 15.8 per cent, respectively, are obese. Furthermore, 70.2 and 57.1 per cent of Maltese men and women are overweight, in comparison to an EU average of 58.4 and 44.6 per cent, respectively. Local obesity and overweight rates showed an increase in comparison to the previous wave of the EHIS, with 2014 rates being equal to 25.2 and 59.6 per cent, respectively.

1.4.3 Similar rankings are observed among children and adolescents. The HBSC, a WHO collaborative cross-national survey that collects data on 11-, 13- and 15-year-olds' health and well-being, social environments and health behaviours within Europe and North America also shows gravely concerning results. The 2018 survey shows that Malta consistently had the highest rates of overweight and obese children across all ages. More specifically, 31.2 and 8.9 per cent of Maltese adolescents were categorised as overweight and obese, compared to an average of 15.6 and 2.8 per cent, respectively, for all participating countries. In addition, among all participating countries, the proportion of boys who were overweight was highest among 11-year-olds in Malta, at 44 per cent, while for girls it was highest among 13-year-olds in Malta, at 35 per cent. Of note is that when compared to the previous wave of the HBSC, conducted in 2014, increases in prevalence rates were noted for both indicators. More specifically, overweight and obesity rates increased by 4.0 and 1.6 percentage points from 2014 to 2018, respectively. When analysing the prevalence rates disaggregated by age and gender, increases for this period are observed for all three age groups and genders, with the largest absolute increase observed for 15-year-old boys.

1.4.4 The WHO COSI involves taking standardised weight and height measurements from 6 to 9-year-olds across the WHO European Region every three years. Data from round five of the study (2018-2020[2]) indicates that Malta has the seventh highest overweight prevalence and the sixth highest obesity prevalence amongst the 33 countries of the WHO European Region, equivalent to 33 and 14.9 per cent, respectively. This shows an improvement of 2.8 and 1.6 percentage points in overweight and obesity, respectively, when compared to the previous round conducted in 2015-2017.[3] When comparing the gender disaggregated statistics of round five to round four, improvements are noted to a greater extent for girls. Malta registered a prevalence of 31.1 per cent and 12.2 per cent for girls in round five compared to 34.6 per cent and 14.9 per cent in round four for overweight and obesity, respectively. In the case of boys, more modest improvements were registered in this period, mainly in relation to the overweight indicator, with obesity rates of 17.5 per cent and 18 per cent, and overweight rates of 34.9 per cent and 37 per cent, registered for round five and round four, respectively. However, preliminary data for round six of the study (2021-2023[4]) shows further regression (back to round four levels), with overall prevalence rates for overweight and obesity being equal to 35.4 per cent and 17.1 per cent overall, 36 per cent and 18.8 per cent for boys and 34.8 per cent and 15.1 per cent for girls.

[2] Data collection for round five was undertaken in 2019 in Malta.
[3] Data collection for round four was undertaken in 2016 in Malta.
[4] Data collection for round six was undertaken in 2022 in Malta.

1.5 Justifying the focus of this review

1.5.1 Obesity is a complex multifactorial disease, defined as abnormal or excessive accumulation of fat, which is linked to an increased risk of various noncommunicable diseases that affect multiple body systems. Adverse effects of obesity on health include those that result from the mechanical effects of increased body weight, metabolic effects, and the effects on mental health. Obesity is considered to increase the risk of type 2 diabetes mellitus, cardiovascular disease, respiratory disease, musculoskeletal complications, depression, various types of cancer, sexual dysfunction, infertility and gestational complications, among other ailments. Obesity also negatively impacts one's quality of life and life expectancy. According to the WHO European Regional Obesity Report 2022, recent estimates suggest that pre-obesity and obesity rank as the fourth highest causes of death, corresponding to more than 13 per cent of total deaths, responsible for more than 1.2 million deaths across the WHO European Region every year. Pre-obesity and obesity are also the leading behavioural factor increasing the risk of disability, responsible for seven per cent of the total years lived with disability in the Region.

1.5.2 Several studies have shown that weight loss is associated with a reduced risk of complications and overall improved health in people with obesity. According to the CDC, even modest weight loss of five to ten per cent of one's body weight can contribute to improvements in one's risk factors for chronic diseases related to obesity. These facts highlight the importance of not only preventing obesity in those of normal weight, but also managing obesity for those who are of excess weight.

1.5.3 The economic burden of overweight has been increasingly documented, in terms of individual, national and global costs, but also in terms of direct and indirect costs. An exercise undertaken by the Economic Policy Division within the Ministry of Finance, the Economy and Investment and the Health Information and Research Directorate within the Ministry of Health, the Elderly and Community Care, as presented in the Healthy Weight for Life (2012-2020) strategy, estimated the excess cost on the national health care system attributed to overweight. In total, in 2008, the state health care cost for medical expenses attributed to the health consequences of overweight in the population aged 15 and over was estimated at €19,540,000. This calculation includes the cost of in-patient stays, day-patient stays, and general practitioner and specialist consultations but excludes the expenses related to medication, surgery, ancillary services and loss of income. This implies that according to this calculation, had overweight (including pre-obese and obese) individuals been of normal weight, the state expenditure on healthcare in 2008 would have been reduced by at least around €20,000,000. Projected state health care costs for 2020, assuming constant prevalence rates, were estimated to be equal to €26,910,000.

1.5.4 A private sector study[5] that aimed to assess the cost of obesity in Malta produced a conservative estimate of €36,300,000 for 2016, based on 2015 EHIS results. Direct costs, categorised as primary, specialist, hospital and pharmaceutical care, cost of allied healthcare professionals, weight loss interventions and public interventions, as well as indirect costs, sub-divided into absenteeism, presenteeism, government subsidies, foregone earnings and foregone taxes were incorporated in

[5] PwC Malta (2017). Weighing the costs of obesity in Malta.

the model. Of the €36,300,000 estimate, €16,200,000 was estimated to be borne by the Government, with the remaining €20,100,000 borne by the private sector, that is, by the obese individuals and private sector employers. If the estimate were to be based on measured rates of obesity, rather than (under-reported) self-reported BMI measurements as in the case of the EHIS, then the total cost of obesity would be much higher.

1.5.5 The high prevalence of adult and childhood pre-obesity and obesity in Malta, the associated additional cost burdens on public expenditure, and the impact of obesity on morbidity, quality of life, mental wellbeing and life expectancy underlie the decision to focus this review on government's efforts aimed at reducing the prevalence of pre-obesity and obesity.

1.6 Policies that regulate Malta's efforts

1.6.1 The Healthy Weight for Life: A National Strategy for Malta 2012-2020 is Malta's main policy aimed at tackling overweight. This strategy is presented within the context of a clear national recognition of the overweight epidemic in the Maltese Islands and is accompanied by Government's commitment to address the issue by means of the appropriate policies and resources. The strategy recognises that obesity has considerable effects on mortality and morbidity, including increased risk of several chronic diseases, such as diabetes, heart disease and high blood pressure, as well as reduced life expectancy and health-related quality of life. The overall aim of the Healthy Weight for Life Strategy is to curb and reverse the growing proportion of overweight children, adolescents and adults in the population to reduce the health, social and economic consequences of excess body weight. To achieve this aim, the strategy promotes an inter-ministerial and multi-sectoral approach, to enable changes within the living environment, which shift it from one that promotes weight gain (obesogenic) to one that promotes healthy choices and a healthy weight for all.

1.6.2 Three domains of actions and 76 areas for actions were proposed in the Strategy. The Strategy proposed areas for action throughout all the life stages, from the period of gestation to the early years, school years, adulthood and late adulthood, as well as areas for action within different settings – school, workplace, community and healthcare settings. The following represent the three domains and the priority areas for action as identified in the Strategy:

a. Promoting healthy eating
    i. To improve the availability and uptake of a healthy diet by the Maltese population through healthy public policies across Government.
    ii. To work with stakeholders on consumer education about healthy eating and moderation as underlying principles of healthy eating.
    iii. To promote exclusive breastfeeding for the first six months of life and to continue breastfeeding in the first years of life.
    iv. To support pregnant women and new mothers to adopt healthy eating habits for themselves and their families through education and community initiatives.
    v. To support schools and families so that meals and snacks, including drinks, prepared for school-aged children are nutritious and appetising, without being energy-dense and/or containing excess amounts of fats, trans-fatty acids, salt and sugar.

vi. To regulate audio-visual advertising, such as advertising of unhealthy foods especially that directed at children.
vii. To support schools to implement all the recommendations of the Healthy Eating Lifestyle Plan document and to strengthen the Personal and Social Development and Home Economics curricula as related to nutrition and healthy choices.
viii. To set up a National Task Force led by the ministry responsible for health to develop action plans on the introduction of agreed mechanisms to reduce salt and sugar, limit saturated fat and eliminate trans fat content in local food products.
ix. To set up a Healthy Food Scheme using colour coding so that healthy food is easily identifiable.

b. Promoting physical activity
i. To increase physical activity through healthy public policies, so that the living environment is one that promotes healthy choices.
ii. To implement the recommendation of three hours of physical activity weekly for all schoolchildren.
iii. To encourage children and parents to use a screen time log, reduce the number of hours of watching television, use of computer/video games to a maximum of two hours per day for children, and to encourage sit down meals as family time as opposed to TV dinners, whenever possible.
iv. To support Local Councils to increase the opportunities available for physical activity, including the use of legislation and enforcement to improve safety on the roads, availability of open spaces and increase walkability in built-up areas.

c. Re-orienting public health services to increase the importance of health promotion and disease prevention
i. To increase and improve weight management and physical activity classes for adults.
ii. To set up community initiatives such as cookery clubs and community gardens, focusing especially on lower socio-economic groups and older persons.
iii. To increase and improve parentcraft and breastfeeding classes.
iv. To provide training and guidelines to health professionals in primary care to improve the delivery of holistic advice and management on all issues related to nutrition, physical activity and weight management and ensure that it contains the same key messages.

1.6.3 The Strategy evaluated various economic instruments to motivate healthy lifestyle choices, including food pricing, tax and subsidy policies, employer tax incentives and incentives to promote physical activities, considering their strengths and weaknesses. The Strategy recognised that such synergistic combinations of interventions could be pivotal in reversing the overweight epidemic in the short-term without disadvantaging or harming communities. However, the proposed areas of action for economic instruments were limited to research on these instruments rather than actual implementation. Proposed research included studies to explore variations by locality in food availability, an analysis of the impacts of subsidies and taxes on income redistribution and people's behaviour, feasibility studies on incentives and restrictions related to food outlets and studies examining the effectiveness of employer tax incentives.

1.6.4 The Strategy was to be accompanied by a detailed action plan that was to identify responsible entities for each area for action, as well as timeframes and financial and human resources required for implementation. The Strategy also included four targets specified in terms of prevalence rates. Monitoring of the targets was to take place on a triennial basis, that is in 2015 and 2018, and a final evaluation was envisaged following the termination of the implementation period.

1.6.5 Apart from the Healthy Weight for Life: A National Strategy for Malta 2012-2020, Government has published other health policy documents that contribute directly to efforts intended to reduce the prevalence of overweight. These include:

a. the Food and Nutrition Policy and Action Plan for Malta 2015-2020 – taking into account the impact of nutrition on health, food consumption patterns and food security considerations, this policy aims to promote healthy nutrition, increase the uptake of fruit and vegetables, reduce the consumption of salt and foods high in saturated fats, trans fats and sugars, address inequalities in food accessibility and halt and reverse the overweight trend in the local population;

b. the National Breastfeeding Policy and Action Plan 2015-2020 – recognising the protective benefits of breastfeeding against gaining excess weight during the early years and the link between accumulation of fat in childhood and obesity in young adulthood, the policy seeks to increase the initiation of breastfeeding at hospital discharge, its exclusive continuation for the first six months of the child's life and its subsequent continuation during the first years of life together with complementary foods;

c. the Strategy for the Prevention and Control of Noncommunicable Disease in Malta – recognising that noncommunicable diseases are by far the biggest cause of mortality and disability, that they put immense burden on public health, and have major economic and social impacts, and that obesity (biological), unhealthy diet and physical inactivity (lifestyle-related) are major risk factors for developing these diseases, the policy proposes concrete and co-ordinated action to encourage healthy lifestyles and create a social environment that supports health at population-level, as well as targeting preventative measures for high-risk individuals;

d. the National Strategy for Sport and Physical Activity in Malta 2017-2027 – recognising the value of sport and physical activity in securing a healthy, inclusive, economically-productive, ecologically-educated and balanced society and the value of engaging in physical activity to reduce excess weight, the strategy aims to build a more active and healthy society and to stimulate a new sporting culture;

e. A Whole School Approach to a Healthy Lifestyle: Healthy Eating and Physical Activity Policy – recognising the increasingly poor eating habits and prevalence of a more sedentary lifestyle, that behaviours and habits formed during childhood are often retained throughout one's life course, that schools can encourage students to take up healthy habits and attitudes about healthy lifestyle choices and also stimulate parental involvement in this process, this policy seeks to push forward healthy eating and physical activity as priorities within every school's agenda, promote health

education and health literacy, and create an enabling school environment to help the adoption of healthier patterns of living by encouraging physical activity, promoting healthy foods and limiting the availability of unhealthy foods; and

f. Annex 4 of A Policy on Inclusive Education in Schools: Route to Quality Inclusion – recognising the need to engage in healthy behaviours from an early age, to grow and develop into healthy adults, this policy prioritises eating and physical activity through the integration of health education in all aspects of school life, provides learners with the knowledge, skills, attitudes and experiences necessary to enable informed healthy choices throughout the life course, actively involves the school community to develop, implement and evaluate healthy eating and physical activity actions, strengthens the necessary framework and support to help the school community adopt healthier patterns of living, makes provision for the inclusion of relevant content in the school curriculum and ensures clear and consistent messaging about the components of healthy living.

1.6.6 Another relevant document is the Health Enhancing Physical Activity policy, which is at an advanced draft stage. This policy is being drawn up in collaboration with the WHO; however, is as yet unpublished due to delays connected with the COVID-19 pandemic. Besides policies focusing on health, food and nutrition and physical activity, policies in the area of agriculture, transport and spatial planning, among others, also impact efforts or contribute in efforts aimed at reducing overweight.

1.7 Local targets

1.7.1 The Healthy Weight for Life (2012-2020) strategy specified the following national targets:

a. reduction in the self-reported proportion of the adult population who are pre-obese[6] from 36 per cent to at least 33 per cent;

b. reduction in the self-reported proportion of the adult population who are obese from 22 per cent to at least 18 per cent;

c. reduction in the proportion (measured by anthropometric studies) of 7-year-olds who are pre-obese[7] and obese from 32 per cent to 27 per cent; and

d. maintenance of the proportion of 13-year-olds above the 95 per cent weight centile (obese) below 15 per cent.

1.7.2 It is to be noted that targets are less ambitious than the long-term international objective of having only 2.8 per cent of the adult population being obese.

[6] Referred to as overweight in the Strategy.
[7] Referred to as overweight in the Strategy.

1.8 The local governance structure

1.8.1 The Healthy Weight for Life Implementation Group within the Superintendence of Public Health was responsible for leading the implementation of the Healthy Weight for Life Strategy and its Action Plan. The Policy envisaged that in its implementation efforts the Implementation Group would work with the Inter-sectoral Committee to Counteract Obesity within the Health Division, which group was responsible for developing the strategy, and other stakeholders. The aim of this collaboration was to create an environment that was conducive to the empowerment of people to maintain a healthy weight at all life stages. Following the enactment of relevant legislation in January 2016, implementation is being supported by the Advisory Council on Healthy Lifestyles.

1.8.2 The Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act was enacted on 15 January 2016 with the purpose of establishing and ensuring an inter-ministerial lifelong approach favouring physical education and healthy balanced diets for a healthy lifestyle and reducing the level of non-communicable diseases throughout all age groups. The Act originated from a private member's bill put forward by the Hon. Robert Cutajar, then Opposition spokesperson for the family, children's rights, the elderly and persons with a disability. The legislation prescribes the composition of the Advisory Council – the Council was to be set up as an inter-ministerial committee, aiming to adopt a whole-of-government, whole-of-society, inter-sectoral and life-course approach to the tackling of overweight, and advocate for health-in-all-policies. The Chair and the Secretary were to be nominated by the Prime Minister and the ministers responsible for health, education, finance, social policy, sports, local government and home affairs were to nominate respective representatives. The legislation promotes a whole-of-government approach to tackling overweight, recognising its necessity to implement actions that are related to creating an enabling environment for healthy lifestyles.

1.8.3 The modus operandi for the Advisory Council was for members to meet to discuss, plan and eventually recommend evidence-based, feasible and sustainable policies, legislative measures and interventions to the Minister for Health. The Council was to meet at least once a month and provide advice on any matter related to healthy lifestyles, including:

a. advising the minister responsible for health on matters relating to health, physical activity, and nutrition;

b. advising the minister responsible for health on policies, action plans, and regulations intended to reduce the occurrence of non-communicable diseases among the general public;

c. on the request of any other minister advising such minister on matters as may be required to achieve the objectives of the Act;

d. encouraging an inter-ministerial approach to issues related to physical activity and a healthy lifestyle; and

e. encouraging a lifelong approach, from intrauterine life till old age, to physical activity and a healthy lifestyle.

1.8.4 Advisory Council members were to discuss any proposed recommendations with the respective entity/ministry they represent to ensure buy-in and to operationalise the recommendations into concrete logistical considerations and implementation procedures. Finally, the Council was responsible for implementing the recommended and approved actions.

1.8.5 The legislation provided the minister responsible for health with the power to legislate, following consultation with the Advisory Council, on matters relating to:

a. the education and promotion of healthy lifestyles and physical activity for persons of all ages, from intrauterine life to old age;

b. food consumption in schools and in their proximity;

c. investment and expenditure by local councils to promote healthy lifestyles;

d. nutritional qualities of food consumed in institutions licensed by public authorities including, but not limited to, old people's homes and day centres;

e. an integrated approach for the promotion of food for healthy lifestyles;

f. the regulation of marketing of products which may have adverse effects on healthy lifestyles; and;

g. any other related issue in the achievement of the promotion of healthy lifestyles.

1.8.6 A number of working groups or sub-committees could be set up, and were in fact established, to undertake work relating to free access to water in schools, for local councils and physical activities as well as for the development of standards for food procured for schools and ongoing evaluation of school inspection reports relating to food procurement.

1.9 Report structure

1.9.1 In this first chapter, SDG2 and its subsidiary Target 2.2 are defined, with Malta's performance in this respect delved into. The first chapter also includes an explanation of the measurement framework for the pre-obesity, obesity and overweight indicators, a presentation of Malta's latest prevalence statistics, reference to the relevant policy framework, the set national targets and the local governance structure responsible for addressing overweight.

1.9.2 The second chapter presents the NAO's analysis of the of the Advisory Council minutes from its inception in 2016 up till 2021. This analysis is intended to shed light onto the operational dynamics, areas of action, achieved output and factors influencing the work of the Council.

1.9.3 Presented in the third chapter is information in relation to the projects, measures and initiatives undertaken across Government to address the areas for action proposed in the Healthy Weight for Life Strategy. This information was collated from different stakeholders by the Strategy Development and Implementation Unit, within the Office of the Superintendent of Public Health, Health Regulation Department. This chapter also includes the NAO's analysis of the information provided, with this Office's commentary focusing on the validity and comprehensiveness of the identified implemented actions in relation to the corresponding area for action and its assessment of implementation progress.

1.9.4 The fourth chapter presents a detailed data analysis. Prevalence rates for children, adolescents and adults were compared across participating countries and over time, to allow for an assessment of the scale of the obesity and overweight problem in Malta relative to other countries and to provide an insight into the trends in local prevalence rates. This chapter also presented statistics for salient indicators disaggregated by demographic characteristics, highlighting patterns in prevalence rates across socio-demographic categories and identifying vulnerable groups that are more susceptible to excess weight, as well as statistics for health determinant behaviours, specifically local food consumption and physical activity levels. Finally, this chapter presents an assessment of whether the targets specified in the Healthy Weight for Life Strategy, corresponding to the implementation period 2012 to 2020, were met. This assessment was based on the analysis of available statistics.

1.9.5 The penultimate chapter comprises a thematic analysis of the stakeholder feedback sought through the several focus groups and interviews held with and the written submissions attained from various stakeholders, including academics, service providers, the Advisory Council, and representatives of the MFH, NGOs, professional associations and the public sector, business stakeholders and officially appointed bodies.

1.9.6 The final chapter presents the analysis and conclusions drawn by the NAO with respect to its terms of reference. Based on the evidence at hand, this Office concluded on whether progress was achieved in addressing pre-obesity and obesity; whether Government's efforts were sufficient and effective and whether they addressed the needs of all vulnerable groups; whether there was sufficient communication, coordination and cooperation within Government; and whether Government was providing an enabling and positive environment for non-governmental actors to contribute.

Chapter 2| An insight into the work of the Advisory Council on Healthy Lifestyles

2.0.1 The National Audit Office (NAO) undertook an analysis of the Advisory Council minutes from its inception in 2016 up till 2021. While the implementation period of A Healthy Weight for Life: A National Strategy for Malta ended in 2020, information corresponding to meetings held in 2021 was incorporated in this analysis to compensate for the decrease in activity in 2020 due to the COVID-19 pandemic. This analysis served to shed light onto the operational dynamics, areas of action, achieved output and factors influencing the work of the Advisory Council. Hereunder is an overview of the main themes elicited from this Office's analysis.

2.1 Stakeholder involvement

2.1.1 Minutes of the Advisory Council indicate the Council's commitment to identify relevant stakeholders for specific initiatives, consult with them (at times inviting them to the Council meetings as guests), integrate their feedback in the proposed plans and recommendations and liaise with them to explore funding options and secure implementation. Relevant experts and stakeholders were invited to participate in discussions and in the formulation of recommendations, with minutes of the Council meetings indicating that Members of Parliament, and representatives of the public sector, industry, private enterprises, an international organisation and a professional association were among the invitees.

2.1.2 A mapping exercise was carried out to identify the main stakeholders by target area of action. Teachers' unions, heads of school, parents, the Education Department, the Environmental Health Directorate, health specialists including nutritionists and public health officers, as well as owners and managers of tuck shops were identified as relevant stakeholders for school-based initiatives. The ministries responsible for local councils, social policy, agriculture and sport, as well as public sector entities such as the Water Services Corporation, the Institute of Tourism Studies (ITS) and the Broadcasting Authority, together with professional associations and private sector players were identified for other non-school-based initiatives.

2.2 Educational campaigns and healthy lifestyle champions

2.2.1 The need for educational campaigns on healthy lifestyles, and considerations relating to funding source/s and possible avenues for the dissemination of such campaigns was another theme that emerged in discussions by the Advisory Council. Discussed avenues included displays on water fountains within localities, drama lessons or programmes for children, road shows visiting schools, outings for school children involving fruit or vegetable picking, and workshops regarding the use of produce. Cited ongoing campaigns included the lunch box campaign, the dissemination of healthy recipes to the

public, a pilot project run by the Malta Chamber of Pharmacists in schools that coupled an educational campaign with screening for non-communicable diseases, cooking and budgeting classes run by the Foundation for Social Welfare Services and health promotion messages targeting children through drama. The benefit of coordinating different characters/mascots familiar to children, such as Ninu 'l-Bninu, to deliver a consistent message, was mentioned. Specific topics to be covered in planned campaigns included knowledge of seasonal fruit and vegetables and their cost advantage, consumer education as part of food reformulation processes, food preparation and cooking skills, knowledge of the health impact of excessive sugar and salt intake and active transportation to schools, such as the walking bus. Other topics included food label interpretation. Envisaged collaboration between the Ministry for Health (MFH) and the ITS, local councils, the Foundation for Social Welfare Services and the Agricultural and Rural Payments Agency was discussed for educational campaigns.

2.2.2 The Advisory Council recognised that the best results were achieved when a champion with vision is involved, such as was the case for local councils that have a champion for sports, which councils tended to organise more events and activities. While legislation regulating food consumption within schools does not apply to teachers and staff, the importance of teachers being good role models in terms of their food consumption was commented on.

2.3 Strategic local governance considerations

2.3.1 From a strategic and local governance perspective, the Advisory Council's focus was directed towards ensuring coherence at the level of policy formulation, spurring legislative change and aiding compliance thereto. In addition, the Council sought to identify and source budgetary allocations to support relevant initiatives and projects, with training measures an essential component of efforts in this regard. Discussions also focused on balancing broader political and economic interests through fiscal measures.

Policy coherence

2.3.2 The Advisory Council considered the impact of non-health policies on the health of the nation and specifically in terms of their impact on overweight. For example, the Council noted that the tax on plastic bottles was also imposed on water bottles, thereby hampering efforts to further encourage water consumption. Similarly, the importance of a safe and enabling environment, including safe roads and open spaces conducive to physical activity, was discussed. The enabling environment was recognised not to fall within the scope of health but within other policy areas. The Council encouraged cross-sectoral measures aimed at tackling overweight and the consideration of health aspects in other policy areas – consistent with a health-in-all-policies approach – as well as in local council decisions and projects. The local government reform, which introduced a mandatory requirement for a councillor to be assigned responsibility for health within each local council, was considered a positive development in this respect. Similarly, the Advisory Council discussed the possibility of including an obesity impact assessment in planning decisions for large new developments.

Legislative changes

2.3.3 Reference to various proposed and effected legislative changes was noted in the minutes of the Advisory Council meetings, recognising that legislative changes were most effective in enabling supportive environments for healthy lifestyles. During an Advisory Council meeting dated 3 August 2016, an Opposition Member of Parliament referred to four proposed legal notices and indicated that the Minister for Health was in agreement therewith. The legal notices were intended to provide a framework for the regulation of education aimed at parents and children on nutrition and physical activity through the life course, minimum requirements for physical activity in schools, food regulation in schools, homes for the elderly and day centres, restrictions for new shops/hawkers selling certain foods in the vicinity of schools and free accessibility of potable water.

2.3.4 Further discussion on the regulation of mobile vendors of unhealthy food within schools proximity, food procurement and water accessibility within schools, the provision of meals in institutional settings, including old people's homes and day centres and the regulation of tuck shops within sports facilities continued during subsequent meetings of the Advisory Council. Draft legislation was also reviewed by the Council. One such law reviewed was Legal Notice 266 of 2018, titled 'Procurement of Food for Schools Regulations', which was enacted in 2018. Subsequently, publicity, monitoring and sanctioning efforts were put in place to ensure effective the implementation thereof, which measures included the setting up of a working group to evaluate reports of school inspections, as well as the guidelines, information sessions and media presence to ensure that the right message was being conveyed.

2.3.5 The Advisory Council acknowledged that opting for the legislative route could at times cause more resistance and implementation failure than opting for policy changes and the issuance of guidelines coupled with educational and promotional campaigns. In this context, the Council sought to mitigate the anticipated resistance to the legislative changes relating to food provision in schools through the introduction of environmental health officers from the Environmental Health Directorate, whose duty included communicating the legislative changes that had recently been enacted through a positive approach, and complemented this effort with the drafting of guidelines to the legislation to ensure buy-in from tuck shop owners and parents. In further feedback provided, the MFH noted that the Advisory Council revised the list of permissible foods relating to this legislation.

Funding and resources

2.3.6 While the Advisory Council does not administer a budget, it may put forward proposals along with cost estimates to the Minister for Health to be in turn approved by Cabinet and assigned to the respective ministries or entities. One such submitted proposal was for an increased budget to be allocated to the Health Promotion and Disease Prevention Directorate (HPDP) to provide cooking classes by a renowned chef with the involvement of a nutritionist. Indicated in the minutes of the Advisory Council meetings was that the inclusion of a representative from the Ministry for Finance and Employment (MFE) within the Council facilitated the sourcing of the required budgetary provision. Additionally, the Advisory Council also considered encouraging local councils, entities and ministries to ring-fence funding from available budgets for specific projects, and explored the possibility of using existing funds

such as those administered by Malta Enterprise or the Development Planning Fund. The Council also attempted to secure funding from industry by tapping into corporate social responsibility initiatives. Some success was registered in this respect, such as in the case of a local bank funding water fountains in ten local schools through a pilot project. Funding requirements and funding sources were often discussed during the Council meetings. For example, discussions were held regarding possible funding sources for the installation and running costs of water fountains within localities.

2.3.7 The need to prioritise activities with long-term impact in the context of limited funding was addressed in the Advisory Council. The Council discussed the importance of increasing the budget for health promotion activities and capacity building. Another proposal was the introduction of a line item under the Department for Local Government budget to fund proposed actions for promoting sustainable healthy lifestyles, with local councils invited to submit expressions of interest for any related projects. In further feedback, the Local Government Division within the Ministry for the National Heritage, the Arts and Local Government (MHAL) indicated that the specific line item was never introduced; however, in 2019, the Directorate was assigned a budgetary measure that provided for a funding scheme encouraging local councils to propose initiatives that promote the wellbeing and healthy lifestyle of residents. Moreover, additional financing was provided on a regional basis to ensure a more active role being fulfilled by the relevant administrative committees. The Directorate's work plan led to the successful launch and finalisation of 12 schemes/initiatives.

2.3.8 An increase in the number of nutritionists within the Department of Primary Health Care, as well as an increase in the number of dieticians at Mater Dei Hospital (MDH) and within the Department of Primary Health Care, were identified as important resource needs. Another identified resource requirement related to the appointment of healthy lifestyle regional coordinators for the five local council regions. The Advisory Council also discussed specific proposals for inter-sectoral budgetary measures led by the MFH, such as that for the inclusion of swimming lessons in the school curriculum and the provision of inflatable or above-ground pools for the 2020 budget and line items for fiscal measures, such as investment in outdoor gyms.

Training professionals

2.3.9 The Advisory Council explored possible training courses and funds for various professionals, including health professionals, social workers, training and professional chefs, policy makers, public sector senior management, local council employees, local wardens and educators, to enhance skills and increase awareness, some of which materialised. An example of training that took place was that delivered by the European Association for the Study of Obesity, with training for health professionals intended to provide the skills and knowledge to encourage the adoption of healthy lifestyles among their patients. Ideas for new professional courses within ITS included food preparation courses for hospitals and medical tourism clients. The inclusion of healthy lifestyle components in existing courses, such as the senior management toolkit provided by the government training organisation and a unit on social determinants of health in various Malta College of Arts, Science and Technology and University of Malta courses, were also explored.

Fiscal measures

2.3.10 The Advisory Council discussed the possibility of introducing financial allowances or vouchers as incentives for healthy lifestyles, including ones for healthy food consumption and others for participation in health-enhancing physical activity or sports. These were considered for the whole population and also restricted only for children under 15 years of age. The possibility of allocating a portion of the COVID-19 vouchers to buy local produce and healthier food options was also considered; however, this restriction on voucher use was deemed somewhat at odds with the supportive economic nature of the voucher scheme. Other non-targeted financial incentives for healthier lifestyles were discussed and the need to substantiate such ideas with a budget proposal was noted. The Council argued that the benefits of the fiscal measures were to be directed to the public, besides the service provider, and that there was a risk that with the introduction of such incentives some businesses may increase their prices and pocket the difference, and that the incentives must sustain a long-term behaviour change, and not simply result in one-off activities or purchases. The possibility of rewarding target weight loss was mentioned. Such a scheme was to be considered for implementation if found to be ethically acceptable.

2.3.11 Also acknowledged by the Advisory Council was that there is mixed evidence on the benefits of taxation as an approach to guiding food choice – the argument for the socio-economic downward drift and risks of pushing low-income earners further into poverty versus other arguments supporting taxation on the basis of the success of other taxes, such as the tobacco tax. Additionally, the Council considered the fact that a sugar tax would be difficult to implement for a number of reasons, including concerns or opposition raised by local industry. The Council considered the increase of two cents on non-alcoholic drinks (other than water) as a milestone that served to introduce the concept of taxing the public for the consumption of unhealthy items, envisaging other developments in this respect in future budgets. The need to couple taxation with subsidies on healthier items was discussed. The reduction of tax for healthy activities such as sports and healthy food was also discussed and considered to be potentially more politically acceptable. The Advisory Council noted that VAT exemptions or reductions are very limited by law. Other tax-driven solutions discussed by the Advisory Council were the provision of tax rebates for companies that offer training facilities on site or promoting physical activity and existing tax rebates for participation in sports activities. The Advisory Council believed tax rebate schemes for the purchase of sports equipment were to be extended and expanded in terms of the capping set.

2.4 Factors external to local governance influencing overweight

2.4.1 Having considered the Advisory Council's focus from a strategic and local governance perspective, attention is now directed towards the factors influencing overweight that are extraneous to local governance. Aspects of relevance identified in this respect included the influential role played by the EU in focusing the Council's attention, and the Council's reflection on the dominant role of market forces, the effect of advertising and marketing in conditioning consumer behaviour, and the centrality and resistance of long-term change in cultural habits.

EU influence

2.4.2 The Advisory Council followed the work being done at EU level on various matters including the banning of trans fats, the setting of fiscal policies, food reformulation, the procurement of healthy food for schools, the audio-visual marketing directives, front-of-pack labelling and school lunches. Focus on EU matters was noted during the term within which Malta held the EU presidency, with attention directed towards cross-sectoral measures intended at addressing childhood obesity. The Advisory Council acknowledged that Malta could benefit from the experience of the joint research committee at the EU level, EU experts and other member states that have introduced various related measures.

Market forces

2.4.3 Of interest was that the Advisory Council often reflected on the impact or reaction of market forces on various decisions and interventions. For example, the Council considered complaints from schools due to commercial operators not showing interest in operating tuck shops under the new regulations for food in schools, and identified the need for a positive approach and prescriptive guidelines to ensure that operators are on board and compliant with changes. The Council also considered the private sector as a possible partner in its work towards enabling healthier lifestyles, acknowledging the sector's corporate social responsibility as a channel through which focus on healthy lifestyle projects could be realised, and cautiously exploring the possibility of working with industry through public-private partnerships. Similarly, feedback from industry when considering food reformulation, such as in the case of decreased sugar in soft drinks, was sought and considered. Other considerations included food product reformulation by industry as a response to healthier specifications in procurement requirements, market availability and local market considerations, market acceptance and profitability considerations for healthier options in restaurant menus, the impact of legislation regulating food on small industry and small countries with large amounts of imported goods and possible price spikes by industry following fiscal measures introduced by the Government.

Advertising and marketing

2.4.4 The influence of advertising of unhealthy food on consumer behaviour, especially in the case of children, was discussed by the Advisory Council. The Council referred to a survey that was to be undertaken by the MFH in collaboration with the Broadcasting Authority. The survey was to consider the effects of advertising, with a focus on adolescents. In further feedback provided, the MFH noted that this study was carried out and the results published and made publicly available.

2.4.5 In addition, the Council noted that the Public Health Alliance was about to table a declaration in the EU Parliament calling for the improvement of the Audio-Visual Media Services Directive through healthier marketing.

Culture

2.4.6 The Advisory Council took into consideration tradition and culture when planning legislative changes or interventions, appreciating that tradition and culture play a strong part in defining dietary habits and physical activity levels. The Council acknowledged that culture cannot be changed overnight and that one should advocate for moderation and gradual change and that political will and stakeholder engagement is required to push such change and provide supportive environments for healthy lifestyles. Promotional activities and marketing were envisaged as key in instigating cultural change, such as the consumption of tap water in the home. Schools were identified as playing pivotal roles in promoting such change, and that a focal point in each school may be required to take care of such issues.

2.5 Physical activity and food-related considerations

2.5.1 Discussions on the need to encourage physical activity and healthy food choices featured prominently in the minutes of the Advisory Council meetings. More specifically the Council discussed current efforts and future projects geared towards promoting more physical activity, and the fundamental yet multi-faceted food-related concerns.

Physical activity

2.5.2 The Advisory Council recognised the physical and social benefits of health-enhancing physical activity and the declining trends in the uptake of such activities, with technology promoting sedentary lifestyles. The Council acknowledged the various opportunities available within schools and within the wider community, but argued that further promotion, and more diversified projects and initiatives are required to further encourage the uptake of these activities and to promote a sports culture. Proposals explored included the expansion of an initiative that involved the setting up of mini gyms within day centres with dedicated coaches, providing additional financial incentives for local councils to invest in outdoor gyms, further promotion of existing physical activity programmes offered by local councils and SportMalta as well as the promotion of walking trails and country walks, and the increased use of facilities within schools after school hours and during the weekend. Also proposed were the revival of traditional games, tournaments consisting of sports and games for teams from different localities, educational campaigns on how to best utilise outdoor gyms and the recruitment of a trainer by local councils to facilitate the proper use of gym equipment. Proposals targeting children included making the physical education kit the standard uniform for students to facilitate physical activity on all schooldays, the introduction of physical education at nursery stage, encouraging active transportation to school, further extending the minimum number of hours of sports in the curriculum, the inclusion of swimming lessons in the school curriculum and the provision of inflatable/above ground pools, and the development of a physical activity schedule for after school clubs. Additionally, the Advisory Council discussed the importance of safe and enabling environments, safe roads and open spaces, conducive to physical activity.

Food considerations

2.5.3 Considerations relating to food were the central focus of much of the Advisory Council's work, with attention in relation thereto shifted towards matters of choice, availability and cost, food reformulation and labelling, the setting of portion sizes and water uptake.

Food choice, availability, and cost

2.5.4 Easy access, ample choice and low price were considered to be factors influencing consumption of unhealthy food, with Malta registering one of the highest consumptions of soft drinks by way of example. In a bid to control food availability, the Advisory Council worked on enacting legislation that now regulates food procurement within schools and prohibits food hawkers from selling unhealthy food within a certain radius of schools during school opening and closing times. Guidelines outlining permissible and non-permissible foods provide guidance regarding the healthy alternatives that can be offered by tuck shop owners and prepared by parents for school lunches. However, the Council expressed its concern regarding the mixed messages being received by school children, having healthy eating promoted at school but being exposed to advertising and easily accessible unhealthy food beyond the school perimeter, including within sports facilities. Legislation was being considered to regulate the food offered within these premises.

2.5.5 The availability and affordability of healthy alternatives also plays an important role in food consumption choices and for this reason the Advisory Council promoted food reformulation as well as the provision of healthy alternatives within schools, elderly homes, workplace canteens and restaurants. Vouchers for the purchase of fruit and vegetables were suggested to make such produce more accessible to all. The need to revise the food items distributed in the EU food scheme to ensure recipients are provided with a healthier selection was also discussed. The Council recognised that healthier food options, especially in the case of ready-made meal options, are generally more costly. The impact of certain interventions on the cost for the consumer was also considered, such as the increase in the case of prices of food items within the hospital canteen following changes in the procurement specifications to ensure healthier food provision. The need to educate and promote consumption of seasonal produce, which is less costly, was also discussed. To fill this need, the HPDP intended to issue a call for kitchen facilities to allow their nutritionists to provide healthy cooking advice for cheap and affordable recipes, first starting with online sessions and eventually transitioning to in-person events. Additionally, the HPDP regularly distribute targeted healthy inexpensive recipes and nutritional advice through the EU food scheme.

Food reformulation

2.5.6 The Advisory Council emphasised the importance of food reformulation, acknowledging that reduced portion sizes, food labelling and consumer education could only secure limited impact. The Council noted the EU Council's work in this area and observed that Malta was lagging compared to other European countries. However, since the majority of products consumed locally are imported, the availability of healthier products in foreign markets was considered to impact our local choice. Also

noted was the fact that, in the case of particular food items, the same product in different countries may have different levels of sugar and salt content, with some countries having proceeded with a reduction in sugar content and the customers having gotten accustomed to the new taste. Local good practice examples included the reduction of salt in bread and reduction of sugar in yoghurts.

2.5.7 The Advisory Council meeting minutes document the Council's engagement with industry with the aim of promoting the healthiest acceptable formulation and securing a lower sugar content in locally manufactured soft drinks. A steady reduction in sugar levels was suggested to allow for a more gradual adjustment of taste. Breakfast cereals were noted as another product type that needs to be considered in terms of sugar content. Noted in the minutes was that the key challenges faced by industry are technical innovation, consumer acceptance and taste, education and communication and regulatory hurdles at the EU level.

2.5.8 The guidelines for the procurement of healthy foods in various institutions was considered as a possible new entry point for food reformulation, with bidders for tenders having to provide healthier alternatives to be compliant with the technical specifications set. The introduction of a sugar tax in the UK was considered to have promoted reformulation, with industry reducing content to fall under a lower tax bracket. While big industry was in favour of legislation relating to food reformulation, the Advisory Council argued that the impact of such regulation on small industry had to be considered.

Food labelling

2.5.9 Despite noting that food labelling initiatives are not as impactful as food reformulation initiatives, the Advisory Council recognised that easily readable and sufficiently informative food labels as well as education about the interpretation of such labels as part of wider health literacy efforts can enable consumers to make more informed choices. Front-of-pack labelling was noted as one of the EU Council conclusions adopted by European Health Ministers, thereby constituting soft law and remaining voluntary for member states. The Advisory Council acknowledged that this was a contentious issue, though strongly supported by France. Different typologies of front-of-pack labelling, as well as their advantages and disadvantages were discussed. The ITS representative who attended an Advisory Council meeting noted various efforts being undertaken by some restaurants in this endeavour – dedicating a section in the menu for healthy options, including calorie counting or some type of labelling. The possibility of supporting restaurants to provide healthier options with nutritional analysis, and of educating current student chefs and operators in the industry to a healthier way of cooking was also discussed.

Portion sizes

2.5.10 Another strategy discussed by the Advisory Council for the address of healthy eating and the maintenance of healthy weight is controlling portion size. The availability of smaller portions, such as in the case of bottle sizes for soft drinks, were noted to have become more predominant over the years. Discussion with an ITS representative revolved around the portion sizes of restaurant meals, noticing that locally the majority of consumers want large volumes of food, and that reducing portion sizes for health reasons would most likely not be feasible from a business perspective.

Water uptake

2.5.11 The Advisory Council was eager to promote the increased consumption of water as a healthier alternative to sugar-sweetened beverages, whether it was bottled or tap water. The Council acknowledged the yearly campaigns undertaken by the HPDP encouraging the consumption of water and the avoidance of sugar-sweetened beverages. The Council pushed for the availability of drinking water in various settings, with original plans to ambitiously introduce drinking water in communities, schools, old people's homes, hospitals and workplaces. Much work was done on introducing water availability within schools and within localities. Different procurement options were considered to determine the most economical option – the installation, maintenance and monitoring of water fountains as opposed to freshwater dispensers providing bottled water. Various funding options as well as partnerships with local councils and the Water Services Corporation and sponsorships were explored to implement this project. Additionally, the Advisory Council was of the opinion that mains tap water consumption was to be promoted as it may be accessible and affordable to all socioeconomic classes and sectors of society, by informing the public that it is safe for drinking and increasing its accessibility in the outdoor environment. It was recognised that private businesses often promote a contrary message regarding the safety of tap water, to further their own business interests. The Advisory Council did however acknowledge that taste and appearance factors contribute to decreased acceptability of tap water, including the intermittent discolouration of the water due to rust, the perceptible taste of chlorine and the high salinity content, noting that warm water is less palatable.

2.6 A focus on children

2.6.1 One strategy adopted by the Advisory Council was to focus its efforts in addressing overweight in children, acknowledging that more control is possible in schools, that children may be more amenable to change than adults, that schools can promote a culture of discipline, and that children may advocate healthy lifestyles within their families. Work in this respect included legislation regulating the procurement of food within schools through the setting of nutrient-based standards, efforts to prohibit street vendors of unhealthy food from operating around the school during school opening and closing time, guidelines for parents and carers on the types of foods and drinks permissible in schools, educational campaigns and the installation of water fountains in schools.

2.6.2 Some discussions relating to the school curriculum for compulsory schooling and ITS courses were noted in the minutes of the Advisory Council meetings. The Council suggested providing feedback with regard to the ITS curriculum once it was revised and proposed that the Institute could include specific courses for food preparation for hospitals, medical tourism clients, and similar settings. Regarding the address of obesity in the school curriculum in compulsory schooling, it was noted that the Education Department runs a Home Economics Unit which caters for all schools and that there are a number of food labs as determined by a national strategy. During school Years 7 and 8, there is a 13 to 14-week compulsory home economics module in state schools, which includes food and health literacy. In Years 9 to 11, this subject is available as an optional subject. While programmes are also in place for parents and carers, the Council noted that children often pass on the knowledge they acquire from school to their parents. The need for food literacy to be more holistically linked to other aspects of

the curriculum was also mentioned. The proposal for the inclusion of swimming lessons in the school curriculum was discussed by the Council and put forward as an intersectoral budgetary measure to be led by the MFH.

2.6.3 In a meeting held by the Advisory Council in June 2017, reference was made to a budget measure intended to allow for the discrete distribution of school lunches to children from low socio-economic backgrounds, an initiative that was to target 800 students in 2017. In November 2017, there were plans in place to extend the provision of school lunches to all school children by 2018, in line with the electoral manifesto; however, to date, this has not been implemented. The ministry responsible for education considered combining the lunch initiative with the fruit and vegetable scheme, and was developing lunch menus with the help of HPDP nutritionists. The school lunch initiative was being discussed at the EU level as an extension of the fruit and vegetables scheme, which scheme was not considered to have been very successful. Locally this was partly due to issues relating to quality and presentation of the produce.

2.7 Considering vulnerable groups

2.7.1 The Advisory Council acknowledged that interventions must be inclusive of vulnerable groups, for example children in vulnerable situations or those coming from low-income families, or that targeted approaches, such as the targeting of low-income families in the Move 360 programme, may be required. Additionally, the Council noted the importance of considering the impact of fiscal measures, such as taxation, on low-income groups. Social interventions for vulnerable groups that also include health literacy skills programmes, such as cooking, budgeting and nutritional education, were considered positive initiatives. More work in this respect was envisioned through the EU scheme distributing food to low-income families, with the HPDP possibly providing healthy inexpensive recipes and information regarding nutritional advice and skills to be distributed with the food packages.

2.8 Research needs

2.8.1 The minutes of the Advisory Council meetings include reference to various identified research needs, including research to determine sugar levels in products, to assess consumer taste and support the drive for sugar reduction, to identify the social determinants of health to support policy development, to assess the impact of advertising on consumer behaviour, to evaluate children's opinions on the fruit and vegetable scheme within schools, and to identify existing health eating policies in schools.

2.9 Monitoring and implementation

2.9.1 The Advisory Council recognised the importance of identifying actions to be undertaken and to set targets and timeframes for completion. The monitoring systems established by the Office of the Commissioner for Children for the National Children's Policy and the National Strategic Policy for Poverty Reduction and Social Inclusion launched by the Ministry for Social Justice and Solidarity, the Family and Children's Rights – with areas outlined, responsible actors identified and status updates obtained from the various stakeholders – were quoted as examples of good practice. Besides high-

level monitoring of the actions being taken to implement the Healthy Weight for Life national strategy, the need to monitor and evaluate in detail specific initiatives was also mentioned in a few cases. In the case of the fruit, vegetable and milk scheme the importance of follow-up, evaluation and audit was mentioned as essential elements in the management of the scheme. Feedback was deemed necessary to close the loop and reinforce the objectives of the work being done. With respect to the Procurement of Food for Schools Regulations, inspections by environmental health officers were carried out to ensure compliance with the regulations and a working group including representatives from the HPDP, the Environmental Health Directorate and Education was set up to evaluate reports of school inspections. Discussions were held between nutritionists and the Environmental Health Directorate regarding a number of issues that environmental health officers were encountering. Additionally, the list of permissible and non-permissible foods was adapted in response to feedback from various stakeholders including the public suppliers. When drafting the regulations relating to the procurement of food for schools, different possible provisions for penalties for non-compliance were discussed and eventually provisions for fines and administrative fees were included in the enacted legislation.

2.10 Weight management services

2.10.1 The Advisory Council expressed the need to further promote available weight management services and to sustain the online delivery of such programmes, which were initiated during the COVID-19 pandemic. Further expansion of weight management services was envisaged through public-private partnerships with nutritionists in the private sector, contingent on the required increase in budgetary allocation. A pilot study aimed at engaging families in physical activity, nutrition, cooking and other useful skills such as budgeting related to healthy choices was found to substantially contribute to weight loss, specifically body fat, in children. The Advisory Council discussed the possibility of expanding this pilot project nation-wide and possibly have local councils develop this initiative, supported by funds from local government.

2.11 COVID-19

2.11.1 The COVID-19 pandemic impacted the work of the Advisory Council, with the Council not having met in 2020 due to efforts having been redirected to the pandemic response. The pandemic was also responsible for an increase in mortality, as well as a worsening in health status, with individuals delaying seeking care due to COVID-19 related fears, increasing food intake and curtailing physical activities, and experiencing a steep rise in the cost of healthy food options thereby magnifying the effect of poverty on health. The Advisory Council acknowledged the impact of the pandemic on many sectors across government besides health, and the need to re-introduce services that had been curtailed or halted, especially those impacting health, such as sports activities. One positive outcome of the pandemic was opportunities for new ways of working, such as weight management classes and exercise programmes held online, which enabled a wider outreach, which initiatives have been identified and retained. Another positive outcome was the greater uptake of walks in the countryside.

Chapter 3| Projects, measures and initiatives implemented by the Government to address overweight

3.1 Methodology for measuring implementation progress

3.1.1 As part of the monitoring and evaluation efforts relating to the Healthy Weight for Life Strategy, as well as efforts intended to inform the new policy framework, the Strategy Development and Implementation Unit, within the Office of the Superintendent of Public Health, Health Regulation Department, undertook a data collection exercise whereby information was sought from various ministries and entities regarding implemented initiatives and ongoing actions aimed at reducing non-communicable diseases, among which are measures targeting overweight. This exercise considered several strategies implemented over the last ten years aimed at preventing non-communicable diseases (including the Healthy Weight for Life Strategy) and identified the most important action measures from more than 300 areas for action. The Strategy Development and Implementation Unit within the Office of the Superintendent of Public Health identified 89 areas for action addressing overweight from the Healthy Weight for Life Strategy.

3.1.2 Data was collected from primary stakeholders, internal and external to the MFH. Stakeholders included the MFH, the Active Ageing and Community Care unit, Aġenzija Sapport, the Ministry for Home Affairs, Security, Reforms and Equality (MHSR), the Local Government Division within the MHAL, the MEYR, the Ministry for Social Policy and Children's Rights (MSPC), the Ministry for Transport, Infrastructure and Capital Projects (MTIP), the National Breastfeeding Steering Committee and the Social Care Standards Authority. Different submissions were obtained from the MFH, submitted by the Chief Medical Officer, the Directorate for Health Information and Research and the HPDP and the Social Determinants of Health Unit within the Superintendence of Public Health (Health Regulation Department). The most recent review on implementation of action measures was initiated in August 2022 and was completed in October 2022, when the information was submitted to the NAO for analysis.

3.1.3 An assessment of the implementation progress for each of the 89 areas for action was undertaken by the Strategy Development and Implementation Unit, within the Office of the Superintendent of Public Health, based on the information provided by the stakeholders. The Unit categorised the 89 areas for action into five groups:

a. Yes – the area for action was addressed in a comprehensive manner;

b. Yes, partial – the area for action was addressed only partially, such as for example an area for action intended for the whole population but designed only for particular groups, or area for action which was to be implemented across government sectors but was only implemented by certain sectors. This category includes areas for action that require ongoing intervention, and

can therefore not be considered as fully implemented at any one point, such as promotional campaigns and the provision of services;

c. In progress – the area for action is in the course of being addressed;

d. No – the area for action was not implemented. This includes cases where the feedback clearly indicates that no action was taken and cases where the feedback provided by stakeholders was incongruent with the intended action; and

e. Unknown – no feedback provided.

3.1.4 This assessment provided the following results: 51.7 per cent (n=46) of areas for action have been implemented, 31.5 per cent (n=28) have been partially implemented, 11.2 per cent (n=10) are a work in progress and 1.1 per cent (n=1) have not been implemented. For 4.5 per cent (n=4) of areas for action, no information was provided by the stakeholders (Figure 4 refers). Regarding progress on the implementation of the Strategy, the MFH representatives noted that some areas for action are ongoing, and that hence, partially implemented areas for action account for these as well. It was also noted that in tackling obesity, one cannot assess areas for action as being categorically implemented or not implemented as many of the actions require ongoing work. Additionally, changes in the behaviour of people and changes in the environment may direct policy to focus on specific areas for action that will have more impact than others.

Figure 4 | Healthy Weight for Life Strategy – Areas for action implementation status

Implementation status	Number of areas for action	Percentage of areas for action (%)
Implemented	46	51.7
Partially implemented	28	31.5
Work in progress	10	11.2
Not implemented	1	1.1
No information provided	4	4.5

3.2 Implemented actions

3.2.1 The ensuing provides a high-level overview of the actions taken by the Government to address overweight as highlighted by the various stakeholders in their submissions to the MFH as part of the policy implementation exercise. The implemented actions have been categorised as promoting healthy eating, promoting physical activity, service provision and other initiatives for the purpose of this exercise.

Promoting healthy eating

3.2.2 The Strategy recommended various areas for action related to healthy eating, which in turn were categorised according to the target age group or setting. Several implemented actions cited by the stakeholders related to healthy eating in the early years up to the age of four, with special emphasis on

the promotion of breastfeeding. These actions included the implementation of the Well Woman Clinic to provide pregnant women and new mothers with education and support; the establishment of dietary guidelines for children, awareness campaigns and continuing professional education for healthcare professionals to ensure that these professionals provide mothers with optimum information and support; and various measures intended to establish the MDH as a recognised baby-friendly hospital that promotes exclusive breastfeeding, which measures included the hospital's breastfeeding policy, promotion initiatives, walk-in breastfeeding clinics for mothers, parentcraft services, the allocation of a discharge liaison officer to all mothers three weeks after discharge and training for paediatricians. Also noted were the updating of the local national breastfeeding policy and action plan, and the undertaking of a monitoring of implementation exercise for this policy; legislation prohibiting the advertising of breast milk substitutes on local media and the banning of the distribution of samples and advertisements of milk substitutes within the MDH; and finally the introduction of workplace guidelines for employers for enhancing employee health and wellbeing (which include guidelines on facilitating breastfeeding at the place of work). Within the education sector, all students in Year 8 are informed of the guideline relating to the breastfeeding of babies for the first six months of life as part of the Home Economics curriculum. Moreover, for students who choose Home Economics as an option, breastfeeding is covered more extensively in the curriculum, including awareness of the advantages and disadvantages of breastfeeding and bottle feeding, knowledge of various terms such as breastfeeding, bottle feeding and weaning, and information regarding the specific mineral requirements of breastfeeding mothers. On providing further feedback, the MFH also referred to a leaflet on breastfeeding produced and disseminated by the HPDP.

3.2.3 Other implemented actions targeted overweight through the promotion of healthy eating during the school years. These include health promotion activities organised by the HPDP targeting students and parents, such as educational sessions on nutrition, portion sizes, food label interpretation and hands-on cooking classes, and the fruit and vegetable scheme. Also noted were the guidelines produced by the HPDP and regular programmes on lunchbox content; the adoption of the Healthy Eating Lifestyle Plan document as a national policy, which was updated as The Whole School Approach to Healthy Lifestyle: Healthy Eating and Physical Activity Policy; and the provision of support to schools to implement the policy through training and the formulation of school development plans. Also mentioned were the provision of a healthy breakfast to all primary school students registered for breakfast club and the provision of a healthy lunch to eligible students from disadvantaged socio-economic backgrounds; the annual Young Chef national competition; and the inclusion of food chain information in the school curriculum. Legislation was introduced to regulate food types made available to children in the case of food procured in schools and food provided during school activities, and to prohibit the marketing of food high in fats, salt and sugar during children's media programmes. Moreover, educators receive professional development training in the field of nutrition, including training on the dietary guidelines for children and physical activity.

3.2.4 Other work focused on tightening legislation on alcohol advertising and improving the enforcement of restrictions on the sale of alcohol to children and adolescents. More specifically, the National Coordinating Unit for Drugs and Alcohol and the National Addictions Advisory Board had several talks with the Police, Sedqa and the Malta Tourism Authority with a view to encourage better monitoring

and enforcement related to underage drinking. Talks included proposals to amend the law and make it mandatory for outlets selling alcohol to have clear signage that asserts that alcohol shall not be sold/served to minors who are less than 17 years old. Collaboration between the Police and Sedqa was initiated in 2021. The National Alcohol Policy also calls for better collaboration by economic operators who sell/distribute or serve alcohol. The policy also proposes adequate training for owner/servers of places of entertainment/catering establishments and bars/pubs.

3.2.5 Another area that has registered substantial progress is the promotion of healthy eating in adulthood. Work in this area includes ongoing collaboration with the WHO and work by a local stakeholder group on food reformulation; advice provided to the public on moderation in food portions; communication with the ITS to promote healthy cooking within the hospitality and restaurant business; the Fund for European Aid to the Most Deprived, the State Funded Food Distribution Scheme and the LEAP Project, which help alleviate food deprivation and aim to reduce the target group's dependence on social support through education and employment; and an increase in the training and recruitment of nutritionists and dieticians. Also mentioned were the health promotion initiatives undertaken by the HPDP and those undertaken as part of the Social Determinants of Health European Social Fund (ESF) project, which include awareness posts on social media platforms, television infomercials, radio adverts, articles on culinary magazines, and the dissemination of healthy recipes, all intended to promote healthier food choices and eating habits. Additionally, as part of this ESF project, stakeholder meetings and capacity building sessions were held across various sectors within the Public Service, including with health care workers, and with non-governmental organisations (NGOs) for general awareness on nutrition and on the social determinants of health for the general population. Additionally, two training programmes – Għaqal id-Dar, Ħajja Aħjar and Proġett Familja 2014-2017 – managed by the MSPC aim to provide participants with basic skills for improving one's quality of life. In further feedback provided, the MFH noted that the Active Ageing and Community Care unit offers educational programmes on nutrition to persons who attend active ageing centres.

3.2.6 The promotion of healthy eating within other contexts – specifically workplaces and hospitals, institutes and homes for older people – was also envisaged in the Strategy. With respect to initiatives within the workplace, workplace guidelines for enhancing employee health introduced by the HPDP in 2022 provide various recommendations for promoting healthy eating within this setting. In further feedback provided, the MFH explained that the document issued for employers, titled 'Improving Employee Health in the Workplace: Guidelines for Employers' has been developed to support the adoption of healthy behaviours in the workplace. The document highlights provisions relating to healthy eating, promoting physical activity and reducing sedentary time, and supporting breastfeeding at the workplace. Through the Healthy Workplace Scheme many workplaces consult with and obtain the support of the HPDP on the matter. The health authorities have ongoing partnerships established with workplaces to increase awareness on nutrition and physical activity and other areas of health. Additionally, within the MHSR, menus within its canteen have been revised to increase the availability of healthy options and reduce high-energy dense food options.

3.2.7 In the context of hospitals, institutes and homes for older people, the Strategy proposed the updating and monitoring of the implementation of healthy dietary guidelines and regulations for canteens

within such institutions to ensure that the range of products and food portion sizes offered in meals and snacks provide an adequate amount and balance of nutrients and that most of the food sold favours healthy eating principles. The new tender issued for meals provision for residential care homes by the Active Ageing and Community Care unit implemented changes to encourage and improve healthy eating in residential care homes for older persons. Additionally, as part of its role as a regulatory body, the Social Care Standards Authority monitors and regulates the standards of care for residential services for senior citizens, including the quality of food provided to ensure that older persons received a varied, appealing, wholesome and nutritious diet that is suited to individually assessed and recorded requirements. The MDH canteen and shop are only allowed to serve and sell healthy food, and the WHO guidelines on healthy public procurement can be implemented in Malta within this specific context. The Strategy also proposed training programmes on healthy eating and physical activity amongst care professionals within these settings, which was noted to have been implemented by the MFH.

3.2.8 In further feedback provided relating to the promotion of healthy eating, the MFH referred to the several guidance documents issued by the HPDP. These include the Dietary Guidelines for Maltese Infants and Young children Aged 6 months to 3 years: A guide for parents; the Dietary Guidelines for Maltese Children aged 3 to 12 years: the Mediterranean way; and the Dietary Guidelines for Maltese Adults: Healthy eating the Mediterranean way. The MFH also referred to the participation of the Superintendence of Public Health in an EU-funded project: Best-ReMaP Healthy Food for a Healthy Future. Through this project, experts are directly contributing to the procurement of nutritious food in public institutions, as well as food monitoring and reformulation efforts.

Promoting physical activity

3.2.9 The Strategy also included various proposed areas for action related to the promotion of physical activity. Ample progress was registered in this regard according to the information submitted to the NAO. Within schools, embellishment and upgrading projects were undertaken to transform school yards and recreational areas to facilitate the uptake of physical activity during school breaks, while primary and secondary physical education teachers were provided with in-service training. Various programmes in schools, such as the Daily Mile, Active Fridays, activity days, the Funfit Football Programme and the Active School Flag, as well as heavy investment in the procurement of physical education equipment provide additional opportunities for physical activity within the school environment. Additionally, some schools promote the walking bus – an active way to get to school, whereby students walk to school on a pre-set route, with the group getting bigger as more stops are covered. Schools also collaborate with SportMalta and private entities to allow use of school premises for sports activities. Also noted was that the 2023 Budget referred to the increase in physical educational lessons to once daily.

3.2.10 In terms of spatial planning, outdoor gyms have been installed in various localities by local councils; funds have been allocated to local councils for the maintenance and development of the localities' infrastructure intended to enable physical activity; and detailed local plan policies have been put in place to protect open spaces from development. Outdoor gym and training facilities within barracks and stations under the responsibility of the MHSR have been introduced and improved. Local funding

administered by the Planning Authority (PA) has been earmarked for measures that promote the creation of open spaces, and the introduction of more greenery, playing equipment, open air exercise equipment, swimming facilities and other equipment, subject to adherence to specific guidance. Moreover, Infrastructure Malta (IM) has assisted local councils with the reconstruction of a number of local roads, has introduced new footpaths in lieu of previous wide asphalted roads, and has pushed for reducing road widths to influence slower speeds in local roads. IM has also been undertaking work towards improving existing cycle lanes and created further networks, as well as designing the necessary policy framework to ensure their safety. It has implemented various projects that included cycling infrastructure, while its employees have attended training organised by Transport Malta (TM) to improve their skills in designing safe and accessible cycling infrastructure. Internal discussions are underway with the MTIP to enhance awareness of shared spaces on the road to allow safe use by all.

3.2.11 Specific efforts were aimed at providing opportunities and incentives to encourage stakeholders to provide physical activity classes, active play and sports that are accessible and affordable to the general population. Several local councils take initiative and organise activities intended to promote an active lifestyle and social inclusion. Other efforts are aimed at ensuring the inclusion of persons with a disability and older persons in opportunities of physical activity. The Motor Activity Training Programme is offered to persons with multiple impairments, aiming to provide adaptable physical training and education, whereas the Sharing Lives programme promotes sports activities within different communities in collaboration with several organisations. Various projects have benefitted from funds intended to encourage integration and accessibility. More physical activities for senior citizens are being promoted by the Active Ageing and Community Care unit, including adapted physical exercise sessions led by qualified tutors, and swimming sessions held in collaboration with SportMalta. Some community centres organise walking and trekking activities for members on a regular basis. In further feedback provided, the MFH highlighted an educational programme aimed at senior citizens titled 'Nibqgħu Attivi', intended to help the target population avoid falls.

3.2.12 Various educational activities (including ad hoc meetings with parents on request and population wide campaigns) were undertaken and guidelines were issued by the HPDP on the types and quantities of physical activity required in different age groups (Be Active 18-65 years and Be Active 65 plus), imparting knowledge on the benefits of health enhancing physical activity and recommending reduced screen time. The HPDP promote their message using a wide array of media, and ensure their content is scientifically reliable by participating in professional networks to keep abreast with any developments. HPDP also participated in an EU-funded project titled Transferring the Swedish Physical Activity on Prescription, which aims to raise awareness on the importance of physical activity on one's health status and the role of physical activity in the management of several non-communicable diseases among health professionals. Maltese health care professionals will be trained in the Physical Activity on Prescription model – a method that involves counselling and prescription of exercise in an individualised manner based on the client's health circumstances. As part of this project, various types of physical activity opportunities in different localities in Malta and Gozo were mapped, providing a resource for ideas and locations of different types of physical activity opportunities to suit the needs, abilities and preferences of different individuals.

Service provision

3.2.13 The Strategy included various recommended areas for action related to the re-orientation of health services and the development of community-level services and specific services. Recommendations included the improvement and increased provision of weight management classes, the setting up of a specialised obesity clinic in the primary health sector, an assessment of the feasibility of including bariatric surgery in public health care and periodic BMI assessments among the public.

3.2.14 Weight management programmes (which also include physical activity sessions) are provided by the HPDP in various locations and physical activity programmes continue being provided through local councils. A paediatric weight clinic is offered as part of the paediatric endocrine service at the MDH. Within primary health care, clients attending the Well-being Clinic undergo a holistic assessment by a nurse, which assessment includes having one's weight and height taken and BMI calculated, resulting in referral to the dietetics or nutritionist service offered within the primary health sector, general practitioner or psychologist if necessary. While the Well-being Clinic is not an obesity clinic, it is an accessible service run by nurses within the community that offers assessment and specialist referral. Clients may also be referred to Dar Kenn għal Saħħtek, a residential day-care and outpatient facility, providing comprehensive and holistic treatment targeting patients with eating disorders and morbid obesity. Bariatric surgery is included in the list of services available free at point of use in the public health care sector. Assessments among children are undertaken to ensure monitoring and appropriate referral for pre-obese and obese children. Students are measured by their physical education teachers and as part of ad hoc studies to assess pre-obesity and obesity prevalence. Children living in alternative care have their weight, height and BMI calculated as part of ongoing holistic assessments undertaken by the Looked After Children Health Service.

3.2.15 With respect to the training of health care professionals, it was noted that healthy lifestyle and behaviour change strategies as well as health promotion and disease prevention content is included in various healthcare undergraduate courses. Continuous professional development training in effective health promotion to health professionals is provided on an occasional basis, while sessions on the social determinants of health were provided to health professionals. Undergraduate and postgraduate programmes in nutrition and dietetics have been greatly expanded to ensure that the human resource pool in the sector is increased. National guidelines are available for health care workers to encourage weight loss and healthy living.

3.2.16 Various initiatives relating to the setting up of cookery clubs or delivery of cookery lessons at the community level were cited, including Dawra Durella 2014-2020, an initiative aimed for children between 7 to 11 years; Kuluri and Kuluri Sajf 2016-2018 and 2020, an initiative aimed for children between 5 to 10 years; Għaqal id-Dar, Ħajja Aħjar, open to persons of all ages; cookery lessons delivered to all children during home economics lessons; and ad hoc cookery lessons delivered by the HPDP, including a summer pilot project titled Kul bil-Għaqal targeting adolescents.

Other initiatives

3.2.17 Structural action taken includes the setting up of the Advisory Council on Healthy Lifestyles to facilitate the implementation and monitoring of the Strategy, the finalisation of the revision of the Malta Food and Nutrition Policy and the launch of the corresponding action plan in 2014. When the Social Determinants of Health Unit was established, several partnerships were initiated across different ministries in Malta and Gozo, to promote a whole-of-government and a whole-of-society approach to health concerns, facilitate the awareness of various stakeholders of the importance of healthier lifestyles, good nutrition and physical activity, and maintain an open channel of communication across different sectors.

3.2.18 In terms of economic instruments, the MFE has various schemes in place for tax rebates, such as in the case of children attending sports or the purchase of cycling or gym equipment, which are intended to incentivise the uptake of physical activity.

3.2.19 Research and evaluation initiatives and prevalence surveillance mechanisms were also mentioned. Research undertaken included a doctorate study mapping potential drivers of obesity in Malta. The Determinants of Health ESF project supported research to assess the social determinants of health and the correlations with health conditions and lifestyles. Weight management programmes are evaluated to assess their effectiveness. Prevalence data is collected through the HBSC, the EHIS and the European COSI. These, and other academic studies, help gather data relating to food consumption and the uptake of physical activity. Additionally, the National Food Consumption Survey was carried out in 2016-2017, which survey served to assess the nutritional status and eating habits of the Maltese population.

3.3 Areas for action with unknown progress

3.3.1 In total there are four areas for action for which the implementation status is unknown due to the fact that no information was submitted by stakeholders. Three relate to areas of action concerning human resource issues. More specifically, skills development of current staff and recruitment of new specialised staff within the MFH, Elderly and Community Care; the strengthening of continuing professional development of health professionals; and training on the health effects of public policies within other Ministries and sectors. The other area of action with unknown implementation status relates to a monitoring and evaluation framework for new services.

3.4 Areas for action not implemented

3.4.1 The area for action which has not been implemented is an assessment of the feasibility of regulatory measures to restrict access by children to nutritionally inappropriate meals and energy-dense snack foods from retail outlets located in the vicinity of schools. The Superintendence of Public Health commented that this is difficult to implement since many schools are situated in village core areas.

3.5 Areas for action that are a work in progress

3.5.1 Areas of action which were reported to be a work in progress relate to food labelling, a needs assessment analysis for the healthcare workforce, and public policies and economic instruments intended to motivate and enable healthy lifestyle choices. With regard to work aimed at improving the clarity of food labelling and the setting up of a Healthy Food Scheme which uses colour coding to easily identify healthy foods the MFH indicated that discussions on these matters were being held at EU level. Additionally, it was noted that the HPDP promote knowledge of food label interpretation as part of their education campaigns. With regard to a needs assessment analysis to identify gaps in the number and skills of the workforce, the MFH indicated that the People Management Unit within the Ministry has published a Health Workforce Strategy, and was piloting a Health Workforce Planning Tool that will assist with longer-term and more evidence-based HR Planning. Moreover, the MFH intended to apply for EU funding to outsource and implement a training needs analysis across the Ministry.

3.5.2 For both the development of healthy public policies to increase physical activity and the development of a national physical activity action plan, the Superintendence of Public Health noted that a Health Enhancing Physical Activity policy/strategy and action plan is being developed, whilst acknowledging that a health-in-all-policies approach is necessary to achieve progress. The MEYR explained that improvements had been registered with regard to the area for action which aimed to revise the national curriculum to include at least 30 minutes of daily physical activity during official school hours to be increased to three hours a week by 2015. More specifically, it was noted that the number of physical education lessons in both primary and secondary schools have doubled from one to two weekly lessons and increased from two to three weekly lessons in middle schools. Furthermore, the Sport Career Development Programme has been introduced- with four lessons per week. With respect to studies analysing the impact of subsidies and taxes on people's behaviour and income redistribution, the feasibility of incentives to increase the availability of healthy food outlets and restrictions related to fast food outlets, and the potential for further employer tax incentives to motivate employee healthy lifestyle choices, the Superintendence of Public Health indicated that there were ongoing discussions with the MFE.

3.6 NAO analysis on information provided

3.6.1 The information regarding the projects, measures and initiatives undertaken across Government to address the areas for action proposed in the Strategy presented in this Chapter was, as explained earlier on, provided to the NAO by the MFH, after the Ministry had gathered, collated and organised information provided by various stakeholders. The NAO is of the opinion that in various instances the identified implemented actions were at best tokenistic or tangential in their address of the respective area for action, or limited in scope, and in a few cases could be argued to be unrelated.

3.6.2 For example, the midwife discharge liaison visit service and the introduction of workplace guidelines for enhancing employee health (which includes guidelines on facilitating breastfeeding at the place of work) were cited as the actions taken to address the area for action relating to the promotion of

the establishment of a breast-feeding friendly environment within our society. These initiatives were considered limited in scope for the creation of a breastfeeding enabling environment. On providing further feedback, the MFH noted that seminars and promotion campaigns are held on a yearly basis to promote breastfeeding, and that prior to the pandemic training sessions were delivered to nutritionists on the latest evidence, which sessions are to be re-introduced.

3.6.3 Similarly, with respect to the issuance of guidelines on messages to be delivered in weight management courses provided in both the public and private sector, the HPDP within the MFH assessed this area for action to be partially implemented on the basis of the manual used internally within its weight loss programme. The NAO is of the understanding that this area for action referred to the introduction of sector-wide guidelines rather than internal SOPs of one particular programme.

3.6.4 In response to the area for action intended to introduce regulations to ensure that all canteens and cafeterias within institutions, hospitals and homes for older people are in line with healthy dietary guidelines, the MSPC noted that the educational programme Nibqgħu Attivi is aimed at senior citizens, offering educational programmes on nutrition and providing opportunities for appropriate physical exercise. The relevance of this programme for the proposed area for action was unclear to the NAO. Similarly, with respect to the area for action relating to the revision of the national curriculum to increase the time spent by children doing physical activity during school hours, the MFH indicated that the Superintendence of Public Health had supported a local longitudinal study analysing the effect of daily physical activity in primary schools on children's academic, physical and mental wellbeing. This implemented action was considered by the NAO to be at best tangentially relevant to the matched area for action. Nevertheless, this Office acknowledges that some progress has been registered within schools in terms of the time allocated for physical activity, as reported above.

3.6.5 Another example relates to the information submitted by the MSPC relating to the Għaqal id-Dar, Ħajja Aħjar training programme and Proġett Familja: 2014-2017 as evidence of the partial implementation of the area for action intended to improve the availability and uptake of a healthy diet by the Maltese population through healthy public policies across Government. The NAO acknowledges that these specific initiatives may have contributed to improved food literacy and better eating habits for participants, however, they do not constitute public policies. In further feedback provided, the MFH referred to the healthy eating policies within schools (relating to food procured in that setting), at the MDH (in relation to the availability of healthy foods in the canteen and shop), and within elderly institutions (in relation to the procurement tender for resident meals).

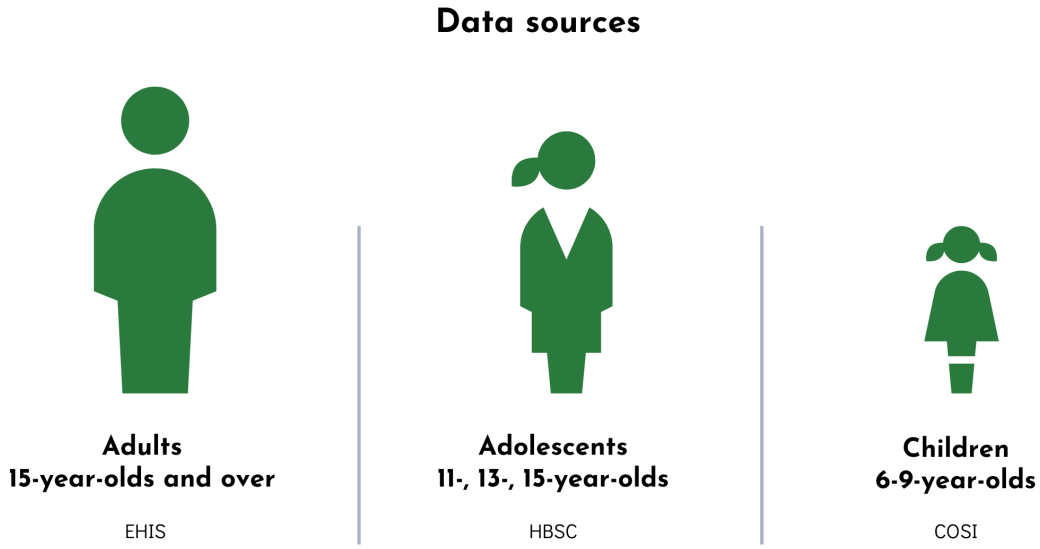
3.6.6 Similarly, the MEYR considered the area for action relating to the establishment of an annual competition and award to reward schools for helping children to adopt healthy lifestyles on school premises as having been implemented through the Young Chef Challenge. However, the NAO observes that this competition rewards individual children for their work on specific themes rather than individual schools for any specific initiatives or projects introduced to encourage the adoption of healthy lifestyles.

3.6.7 Finally, in response to the area for action intended to increase the complement of registered nutritionists and dieticians and to recruit food community workers, the University of Malta and the MFH indicated that more nutritionists and dieticians had been trained and recruited, and that therefore this area for action had been implemented. However, the NAO noted that no reference was made in the stakeholder response to the recruitment of community workers, intended to act as a resource within healthcare and community settings, and that therefore, this area for action can be considered to be partially and not fully implemented.

Chapter 4| Trends and patterns emerging from overweight data

4.1 A comparative and trend analysis of prevalence rates

4.1.1 Prevalence rates for children (6–9-year-olds, COSI), adolescents (11-, 13-, 15-year-olds, HBSC) and adults (15+-year-olds, EHIS) were compared across participating countries and over time. The analysis across countries allows for an assessment of the scale of the pre-obesity, obesity and overweight prevalence in Malta relative to the average in participating countries, or in comparison to the best or worst performing countries. The analysis over time provides an insight into the trend in prevalence rates, specifically whether an increase or decrease is being registered. To facilitate the presentation of results, COSI data will be referred to as child data, HBSC data as adolescent data and EHIS data as adult data.



Childhood Obesity Surveillance Initiative

4.1.2 Malta's childhood pre-obesity, obesity and overweight ratings as established through COSI stood at 18.1, 14.9 and 33.0 per cent, respectively, in 2019 (Figure 5, Figure 6 and Figure 7 refer). In round five (2018-2020), among all 27 participating countries that had sampled seven-year-olds, Malta ranked seventh, fourth and third worst in terms of the pre-obesity, obesity and overweight indicators, respectively. Also of note is the fact that Malta recorded substantially higher rates than the average recorded for the 27 countries, most noticeably for overweight, followed by obesity, and least for pre-obesity. More specifically, Malta's rates for pre-obesity, obesity and overweight were 2.1, 4.2 and 6.3 percentage points higher than the average in round five.

Figure 5 | Pre-obesity child prevalence rates, round five, 2018-2020

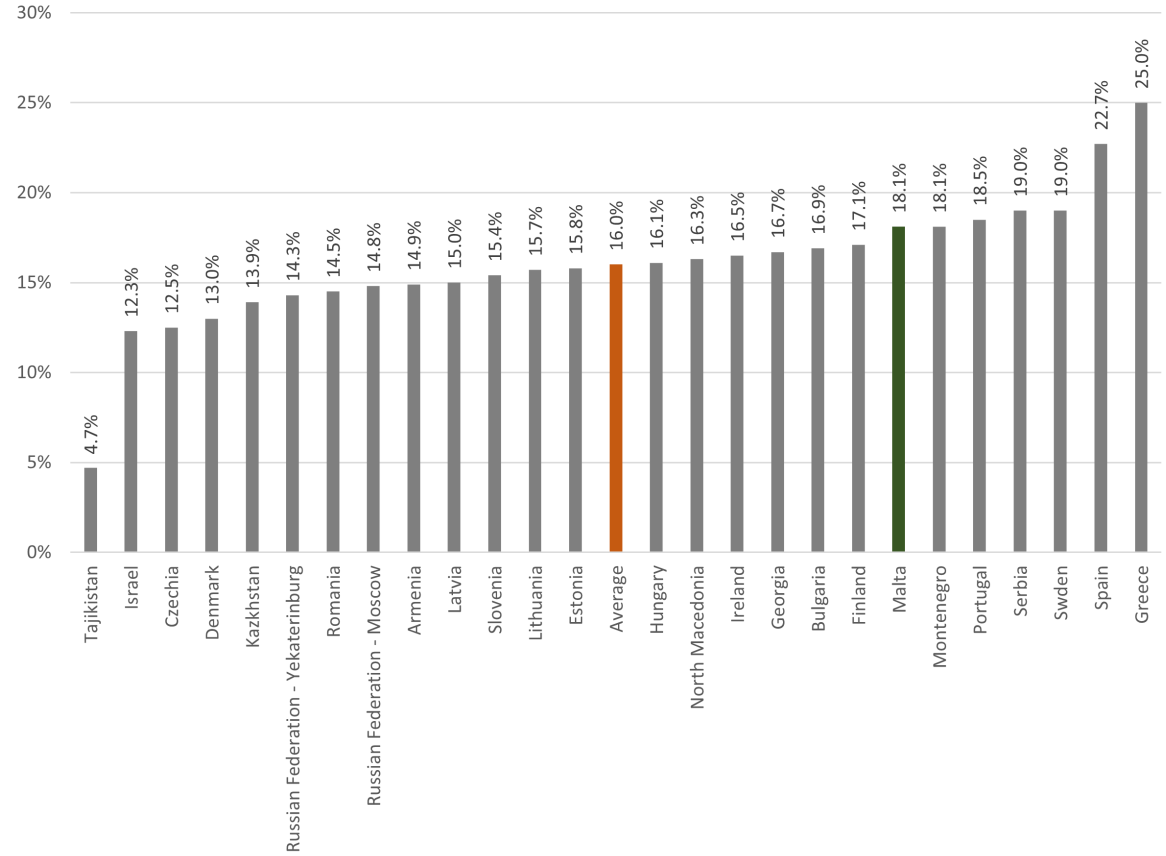


Figure 6 | Obesity child prevalence rates, round five, 2018-2020

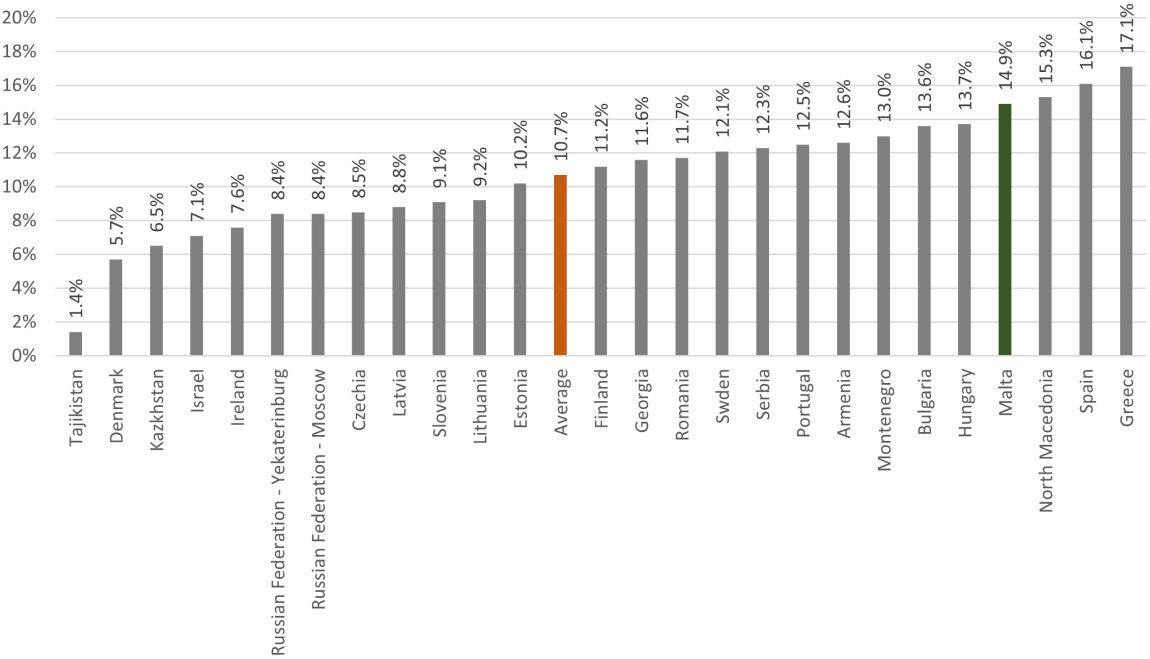
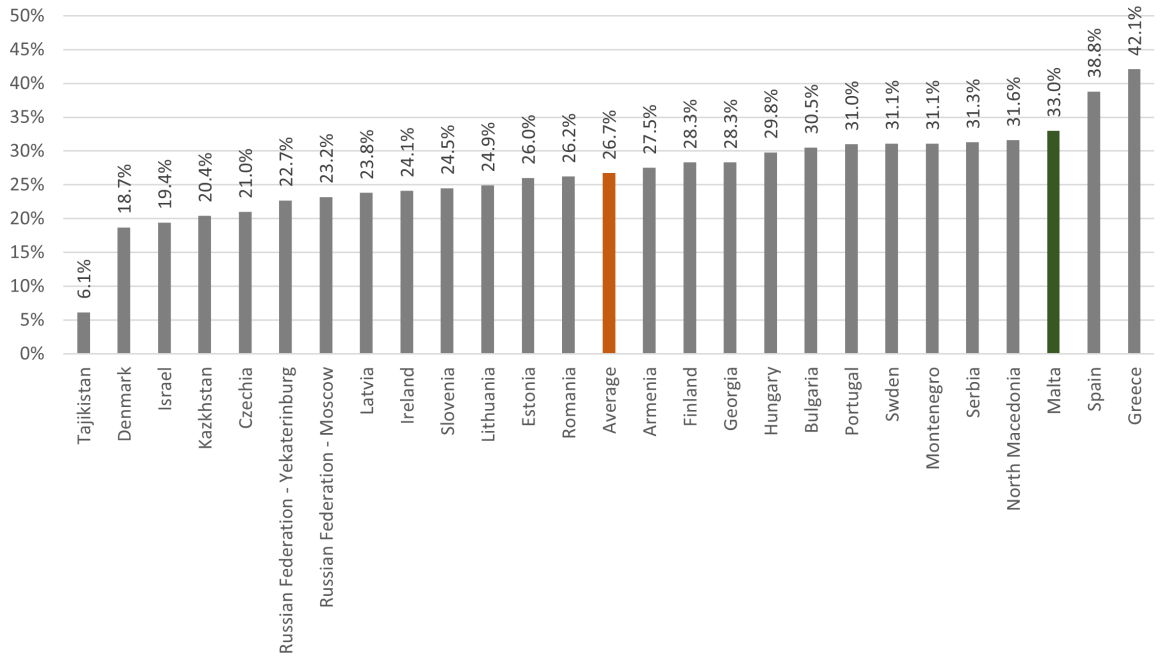


Figure 7 | Overweight child prevalence rates, round five, 2018-2020



4.1.3 Since age-combined estimates are only available for round five (2018-2020) for international data, and different countries sampled different ages in different rounds (which cannot be compared), the trend analysis for COSI will be restricted to Malta. Although prevalence rates for Malta are available for rounds one to six (2008-2022), the trend analysis is restricted to rounds three to six (2013-2022), since 7-year-olds were sampled from round three onwards. While obesity rates for seven-year-olds showed a monotonic improvement from round three to round five (2013 to 2019), the improvement registered in this period is lost in the last round, with the round six (2022) rate observed to be approximately equal to the round three (2013) rate, 17.1 per cent versus 17.0 per cent (Figure 9 refers). Pre-obesity rates show fluctuations in the period under review, but overall an increase of 2.3 percentage points (equivalent to a 14.4 per cent increase) is noted when comparing round six (18.3 per cent) to round 3 (16.0 per cent) (Figure 8 refers). The same fluctuations and overall increase are noted for the overweight indicator, with the rate having increased by 2.4 percentage points (equivalent to a 7.3 per cent increase) from round three (33.0 per cent) to round six (35.4 per cent) (Figure 10 refers).

Figure 8 | Malta's child pre-obesity prevalence rates

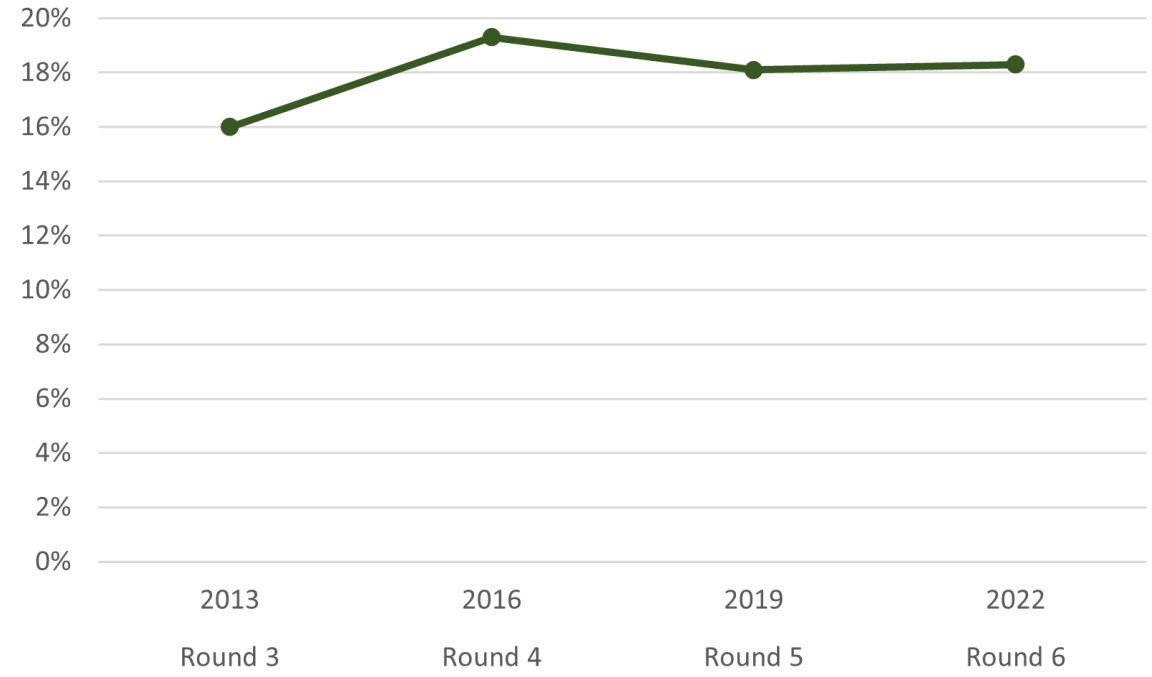


Figure 9 | Malta's child obesity prevalence rates

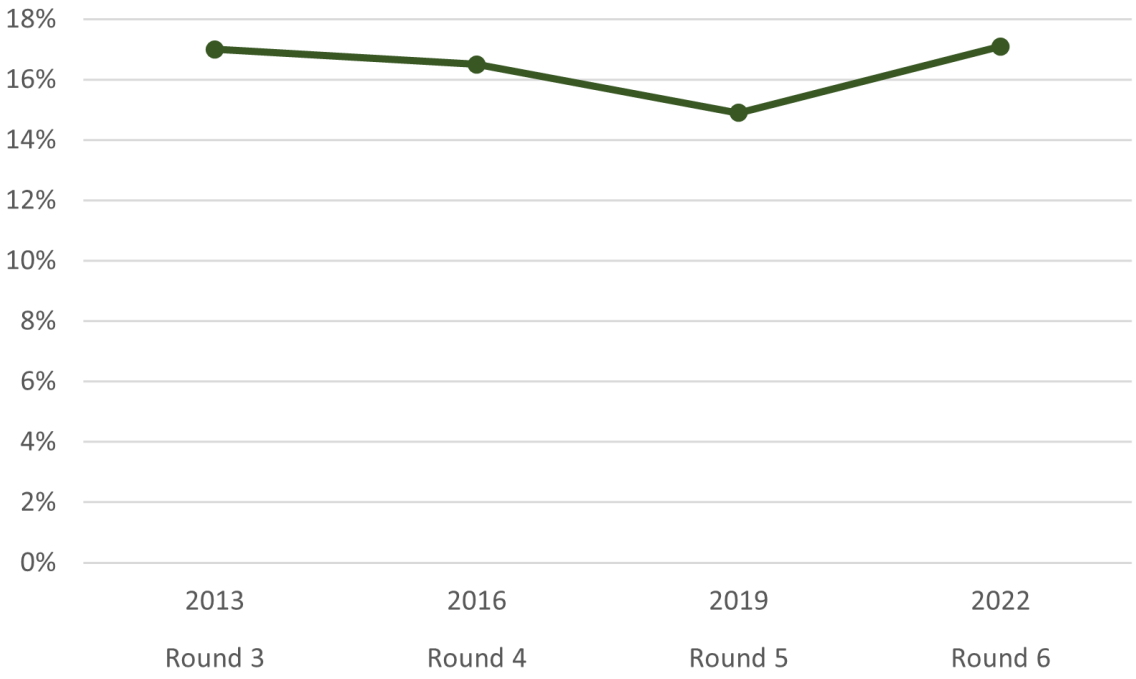
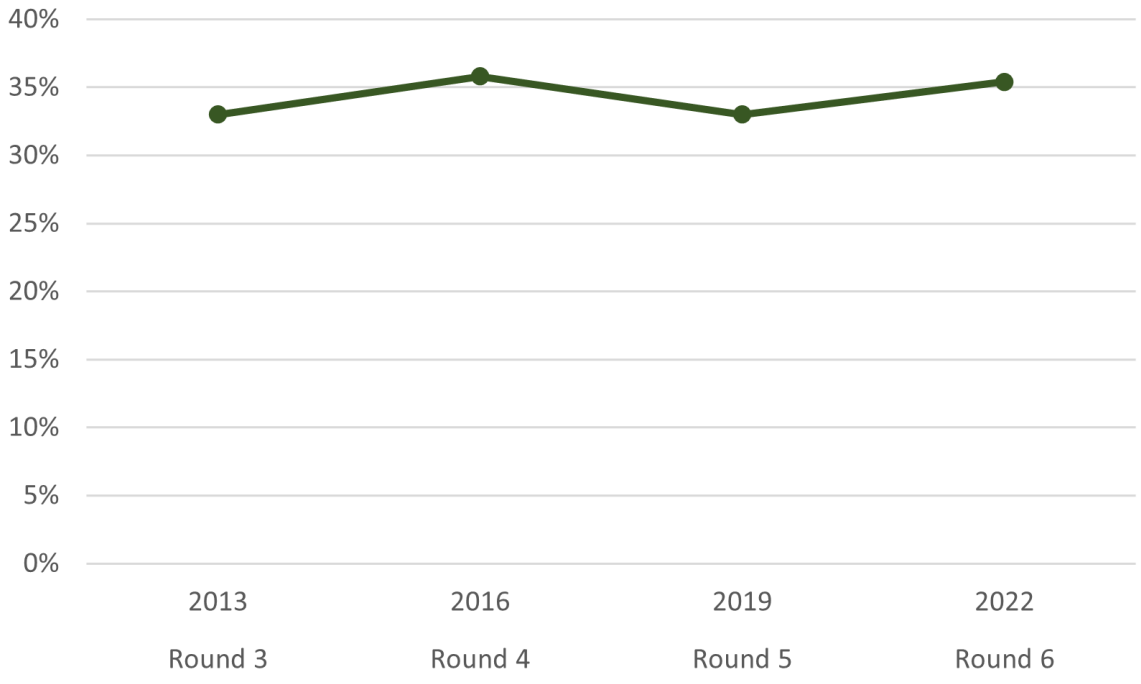


Figure 10 | Malta's child overweight prevalence rates



Health Behaviour in School-aged Children

4.1.4 In 2014 and 2018, Malta ranked worst across all three indicators (pre-obese, obese and overweight) among all countries participating in the HBSC study. For 2014, Malta's adolescent pre-obese, obese and overweight prevalence rate stood at 20.0, 7.3 and 27.3 per cent, respectively (Figure 12, Figure 14 and Figure 16 refer). These rates increased to 22.4, 8.9 and 31.2 per cent, respectively, in 2018 (Figure 11, Figure 13 and Figure 15 refer).

4.1.5 Additionally, the local rates are substantially higher than the second worst ranked country, by 2.8 (Macedonia), 3.3 (Canada) and 6.7 (Macedonia) percentage points in 2018 and by 1.6 (Greenland), 1.5 (Canada) and 4.4 (Canada) percentage points in 2014 for pre-obesity, obesity and overweight, respectively. The gap between Malta and the second worst ranking country is therefore wider in 2018 than in 2014. Also of note is the fact that Malta recorded substantially higher rates than the average recorded for all participating countries in both waves of the survey. More specifically, Malta's rates for pre-obesity, obesity and overweight were 9.6, 6.0 and 15.6 percentage points higher than the average in 2018. In 2014, Malta's rates were 7.5, 4.8 and 12.3 percentage points higher than the average for pre-obesity, obesity and overweight respectively. The gap between Malta's rates and the average rates is most pronounced for the overweight indicator, followed by the pre-obesity indicator. Moreover, this gap has also widened in 2018 compared to 2014.

Figure 11 | Adolescent pre-obese prevalence rates, 2018

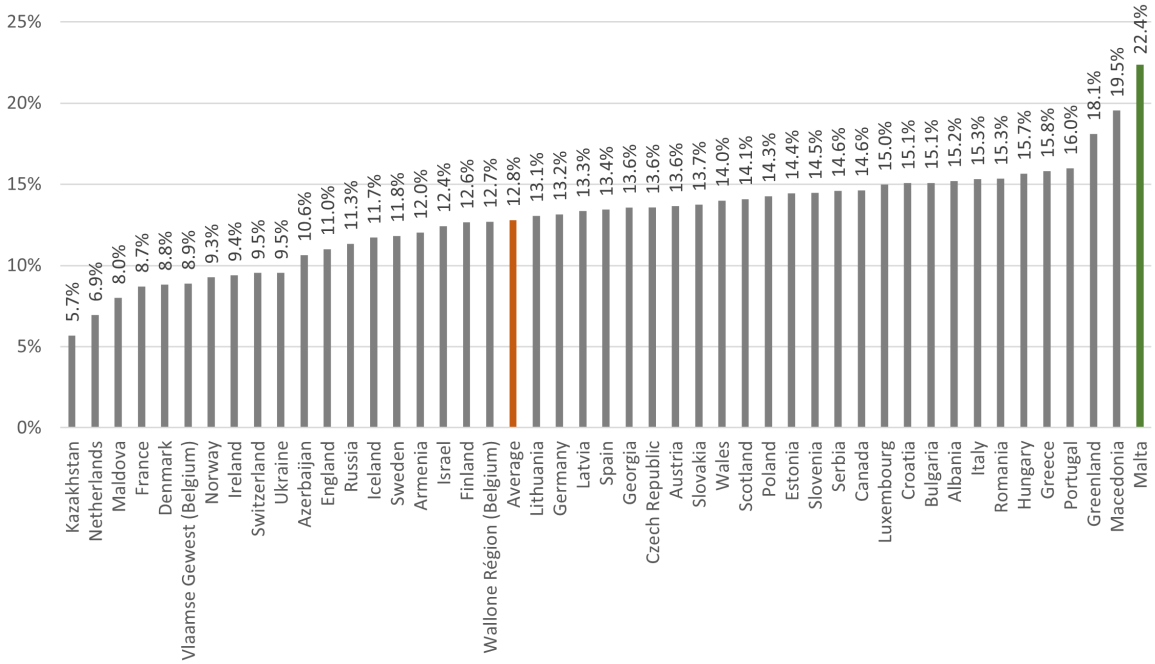


Figure 12 | Adolescent pre-obese prevalence rates, 2014

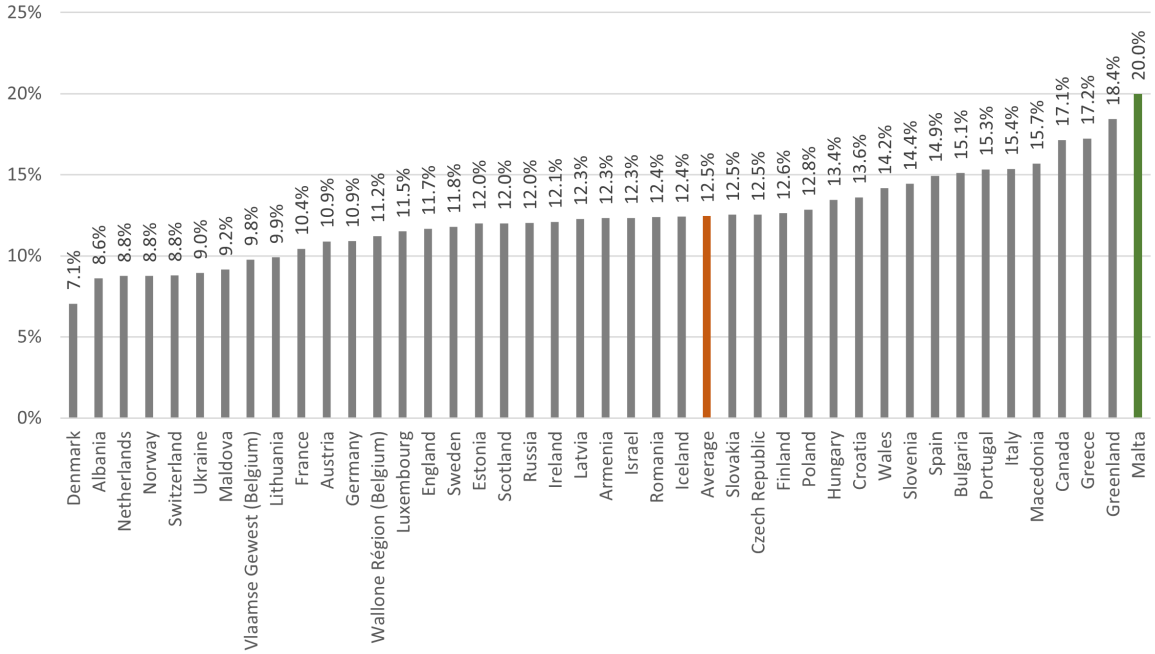


Figure 13 | Adolescent obese prevalence rates, 2018

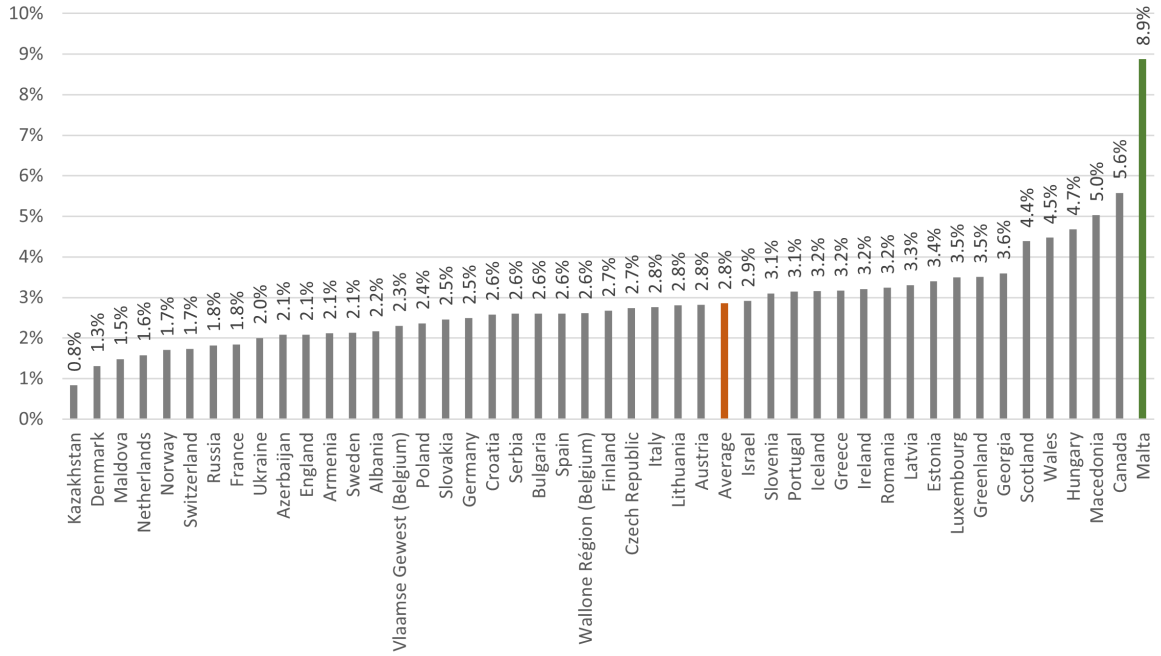


Figure 14 | Adolescent obese prevalence rates, 2014

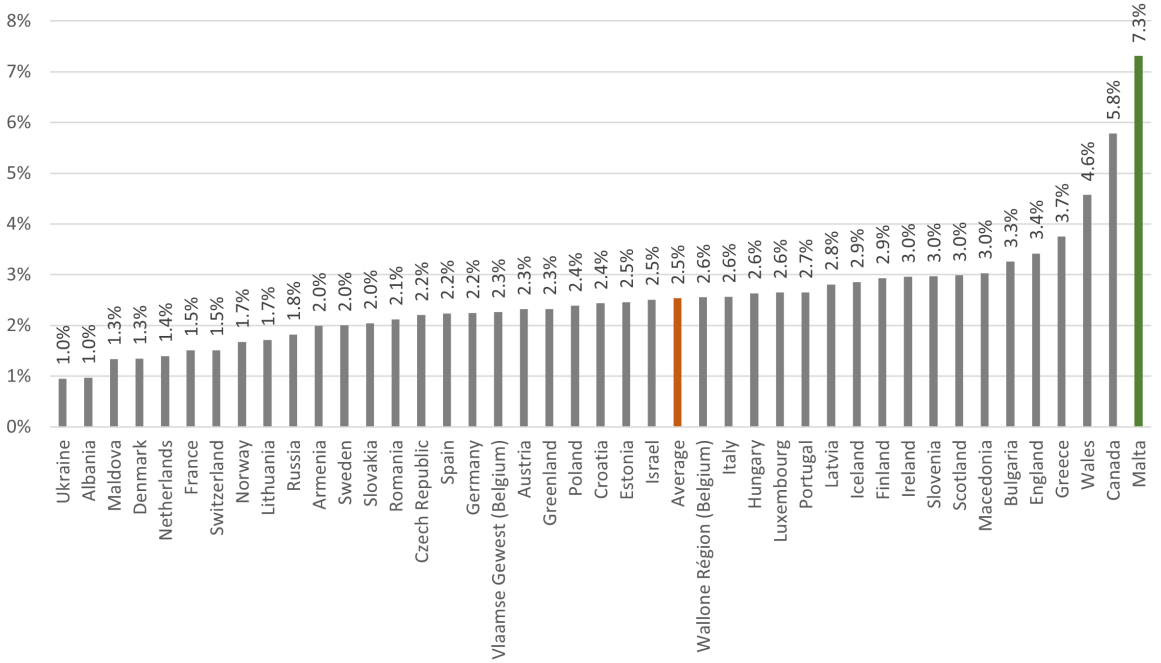


Figure 15 | Adolescent overweight prevalence rates, 2018

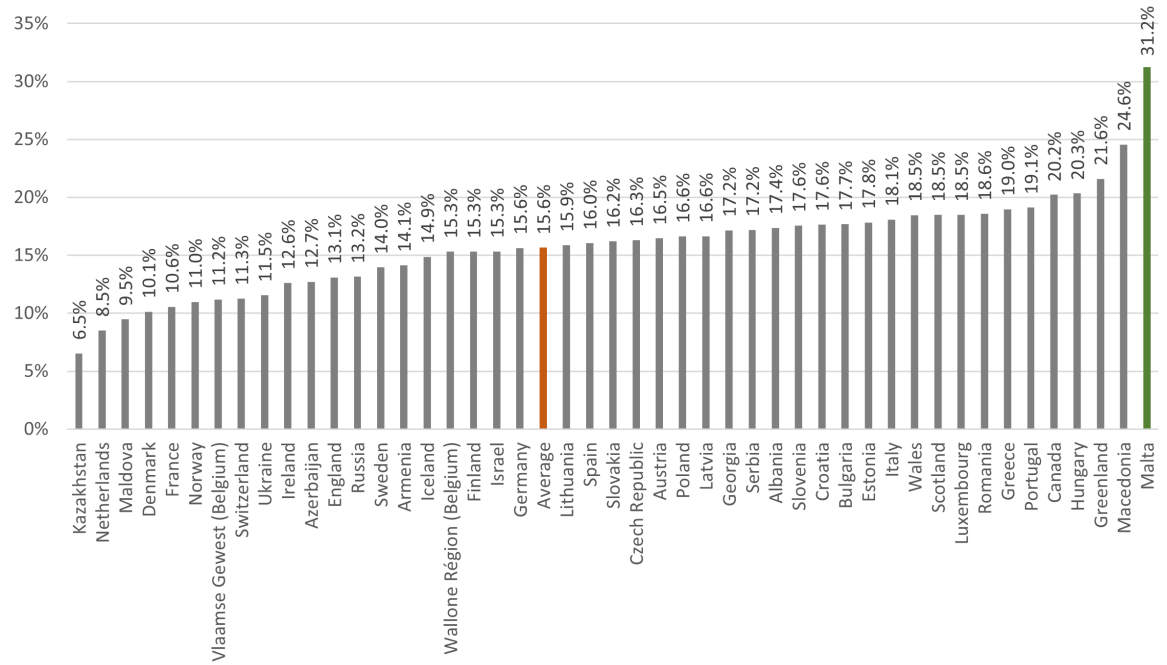
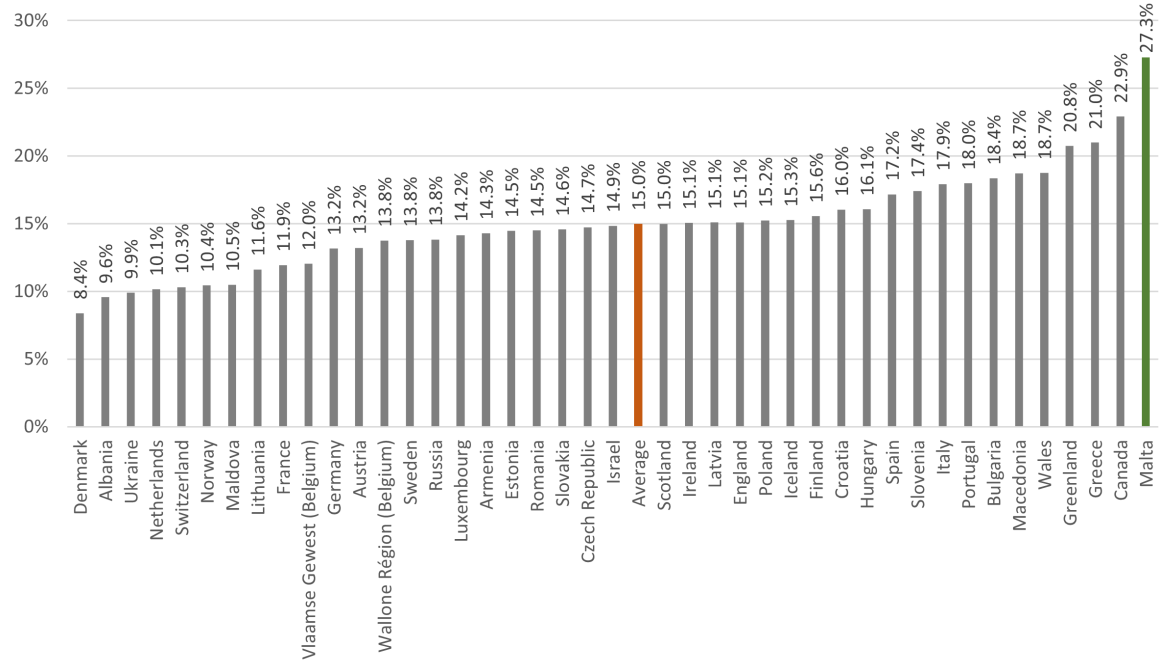


Figure 16 | Adolescent overweight prevalence rates, 2014



4.1.6 An additional analysis undertaken comprised the comparison of prevalence rates for 2018 with those equivalent for 2014 for each country that participated in both waves. This comparison allowed for the determination of the percentage change[8] (Figure 17, Figure 19 and Figure 21 refer) and the change in terms of percentage points[9] (Figure 18, Figure 20 and Figure 22 refer) during the period 2014-2018. Only countries that participated in both waves were retained in this analysis, resulting in 42 countries. However, the averages as computed for all countries at each wave (46 countries in 2018 and 42 countries in 2014) were retained for the comparison of averages.

4.1.7 On average, pre-obesity, obesity and overweight rates for adolescents increased by 2.7, 12.4 and 4.3 per cent for the period 2014 to 2018. Of the 42 countries included in this analysis, 21, 29 and 22 countries recorded increases of at least five per cent in the pre-obesity, obesity and overweight rates, respectively, for the period under review. Malta registered a 12.0, 21.3 and 14.5 per cent increase in the pre-obesity, obesity and overweight rates, respectively. These increases were deemed to constitute an alarming rate of regression by the NAO, well above the average percentage change observed for all participating countries. Malta consistently ranked 13th worst in terms of the percentage change. During the period under review, Albania consistently ranked the worst, registering a 76.7, 124.2 and 81.5 per cent increase in the pre-obesity, obesity and overweight indicators, respectively.

4.1.8 If one had to consider change in terms of percentage points rather than percentage change, then on average pre-obesity, obesity and overweight rates would be considered to have remained stable for adolescents for the period 2014 to 2018, with average values less than 1 percentage point in each instance (Figure 18, Figure 20 and Figure 22 refer). Of note is that 18, 9 and 20 of the 42 participating countries recorded an increase in pre-obesity, obesity and overweight rates of more than one percentage point in the period under review, respectively. For the period 2014 to 2018, Malta consistently registered an increase, albeit small for pre-obesity and obesity, of 2.4 and 1.6 percentage points, respectively, and a more substantial increase for overweight, of 4.0 percentage points. In terms of change in percentage points, Malta ranked eighth, third and seventh worst from 42 countries. The highest change in percentage points was recorded by Albania (6.6 percentage points), Hungary (2.0 percentage points) and Albania (7.8 percentage points) for the indicators of pre-obesity, obesity and overweight, respectively.

[8] percentage change = (rate 2018- rate 2014) / rate 2014

[9] change in terms of percentage points = (rate 2018- rate 2014)

Figure 17 | Percentage change in adolescent pre-obese prevalence rates, 2014 vs 2018

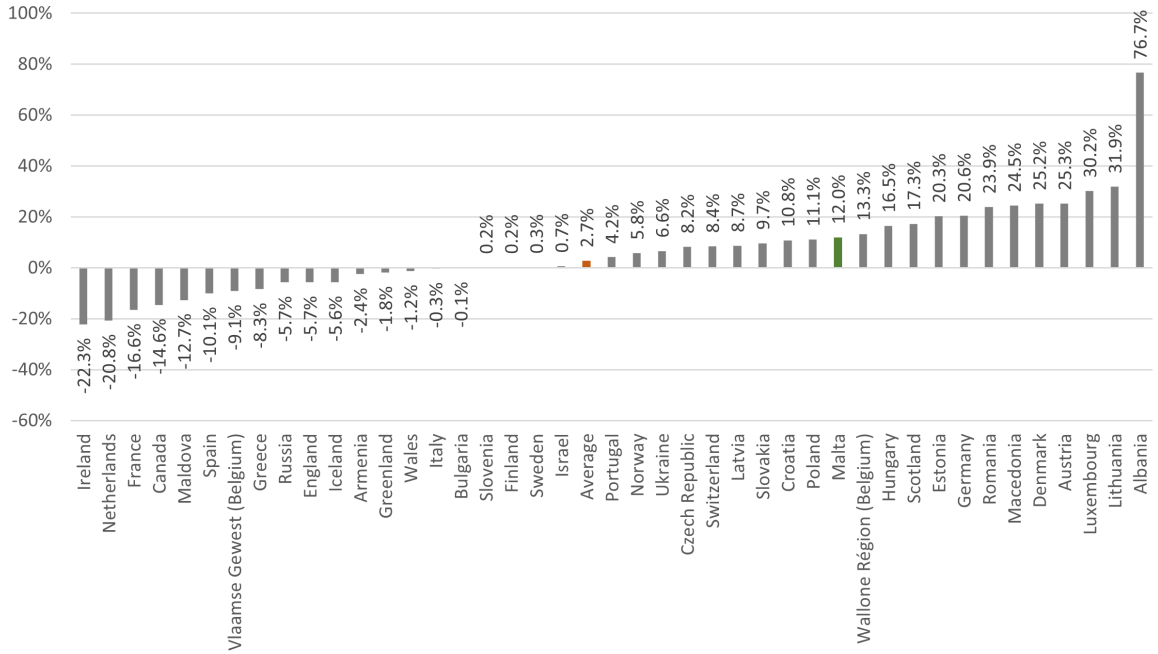


Figure 18 | Change (in percentage points) in adolescent pre-obese prevalence rates, 2014 vs 2018

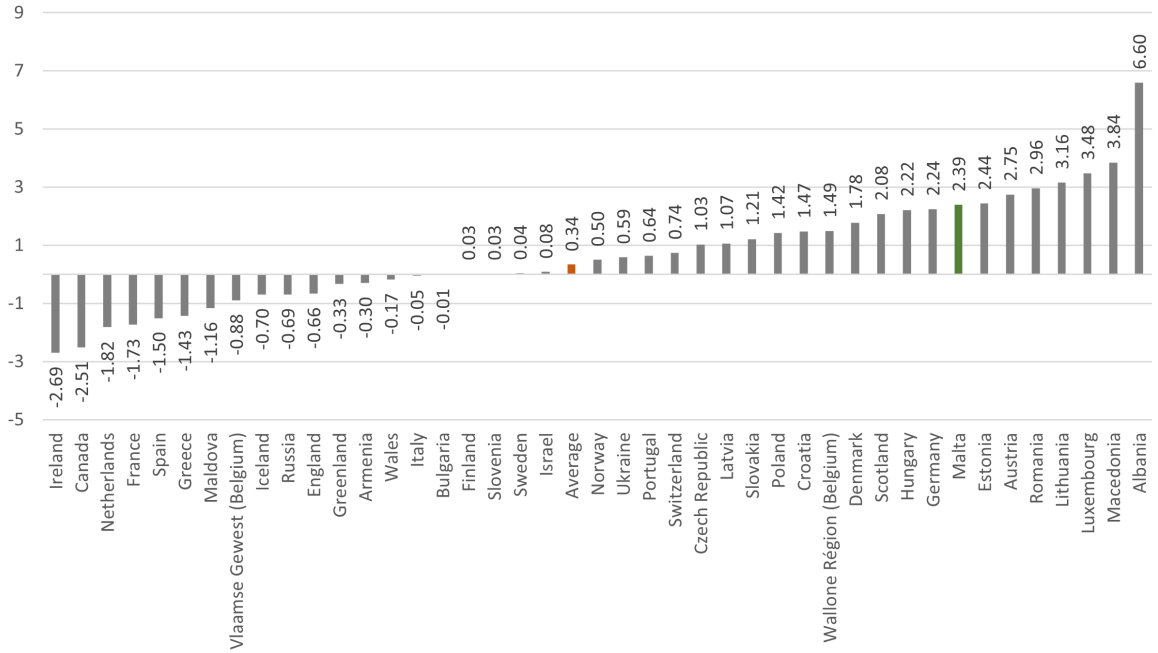


Figure 19 | Percentage change in adolescent obese prevalence rates, 2014 vs 2018

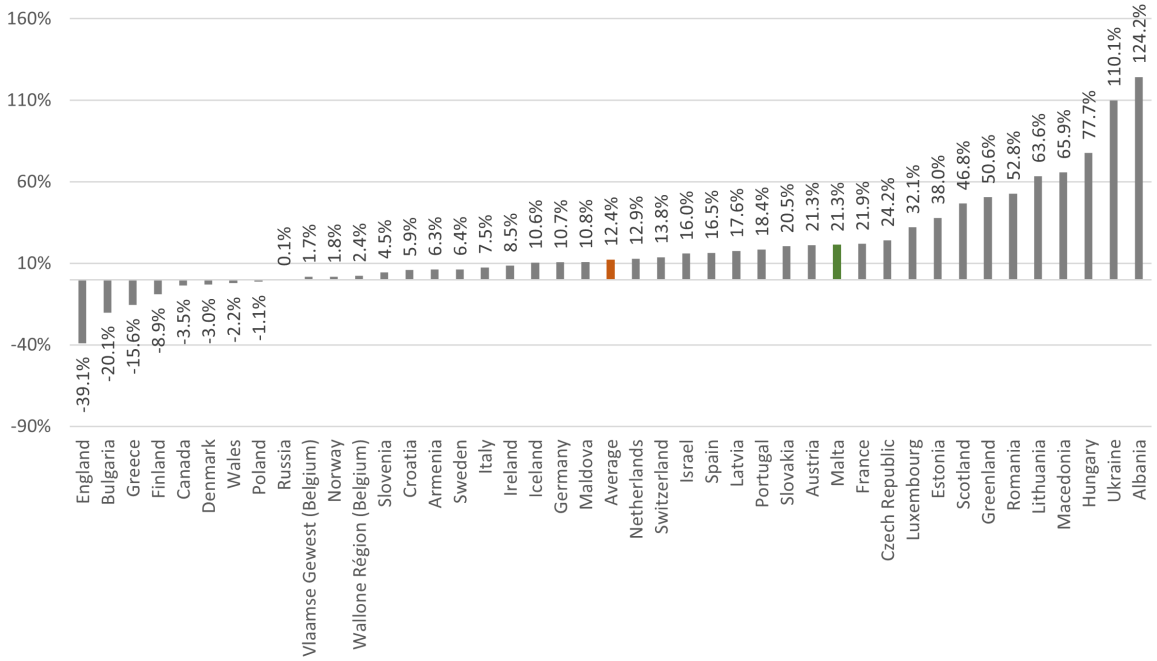


Figure 20 | Change (in percentage points) in adolescent obese prevalence rates, 2014 vs 2018

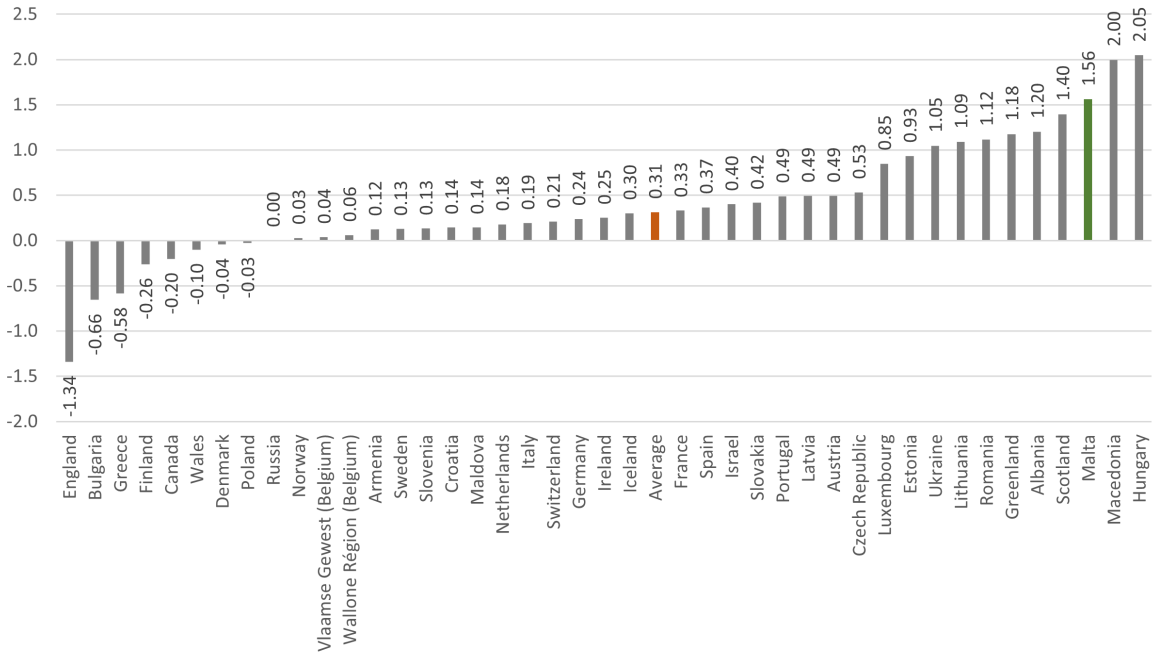


Figure 21 | Percentage change in adolescent overweight prevalence rates, 2014 vs 2018

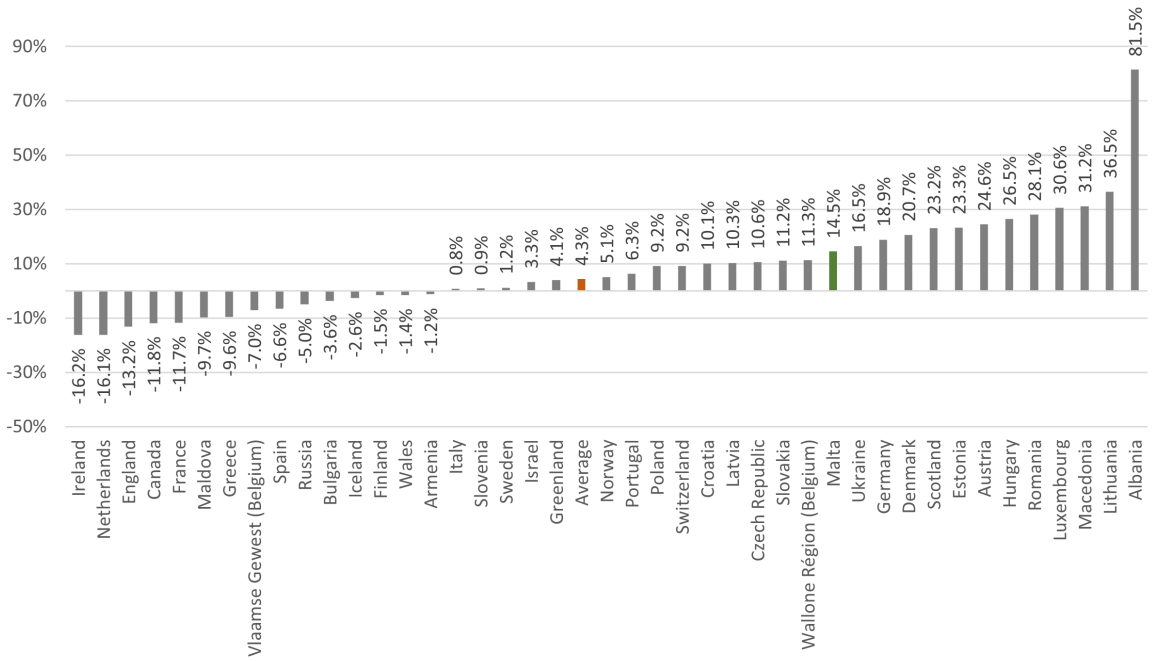
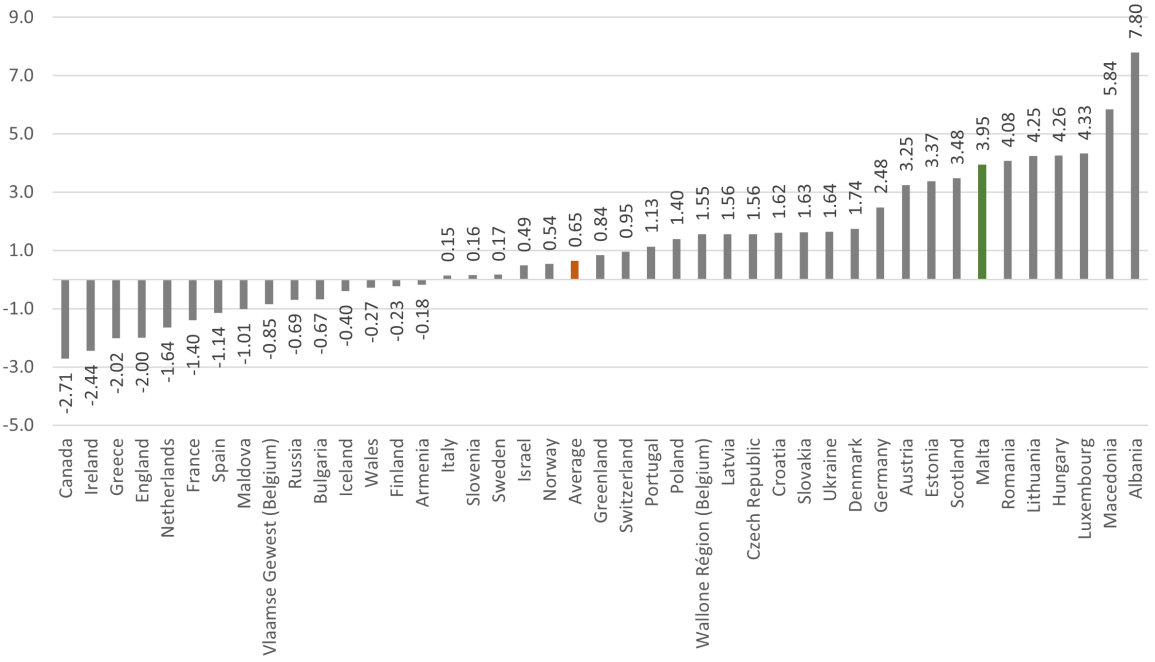


Figure 22 | Change (in percentage points) in adolescent overweight prevalence rates, 2014 vs 2018



European Health Interview Survey

4.1.9 The pre-obese, obese and overweight prevalence rates registered by Malta in respect of its adult population, as captured by the EHIS for 2019 were 35.7, 28.1 and 63.8 per cent, respectively (Figure 23, Figure 25 and Figure 27 refer). These figures were up from those of 2014, when prevalence rates for pre-obese, obese and overweight adults stood at 34.4, 25.2 and 59.6 per cent, respectively (Figure 24, Figure 26 and Figure 28 refer).

4.1.10 In the case of the population aged 15+, it can be noted that Malta consistently ranked above the EU27 average for the obesity and overweight indicators for 2014 and 2019. More specifically, in terms of obesity the prevalence rates for Malta were 10.3 and 12.1 percentage points higher than the EU27 average in 2014 and 2019, respectively. Similarly, in terms of the overweight indicator, the prevalence rates for Malta were 10.0 and 12.6 percentage points higher than the EU27 average in 2014 and 2019, respectively. Moreover, Malta recorded the highest obese and overweight rates in 2014 and 2019 among all EU27 countries. A negligible minimal difference was shown for the pre-obesity indicator for both years, with Malta registering a prevalence rate of 0.3 percentage points lower in 2014 and 0.5 percentage points higher in 2019 than the EU27 average. On the other hand, Malta ranked 16th and 13th worst for pre-obesity in 2014 and 2019, respectively. The fact that Malta had the highest prevalence rates for obesity and overweight (which includes the pre-obese and obese) but ranked mid-way for pre-obesity confirms the gravity of the situation and indicates that Malta performs poorly when compared to the rest of the EU. Additionally, in the case of obesity and overweight, the gap between Malta's and the EU average prevalence rate has widened when comparing 2019 to 2014.

4.1.11 To compare Malta's performance with the best fairing country in the EU, Malta's prevalence rates were compared to the lowest prevalence rates obtained among the EU27 for each of the indicators. The greatest discrepancy is noted for overweight, with Malta's rate in 2019, 63.8 per cent, being 19.2 percentage points higher than the rate of 44.6 per cent obtained by Italy. A similar discrepancy is noted for obesity in 2019, with Malta's rate of 28.1 per cent being 17.6 percentage points higher than Romania's rate of 10.5 per cent. A narrower gap is observed for pre-obesity in 2019, with Malta scoring 4.7 percentage points higher than France and Luxembourg, 35.7 versus 31.0 per cent. Similar patterns are noted for 2014, though the discrepancy in rates between Malta and the best performing country in the EU is smaller than for 2019, with Malta's rates being 15.8, 16.1 and 3.6 percentage points higher for overweight, obesity and pre-obesity, respectively.

Figure 23 | Adult pre-obese prevalence rates (BMI 25-29), 2019

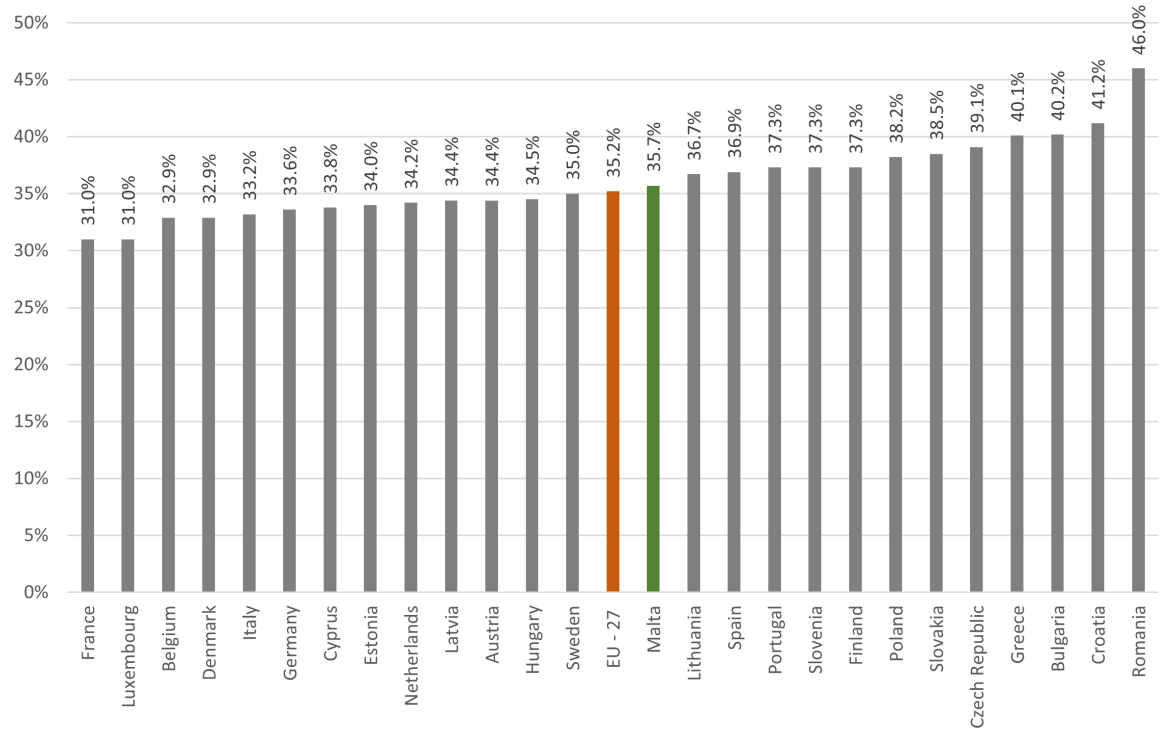


Figure 24 | Adult pre-obese prevalence rates (BMI 25-29), 2014

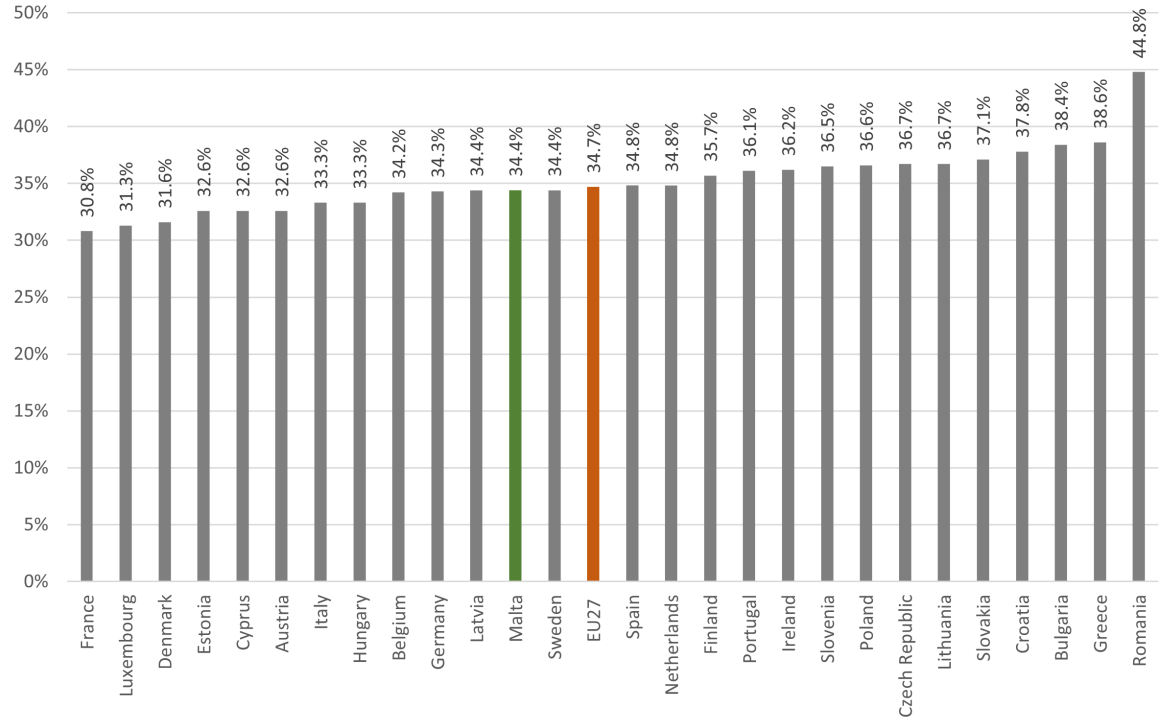


Figure 25 | Adult obese prevalence rates (BMI 30+), 2019

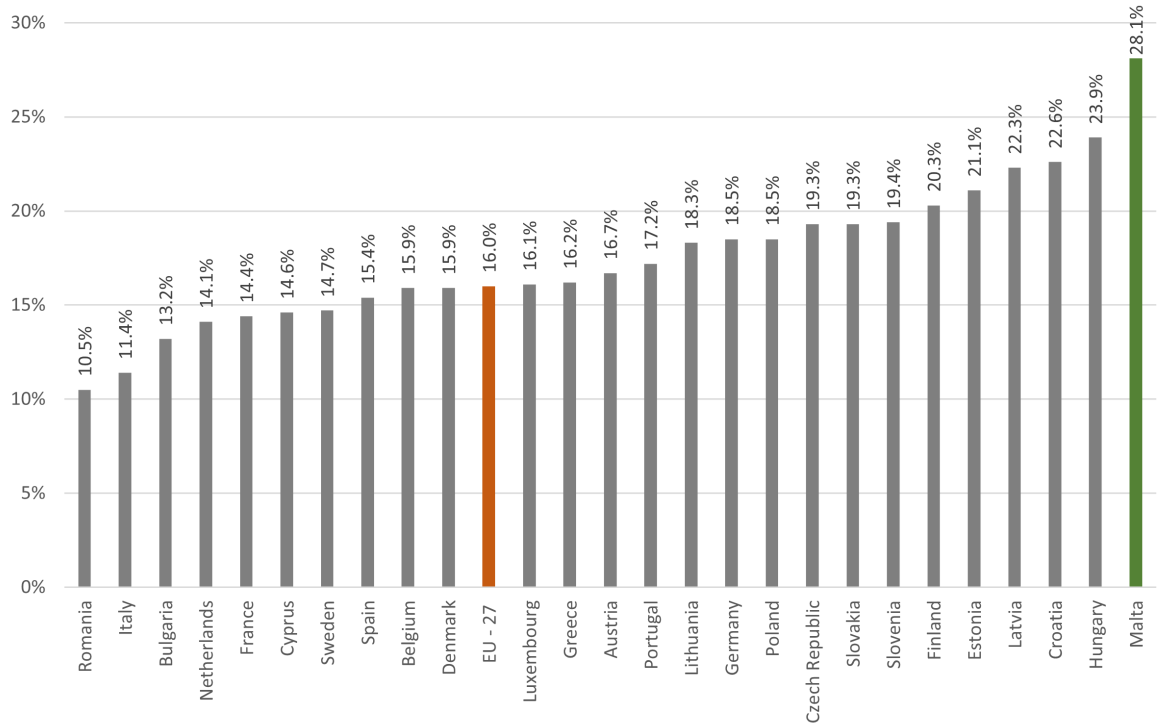


Figure 26 | Adult obese prevalence rates (BMI 30+), 2014

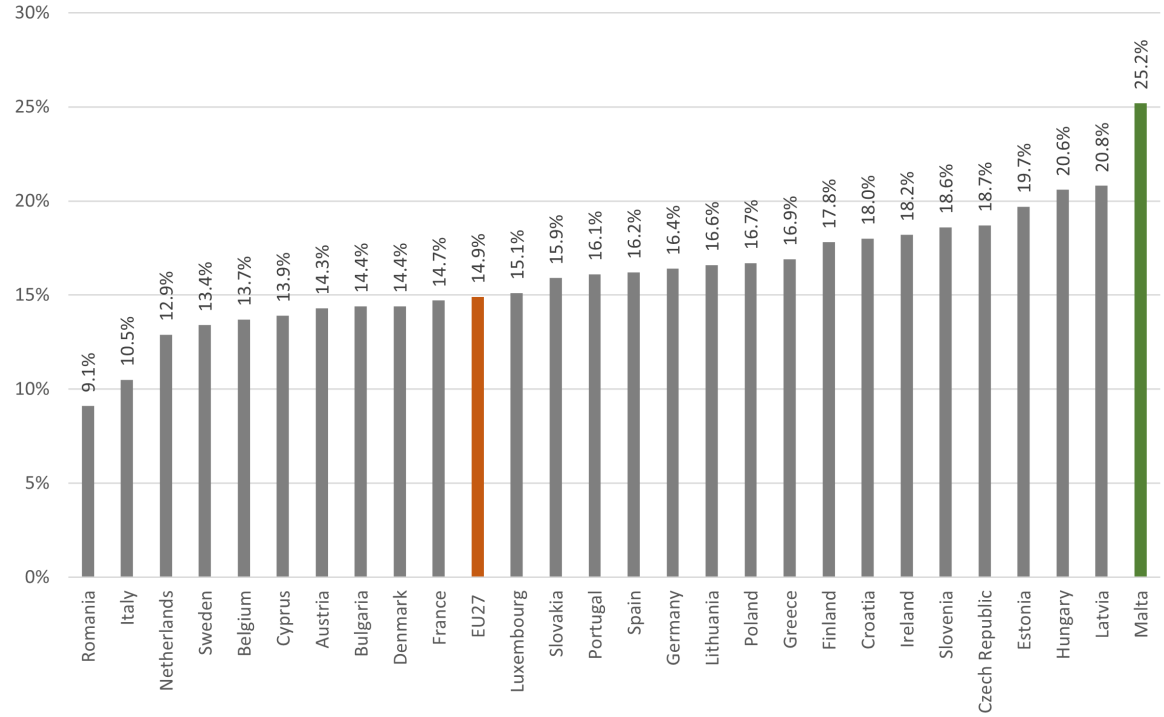


Figure 27 | Adult overweight prevalence rate (BMI 25+), 2019

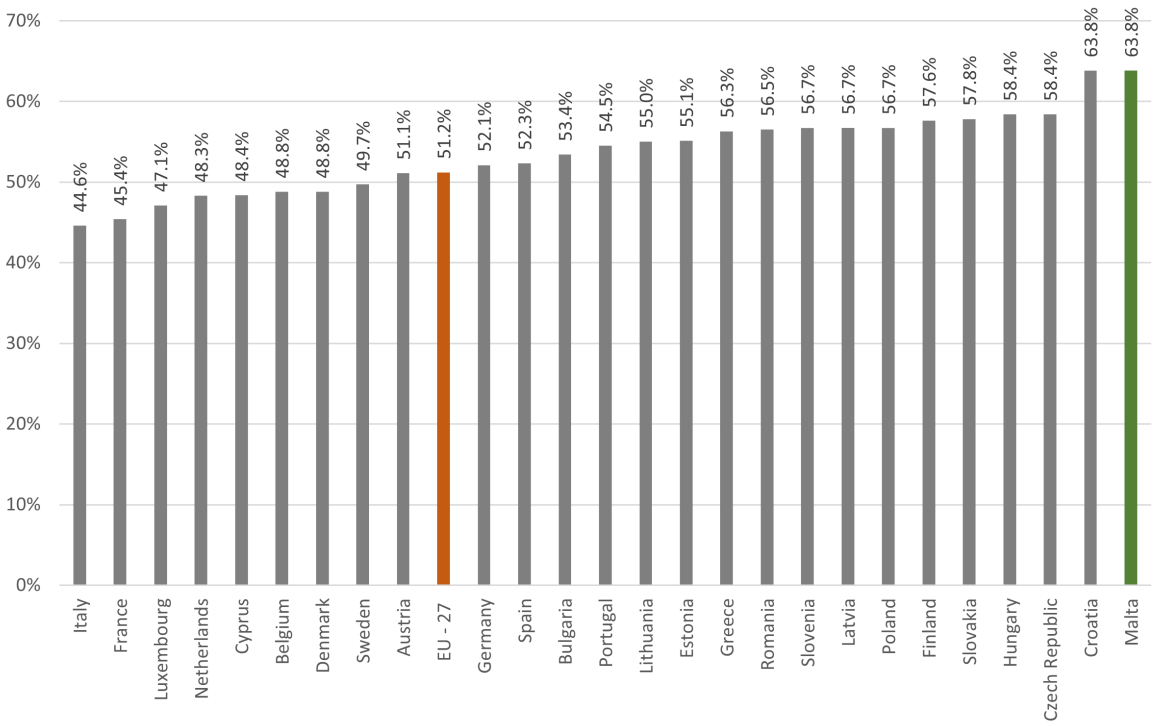
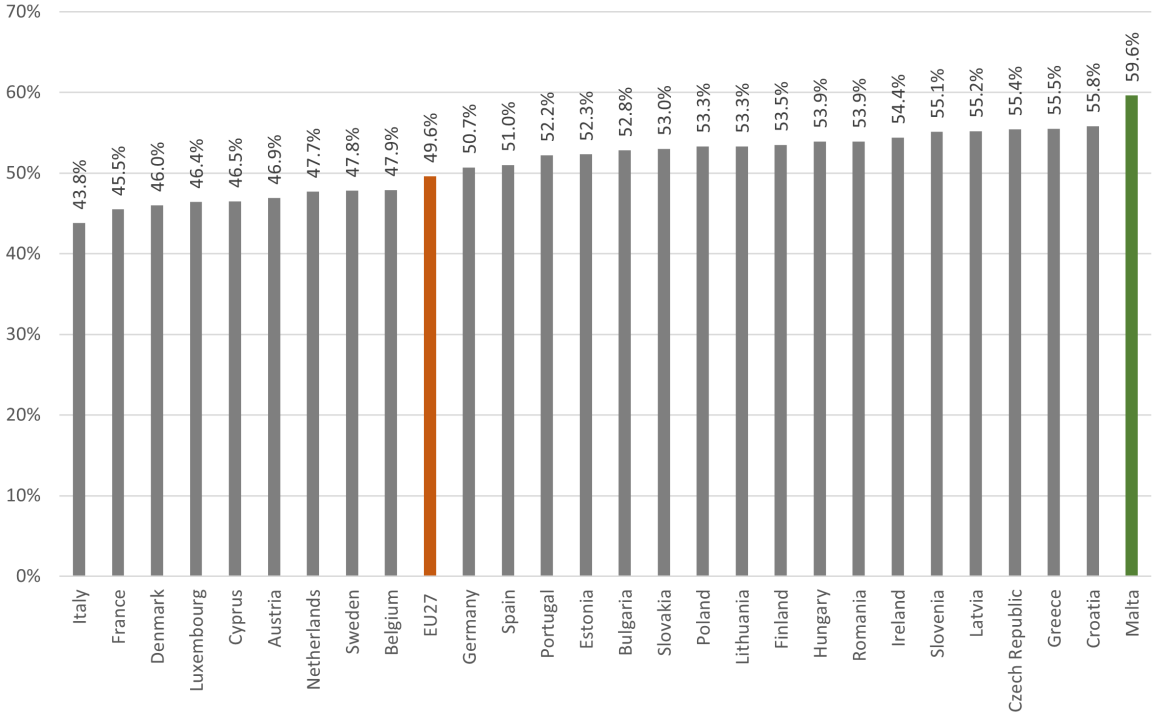
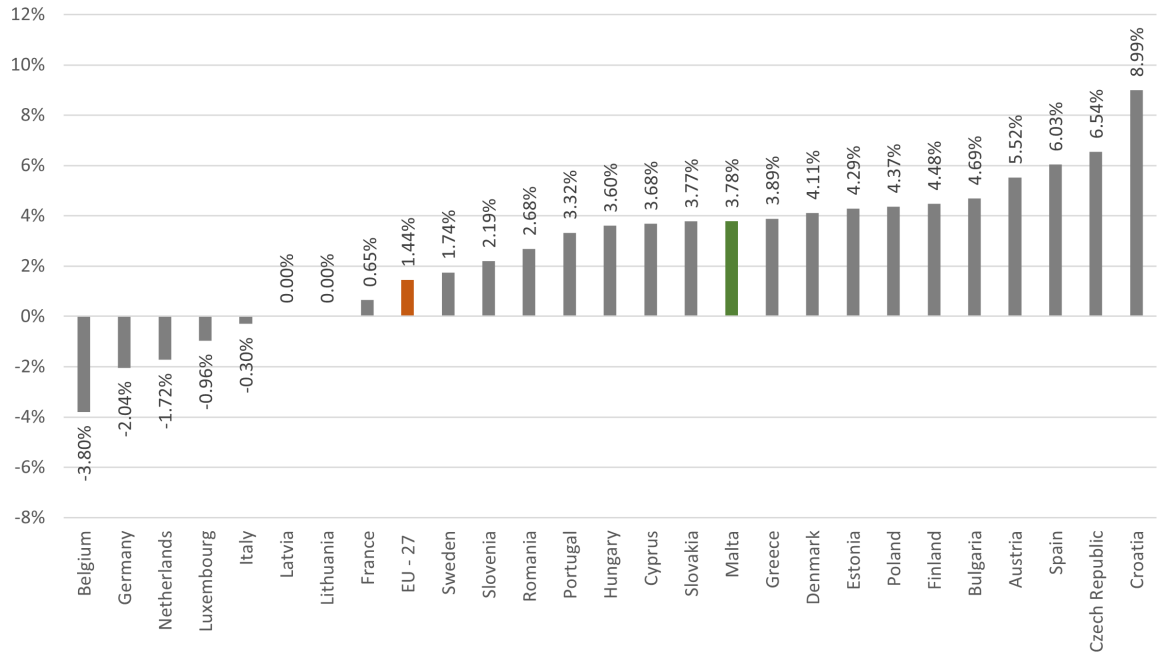


Figure 28 | Adult overweight prevalence rates (BMI 25+), 2014



4.1.12 An additional analysis undertaken consisted of comparing the prevalence rates for 2019 with those equivalent for 2014 for each country, to determine the percentage change[10] during the period 2014 to 2019 (Figure 29, Figure 31 and Figure 33 refer). Consistently, for the majority of EU27 countries, an increase is noted in the pre-obesity, obesity and overweight rates for the period 2014 to 2019. For all three indicators, Malta's increase for the specified period was greater than that of the EU27 average, though this was minimal for the pre-obesity rates. More specifically the percentage change for Malta and the EU27 was equal to 3.8 and 1.4 for pre-obesity, 11.5 and 7.4 for obesity and finally 7.0 and 3.2 for overweight, respectively. Malta ranked eleventh, ninth and sixth worst for pre-obesity, obesity and overweight, respectively. If one had to consider change in terms of percentage points[11] rather than percentage change, then Malta's relative performance worsens substantially for obesity and overweight, ranking 23rd for both indicators (Figure 32 and Figure 34 refer). On the other hand, Malta ranks 11th worst for pre-obesity when considering change in terms of percentage points (Figure 30 refers).

Figure 29 | Percentage change in adult pre-obese prevalence rates, 2014 vs 2019



[10] percentage change = (rate 2019- rate 2014) / rate 2014

[11] change in terms of percentage points = rate 2019- rate 2014

Figure 30 | Change (in percentage points) in adult pre-obese prevalence rates, 2014 vs 2019

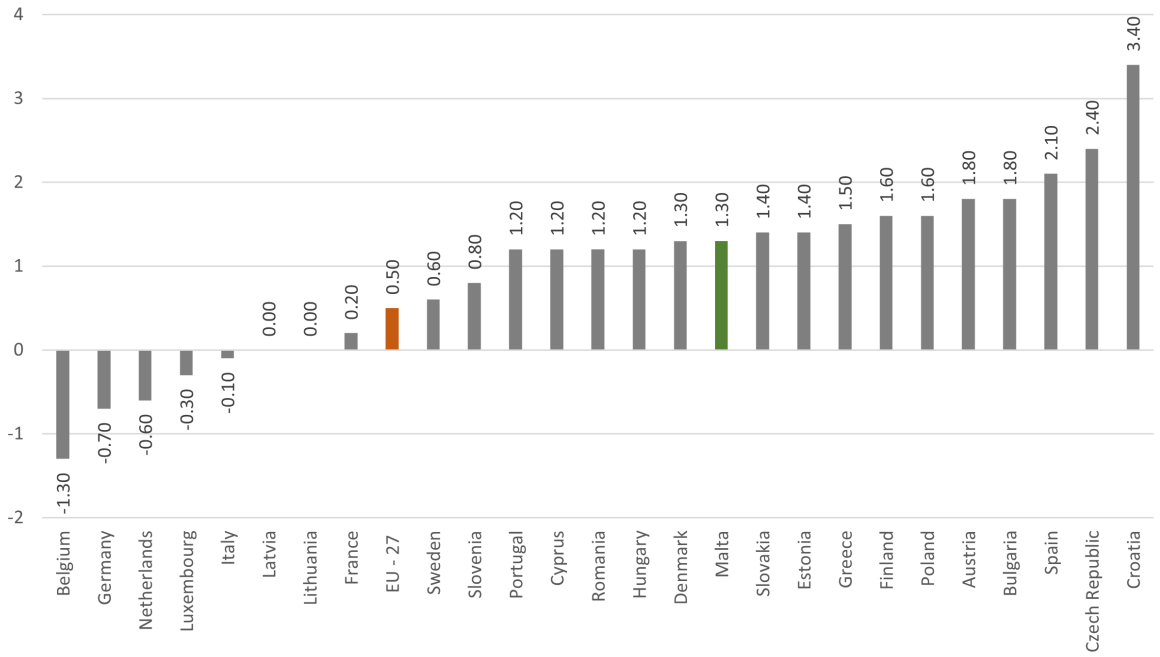


Figure 31 | Percentage change in adult obese prevalence rates, 2014 vs 2019

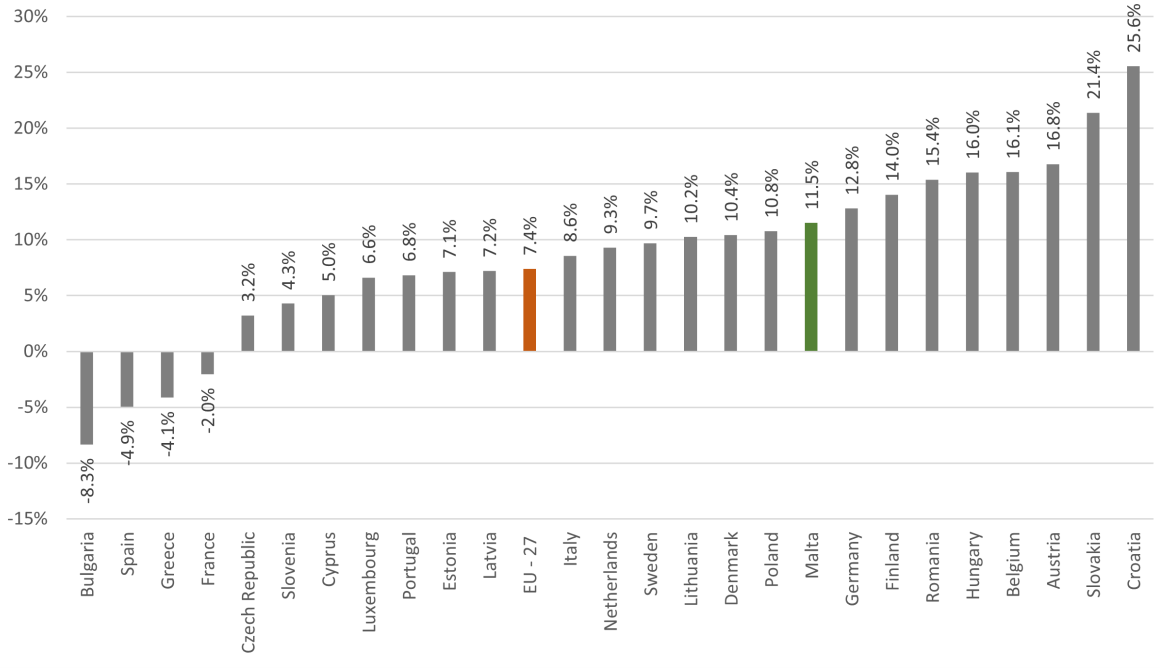


Figure 32 | Change (in percentage points) in adult obese prevalence rates, 2014 vs 2019

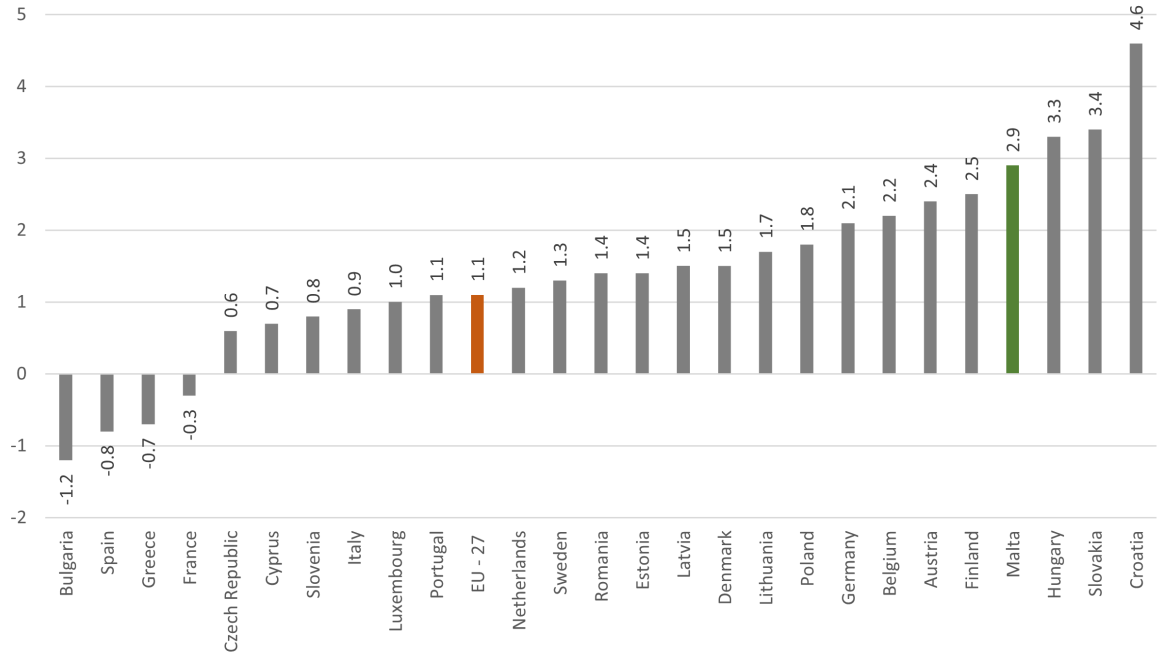


Figure 33 | Percentage change in adult overweight prevalence rates, 2014 vs 2019

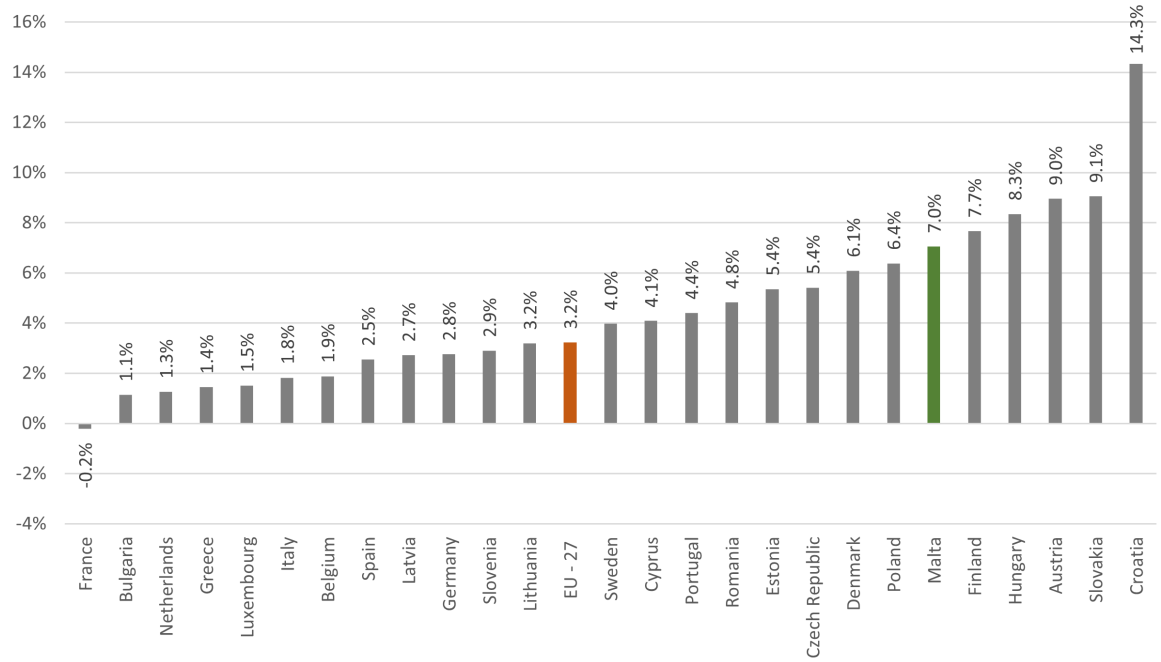
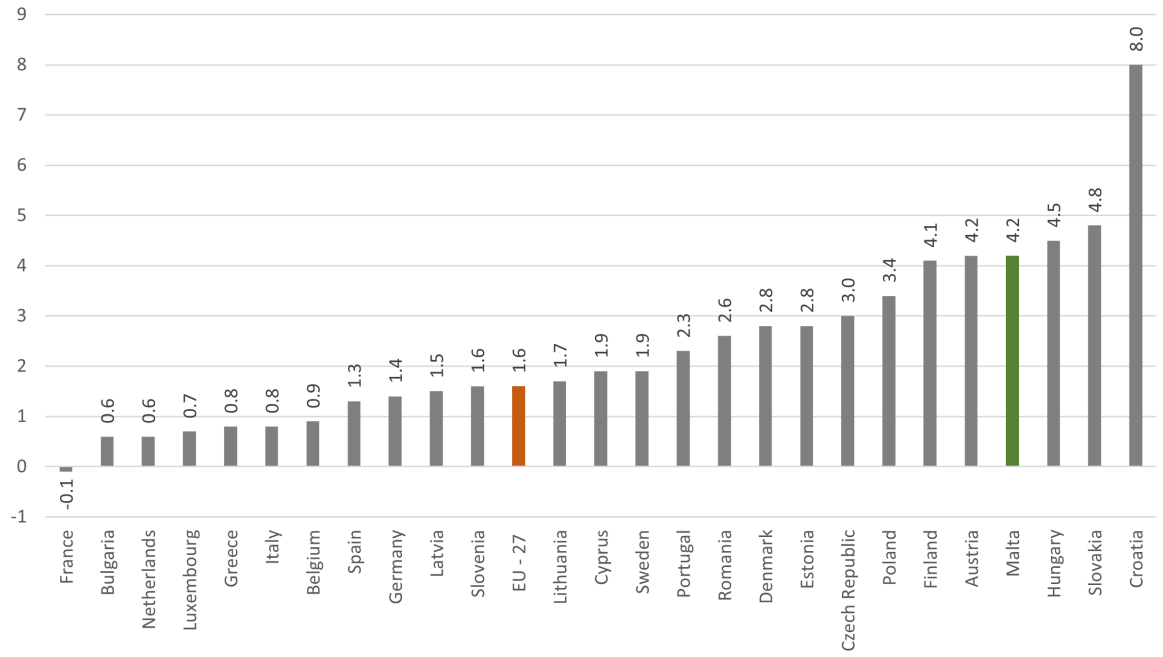


Figure 34 | Change (in percentage points) in adult overweight prevalence rates, 2014 vs 2019



4.2 Disaggregated prevalence rates

4.2.1 The pre-obesity, obesity and overweight indicator figures have been disaggregated by important demographic variables, including sex, education level and wealth, for the most recent available data for each data source, that is, 2019 data for COSI, 2018 data for the HBSC and 2019 for the EHIS. The indicator figures have also been disaggregated by family structure for 2018 HBSC data. A review of these disaggregated rates allows for an assessment of differences in the prevalence rates for specific categories of the population and the identification of vulnerable groups that are more susceptible to excess weight.

Gender

4.2.2 Disaggregated prevalence rates by gender show generally higher rates for males compared to females, with a more evident pattern in this respect emerging for older cohorts. More specifically, in 2019 adult male rates were higher by 8.9, 4.3 and 13.2 percentage points for pre-obesity, obesity and overweight, respectively, when compared to female rates (Figure 35 refers). Similarly, though to a lesser extent, in 2018, adolescent males recorded higher rates than their female cohort for pre-obesity, obesity and overweight, by 2.2, 2.6 and 4.8 percentage points, respectively (Figure 36 refers). In the case of child data, 2019 COSI statistics show higher rates for boys for the obesity and overweight indicators, by 5.3 and 3.8 percentage points (Figure 37 refers). On the other hand, girls registered higher rates for pre-obesity compared to boys, 18.9 per cent versus 17.4 per cent.

Figure 35 | Adult prevalence rates by gender, EHIS 2019

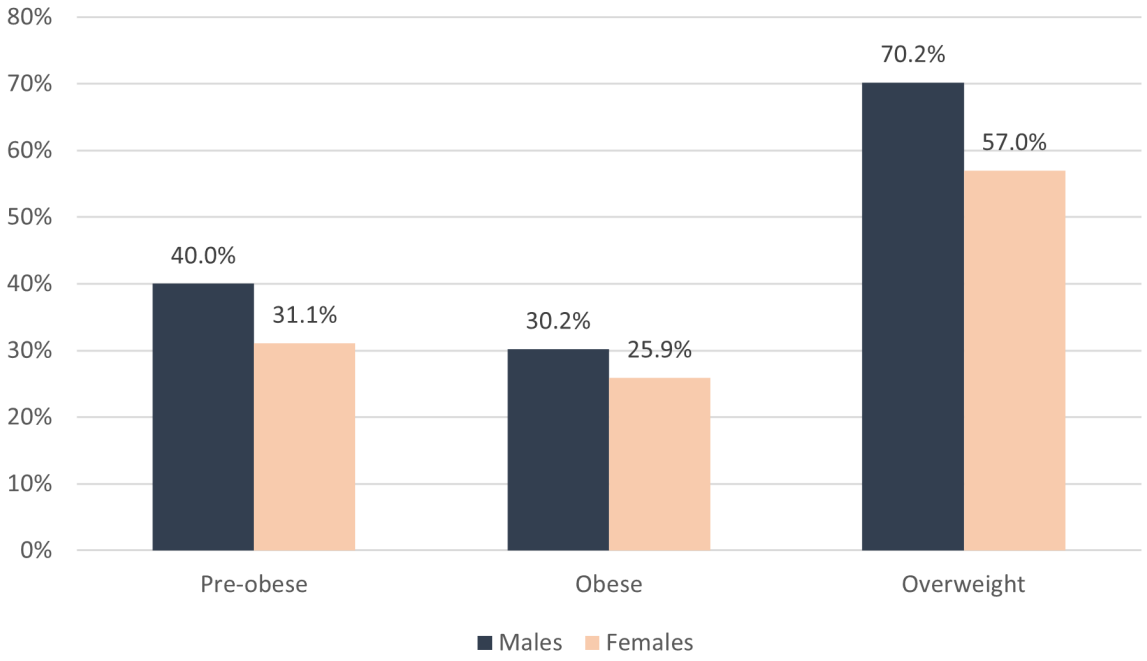


Figure 36 | Adolescent prevalence rates by gender, HBSC 2018

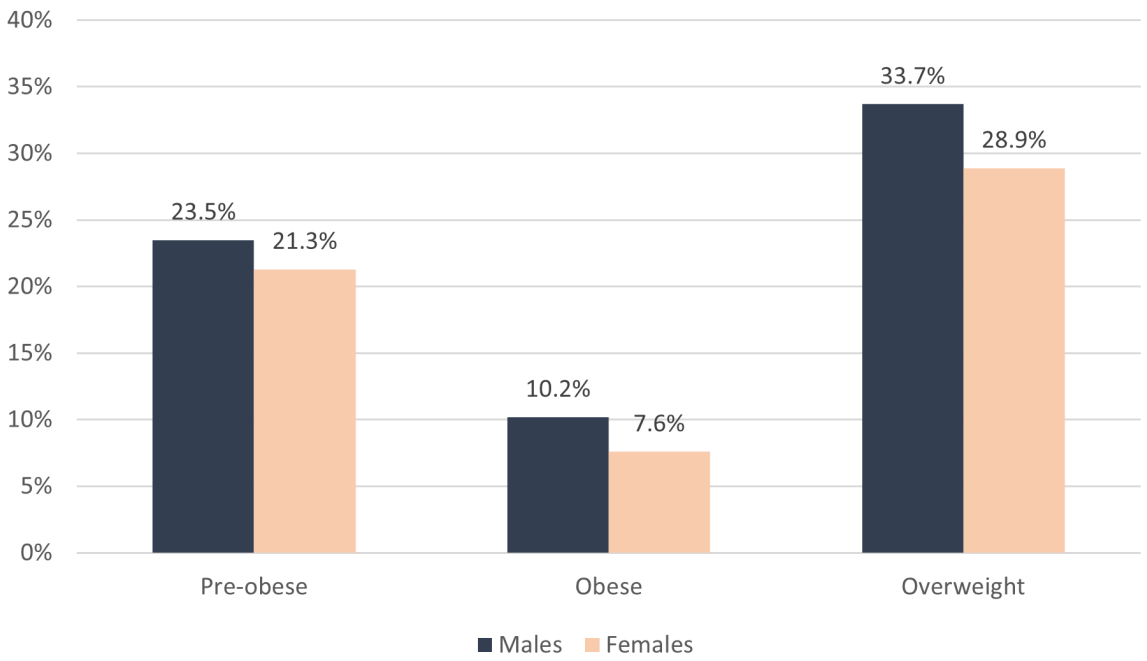
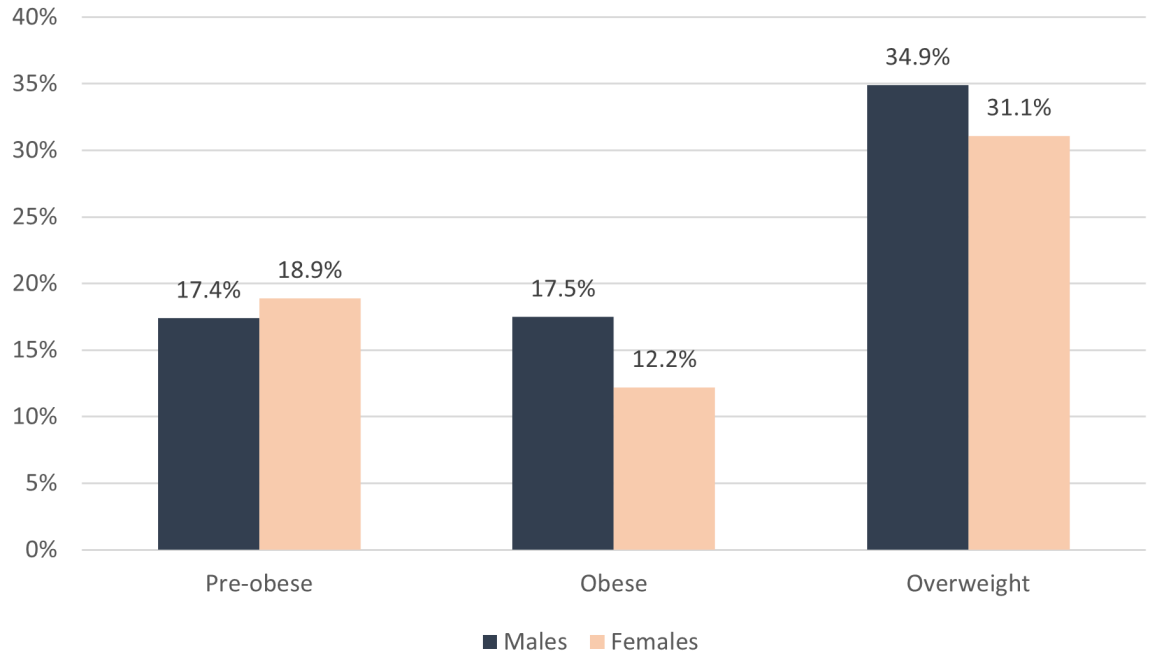


Figure 37 | Child prevalence rates by gender, COSI 2019

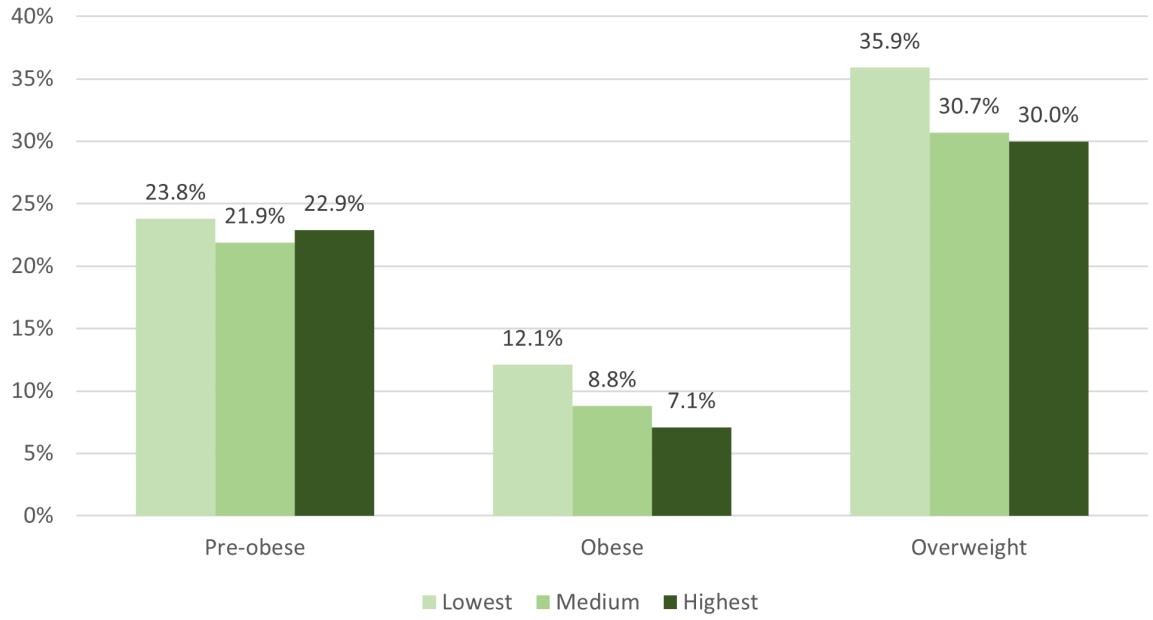


Wealth

4.2.3 For the EHIS, the income level of a respondent is computed based on the total equivalised disposable income attributed to each member of the household. The data are ordered according to the value of the total equivalised disposable income and divided into five quintiles, each representing 20 per cent of the distribution. In the HBSC, a more age-appropriate measure of family wealth is utilised, with responses to items gauging common material assets or activities (vehicle ownership, dishwasher ownership, number of computers owned, number of bathrooms in home, personal bedroom, vacation frequency) scored and summed and compared to the other scores within the country, to identify low (lowest 20 per cent), middle (middle 60 per cent) and high (highest 20 per cent) affluence groups. Relative family affluence therefore provides a measure of the relative socioeconomic position of the adolescent's family when compared to others within the country. In COSI, family wealth is gauged through the perception of the parent or guardian on the ease with which the family meets its needs by the end of the month through its collective earnings. The parent or guardian indicates whether the family manages easily or without serious problems, has trouble, or barely manages with its earnings.

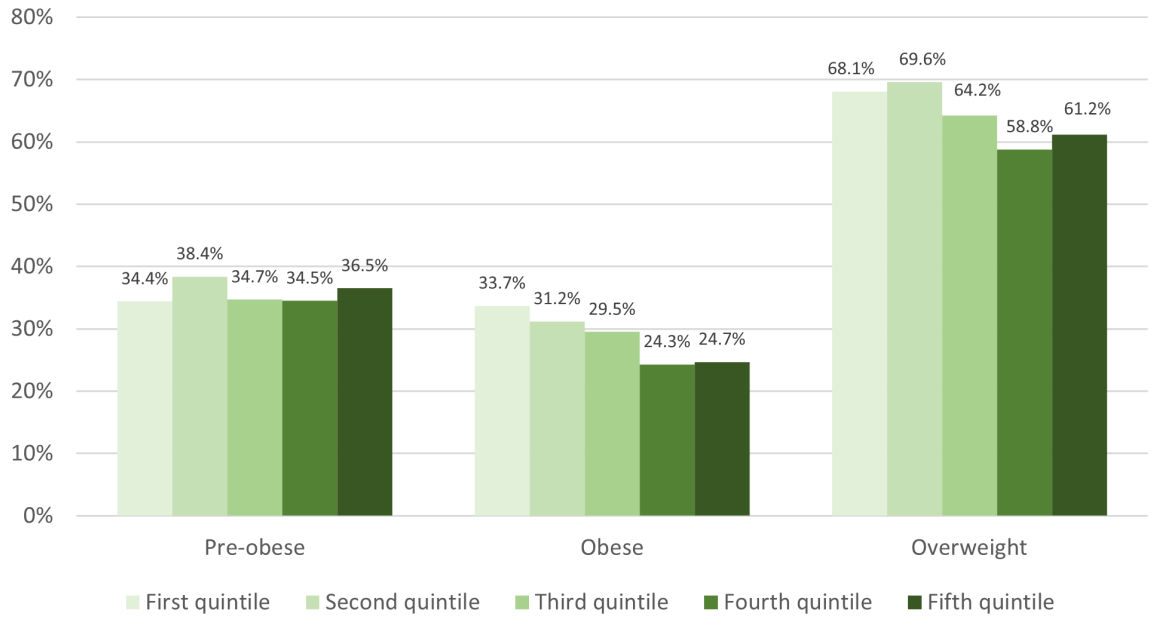
4.2.4 In the case of adolescents, while a clear association between obesity and wealth emerges, the relationship between overweight and wealth and pre-obesity and wealth is less straightforward (Figure 38 refers). Adolescent obesity prevalence rates show a clear trend of lower rates for higher family affluence groups. More specifically, in 2018, the lowest, medium and highest affluence categories recorded 12.1, 8.8 and 7.1 per cent obesity, respectively. In the case of overweight, the clear discrepancy is between the lowest category of affluence and the other two categories, with 35.9, 30.7 and 30.0 per cent of the lowest, medium and highest family affluence groups being overweight. The pre-obesity indicator shows small discrepancies between the three affluence groups, with the lowest category recording the highest rate of 23.8 per cent and the medium group recording the lowest rate of 21.9 per cent.

Figure 38 | Adolescent prevalence rates by family affluence, HBSC 2018



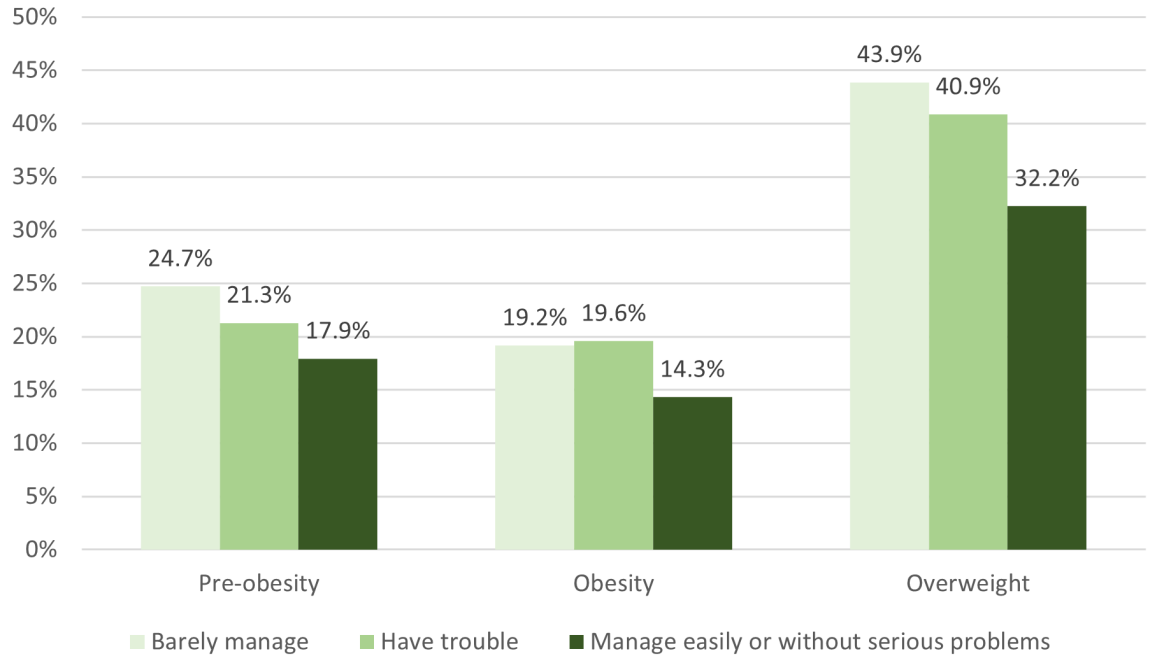
4.2.5 The EHIS data for the population aged 15+ shows similar patterns for obesity as observed with that of adolescent data, in that lower rates are observed for wealthier categories, with the exception of the fourth and fifth quintile, which register similar rates (Figure 39 refers). More specifically, the obesity rates for the income quintiles in ascending order of wealth are 33.7, 31.2, 29.5, 24.3 and 24.7 per cent. The pattern is less clear for overweight and pre-obesity. For both these indicators, the highest rates are observed for the second quintile, while the lowest rates are observed for the fourth quintile. Also of interest is that the fourth quintile consistently records lower rates than the fifth quintile, though minimal in the case of the obesity indicator, 2.0, 0.4 and 2.4 percentage points less for pre-obesity, obesity and overweight, respectively.

Figure 39 | Adult prevalence rates by income level, EHIS 2019



4.2.6 COSI data for third graders shows clear consistent increases in pre-obesity and overweight rates for categories of families with self-perceived higher levels of financial difficulty (Figure 40 refers). More specifically, 17.9, 21.3 and 24.7 per cent of third graders corresponding to families that manage easily or without serious problems, that have trouble or that barely manage, respectively, are pre-obese. Similarly, 32.2, 40.9 and 43.9 per cent of third graders corresponding to families that manage easily or without serious problems, that have trouble or that barely manage, respectively, are overweight. In the case of obesity, children belonging to families that manage easily or without serious problems show lower prevalence rates than children belonging to the other two categories, 14.3 per cent as opposed to 19.6 and 19.2 per cent.

Figure 40 | Child prevalence rates by family-perceived wealth, COSI 2019

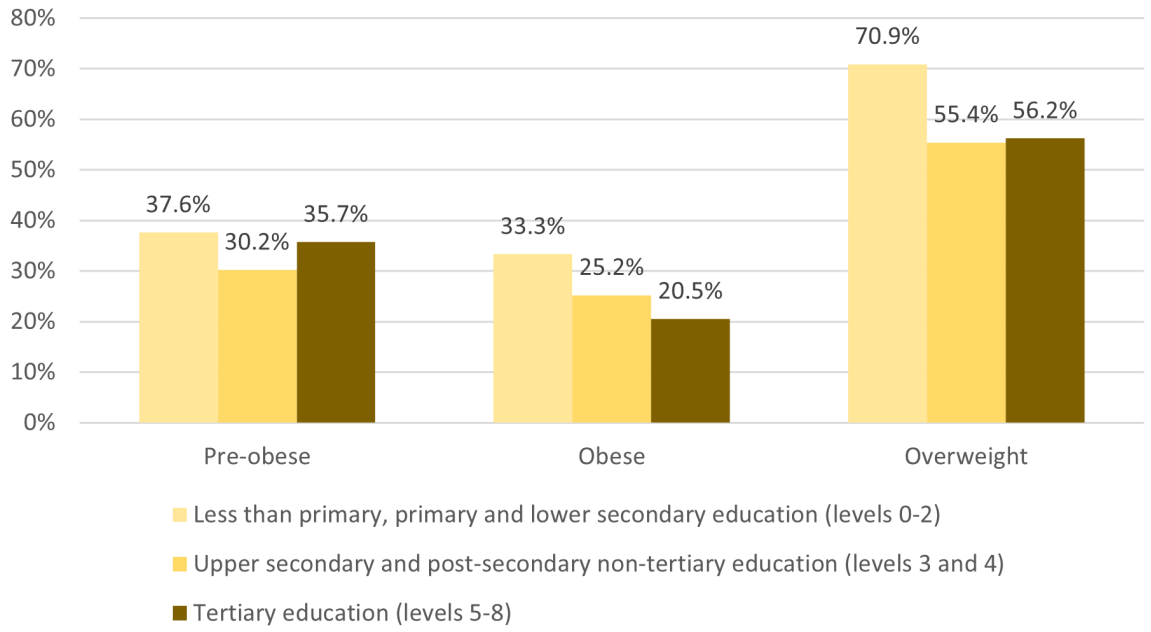


Education

4.2.7 Education is categorised in the EHIS using the International Standard Classification of Education (ISCED) classification system. For the purpose of analysis, respondents are grouped in three categories: those with less than primary, primary and lower secondary education (ISCED levels 0-2), those with upper secondary and post-secondary non-tertiary education (ISCED levels 3-4), and those with tertiary education (ISCED levels 5-8). For COSI, the level of parental education is classified as low, medium or high. On the other hand, for the HBSC, an item gauging the extent to which the adolescent likes school is used as a proxy for educational achievement. In this context, adolescents are categorised as either liking school (a lot or a little), or not liking school (very much or at all). The limitations of this proxy variable are acknowledged by the NAO.

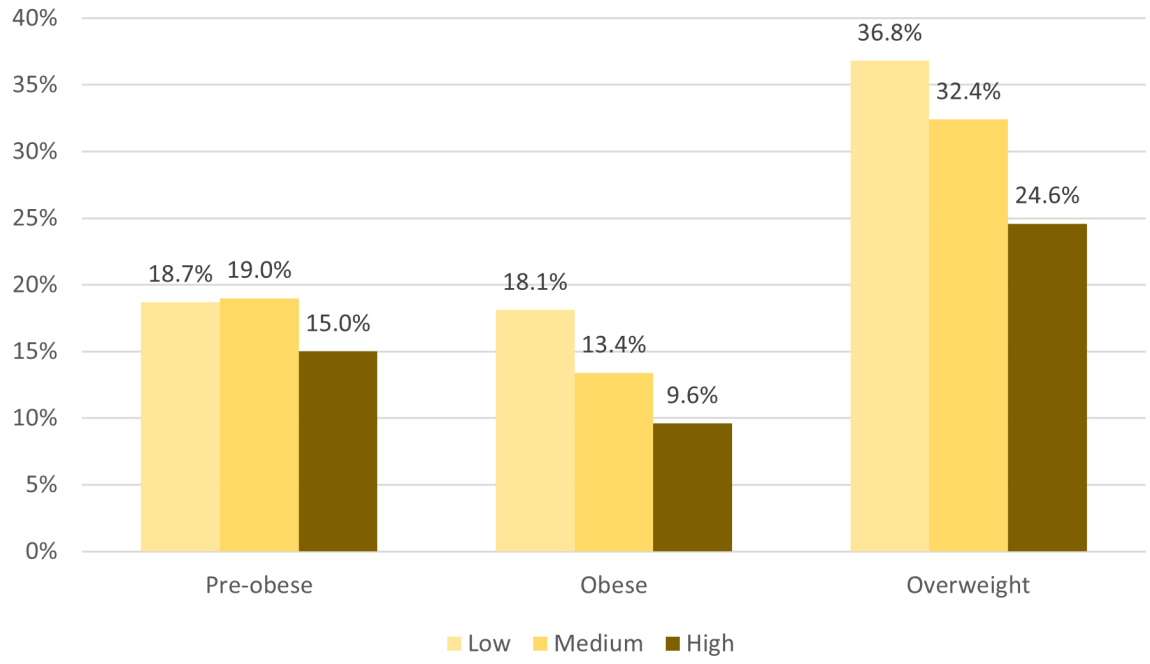
4.2.8 In the case of adults (15+ years), an evident pattern of lower rates of obesity for higher levels of educational achievement is observed (Figure 41 refers). In 2019, 33.3, 25.2 and 20.5 per cent of those with lower secondary or lower education (ISCED levels 0-2), upper secondary and post-secondary non-tertiary education (ISCED levels 3-4) and tertiary education (ISCED levels 5-8), respectively, were obese. For the pre-obesity and overweight indicators, the lowest rates are observed for the middle category, while the highest rates are observed for the category corresponding to those with the lowest educational achievement. The gap between these two categories is substantial and corresponds to 7.4 and 15.5 percentage points for pre-obesity and overweight. Therefore, consistently for all indicators, those with the lowest academic achievement record the highest rates. On the other hand, those with tertiary level education are more susceptible to pre-obesity (by 5.5 percentage points) and marginally more susceptible to overweight (by 0.8 percentage points) but less susceptible to obesity (4.7 percentage points) than the middle category.

Figure 41 | Adult prevalence rates by educational level, EHIS 2019



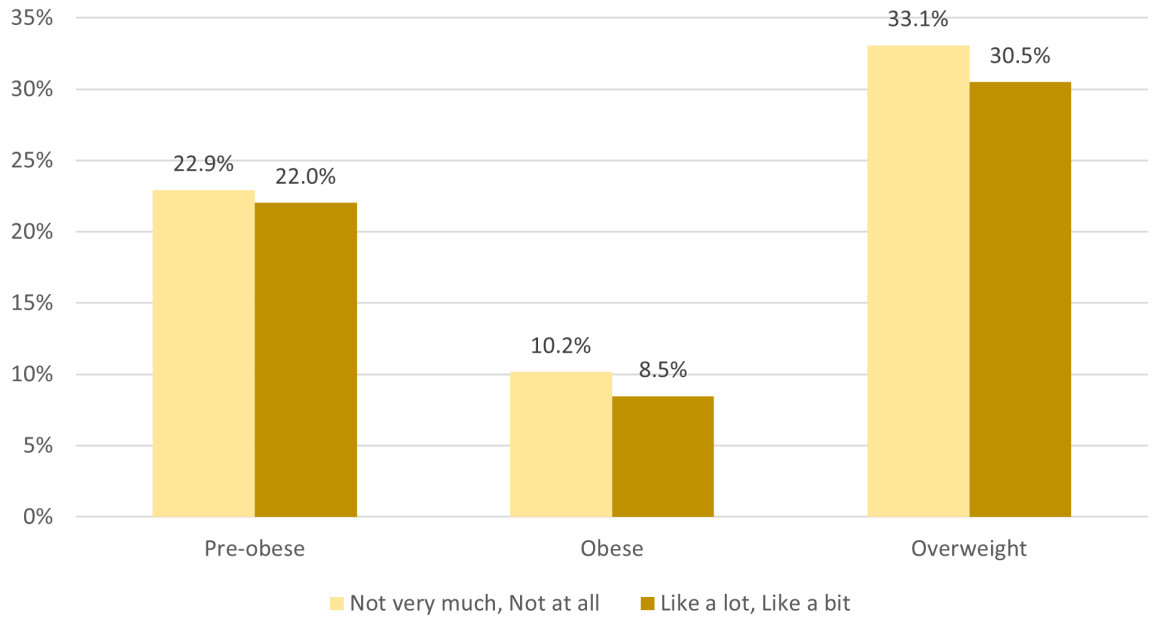
4.2.9 In the case of children, there is a clear inverse relationship between parental education and the child's likelihood of having excess weight (Figure 42 refers). This is consistent with results found in other high-income countries. More specifically, in 2019, COSI overweight and obese rates are consistently substantially lower for groups with higher parental educational. The gap between the low and the medium parental education categories is 4.7 and 4.4 percentage points for obese and overweight children, respectively. The gap between medium and high parental education categories is 3.8 and 7.8 percentage points for obese and overweight children, respectively. For pre-obesity, similar rates are observed for low and medium parental education groups, 18.7 and 19 per cent, respectively, compared with 15 per cent for the high parental education category.

Figure 42 | Child prevalence rates by parental education, COSI 2019



4.2.10 In the case of adolescents, marginally higher rates for all three indicators are observed in 2018 for those who do not like school compared to those who do (Figure 43 refers). More specifically, those who do not like school recorded prevalence rates 0.9, 1.7 and 2.6 percentage points higher than those adolescents who like school.

Figure 43 | Adolescent prevalence rates by school appreciation, HBSC 2018

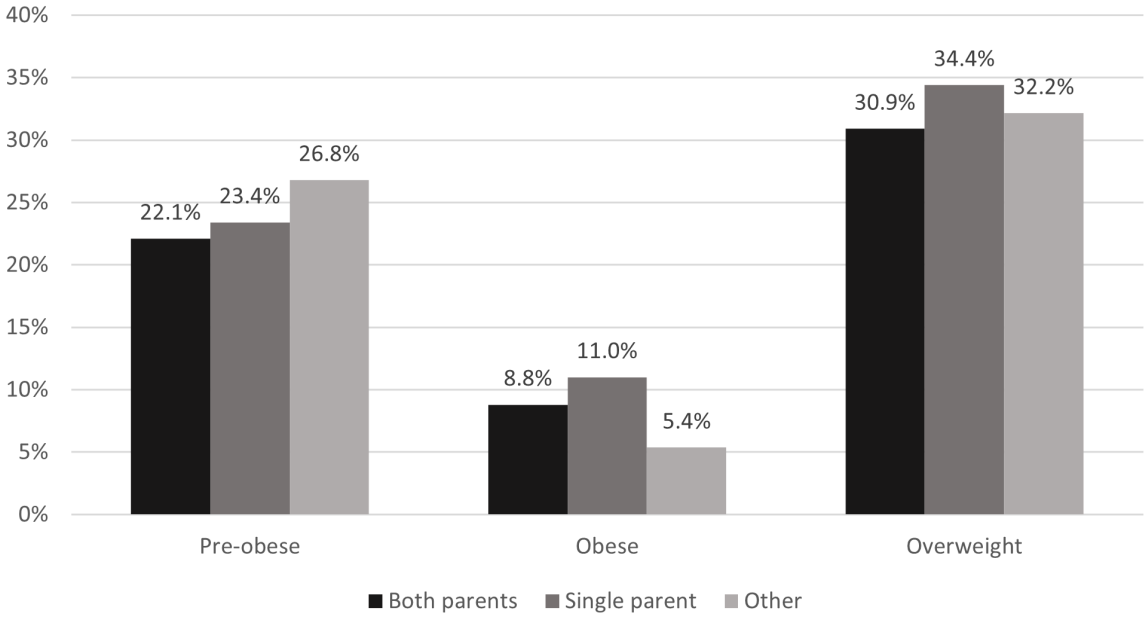


Family structure

4.2.11 The HBSC includes a variable for family structure, distinguishing between adolescents that pertain to a family consisting of both parents, a single parent, and other family structures (that includes stepfamily structures).

4.2.12 Of note is the fact that for 2018, adolescents pertaining to single parent households showed the highest prevalence rates for obesity and overweight among the three categories of family structure, while those adolescents pertaining to other family structures registered the highest pre-obesity rates (Figure 44 refers).

Figure 44 | Adolescent prevalence rates by family structure, HBSC 2018



4.3 Health determinant behaviours

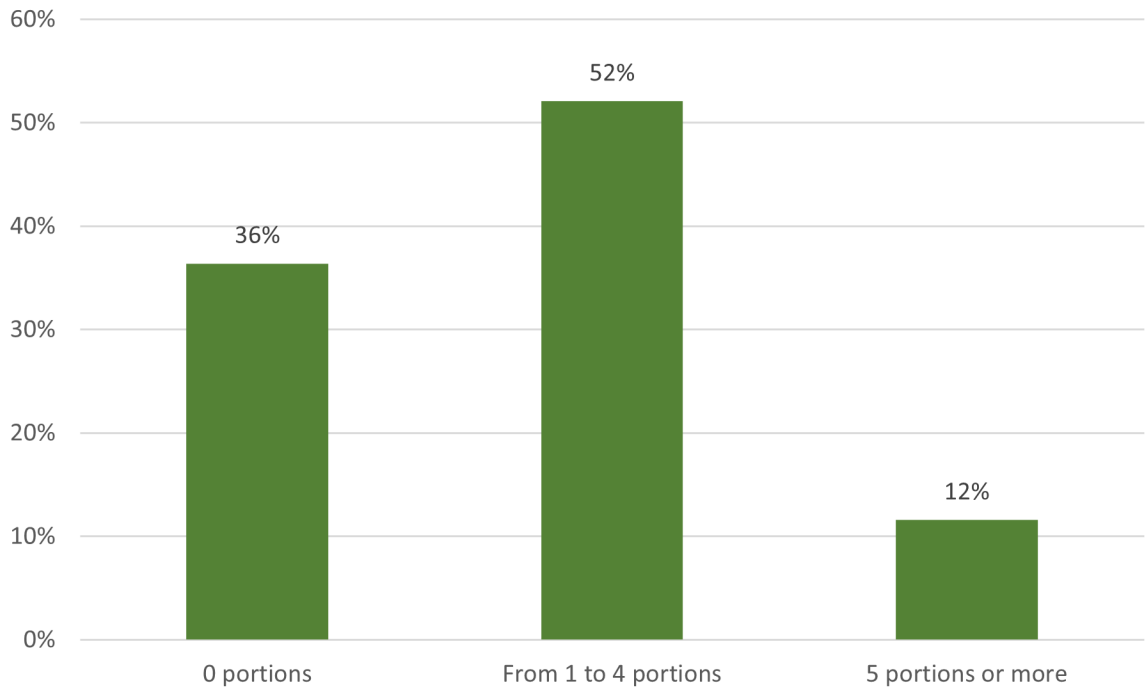
4.3.1 Data from COSI 2019, HBSC 2018 and EHIS 2019 relating to food consumption patterns and physical activity was analysed to provide insights into the prevalence of behaviours that may impact health outcomes, including overweight and obesity.

Food consumption patterns

4.3.2 Overall statistics indicate sub-optimal consumption of fruit and vegetables, more pronounced with respect to vegetables among all age categories. With respect to soft drink consumption, there is still a considerable percentage of the population, within all age groups, that consume this product regularly, this being highest among adolescents. Statistics relating to the consumption of sweets among adolescents (this data is not available for children and adults) also indicate over-consumption. Daily breakfast consumption is not consistent for most adolescents and a substantial proportion of children.

4.3.3 The WHO recommends that adults consume at least 400g (five portions) of fruit and vegetables per day. The EHIS 2019 shows that only a minority of adults, more specifically, 11.6 per cent of those aged 15+ follow this nutritional guideline (Figure 45 refers). Alarmingly, 36.4 per cent of adults do not consume any fruit and vegetables daily.

Figure 45 | Adult daily consumption of fruit and vegetables, EHIS 2019



4.3.4 The data relating to the frequency of fruit and vegetable consumption similarly indicates sub-optimal uptake, again more pronounced for vegetables (Figure 46 refers). Only 29.6 and 56.7 per cent of those aged 15+ indicated consuming vegetables and fruits at least once a day, respectively. In terms of the consumption of sugar-sweetened soft drinks, an unhealthy beverage, only 12.4 per cent consume it daily and 70.8 per cent only drink it occasionally or never consume

4.3.5 Adolescent food consumption patterns also indicate some worrying eating habits (Figure 47 refers). Only 37.4 and 25.5 per cent of adolescents indicated consuming fruit and vegetables at least once a day, respectively, in the HBSC 2018. On the opposite end of the spectrum, a worrying 24.1 and 35 per cent of adolescents indicated consuming fruit and vegetables once a week or less, respectively. Consumption of soft drinks and sweets among adolescents is concerningly high, with 31.5 and 51.4 per cent of adolescents having these items at least five times a week. Inconsistency is noted in the daily uptake of breakfast, with only 39.7 per cent having breakfast every day (Figure 48 refers). Encouragingly, 58.6 per cent of adolescents have breakfast at least five times a week, and only 8.2 per cent never have any breakfast.

Figure 46 | Adult food consumption, EHIS 2019

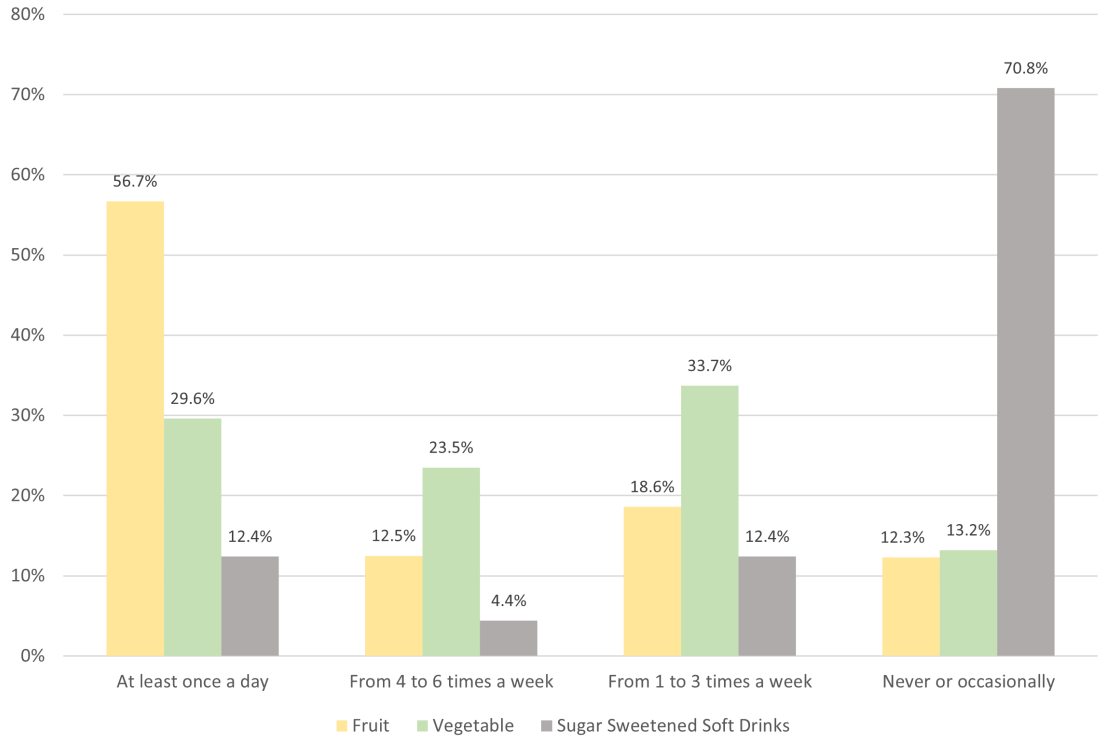


Figure 47 | Adolescent food consumption, HBSC 2018

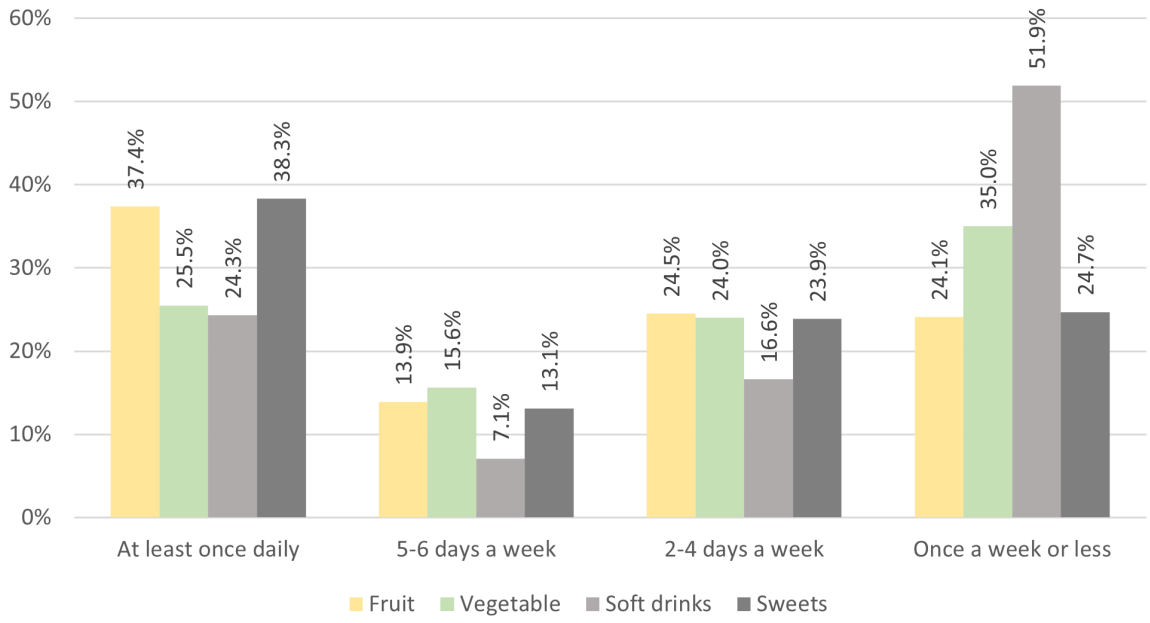
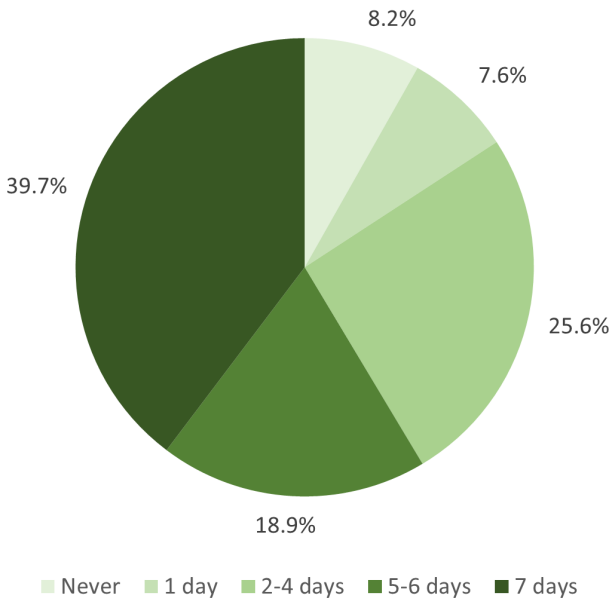


Figure 48 | Adolescent breakfast consumption, HBSC 2018



4.3.6 Breakfast features more consistently in children's meals in COSI 2019, with 54.4 per cent of seven-year-olds stating that they eat breakfast every day (Figure 49 refers). Another 15.9 per cent eat breakfast on most days, on four to six days per week, while only 8.2 per cent never eat breakfast. Fruit consumption is more common than vegetable consumption among children, with 66.8 per cent and 34.5 of seven-year-olds in COSI 2019 indicating consuming fruit and vegetables, respectively, at least four times a week (Figure 50 refers). On the other hand, encouragingly 65.3 per cent of seven-year-olds indicated consuming soft drinks less than once a week or never.

Figure 49 | Child breakfast consumption, COSI 2019

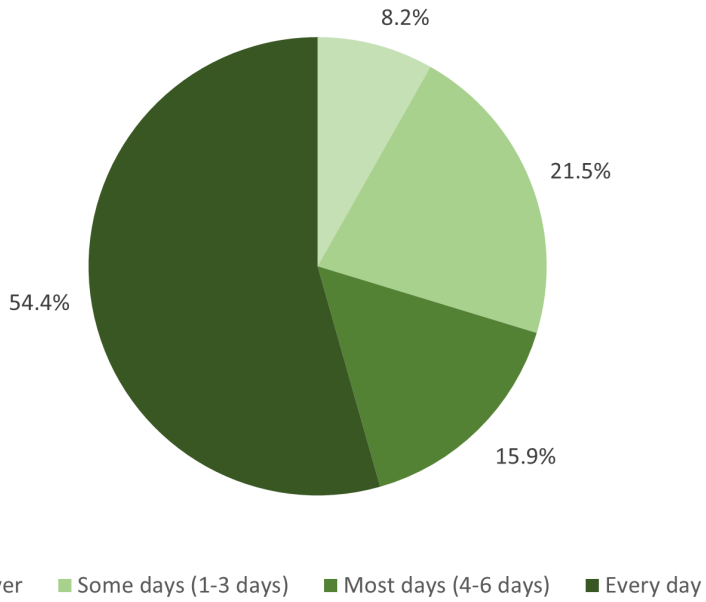
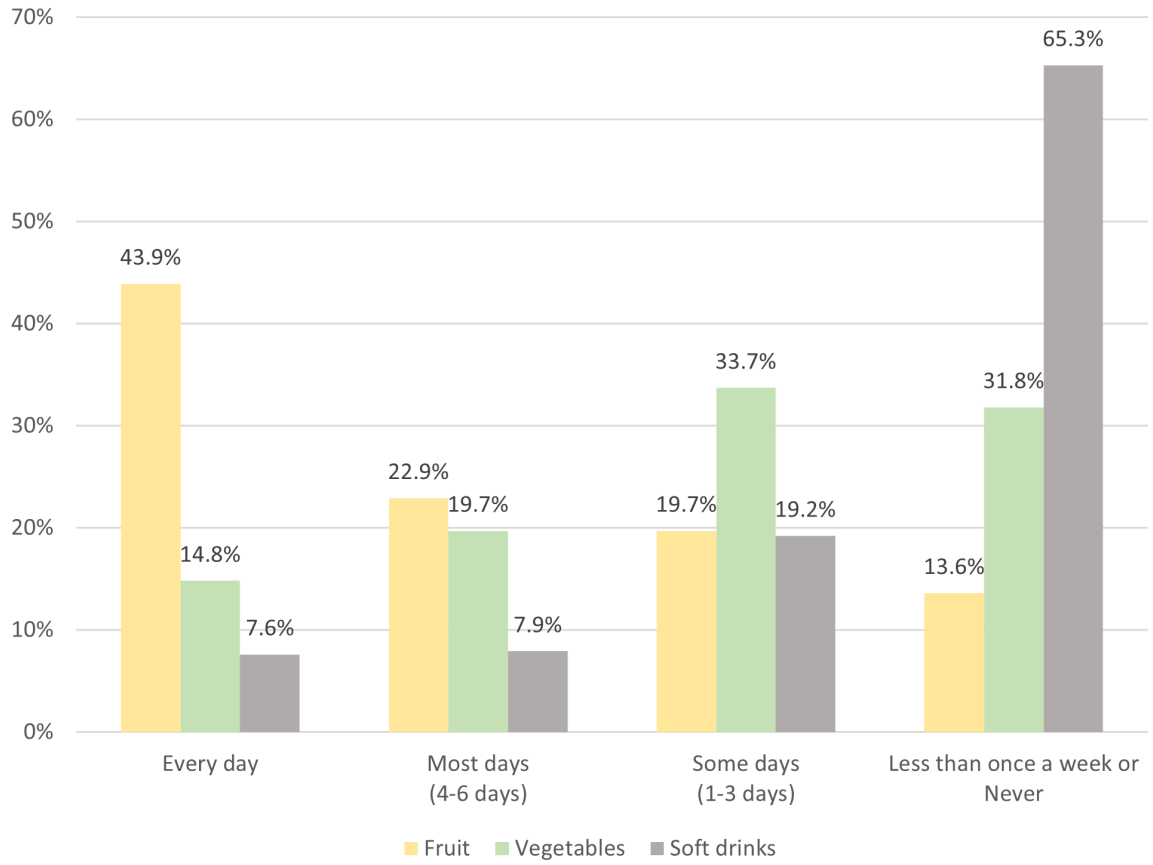


Figure 50 | Child food consumption, COSI 2019



Physical activity

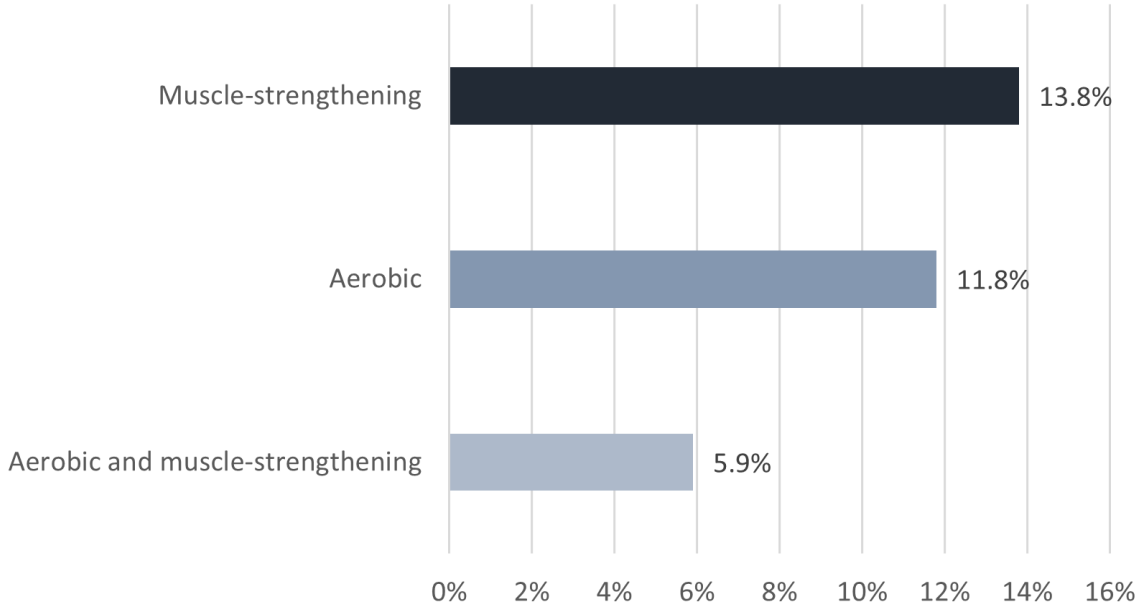
4.3.7 Statistics indicate that most adolescents and adults do not partake in the minimum level of recommended weekly physical activity. The results are more encouraging for children.

4.3.8 The EHIS comprises various items to measure physical activity uptake, including health enhancing physical activity and non-work-related physical activity. Health enhancing physical activity refers to aerobic physical activities of moderate intensity for at least two and a half hours per week, or muscle-strengthening activities for at least two days per week. Non-work-related physical activity includes activities that reflect the way people usually get to and from somewhere in a typical week, for example walking or cycling for at least 10 minutes to get to and from work, school, shopping or markets, and includes leisure-time physical activities that persons engage in for at least 10 continuous minutes throughout a typical week. These leisure-time physical activities cover sports, fitness and recreational activities that cause at least a small increase in breath or heart rate, as well as muscle-strengthening activities, such as resistance training or strength exercises. The EHIS also includes an indicator of daily walking or cycling for at least 30 minutes. Similarly, the HBSC includes a measure of the number of days the adolescent was engaged in moderate-to-vigorous physical activity for at least 60 minutes (in and out of school, at a stretch and in piece-meal fashion) in the previous seven days. Moreover, adolescents were asked how often they usually exercise in their free time (outside of school hours) at an intensity level that leads them to get out of breath or sweat, that is, engage

in vigorous physical activity. COSI includes a measure of the weekly time spent playing actively and/or vigorously on weekdays, and separately on weekends. Another measure captures the weekly participation in sports clubs or dancing classes.

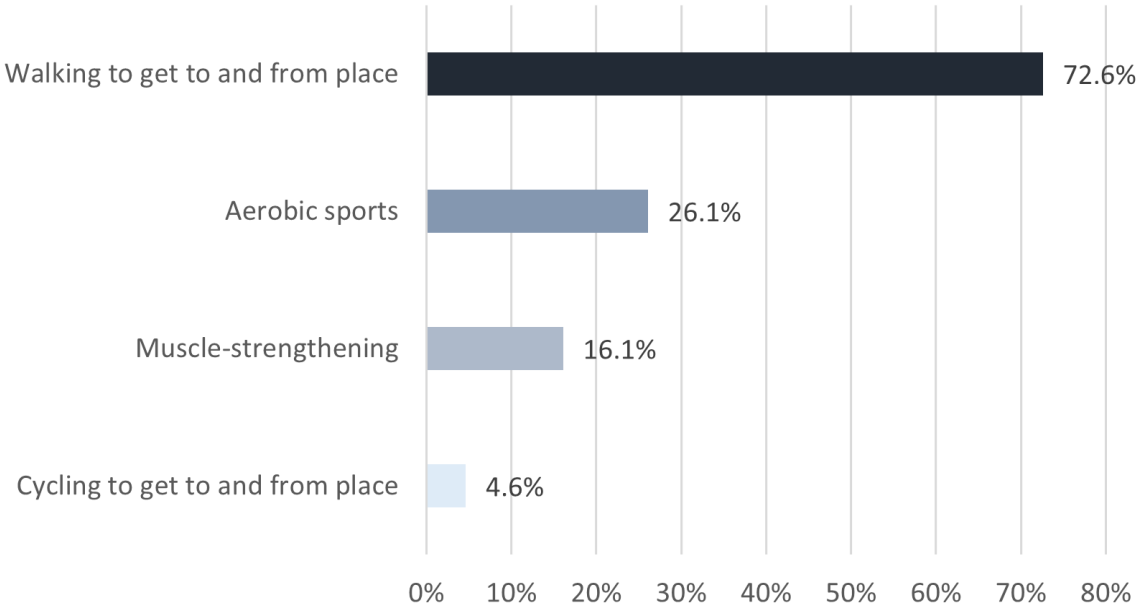
4.3.9 WHO recommends a minimum level of two and a half hours of moderate-intensity aerobic physical activity per week for adults, which should be performed in bouts of at least 10 minutes duration. It also suggests that muscle-strengthening activities involving major muscle groups should be done at a frequency of two or more days per week. This level of physical activity is captured by the health-enhancing physical activity indicators in the EHIS (Figure 51 refers). Of concern is that only 11.8 and 13.8 per cent of adults undertake aerobic and muscle-strengthening activity at this level, while a mere 5.9 per cent undertake both activity types.

Figure 51 | Percentage of adult population performing health-enhancing physical activity, EHIS 2019



4.3.10 Of the non-work-related physical activities, which refer to activity for at least 10 continuous minutes a week, walking to and from specific places is the most common activity cited by adult respondents in the EHIS 2019 (Figure 52 refers). Of note is that 72.6 per cent of respondents indicate undertaking this activity. On the other hand, 26.1 per cent indicated carrying out aerobic sports, 4.6 per cent indicated cycling as a means of transport and 16.1 per cent highlighted undertaking muscle-strengthening exercises.

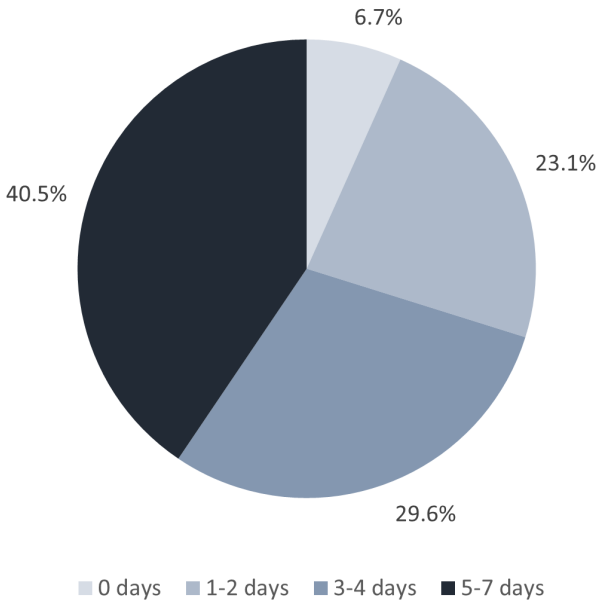
Figure 52 | Percentage of adult population performing non-work-related physical activity, EHIS 2019



4.3.11 Only 2.4 per cent of the adult population indicated walking or cycling at least 30 minutes per day.

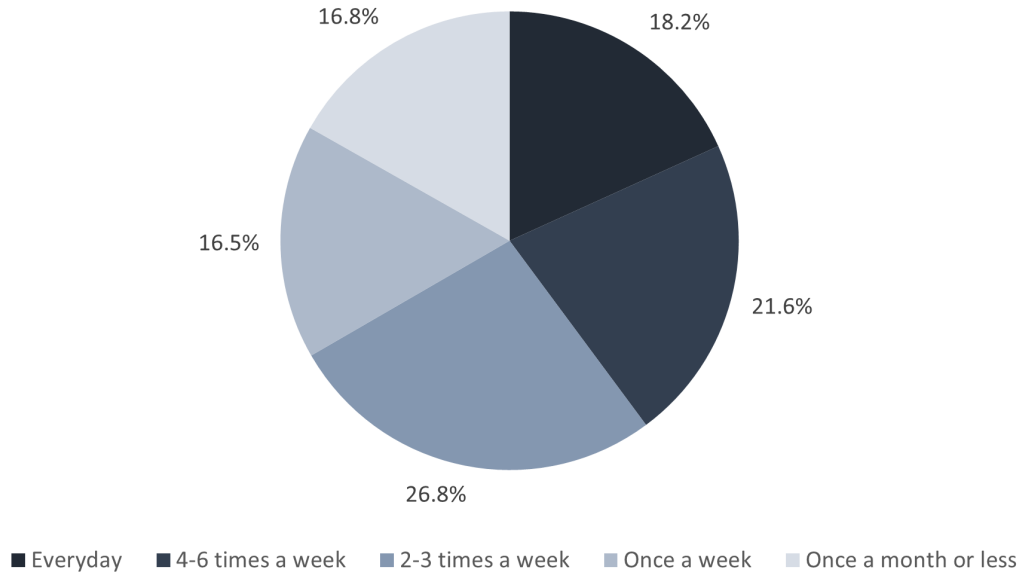
4.3.12 Of note is the fact that, in 2018, only 40.5 per cent of adolescents indicated that they exercise for a minimum of 60 minutes at least five days a week (Figure 53 refers). Of the remaining 59.5 per cent, 29.6 per cent only exercise for this length of time three to four days a week, another 23.1 per cent for one or two days a week, while 6.7 per cent do not carry out this activity on any day of the week. These statistics need to be considered in the context of the current international guidelines for physical activity of moderate-to-vigorous intensity for at least 60 minutes a day for children and adolescents aged 5 to 17 years, indicating that the majority of adolescents are not meeting this requirement.

Figure 53 | Adolescent weekly frequency of moderate-to-vigorous physical activity, HBSC 2018



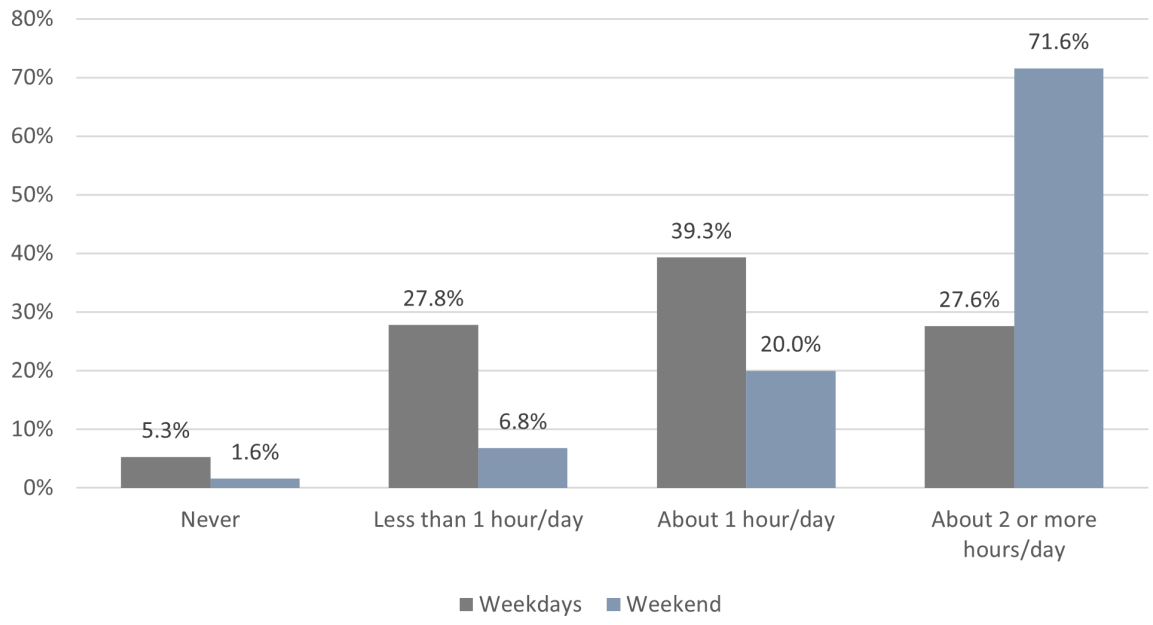
4.3.13 The survey question gauging the frequency with which the adolescents exercise vigorously (such that they get out of breath or sweat) outside school hours in their free time similarly indicates low uptake (Figure 54 refers). More specifically, 33.3 per cent of adolescents indicated only undertaking such activities once a week or less.

Figure 54 | Adolescent uptake of vigorous physical activity outside school hours, HBSC 2018



4.3.14 Encouragingly, 66.9 and 91.6 per cent of seven-year-olds reported engaging in active and/or vigorous activity for at least one hour daily during weekdays and weekends, respectively, in COSI 2019 (Figure 55 refers). Only 5.3 and 1.6 per cent indicated never undertaking this activity in either weekdays or

Figure 55 | Child weekly time spent playing actively/vigorously, COSI 2019



the weekend, respectively. Another positive statistic relates to the participation in sports clubs or dancing classes, with 69 per cent of seven-year-olds participating for a minimum of one hour every week in such activities. On a less positive note, most children, that is, 77.4 per cent, indicated that transportation to school is by vehicle, with only 18.5 per cent opting to walk, cycle or skate, and 4.1 per cent utilising a combination of these methods. Of note is that, for COSI 2019, Malta ranks third lowest among participating countries in terms of active transportation to school.

4.4 Assessing the achievement of the set targets

4.4.1 Available statistics are key in determining whether the targets specified in the Healthy Weight for Life Strategy, for the implementation period 2012 to 2020, were met. The targets comprised:

a. a reduction in the pre-obese adult population from 36 per cent to at least 33 per cent;

b. a reduction in the obese adult population from 22 per cent to at least 18 per cent;

c. the maintenance of the proportion of 13-year-olds who are obese below 15 per cent; and

d. a reduction in the overweight seven-year-old population from 32 per cent to 27 per cent.

4.4.2 Overall, the NAO's assessment as to the achievement of these targets is negative (Figure 56 refers). Of the four targets set, only that relating to adolescents has been met.

Figure 56 | Assessment of target achievement

Target	Evidence	Assessment
Reduction in the pre-obese adult population from 36% to at least 33%	EHIS 2019 – 35.7% of the population aged 15+ is pre-obese	Target was not met, and the rate at the starting point was maintained
Reduction in the obese adult population from 22% to at least 18%	EHIS 2019 – 28.1% of the population aged 15+ is obese	Target was not met, and the rate has increased substantially from the starting point
Maintenance of the proportion of 13-year-olds who are obese below 15 per cent	HBSC 2018 – 7.4% of 13-year-olds are obese	Target reached, and the current rate is substantially below the target level
Reduction in the overweight 7-year-old population from 32 per cent to 27 per cent	COSI 2019 – 33% of 7-year-olds are overweight COSI 2022 – 35.4% of 7-year-olds are overweight (preliminary data)	Target was not met, and the rate has increased from the starting point

4.4.3 A reduction of three percentage points was envisaged for the adult pre-obesity rate, from the 36 per cent reported in the EHIS 2008 down to 33 per cent. In this respect, no progress was registered and a constant level maintained, with EHIS 2019 reporting adult pre-obesity prevalence at 35.7 per cent. Similarly, a reduction of four percentage points was envisaged for the adult obesity rate, from the 22 per cent reported in the EHIS 2008 down to 18 per cent. Instead, an increase of around six

percentage points was observed, with 28.1 per cent of the population aged 15+ being classified as obese in the EHIS 2019. While it is acknowledged that the target refers to the adult population, it is noted that the figures presented in the Healthy Weight for Life Strategy, presenting the prevalence rates disaggregated by age groups includes the whole eligible population for EHIS, that is, the population aged 15+.

4.4.4 In the case of children, a reduction of five percentage points was envisaged for the overweight rate, yet an increase in rates is observed. In 2010 (round two of COSI), the overweight rate stood at 32.1 per cent, which rate increased to 33 per cent (round five, 2019) and 35.4 per cent (round six, 2022 – preliminary) in COSI data collection rounds just prior to and subsequent to the end of the Healthy Weight for Life Strategy implementation period.

4.4.5 All four targets, except for that relating to adolescents, include the starting prevalence rate and the envisaged prevalence rate as at 2020. The Healthy Weight for Life Strategy states that 15 per cent of 13-year-olds were above the 95th weight centile, that is, they were obese in the 2006 HBSC. The target was for the maintenance of the proportion of 13-year-olds who are obese below 15 per cent. The HBSC 2018 data sourced by the NAO indicates that 7.4 per cent of 13-year-olds were obese as at 2018. Consequently, the target has not only been reached, but the obesity prevalence rate among 13-year-olds effectively halved in the period 2006 to 2018.

4.4.6 While the substantial reduction in the prevalence of obesity among 13-year-olds is deemed as indicative of significant progress registered, an aspect of concern emerges when one considers changes in overweight prevalence as reported in the international publications of the HBSC. In these publications, statistics for the overweight (pre-obese and obese) indicator are presented separately for males and females in the 13-year-old group. It is to be noted that statistics for the pre-obese and obese indicators are not available in these publications. For boys and girls, the prevalence rate for the overweight indicator reported for 2006 was 31 per cent for both genders. In 2018, 38 and 35 per cent of boys and girls were reported to be overweight. If compared to 2006, the 2018 overweight rates indicate regression for both genders within the 13-year-old group. This result points to a bleaker picture for adolescents than originally observed when only focusing on the obesity indicator. For the increase in the prevalence of overweight, when considered in the context of the decrease in the rate of obesity, implies that a larger percentage of the target population is now classified as pre-obese.

Chapter 5| Stakeholder perspectives

5.0.1 This chapter presents stakeholder feedback, including areas of shortcomings and recommendations, on various matters relating to Government efforts aimed at a reduction in the prevalence of pre-obesity and obesity in adults and children, including whether Government:

a. provided for an enabling legal framework;

b. provided for an enabling policy framework;

c. established an enabling institutional set-up;

d. adequately planned and budgeted for the actions required;

e. implemented sufficient actions to address pre-obesity and obesity and whether such actions were effective and inclusive;

f. has undertaken sufficient efforts to facilitate the engagement of multiple non-governmental stakeholders, including civil society, the private sector and NGOs; and

g. achieved planned progress.

5.0.2 The chapter is mainly based on the feedback provided during focus groups and through written submissions by academics, service providers, the Advisory Council, and representatives of the MFH, NGOs, professional associations and the public sector. Unless otherwise specified, the term stakeholders refers to these contributors. This feedback is supplemented by the views of officially appointed bodies and business stakeholders. Where necessary, relevant information provided during meetings with the MFH, the Director Sustainable Development Directorate, the Member of Parliament who had tabled the private member's bill on the address of obesity and a WHO health expert were also included. All these contributions were deemed instrumental by the NAO and add value and depth to this Office's review.

5.1 Obesity – A complex issue requiring complex solutions

5.1.1 The evident link between obesity and health-related problems was acknowledged by the stakeholders. Ailments cited in this respect included cardiac, respiratory, nephrological and musculoskeletal complications, sleep apnoea, diabetes, mental health issues and cancer. The stakeholders noted that these conditions can in turn lead to disability, inactivity, poverty, decreased quality of life, stigmatisation, social isolation, and even premature death. At the population level, this translates into significant

public cost, decreased productivity, suboptimal use of human resources when seen from an economy perspective and various social problems. In this respect, a service provider and an NGO representative emphasised the utility of understanding and treating obesity as a disease that requires long-term management, specialised staff and treatment options. A few academics were of the opinion that the gravity of the situation, in terms of scope and severity, is not being fully acknowledged by the Government or the public. Expanding on this point, an academic noted that a local study indicated that only 10 per cent of the adult population have normal weight and are metabolically healthy (do not suffer from high blood glucose levels, high cholesterol levels and high blood pressure). Similarly, an NGO representative commented that the real pandemic of this century is that of non-communicable diseases, including obesity.

5.1.2 A health provider explained that, at present, there is a greater focus on treating the consequences and target damage of obesity, in terms of for example providing cardiac care, rather than addressing obesity as the root cause of these many body ailments. Additionally, representatives of the MFH acknowledged that a preventative approach to tackling obesity would be preferrable in terms of health outcomes, quality of life and life expectancy, and in terms of public expenditure as opposed to an interventionist approach. The latter approach focuses on reversing excess weight or managing the complications and comorbidities arising therefrom. Another MFH representative highlighted that in terms of finances, the Ministry is impacted negatively by obesity – as this condition increases one's risk of various health conditions that in turn burden the public health system. A few stakeholders noted that the successful prevention of excess weight will translate into the reduction of various health problems including cardiovascular disease, stroke and cancer, and improved quality of life, and consequently result in cost savings for the public health system from prevented complications. Notwithstanding this, the MFH representatives and service providers observed that the healthcare vote and the staff complement allocated for the central coordination of health promotion and prevention initiatives in non-communicable diseases is very limited, and that these areas of health merit better prioritisation in national government resource allocation.

5.1.3 Various stakeholders explained that obesity is a complex problem that requires complex and systemic solutions, coordinated efforts and ample resources. Tackling obesity requires a transdisciplinary approach, communication and collaboration among different disciplines and sectors, and a whole systems approach – an integrated approach which is tailored to the specific context, considers how systems work together, how parts communicate and provide feedback to each other and how leadership functions at all levels. Many stakeholders emphasised that obesity is not solely the responsibility of the MFH, and that efforts by this Ministry will never be sufficient to effectively tackle obesity – for the input of several other arms of government, as well as that of other sectors, including NGOs and business, is required.

5.1.4 A service provider argued that obese persons may experience stigma, bias and discrimination, with implications on their socio-economic status and relationships. Moreover, health care providers may sometimes blame the patients or abruptly scold them for their excess weight, resulting in many persons hesitating to seek medical attention for their obesity. Two academics emphasised that we have to move away from associating obesity with laziness and carelessness, as such narratives may do more

harm than good. A service provider noted that recognising obesity as a disease is an important step in its destigmatisation; however, also warned against normalising obesity, and that while not shaming obesity and promoting body confidence is a positive approach, obesity should still be recognised as a disease that requires treatment.

5.1.5 Various stakeholders asserted that it is important to recognise that excess weight is not solely driven by individual factors, such as individual biology and genetics, psychology, food and physical activity choices and behaviours. Obesity is also driven by numerous other environmental and societal factors, including the built-up environment, transport systems, advertising efforts and influencers, culture, lifestyle, as well as the availability and accessibility of different types of food and sports facilities. In this respect, a service provider asserted that stakeholders, including policymakers and health professionals, must recognise obesity as a disease that is facilitated by an obesogenic environment, and not as a self-inflicted manifestation of lack of willpower and laziness. Several stakeholders conceded that our environment is obesogenic, encouraging the consumption of energy-dense and low-nutritional value food and sedentary lifestyles. The MSPC commented that structural changes that have occurred over the past decades have contributed to this obesogenic environment, which has led to multiple unintended consequences, including unregulated marketing and advertising; high prices for fruit and vegetables compared to low-nutrient and processed food, encouraging an imbalance in consumption; and food subsidies on obesogenic foods that foster addiction.

5.1.6 Some stakeholders noted that an appreciation of this context leads to the understanding that policy interventions and corresponding action cannot be solely focused on individual responsibility and choice, or be limited to considerations of the classic energy balance equation, but must acknowledge the broader system influencing obesity and must aim to create an enabling environment. An enabling environment makes the healthy choice with respect to physical activity and food consumption the easy choice, making it an accessible, affordable and culturally acceptable choice. Consequently, stakeholders were of the opinion that policy measures should put more focus on controlling and improving the physical and food environment, including industry, through various instruments, such as taxes, subsidies, the control of portion size, front-of-pack labelling, food reformulation and the built infrastructure.

5.1.7 On the other hand, various stakeholders also argued that one cannot simply put the blame and responsibility for addressing obesity on politicians, policy makers and government officials, and that instead the public also carries an element of responsibility in terms of personal choice and individual willingness to make the right choices, such as opting for active and greener transportation and home cooked meals. In this respect, an Advisory Council member asserted that irrespective of any strategies, measures or interventions the ultimate decision rests with the individual. It is the person's willingness to change one's lifestyle and be part of a cultural change, especially with respect to parents within their family unit, that will ultimately determine whether obesity is addressed effectively. In line with this argument, the Council member expressed the need to highlight this individual responsibility and need for cultural change in the subsequent strategy document.

5.1.8 A member of the Advisory Council explained that because of this necessary cooperation and willingness from the public, a mix of measures have to be implemented, which include both interventions that incentivise healthy behaviours and those that penalise or impede unhealthy behaviours. This was referred to as the carrot and stick approach. In the case of food consumption, providing subsidies or vouchers for fruit and vegetables and introducing a sugar tax would be examples of a carrot and stick approach or the push and pull approach. While the 'carrot' approach measures are generally preferrable, the 'stick' approach measures may be required to instigate the required change and should still be considered despite being generally unattractive options due to not being well received by the public or not garnering political support. However, coupling 'stick' approach measures with 'carrot' approach measures renders them more politically acceptable, ensures more acceptance by the public, enhancing feasibility and increasing the likelihood of achieving positive results. So, for example, the introduction of car-free pedestrian zones within town centres needs to be coupled with parking management and the provision of centralised parking facilities. This coupling argument was also put forward by other stakeholders, including representatives of a professional association, academics and a public sector representative.

5.2 Tackling overweight – a joint effort

5.2.1 Various stakeholders recognised that overweight is not solely the responsibility of the MFH and emphasised the need for coordinated efforts by public and private sector stakeholders to create an enabling environment that facilitates healthy choices. Details of current collaborations and required future partnerships were highlighted, including those relating to NGOs, employers and workplaces, local councils and schools.

United, aligned and coordinated efforts

5.2.2 Most stakeholders spoke of the need for further united, aligned and coordinated efforts across diverse sectors in the public and private spheres, at local and European levels, to address overweight. An enabling environment that facilitates healthy choices requires a whole-of-government and even a whole-of-society approach, and sustained commitment from the highest levels of Government [more details in 'Political will'] to adopt a health-in-all-policies approach, as well as the participation of the business and the NGO sector. This can only be possible if there is increased awareness and knowledge of the negative impact of obesity on health and other matters, including economic ones [more in Obesity – a complex issue requiring complex solutions] as well as knowledge of the roles of various sectors in creating the much needed enabling environment.

5.2.3 A representative of a professional association argued that tackling obesity effectively requires an understanding that the wellbeing, wealth and productivity of a nation depends on its health status and a commitment for health to be given priority over other considerations, such as economic ones. An academic explained that obesity is a complex problem requiring complex solutions through a whole systems approach, which involves the consideration of complex interrelated systems and their impact on the phenomenon, and a transdisciplinary approach, which is the highest level of collaboration among different disciplines and sectors. Coordinated efforts by all sectors ensure lack of

replication and enhanced endeavours through more synergistic and impactful activities and initiatives. Similarly, the Malta Chamber argued that no intervention can be implemented in isolation, and that instead legislative actions, educational campaigns and enabling conditions must be supported by the cooperation of all involved and the availability of necessary facilities. Besides cooperation in respect of efforts undertaken at a national level, the need for coordinated efforts at EU level was mentioned specifically in the case of advertising regulations, food labelling, food reformulation, pesticide use and the management of market forces.

5.2.4 Several stakeholders maintained that the MFH alone cannot be held responsible for addressing overweight since this phenomenon is the result of multiple compounding parameters within our environment that are outside the control of the Ministry. Representatives of the MFH and the Advisory Council explained that while health entities can educate the public as to the benefits of a healthy lifestyle and advocate for policies and initiatives that promote healthy lifestyles across all sectors, their influence in preventing overweight and creating an enabling environment is limited. By way of example, the MFH's promotion of regular exercise and sustainable transportation must be supplemented by road construction that ensures pedestrian safety and provides for safe cycle paths and walkways. Similarly, the MFH has no control over the licensing of fast-food outlets, and research clearly shows that there is an association between the accessibility/concentration of fast-food outlets within one's locality and the BMI of the residents therein.

5.2.5 Various stakeholders acknowledged that for progress to be registered the cooperation and ownership of other non-health stakeholders and sectors, including planning, transport, industry, law enforcement, urban development and environment, must be secured. The Malta Chamber was of the opinion that the stakeholders to be involved range from medical practitioners to educators, manufacturing companies, retailers and the fitness industry. The Environment and Resources Authority (ERA) was of the opinion that improved communication and coordination and stronger policy integration between the relevant Ministries would be desirable, and that the services that can be provided by NGOs and private businesses which focus on active mobility are not necessarily being optimised to their full extent, and that more collaboration with these stakeholders is required to achieve better results. A few participants commented that the silo mentality within the MFH and across government hampers such cooperation. In further feedback provided, the MFH questioned how this silo mentality can be addressed – whether it is through the allocation of specific responsibilities and monitoring and evaluation efforts to ensure effective implementation, or through a governance structure that encourages cooperation. The MFH representatives proposed the designation of an officer within each department/ministry to facilitate ownership and to enable the assessment of the impact of any proposed policy on health. Nevertheless, an NGO representative commented that a multi-disciplinary approach should not preclude having one responsible entity that coordinates the work of various stakeholders and ensures progress. In this respect, the MFH representatives suggested that the Ministry can continue to lead such efforts. Similarly, the MSPC suggested that the Government may consider embarking on a horizontal approach to address policy through different instruments; however, this approach would need to be driven by the MFH.

5.2.6 The MFH representatives explained that the Ministry endeavours to include other actors and stakeholders in its fight against overweight, and works to guide and encourage others to take action and provide them with tools and knowledge on possible actions. Examples of such endeavours include promoting healthy lunches among parents, collaborating with the MAFA to promote healthy food and working with NGOs, medical and dental students associations and various health professionals to promote healthy eating and physical activity. Other examples include liaising with food manufacturers to reformulate their products to decrease fat, sugar and salt content, encouraging local councils to apply for funds for sustainable health-related projects and initiatives, and collaborating with the Water Services Corporation to install more water dispensers to make potable water cheap and more easily available. The MFH representatives explained that in working with other stakeholders the Ministry tries to capitalise on accessible settings and environments that are more easily influenced, such as schools.

5.2.7 Further collaboration was also advocated within the health sector, between different providers of weight management programmes, and between different health care professionals and health care entities, within the public and private sector, to optimise resource use for the common goal of addressing obesity [more details in 'Capacities']. Integrated health patient records, a comprehensive database of available services, established information dissemination channels and educational seminars for professionals were considered helpful at improving cooperation within the healthcare sector. Besides some overlap in the weight management programmes being provided within the public sector, the existence of small-scale fragmented educational campaigns with different marketing characters was noted as another example of the lack of communication and coordination within the health sector. A representative of a professional association noted that private practitioners have not yet been given access to the Electronic Patients Health Records, two years after it was introduced in health care centres, despite plans to this effect. This lack of access hampers coordination efforts across the public and private sectors.

5.2.8 The Advisory Council explained that the strength of the Council lies in the inter-ministerial discussion and cooperation, the common understanding and the willingness of the different ministries represented in the Council to work together to promote healthy lifestyles. Moreover, the Advisory Council seeks to inform and empower various ministries and public sector entities to contribute to the promotion of an enabling environment within their sector. Substantial achievements were garnered within schools through this platform, including the introduction of water fountains, food regulation and the provision of free school meals for children in need, which mainly entailed cooperation between the health, education and social policy arms of Government. The Council also reaches out to other ministries or public sector entities (such as TM, the ITS and the Agriculture and Rural Payments Agency), other officials of the ministries represented in the Council or other stakeholders when required, for consultation and to foster areas of cooperation for implementation. One case of successful collaboration mentioned was that with the ministry responsible for recreational parks, through the provision of fitness equipment and the organisation of physical activity events at these sites.

5.2.9 For the future, the Advisory Council is in favour of further extending such invitations and consulting with ministries with which there has been little to minimal contact so far, to explore possible areas of

collaboration. This approach was favoured to including additional members on the Council to include more sectors. Another Advisory Council member suggested having designated points of reference/ contact within other ministries, to be consulted and invited to attend to meetings on an ad hoc basis as necessary. Further consultation was also envisaged with other stakeholders, to allow their experience and expertise to inform the Council's decisions on future action. The Advisory Council and the MFH representatives acknowledged that going forward further commitment needs to be secured from different sectors, and that with respect to specific remits and initiatives individual stakeholders need to be identified to take responsibility and be accountable for their implementation.

5.2.10 Various examples of the current collaborations and niche contributions by stakeholders outside the health sector were mentioned. The MSPC noted that it collaborates with local councils for the Għaqal Aħjar Training programmes, with the HPDP for the Looked After Children Health Care Services, and with SportMalta for the Nibqgħu Attivi sessions. SportMalta promotes physical activity within the education sector, workplaces, sports organisations and the community, by fostering strategic partnerships, supported by EU funding. A public sector representative noted that the tourism sector interest in promoting local and healthy restaurant food and the green star scheme, which stands for sustainability, may contribute towards efforts aimed at promoting healthy lifestyles. An academic identified parish priests as playing a central role in identifying low-income families or families facing difficulties in a dignified and effective manner for targeted interventions. ERA highlighted its representation in a working group with the Superintendence of Public Health and the Environmental Health Directorate, set up to develop a national portfolio of actions on environment and health. This working group is an obligation arising from the Declaration of the Sixth Ministerial Conference on Environment and Health (Ostrava Declaration), which is intended to tackle obesity, alongside various other environmental health issues.

The role of specific stakeholders

5.2.11 The role of specific stakeholders or sectors, such as NGOs, employers and workplaces, local councils and schools was discussed in further detail.

5.2.12 The need for ongoing collaboration with NGOs and professional associations that transcends individual relationships between entity and NGO management personnel, and that is maintained in the event of changes in leadership, was mentioned by an MFH representative. An NGO representative suggested that the strong network established through the Malta Health Network and the Malta Council for the Voluntary Sector could be capitalised to garner further cooperation with NGOs.

5.2.13 A few stakeholders recognised that more focus needs to be placed on workplace settings, and on securing the cooperation of employers. Greater awareness from employers as regards the positive impact of healthy lifestyles on physical and mental wellbeing, and by consequence on employee focus, sick leave utilisation and productivity, was considered necessary. The public sector was considered to be lagging in this area, the relevance of which is accentuated when considering that this sector is a major employer and that consequently any internal initiatives could have a major impact and be an example of good practice for other employers. In this respect, the Malta Chamber of SMEs suggested

that guidelines for the public sector should be issued regarding food provision similar to the guidelines issued relating to the consumption of electricity. Besides encouraging a shift in culture, these guidelines would also create business opportunities for private operators that are offering healthier options, particularly in view that the public sector is an important consumer.

5.2.14 Proposed measures put forward by participants include further health promotion activities, possibly during break time, the availability of healthy snacks and meals at work canteens and events, exercise breaks, the provision of gym allowances or gyms on site and the organisation of sports events. Additionally, a service provider noted that employers should be encouraged to support employees who require residential weight loss programmes, by sponsoring their leave to attend such programmes. These programmes ordinarily last eight weeks. However, the Malta Chamber of SMEs noted that for over 80 per cent of employers, which are microenterprises, the scope for any health-focused initiatives is constrained due to limited resources and competing priorities. Nevertheless, the Chamber recognised that even microenterprises may be responsive to government schemes offering financial support to encourage the further uptake of initiatives that promote healthy lifestyles within the workplace. On the other hand, the Chamber recognised that it is often the staff themselves that organise activities that promote wellness.

5.2.15 An MFH representative noted that guidance documents for employers to improve health and wellbeing at the workplace, which include guidelines on providing healthy options within canteens and vending machines, were being finalised at the time of the focus group discussions. The Health Policy and Strategy Board also referred to this guidance document, 'Improving Employee Health in the Workplace: Guidelines for Employers'. The Board explained that this document was developed by the HPDP with the aim of supporting the adoption of healthy behaviours in the workplace. Included therein are chapters on healthy eating, promoting physical activity and reducing sedentary time, and supporting breastfeeding at the workplace. Additionally, the MFH also noted that a guidance document for the procurement of food within canteens was also available.

5.2.16 The representation of local councils within the Advisory Council and the work done in collaboration with local councils through this channel was acknowledged by some participants; however, it was also noted that not all local councils are equally receptive and that different councils have different agendas. The provision of free exercise classes from local council venues was considered to be positive outreach work, increasing geographical and financial accessibility. An MFH representative asserted that local councils have the responsibility of providing safe and pleasant areas for residents to exercise within. Furthermore, the MFH representatives noted that the MFH can continue to provide local councils with recommendations and contacts to ensure that any service provided is of a professional standard. A public sector representative explained that for the last few years the ministry responsible for local government allocated an ad hoc fund for special initiatives enabling physical activity. The MFH representatives also noted that the Ministry has in the past worked with local councils to encourage them to apply for funds to undertake sustainable health-related projects and activities. The MFH then provided the Department for Local Government with guidelines to assess these projects and activities. A representative of the Department for Local Government noted that to further encourage input from local councils the Department was considering the possibility of introducing an annual

award for good practice initiatives undertaken by local councils. While some participants put forward a recommendation for local councils to provide various open markets within the community for the selling and buying of healthy produce, a representative of the Department for Local Government noted that local councils already have difficulties accommodating the vendors currently licensed to operate in open markets, and that instead, buying directly from the producer should be encouraged.

5.2.17 Stakeholders mentioned various initiatives within schools and during afterschool clubs that help in the fight against overweight. These include the introduction of potable water through water fountains in schools, the fruit, vegetable and milk scheme, the increase in the number of physical education classes for children in compulsory schooling, the introduction of home economics as a compulsory subject in the first two years of secondary school in state schools and health promotion initiatives targeting students, teachers and parents, lectures by TM promoting active transportation, and training sessions for teachers. Additionally, a legal notice restricting the procurement of food and prohibiting the advertising or acceptance of sponsorships of food products within schools (Procurement of Food for Schools Regulations, Subsidiary Legislation 550.01) was issued, while children from lower socio-economic backgrounds were provided with free lunches (Skema 9). Also mentioned was the Move 360 pilot project, an afterschool programme for children coming from lower socio-economic backgrounds, which provided nutritious snacks, food preparation activities, lessons in food budgeting and opportunities for physical activities. Various participants spoke of the role of home economics in imparting health and nutrition literacy, planning skills, budgeting and knowledge on how to make smart, healthy and sustainable choices and minimise waste.

5.2.18 An academic noted that the various efforts within schools have contributed to greater nutrition knowledge and better food choices, as manifested in children's lunch boxes, especially in primary schools, where healthy food is becoming more of a norm. An NGO representative commented that schools have managed to create a supportive enabling environment with respect to food consumption. The cooperation of parents was noted as essential in ensuring the effectiveness of initiatives undertaken in schools to promote healthy eating and active lifestyles. Parents' priorities and behaviours can either reinforce or can be counterproductive to the work being done in schools. An MFH representative and an academic observed that educating children also indirectly translates into higher health literacy among parents, as children can inform other household members and motivate lifestyle changes within their families.

5.2.19 Academics proposed extending the entitlement of home economics classes to all primary and secondary school children. Two academics proposed including health literacy and specifically nutrition education in the learning outcome framework of primary and secondary schools, and possibly including peripatetic teachers specialised in health or home economics to rotate among schools and provide this education. These academics noted that this proposal underlies research that shows that children acquire their health behaviours and attitudes from a young age. In this respect, it was noted that there is no structure for food education, food literacy and health in the curriculum of primary schools years, and it is left to the discretion of the primary school teacher whether to include such knowledge, based on their understanding and skills. Additionally, primary school teachers have just one academic unit in their teacher training programme on health and nutrition education and most are self-taught with respect

to knowledge on nutrition and food preparation skills. A similar study unit is now also being offered to those training to be child carers and kindergarten teachers. In addition, an academic noted that there is scope for food education in a post-secondary setting, similar to the adulting courses offered in the US and Australia. Such courses would offer creative, age-appropriate and targeted education to young adults as they transition into adulthood and living independently, to teach them how to make smart, responsible and healthy decisions when shopping, storing and cooking food.

5.2.20 Proposals for additional initiatives to be undertaken within schools were also put forward by various stakeholders. Representatives of professional associations advocated for a greater emphasis on soft skills and life skills, and specifically planning skills, in the school curriculum. However, another representative urged caution in assigning additional responsibilities to educators when arguing that the curriculum is already extensive. In further feedback provided, the MFH warned against assigning tasks to educators for which they have not been trained.

5.2.21 Various stakeholders asserted that more time needs to be allocated for physical education classes and other physical activity (such as movement during assembly time or the daily mile) during school hours, as children spend most of their school day sitting down. One academic suggested the uptake of outdoor physical learning, especially for young children. The Malta Chamber suggested that more physical education opportunities should be included as part of the curriculum, with children leaving school having mastered basics such as swimming, riding a bike and running properly. In supplementary feedback by the MFH, the Ministry agreed that support is needed for professional sports; however, contended that for basic skills such as swimming or riding a bike, these are usually acquired from parents. Additionally, the Malta Chamber was of the opinion that all public colleges from Year 3 onwards should offer mandatory, daily physical activity of at least an hour, involving different disciplines. Finally, the Chamber suggested introducing a system of compulsory sports credits as part of the curriculum at tertiary level education, similar to the system in place in some liberal arts programmes in foreign universities. The Office of the Commissioner for Children similarly advocated for increased physical education classes, as well as more varied classes to better meet the interests and abilities of children. On the matter of increased time allocated to physical education classes, the Health Policy and Strategy Board highlighted that the 2023 Budget speech referred to the Government's commitment to increase the number of hours of physical activity within schools and establish the minimum number of physical educational lessons.

5.2.22 Academics noted that further training needs to be provided to school teachers as there may be cases where the teacher is still promoting the food pyramid, rather than the healthy plate introduced in 2016, or the consumption of cereal bars that are high in sugar as healthy snacks. An NGO representative proposed further legal restrictions and a buffer zone around schools with respect to the licensing of food outlets. Some academics also argued that children must be provided with the skills to assess the reliability and accuracy of different sources of information and to appraise information before accepting it as factually correct. Another proposal related to the introduction of universal free school lunches [more details in 'Food accessibility and affordability'].

5.2.23 An academic suggested that certain practices within schools need to be revised. The academic referred to a post-secondary school where students are not allowed to take their own lunch to the canteen, thereby favouring the interests of the company running the canteen. Moreover, most schools do not have canteens that allow students to either get good food from home and warm it up and enjoy lunch with their friends, or to buy good healthy inexpensive food to enjoy with their friends. In further feedback provided, the MFH noted that this restriction is also present in some workplaces.

5.3 Market and political considerations

5.3.1 Stakeholders considered the impact of market and political forces on the current obesity problem and changes required to reduce any negative impact and encourage a positive influence. Discussions considered the contribution of the free market economy to the obesogenic environment, possible areas of cooperation and incentives to encourage businesses to offer healthier choices, the need for further regulation of marketing and advertising, the need for a greater presence of public health officials on the media, and the lack of political will to prioritise the address of obesity.

Market forces

5.3.2 Representatives of the MFH, service providers and academics recognised that business is primarily motivated by profit, rather than health and social considerations, yet its actions, including marketing and advertising [more details in 'Marketing and advertising'], influence the health of the consumers and society at large. A service provider argued that the fact that marketing budgets of fast-food companies substantially exceed government budgets aimed at health promotion, and the fact that such marketing is in large part unregulated leads to the drowning out of the positive messages being disseminated by public health entities. The MFH representatives explained that tourism, globalisation and commercial interests (including international trade agreements and trade licenses) directly influence food product availability and pricing, and shape the diet consumed locally, which seems to be drifting further away from its healthy Mediterranean roots.

5.3.3 In explaining why the free market economy contributes, sustains or exacerbates overweight within the population, an academic noted that the market operates an economic model that prizes short-term market economic activity by default. The model favours a quick return on investment and high profit margins (which are secured to a greater extent through highly processed foods). This system comes with some unintended negative side effects, such as inequitable outcomes, pollution and overweight. This is mainly due to the market being agnostic to whether products are harmful, and is solely interested in the cost of the resource to make the product, the product to be made, and demand and supply considerations. Harmful products are not penalised in any way by the free market.

5.3.4 Various participants acknowledged that powerful lobby groups oppose legislative and policy changes that can impact their business interests and exert significant influence on policy makers at European and local levels. Such opposition has been exerted in terms of food labelling efforts, the introduction of a sugar tax by food producers and importers, and in terms of a small-scale local initiative to promote children walking to school by local transport companies. Having gained experience from

other conventions and regulations, such as in the case of the Framework Convention for Tobacco, industry is becoming more proactive, rather than reactive, in challenging change, and it has the financial backing to do so.

5.3.5 For this reason, a public sector representative insisted that the optimal way to achieve results is to encourage and incentivise business, and not impose requirements and limitations. Similarly, an academic argued that when designing interventions market forces must be thoroughly analysed and solutions proposed should as much as possible be acceptable to business to ensure that the market does not oppose the interventions and instead supports and facilitates the intended output and outcomes. The Malta Chamber of SMEs similarly argued that businesses can be instrumental in affecting the required changes, and that for this reason the private sector needs to be consulted to explore areas of cooperation and incentivised and supported to offer healthier products and services. Instead, the Chamber observed, that businesses are not integrated as part of the solution, but are often roped in solely as tax collectors, such as in the case of the tax on sugar-sweetened non-alcoholic beverages.

5.3.6 The Advisory Council noted various instances where it undertook discussions with business leaders, such as in relation to food reformulation and portion sizes of sweetened beverages with manufacturers and spatial planning with developers, with the aim of finding possible areas of agreement and cooperation. Suggestions of additional ways of cooperating with business explored by stakeholders included encouraging importers to include healthier products in their range, encouraging chefs to opt for healthier cooking methods and ingredients and provide for healthy meals in their menu, encouraging restaurateurs to present nutritional information in their menus, facilitating the direct selling of produce from the farmer to the consumer and providing financial support to local producers and businesses providing healthy options. In further feedback provided, the MFH suggested that businesses that make the effort to provide healthy options should be advertised freely and widely, to help increase their clientele.

5.3.7 A few academics acknowledged the fact that some businesses are interested in providing healthier, local and more sustainable products, and in having a positive impact on society's wellbeing, and that they could be responsive to any nudging provided by fiscal incentives and voucher schemes. This view of some businesses' willingness to engage and their envisaged responsiveness to the right incentives was also shared by the Malta Chamber of SMEs. An academic commented that business is a big machine and that should business catch on to this agenda and consider it a profitable endeavour, then it could substantially aid Government's efforts. In additional feedback by the MFH, the Ministry recognised the need to promote a mentality among businesses that recognises that healthy products can also lead to profits, and that steers away from quick profits that are earned at the detriment of the customer. Regarding the suggestion of supporting local production, an academic commented that Government has been advised and encouraged to do so, yet there is a lack of political will, as Government is more inclined towards supporting the interests of larger corporations in securing substantial profits rather than small enterprises.

5.3.8 The Malta Chamber of SMEs noted that in 2022 it introduced business awards at a national level, with one of the awards focusing on wellbeing at the workplace, and another on innovation. The nominations for these awards could shed light on good practices within the private sector, inspiring other operators to make positive changes.

Marketing and advertising

5.3.9 The advertising and marketing (including packaging) of unhealthy food was considered by various participants to be a significant aspect of the commercial determinants of health, which requires a whole-of-society and whole-of-government approach to address. It represents an element of the obesogenic environment that favours energy-dense food as opposed to healthy food. Since the absolute majority of food items consumed locally are produced abroad, and since the local population is exposed not only to local media but also to international media, the wider market and media influence local behaviour and attitudes.

5.3.10 The Advisory Council, the MFH representatives and academics noted that the further regulation of advertising, especially that targeting children, at local and EU level, is an essential element in efforts aimed at reducing obesity. The work undertaken during Malta's EU presidency, the EU audio-visual directive and the guidelines in place by the Broadcasting Authority to regulate what can be advertised during children's programmes, were mentioned as examples of good practice that have provided some level of child protection. The Malta Chamber supports efforts aimed at banning the advertising of unhealthy food during the airing of children's TV programmes and from digital streaming platforms that include advertising.

5.3.11 Market forces were noted as impeding progress in the area of advertising regulation, by putting pressure or raising objections during the drafting of new legislation, but also through their advertising efforts, with budgets of a single multinational company often exceeding the WHO budget for a five-year term. In supplementary feedback, the MFH noted the extensive digital marketing and advertising on social media, including influencers. The health expert explained that the European nutrient profile model proposed by WHO provides a common tool for use or adaptation by member states to reduce food marketing pressure on children, and includes guidelines as to the marketing that should be permitted for each food type. Besides influencing national legislation with respect to marketing, such standards also aim to nudge the population into making better choices and companies into producing foods that are below the indicated thresholds for allowable items to be marketed to children. Such influences aid in making the food environment less obesogenic and more conducive to maintaining a healthy weight.

5.3.12 Another aspect of advertising discussed by service providers was that relating to weight loss products and regimes, which often promote fad diets that are neither healthy nor sustainable. Products and diets are sometimes promoted discreetly by influencers through the content they share. Service providers questioned whether such marketing could be in any way regulated. Currently, existing regulation

only prohibits persons from promoting themselves as nutritionists or dieticians unless they are duly registered, and does not in any way regulate the content of advice or marketing. Service providers discussed the feasibility of introducing regulation in this respect. In additional feedback, the MFH asserted that paid sponsorships should be disclosed.

5.3.13 While the media presence of public health officials and conscientious professionals whose advice is not shaped by commercial interests can mitigate the negative influences of advertising and marketing, the feasibility of a strong presence is hampered due to the high costs involved, with TV stations rarely inviting speakers without requesting payment for the slot. An MFH representative explained that the obesity vote, which covers promotional campaigns and staff costs for weight loss programmes within the HPDP is limited to around €80,000, which falls short of the requested budget and limits the media advertising that can be undertaken. Additionally, procurement regulations require choosing the cheapest media company, which may not yield the best results in terms of coverage. Academics proposed a public health marketing campaign focusing on promoting healthy products and diets as trendy food may mitigate the negative effect of commercially motivated marketing.

5.3.14 Packaging was also recognised to be a powerful marketing strategy. The WHO health expert also noted that with respect to tobacco there was a push for plain packaging, or at least the inclusion of a very prominent graphic health warning, so that the packaging is not used as a tool to market cigarettes. However, the WHO representative and an academic acknowledged that it can be more difficult to attain significant interventions with respect to packaging, though many acknowledged the impact of packaging on consumer choice, especially with respect to items targeting children that include cartoon characters and vibrant colours on their packaging. On the other hand, another academic suggested that attractive, informative and consumer-friendly packaging, which highlights the benefits of specific products, can entice customers to choose healthy options.

5.3.15 One marketing strategy that was considered to encourage bad shopping and consumption habits is the placing of unhealthy foods at strategic locations within supermarkets, such as close to the payment aisles. An academic argued that it is common knowledge that wholesalers and other supermarket suppliers pay a premium to secure the best, most prominent display areas on supermarket shelves and that a significant portion of shopping by consumers during every visit to the supermarket is done impulsively. Vendors are fully aware of such impulse buying and several effective point of sale displays have been developed over the years to tempt consumers into purchasing what are usually unhealthy food items, with high fat, sugar or salt content. This academic suggested that one could attempt to rope in marketers and vendors who would be willing to collaborate with researchers and the local health authorities to find ways of promoting healthier food items without jeopardising their revenue and profit. For example, supermarkets could be financially incentivised to prominently display and promote healthy food products on their point-of-sale displays. Similarly, another academic suggested that just as cigarettes are no longer placed on prominent shelves, unhealthy food should not be displayed within areas that encourage impulsive buying, such as within two metres of the paying aisles, where customers are often waiting their turn, possibly exhausted and hungry and displaying limited self-control. However, the Health Policy and Strategy Board noted that the changes in the placement of food items in supermarket aisles require complete cooperation from the private sector, and that to date, most supermarkets have not been willing to carry out such changes.

Political will

5.3.16 In discussing specific recommendations some stakeholders considered whether particular proposals would be politically acceptable and how they could be improved in this respect. For example, in considering whether the Council should be given regulatory and implementing powers, whether menus should mandatorily include nutritional information, and whether certain food items should be taxed, the Advisory Council members commented that the feasibility of such proposals was conditional on their acceptance by politicians, specifically Cabinet, and the political will to introduce certain measures despite resistance from powerful lobby groups. One Council member argued that irrespective of the assumed resistance of politicians to certain proposals or other opposing factors, public officials were still to put forward proposals that they deem potentially effective in reducing the prevalence of obesity, irrespective of the anticipated political resistance.

5.3.17 The impact of political will and political influence on progress achieved with respect to efforts aimed at reducing overweight, including the implementation of existing policies, was mentioned by stakeholders in the focus group discussions. On one hand, acknowledging political interest in addressing overweight, an NGO representative noted that various political parties had approached the respective NGO and requested input regarding which actions should be prioritised. On the other hand, several stakeholders observed how political influence may stall or disrupt progress against overweight. Two academics argued that, specifically with respect to sustainable mobility, poor progress could be explained in terms of lack of political direction and will. One academic argued that politicians are geared towards giving people what they want, rather than what they need, and generally, the average citizen mostly values policies that increase their economic power rather than those that improve sustainability and health. Similarly, another academic argued that there is hesitancy in tackling issues that have a monetary bottom line, and the health of the population cannot be improved unless this hesitancy is overcome. An Advisory Council member and an academic acknowledged that politicians can be pressured into rejecting specific proposals on grounds that it would lead to loss of business, loss of jobs or international implications in terms of trade and other issues, such as cooperation on immigration issues.

5.3.18 For this reason an academic argued that a grassroots approach to tackling obesity is required, as politicians are not committed to tackling overweight as a priority. The need for a grassroots or non-institutional or bottom-up approach to tackling overweight was mentioned by a few other academics, who argued that relying on institutions to solve this problem will most likely lead to the maintenance or exacerbation of current levels of overweight, due to issues of lack of collaboration and communication, political expediency and nepotism. Another proposal put forward by an academic to bypass political influence was for the institutional structure responsible for obesity to not fall under the responsibility of any ministry but be an independent body.

5.4 Lifestyle and culture

5.4.1 Several stakeholders noted that there is a growing social and cultural trend for people to prefer buying ready-made meals and convenient snacks, rather than preparing meals themselves, either because they do not have the time (in view of increasing financial and work pressures and hectic schedules),

or the skill to plan, prepare and cook food. Additionally, the pandemic was noted to have instilled in many the habit of ordering food delivery, which has been sustained beyond the acute phase of the pandemic. It was also noted that changing gender roles and family structures have also resulted in a lacuna with respect to food preparation activities, a role previously clearly fulfilled by housewives. The gratification sought from food was also discussed, and cultural attitudes to fatten small children up or to not negate a pregnant woman's wish for food, were recognised to encourage over indulgence.

5.4.2 Similarly, the modern lifestyle was considered not to encourage physical activity – in view of sedentary work, heavy workloads and extended working hours in the case of adults, ample homework and restricted active time at school in the case of children, and restricted leisure time that has become less active in nature. It was argued that the Maltese favour social activities that involve sitting down and indulging in most-often energy-dense or processed food, rather than physical activities. Moreover, our environment was recognised to be car-focused, and that it does not facilitate active lifestyles and the use of alternative forms of mobility. Some academics argued that lack of child independence in terms of experiencing the environment outside the home, such as for example by walking to school or local amenities, means that walking as a transport mode is not ingrained within us. This lack of child independence was partly explained by poor walking infrastructure, lack of road safety, and a land use planning system which has not helped in maintaining services, such as sport amenities, at the community level.

5.5 Instigating change through an enabling environment

5.5.1 Tackling overweight requires behavioural and culture change among those of normal weight (to prevent pre-obesity and obesity) and among individuals with excess weight (to achieve weight loss and reduce the likelihood of complications and comorbidities). For this reason, an academic suggested that a team could be established to identify the cultural specificities that are contributing to the high overweight prevalence rates locally and to disseminate knowledge in relation thereto among key stakeholders. Many recognised that changing culture and behaviour is a difficult and complex endeavour. On the other hand, one academic recognised that while culture is difficult to change, culture is innately transformative, as it is not fixed and is in a continuous process of flux. The difficulty is in finding the right probes to instigate the required change. While one public sector representative suggested dealing with changing behaviours related to unhealthy food in a similar fashion to cigarettes and alcohol, another public sector representative warned that this approach is not suitable, as unlike cigarettes and alcohol, which are substances that the body does not need in any quantity to function, food is a basic need and therefore should be addressed differently.

5.5.2 Academics recognised that change is especially difficult for older persons. Children and adolescents are more malleable to change, especially if the environment at home is supportive in this respect. However, an academic did claim that behaviour change in adults is not an impossible task, and that she had come across many, including older persons, who are receptive to implementing small changes in their daily routines on receiving concrete practical advice in this respect. Nevertheless, behavioural change could become more complex in the presence of complicated psychological relationships with food, mental health issues and eating disorders, underlining the role of qualified dieticians, clinical

psychologists and psychiatrists in specialised weight loss programmes. NGO representatives suggested that in enabling behavioural change it is important to recognise that eating can be a hedonistic activity by its nature, as many derive pleasure from food, and that eating may be a stress reliever for some.

5.5.3 Mental health is interrelated with obesity, with mental illness leading to overeating and reduced mobility, and therefore excess weight. Also noted was the inverse, that is, how obesity negatively affects a person's mental health. Intrinsically related to mental health is a person's coping skills. A representative of a professional association commented that the extent to which a person can cope with loneliness, life's struggles and possible traumas, will determine the extent to which healthy lifestyle choices are made and required behavioural changes sustained. Another psychological aspect related to obesity and specifically weight loss mentioned in the focus group discussions is the expectation of instant gratification and fast results. Professional non-commercialised weight loss programmes emphasise that excessively fast weight loss is not the right way of dealing with obesity.

5.5.4 Health education was acknowledged by various stakeholders as an essential, but alone insufficient, element to motivate change in dietary and physical activity behaviours [more details in 'Health education, health literacy and health promotion']. Health education needs to be supplemented with measures that motivate and empower behavioural change, and make the healthy choice the easy one by creating an enabling environment. Various efforts, including policy and legislative changes, fiscal measures, and efforts relating to food labelling, food reformulation, portion size regulation, aisle placement changes, pesticide use control and spatial planning, help create an enabling environment. Academics argued that more effort needs to be invested in such measures and political goodwill mastered to back such measures.

5.5.5 The WHO health expert noted that there is scope for influencing culture through the setting of or influencing of social norms. WHO's standard for healthy and sustainable meetings is an example of an effort to shift preferences by setting voluntary norms that in turn help to influence social norms. An academic explained that besides taxation and subsidies, economics also promotes behavioural nudges to instigate behavioural change [more details in 'Fiscal measures']. Changes in the choice architecture are effected to make healthy choices fun, easy, attractive, social and timely (FEAST).

5.5.6 Also cited by an academic was that the effectiveness of specific economic instruments may depend on the financial affluence of the particular individual. Taxation may be more effective on persons with low-income. On the other hand, other nudge-based interventions, such as the availability of smaller portion sizes and the placement of healthy and unhealthy food next to or away from the paying aisles respectively, may be successful among high-income earners. These non-fiscal interventions were considered by an academic to be politically non-controversial and to be therefore capable of achieving faster results. The aisle placement intervention acknowledges that food consumption choices are often outside the realm of rational thinking, but may be more instinctive, automatic and pleasure-driven, and therefore one should seek to create a choice environment where unhealthy choices are harder to make. The underlying strategy centres around the concept that availability beats cognition.

5.6 Institutional set-up

5.6.1 Following the publication of the strategy, the Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act was enacted, and subsequently an Advisory Council was formed. This Council meets monthly and forwards recommendations often requiring inter-ministerial cooperation to the MFH, which are in turn implemented by the MFH and other ministries. The members of the Council voiced positive experiences of their involvement, asserting that while progress may have been somewhat slow, various improvements with positive impact had been registered, and that there is a good spirit of collaboration and understanding between members. Members recognised that the strength of the Council lies in inter-ministerial discussion and cooperation, and its role of offering advice and empowering other stakeholders to take action to create an enabling environment. An Advisory Council member observed that a lot of work undertaken by the Council is not visible to the public, as it is of a consultative or exploratory nature. The members of the Council who were not representing the MFH were thought to be instrumental for pushing change within their respective Ministries. The legislative powers held by the Chair of the Advisory Council, who also holds the position of Superintendent of Public Health, were noted as facilitating change in areas that are within the direct control of the Superintendent.

5.6.2 While some stakeholders were content with the current institutional set-up, including the MSPC, which Ministry considered the set-up adequate and inclusive, others criticised the Advisory Council for having managed to secure little progress in terms of the set targets. An academic commented that he had higher hopes for this Council and what it would achieve than has transpired since its inception. An academic believed that although the Council had not attained expected results, this did not necessarily mean that the governance structure was inadequate. Some stakeholders suggested improvements to the current set-up, including extending the resources and powers of the Council and changes to the member composition, while others suggested a completely different governance structure.

5.6.3 A few stakeholders noted that the Advisory Council has limited powers, with an NGO representative, a representative of a professional association and an academic even describing the Council as 'toothless'. The NGO representative observed that this was partly due to the fact that the MFH heads this governance structure, rather than other ministries, such as the MFE, which have the resources and influence to effect change. On the other hand, a few representatives of different professional associations argued that having an advisory role, the Council does not have the legal means to become an effective implementing body. A representative of a professional association criticised the Council for its weak accountability, monitoring and implementation frameworks. An academic claimed that the current institutional set-up was not adequate to ensure that obesity is recognised as a national priority. An NGO representative argued that the Council cannot achieve substantial progress unless the appointed members are dedicated to this task, rather than this task having to compete with the various other tasks and roles that the current members are responsible for. The NGO representative was of the opinion that members should have full-time roles, be well remunerated and be allocated the necessary resources, having supporting teams responsible for research and implementation.

5.6.4 A few stakeholders suggested that the Advisory Council should be allocated a budget and implementing powers. On being presented with this proposal, the Council acknowledged that their advisory capacity has certain limitations in terms of the expediency and power to execute. However, it indicated that the remit and powers of the Council was decided at a political level, as mandated by the legislation regulating its function, and that it operated within the parameters given. Moreover, the Council noted that having executive or regulatory powers would hamper its strategic approach of empowering different stakeholders to assume responsibility and make changes within their respective sector to create an enabling environment. A member also asserted that in their opinion it would be unwise for the Council to take decisions about matters not under its direct responsibility, such as tax, when such a decision should clearly emanate from the MFE. Elaborating in this respect, the Council member noted that it was unlikely that politicians would want to relinquish power to non-politicians. Similarly, another member commented that the autonomy of Ministries must be respected. An MFH representative argued that allocating executive powers to the Advisory Council is not cost-effective, as this would necessitate a wider governance structure and a human resource complement to support implementation within the Council when such structures and human resources are already present within other ministries. Additionally, the MFH representative commented that this operating system would likely result in duplication of work by the Council and the other stakeholders/entities responsible for specific areas. An MFH representative suggested that the Council should play a more active and decisive role in ensuring that the strategy and planned actions are implemented by the various stakeholders.

5.6.5 Some comments also related to the members appointed to the Council. An NGO representative suggested including a representative of TM or IM as a member of the Council, considering their role in fuelling the dependence on cars and sustaining an infrastructure that does not enable active lifestyles. Similarly, an academic expressed surprise that TM was not represented in the Council. Additionally, a representative of a professional association suggested that a member of the MAFA should also be part of the Council. An academic suggested that academics with a special interest in this area could also be members in the Council. The Advisory Council was more amenable to continuing to widen its practice of inviting other stakeholders on an ad-hoc basis to its meetings, rather than making its structure more cumbersome with additional members. However, one member of the Council did acknowledge that there is an overrepresentation of MFH representatives.

5.6.6 Some suggestions related to the work practices of the Council. An NGO representative recommended for the Advisory Council to widen its consultative practices, as it noted that the NGO was neither aware of the Council, much less contacted for feedback, despite being a major stakeholder in the social field. Academics also suggested that the Council widen its scope to be included as a required statutory consultee in planning processes for major infrastructural projects and to vet all new policies or projects across government to ensure they are coherent with Government's strategic objectives intended to promote health and reduce obesity. An academic argued that, ideally, an advisory committee should be directly reporting to Parliament on matters of such importance in terms of health promotion. Two members of professional associations also recommended for the Council to start making public the minutes of its meetings, to strengthen accountability, transparency and implementation efforts.

5.6.7 An academic suggested that the Advisory Council should start proposing a work programme to Parliament every year or electoral cycle within the budgetary measures and electoral manifesto framework, possibly linked to SDGs. The work programme would clearly delineate the stakeholders (ministries/departments/entities) responsible for each measure and would initially be vetted and approved by the Budget Office to ensure that funds are provided to the respective stakeholders. This academic also proposed that the Council creates a multidisciplinary forum/platform with academics and professionals, a thinktank, under either the University of Malta or the Malta Foundation for the Wellbeing of Society, to ensure an inflow of ideas to feed into the work programme. The academic also suggested the possibility of providing a small funding stream to encourage research in the area. Another academic noted that the Malta Foundation for the Wellbeing of Society had already organised a forum to discuss obesity and children, and that a substantial number of professionals from different sectors had attended, and that possibly this forum could be revived, with a smaller group making up the core thinktank that could consult with various stakeholders. Similarly, another academic highlighted the importance of a structure or task force focused exclusively on research and innovation, which is to be separate from the implementing arm.

5.6.8 Different alternative structures were proposed. An NGO representative was of the opinion that a commissioner for obesity rather than the current governance structure would be more suitable for securing progress and impact, as a single figurehead with a supporting team was deemed to be better at ensuring implementation than a consultative committee. An academic suggested having a parliamentary group similar to the one which was set up to address diabetes and the introduction of new medication. A strong monitoring and implementation system would ensure accountability, transparency and a results-driven operation. Two academics proposed instituting a task force, similar to the one set up to enable appropriate school nutrition environments, which focuses exclusively on addressing obesity. The Advisory Council opposed the idea of additional governance structures, such as working groups focused on specific issues to aid collaboration across government, as this could lead to further fragmentation, duplication and stretched resources. Instead, the Council emphasised that efforts need to be coordinated and consolidated, and that the Council can fulfil this coordinating role.

5.7 Resources

5.7.1 Feedback provided also included considerations relating to the funding and capacity requirements needed to effectively address overweight. Reflections on current capacity capabilities, additional needs and ways of maximising existing resources through collaboration and training were provided.

Funding

5.7.2 Various stakeholders acknowledged that addressing overweight requires substantial financial allocations and resources, the sourcing of which must be seen in the context of overwhelming needs, priorities and requests on the national budget. Mixed opinions regarding the sufficiency of funding were expressed. A member of the Advisory Council commented that though funding allocations are always contentious and never sufficient, funding for important projects was always allocated. On the other

hand, an MFH representative questioned whether tackling obesity is really a priority for the MFE, and noted that financially a focus on prevention and health promotion is required to ensure better outcomes with respect to obesity. The MFH representatives explained that there is a specific obesity vote, which was allocated following the issuance of the Healthy Weight for Life Strategy, that is ringfenced for health promotion and disease prevention work, under which are included adverts and weight management programmes. One MFH representative added that this vote is normally in the region of €80,000 to €180,000, which is substantially lower than the amount requested, usually in the region of €700,000. When considering the high cost of advertising, and the limited possibility of public health specialists to appear on the media without airtime cost, this allocation was considered inadequate. A service provider noted that the funds allocated for weight management programmes are consistently below the funds requested, which results in the postponement of new projects and roll-out of new services. Another service provider noted that while substantial funding is allocated for treating the consequences and target damage of obesity, such as cardiac care, minimal funding is spent on addressing obesity as an end in and of itself. Funding for monitoring and evaluation efforts, and more generally for research, was also acknowledged to be lacking.

5.7.3 Stakeholders noted that, apart from the obesity vote, other funds contribute to the fight against overweight, including allocations made for specific initiatives and the corresponding human resources participating in relation thereto. These include local and EU funds relating to finance (subsidies for the purchase of bicycles and gym equipment, tax subsidies), sports, youth, education (increase in physical education lessons, the introduction of compulsory home economics), infrastructure (inclusion of gym equipment within parks), social services (initiatives delivered from LEAP centres), local councils (special initiatives scheme), agriculture, and health, such as the general health education budget. However, these complementary funds are not quantified. The PA noted that there are various health-related projects that include components which facilitate recreation and physical exercise that qualify for PA funding. Examples include projects related to gardens, playing fields and outdoor exercise machines.

5.7.4 It was noted that the Advisory Council does not directly secure funding for initiatives to be undertaken, but that in proposing new initiatives to a responsible authority the Council considers funding and sponsorship options to be pursued by the relevant authority. Some stakeholders suggested that the Advisory Council should be allocated a budget and implementing powers; however, the Council noted that this would run contrary to the concept of empowering different stakeholders to assume responsibility and take action, and that it should be individual stakeholders who seek funding to implement specific initiatives. Moreover, should the Advisory Council be allocated a budget, initiatives across government would be limited to those which fit the designated budget, rather than open to the various budgets across government, as is currently the case.

5.7.5 The need to ensure adequate funding to implement policy and to adequately address overweight was mentioned by some stakeholders. An MFH representative suggested that financial commitments for all areas of action outlined in the strategy should be secured a priori and ringfenced for specific actions to facilitate policy implementation. On the other hand, an academic noted that the MFE was no longer interested in investing in a bottomless pit, which the obesity phenomenon was turning out to be, as despite investment, limited or no results were observed in terms of a reduction in prevalence

rates. For this reason, this academic suggested that an action research approach to securing funding should be adopted, with funding for additional projects only secured once initial projects have been shown to be successful through independent evaluation studies. Another academic suggested that a roadmap approach to planning would benefit this funding mechanism, with staggered funding secured on the achievement of consecutive goals.

Capacities

5.7.6 Representatives of the MFH, professional associations and service providers acknowledged that the provision of additional skilled human resources can aid efforts aimed directly at reducing overweight. Specifically mentioned were professionals specialised in relevant fields, such as nutritionists and dieticians, medical physicians specialised in the treatment of obesity, as well as psychologists and psychiatrists with a special interest in eating disorders and weight issues. Psychologists were considered instrumental for weight management interventions as they can offer clients support in undertaking behavioural change and help clients to unravel the root cause of the problem. Additional human resources were considered necessary to increase service provision coverage, reduce waiting times, and to provide a service where currently there is none, such as in the case of a dietetics service within the compulsory schooling system.

5.7.7 Providers of weight management programmes indicated experiencing capacity shortages and struggling to find suitable candidates to recruit. Capacity shortages were partly explained by lack of supply, with few choosing to specialise in this area, and choosing to work in private practice if they do, but also due to funding limitations. In the case of dieticians, it was noted that the course was only recently offered by the University of Malta. Strategic work within ministries was also highlighted by an academic to be hampered by staffing shortages and political pressures, which often take up most of one's working day.

5.7.8 One recommendation put forward by various stakeholders to mitigate capacity shortages and reach more people was to make better use of and better support existing health care resources, such as community pharmacists and general practitioners, in a more systematic manner, possibly through public private partnership agreements. Such an agreement would further capitalise on existing resources that are highly accessibly to the public, to provide information, health education and individualised advice, as well as effective referrals to specialised services. An Advisory Council member noted that such a proposal had not as yet been discussed within the Council, but that it could be considered. Another Council member expressed some reservations regarding such collaboration, specifically with respect to the costs involved. In further feedback provided, the MFH stated that involving general practitioners is evidence-based practice, and that general practitioners need to be trained and incentivised to implement brief interventions for non-communicable disease risk factors in primary care.

5.7.9 Two representatives of professional associations commented that access to public health system medical records by private practitioners is imperative to providing quality advice and care, in the area of overweight and also more holistically in health care. Home economics educators as well as trained citizens, referred to as community developers, were also suggested as potential resources for

the dissemination of health education and the provision of practical advice. Additionally suggested by the MFH was the involvement of youth workers and Personal, Social and Career Development teachers. Other lines of action mentioned in the context of more effective use of currently available resources was greater collaboration and cooperation between different service providers of weight management programmes as well as capacity building. Capacity building was mentioned in the context of training for policy makers in different sectors to ensure they consider health implications when drafting new policies and for professionals engaged to deliver weight management programmes to ensure consistent messages and service quality.

5.7.10 An MFH representative commented that despite limited human resources, the health professionals employed with the Ministry do have the knowledge and skills to educate, advise and support clients in their weight loss endeavours. However, an academic highlighted that there may still be some misconceptions or knowledge lacunas that need to be addressed among some professionals. An MFH representative noted that prior to the COVID-19 pandemic, the HPDP was organising information sessions for health professionals to update them with the latest information for educating and advising patients. Additionally, healthcare professionals were provided with courses to develop skills in motivational interviewing, which has been shown to be effective in supporting behavioural change. Medical and dental students associations are also engaged to promote healthy lifestyles, and the MFH engages with these associations to make sure that their messages are in line with public health recommendations, to further train and inform future healthcare professions with evidence-based knowledge and to utilise the students as an additional supply of human resources. An MFH representative noted that, on being recruited to work with the HPDP, facilitators and nutritionists are given training prior to them starting to deliver weight management programmes, to ensure a consistent and up-to-date baseline in the knowledge of all staff. Training for staff was also mentioned by other providers of weight management programmes, including those offered by Dar Kenn għal Saħħtek. An academic acknowledged the responsibility of academia to train future health professionals to be aware, knowledgeable and sensitive to the consequences of obesity and committed to support their clients manage excess weight. Currently, within University, students choosing to become child carers and kindergarten teachers, primary school teachers and home economics secondary school teachers are all provided with varying levels of training on health and nutrition education.

5.7.11 Further training needs were identified by various stakeholders. A service provider mentioned the need for training on culture, to ensure effective and culturally-appropriate engagement with different clients and patients, such as foreign nationals working and residing in Malta. The need for additional in-service training for teachers on health and nutrition education, possibly targeting teachers who completed their education a while back and casual teachers, in view of the fact that nutrition recommendations have changed over the years, was also mentioned by academics. Academics also suggested specialised training for chefs at the ITS, to teach them healthier cooking methods and inspire them to prepare healthier menus and for waitering staff to provide them with knowledge of different food options for clients with specific dietary requirements. An academic suggested designing a university module, open to all students university-wide, focused on delivering consistent messaging on healthy lifestyles to graduates, to benefit them personally and possibly even their profession and their clients. The same academic also suggested a bespoke module, specifically for communication students, to adequately

train journalists on health and nutrition and sustainable lifestyles as well as communication science, to ensure that scientific papers can be translated into understandable and accessible messages that are also accurate. Additionally, academics suggested including infodemic management as part of teacher training, so that they can transmit information appraisal skills – skills of how to access and evaluate available information – to their students.

5.7.12 Strengthened cooperation and networking within the public sector and between the public sector and NGOs, including sports organisations, religious organisations and scouts, academics, and industry, as well as between different healthcare providers across the public and private sector was considered another potential avenue for maximising the effectiveness of current resources to overcome capacity shortages. A representative of SportMalta commented about human resource shortages in sports non-profit organisations, where volunteers are often responsible not only for the management and operation of the organisation and service provision but also with ensuring compliance with bureaucratic requirements, including those relating to SportMalta and the Council for the Voluntary Sector. It was suggested that Government should consider ways of facilitating and streamlining such requirements. The financial assistance currently provided to these organisations by SportMalta through various schemes was positively acknowledged.

5.7.13 Various academics discussed their potential contribution to the work being done to decrease obesity prevalence rates. Cited in this respect was their work in conducting research and in proposing further action, capitalizing on their strength at multidisciplinary work, expertise in various disciplines and research capabilities.

5.8 Legislative and policy considerations

5.8.1 Stakeholder feedback also included insights on legislative and policy considerations. More specifically, an overview of effected regulatory changes, shortcomings of the current legal framework, the difficulties encountered in the legislative change process, areas which need further amendments, and required enforcement efforts were discussed. With respect to policies, the consultation process to policy formulation, plans for the future development of the policy framework, the wider policy scenario influencing obesity and implementation, monitoring and enforcement efforts were examined.

Legislation and enforcement

5.8.2 The Member of Parliament who had originally tabled the private members bill that eventually led to the enactment of the Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act and the instatement of the Advisory Council on Healthy Lifestyles criticised the way the original bill was altered. He claimed that the original proposal was watered down due to a lack of political will to implement the necessary legislative changes. The original bill had proposed enacting legislation that focuses on different stages of the life course – expectant parents, children, adults and the elderly. More specifically, the bill proposed including information on healthy lifestyles during parentcraft sessions; introducing various requirements for schools, including the provision of potable water, the introduction of a minimum number of hours dedicated for physical education classes within

pre-compulsory and compulsory schooling and the regulation of food accessible within schools and in their proximity; as well as measures related to local councils, including the ring fencing of funds for the promotion of healthy lifestyles and the provision of physical activity and nutrition sessions within day centres for adults and older persons and within residential homes for older persons. The bill was amended from one focused on obesity to one addressing non-communicable diseases more generally, which excluded many of the original proposals. The Member of Parliament observed that, for many of the proposed legal amendments, no subsequent legal notices were issued to address them, despite initial assurances to this effect. Similarly, an academic commented that the exclusion of the word obesity from the title, on Government's insistence, meant that the focus on this national problem was downplayed, and that subsidiary legislations mentioned in the parliamentary debates on the law have not been published. The academic argued that these developments highlight the fact that the address of obesity is given minimal importance at the policy level.

5.8.3 The Advisory Council noted that the implemented legislative changes helped regulate the food that is procured within schools. A member of the Council explained that such changes were facilitated by the Chair of the Advisory Council, who also holds the position of Superintendent of Public Health, and who therefore holds certain legislative powers. Much progress was attained within schools, as it is easier to regulate and enforce legislation within this environment than other environments, such as workplaces. However, legislative changes relating to other sectors, including taxation, transport and infrastructure, are not within the control of the Council, and the Council can merely suggest changes. Other stakeholders noted that legislation at EU level also impacts the local scenario, including the upcoming food directives, which should include regulations relating to food labelling and legislation relating to advertising, pesticides and trans-saturated fats. In providing further feedback, the MFH observed that some countries implement legislative changes without waiting on other member states to agree on a common ground, as this process could take several years.

5.8.4 The Health Policy and Strategy Board noted that the Government enacted several legislative acts or amendments thereto to promote healthy eating, namely the:

a. Nutrition Labelling for Foodstuffs Regulations (Subsidiary Legislation 449.20), which mandates that prepacked food that is sold must bear a label informing consumers about its energy and nutrient content, including the energy value, and the amount of total fats, saturated fats, carbohydrates, sugars, protein and salt;

b. Procurement of Food for Schools Regulations (Subsidiary Legislation 550.01), which sets out the criteria for food procurement of food for schools during school hours in accordance with Chapter 550 of the Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act;

c. Healthy Lifestyle Promotion and Care of Non-communicable Diseases Act (Chapter 550), which Act was amended to prohibit the marketing of foods high in fats, salt and free sugar during children's programmes. Article 6f of this Act included explicit powers to enact specific subsidiary regulation to implement marketing restrictions for products that may have adverse effects on healthy lifestyles. However, this requires action at EU level; and

d. Infant Formulae and Follow-on Formulae Regulations (Subsidiary Legislation 449.52), which imposes restrictions on the advertising and sales promotion of infant formulas. Point-of-sale advertising, distribution of samples or any other promotional activities marketing infant formula directly to the consumer at retail level, including special displays, discount coupons, premiums, special sales, loss-leaders and tie-in sales are explicitly prohibited.

5.8.5 The Board explained that while there is no Maltese legislation mandating front-of-package labelling, the Government is working together with other EU Member States on harmonising front-of-pack nutrition labelling as part of the European Commissions 'farm to fork strategy for a fair, healthy and environmentally-friendly food system'.

5.8.6 Various stakeholders acknowledged that people's behaviours cannot be completely shaped by legislation as we live in a free market and that restrictions could have the opposite effect from that intended. Therefore, it is important that people are well informed, empowered and enabled to make healthy decisions for them and their families. An academic and two public sector representatives noted that restricting the access of unhealthy foods within the school environment without introducing complementary measures in other settings, coupled with adequate health education, may simply be shifting the eating of unhealthy food from the school setting to another setting, or driving covert selling of unhealthy food to students. However, other academics disagreed with this viewpoint, and noted that availability is key in driving food consumption choices, and that one should distinguish between coercion and availability, and argued that this legislation has helped create the right environment to allow children to be exposed to healthy food. Moreover, various academics acknowledged that this measure was accompanied with some nutrition education within the schools.

5.8.7 A member of the Advisory Council suggested that any new policies or legislation be assessed for their impact on health, including overweight, similarly to the way they are assessed for their impact on business and the general economy. However, other Council members noted that this requirement would result in a more lengthy and cumbersome process for the enacting of legislation and would impose a heavy burden on already overstretched resources within the MFH. It was therefore recognised that such a requirement would necessitate a separate administrative set-up and additional human resources.

5.8.8 The Advisory Council explained that legislative changes are lengthy processes. A member of the Council noted that legislative changes impact people's lives and their freedoms, comforts or choices, and it is in that respect that politicians, who are answerable to the electorate, have the power to legislate, a power not borne by technocrats forming part of a consultative or advisory committee. Additionally, legislative changes may be unpopular and be opposed by businesses, unions, the public or even local government and enforcement entities, as they may limit various sectors in important ways. This creates the need for a legislative change to be accompanied by an educational campaign to mitigate, as much as possible, any resistance. The MFH representatives explained that in certain cases, guidelines, rather than legislation, are sufficient. However, where enforcement action is required, legislation is the right tool. For example, the guideline to increase the time allocated to physical activity within schools is tackled through the national curriculum issued by the MEYR. Similarly, guidelines for food options

within institutions and hospitals were considered sufficient by the MFH representatives (in view of the control afforded by tendering requirements), though an academic had an opposing view on the matter. On the other hand, food procurement within schools was considered to be better regulated through legislation. An academic confirmed that it was only once the guidelines for school canteens obtained legislative backing (years after the issuance of the initial guidelines) that schools put in the effort to ensure compliance. In this respect, the academic argued that initiatives that are implemented on a voluntary basis and are steered by guidelines, rather than regulated by mandatory legislation, are less likely to have a substantial impact. Legislation and enforcement were therefore considered important tools for affecting change.

5.8.9 Stakeholders mentioned various areas that require further legislation or legislative amendments, including advertising content, product packaging, food labelling, food reformulation, pesticide use, built environment and development planning, the Advisory Council's enabling legislation, as well as food within workplace canteens and within elderly homes and institutions. An academic suggested that there is scope for actively seeking out legislative proposals from different sectors, possibly from the proposed thinktank [more details in 'Institutional set-up'], as most ministries lack the required resources, while political pressures and routine work do not leave much room for strategic work.

5.8.10 Also mentioned by academics was the need to revisit procurement regulations, as it was claimed that a one size fits all approach, with the least expensive bid which is technically compliant with basic specifications being preferred, is not adequate when it comes to choice of medication, caring services and also catering provision in elderly institutions. However, an academic noted that Most Economically Advantageous Tender criteria, which consider quality and price, expose government to more contestation and delays, and therefore policy makers are disincentivised from deviating from cost-based tender evaluations. Academics argued that price considerations also have to move past simplistic calculations, such as the cost per tablet of medication, but must also consider how many tablets are needed for the required outcome, the medical follow-up intensity required (and any consequential additional resource requirements) and the side effects associated with each drug. Additionally, existing guidelines must be more detailed. For example, rather than stating that food provision in a home must include one yoghurt a day, specifications with respect to the nutritional profile of the product should be included, to avoid situations where residents are provided with the cheapest item on the market which is of sub-optimal nutritional value. Additionally, an academic suggested that there needs to be someone responsible for checking the compliance of catering services with the established guidelines. Nevertheless, an academic acknowledged that, at the time, efforts were being undertaken to safeguard the nutritional and dietary requirements of persons residing within residential community homes.

5.8.11 Academics argued that to encourage the uptake of active transportation and physical exercise and to ensure pedestrian and cyclist safety there must be enforcement with respect to parking and driving, as well as regulation of scooters. It was noted that, too often, cars are parked on footpaths or on bus stops, scooters are driven on pavements at high speed, and pedestrians, joggers and cyclists are sometimes at risk because of reckless driving on the roads. An academic noted that cutbacks on enforcement are simply the result of the unplanned expansion of transport infrastructure, organic growth driven purely by the market and individual initiative with respect to the buying of cars, motorcycles and

scooters. Another academic queried whether enforcement is currently feasible in the context of a lack of alternatives, such as in the case of illegal parking when parents drop their children off to childcare considering the lack of parking space. This academic insisted that, in line with the carrot and stick or the push and pull approach to public policy, enforcement needs to be coupled with alternative solutions, such as parking management facilities outside of the core zones of towns, or incentivising parents to choose childcare centres close to their home and walking to the premises.

Policy consultation

5.8.12 The MFH explained that the process of developing the Healthy Weight for Life Strategy involved various stages. Initial consultation meetings with all the stakeholders were conducted at the start of the process. Subsequently, a working group was formed, which included stakeholders from across government, including representatives from the MFE to carry out the financial assessment and representatives from the MEYR. This working group drafted the strategy that was then issued for public consultation. At the time, the structured approach provided by the online consultation platform was unavailable; however, the MFH still consulted with multiple stakeholders. Following necessary revisions, the strategy was launched.

5.8.13 The Advisory Council explained that several consultations were undertaken in drafting the obesity strategy. However, initial buy-in and commitment from consulted stakeholders did not necessarily translate into implemented actions because of multiple conflicting agendas and competing priorities. On the other hand, while certain public sector representatives acknowledged their ministry's contribution to the drafting of health policies, and specifically the obesity strategy, the representative of the Sustainable Development Directorate commented that consultation is not being done with all sectors, and that specifically the input of the Directorate is not being sought.

5.8.14 Some representatives of NGOs and professional associations claimed that they were not involved in the process of drafting the policy, and in some cases they were not even aware of the existence of the published policy itself. A few representatives of professional organisations stated that, in general, consultation with stakeholders in the policy process in the wider public sphere has been declining over the past few years. Direct input at an earlier stage in the drafting process is not sought, and while these organisations contribute at the public consultation stage, their input is not sufficiently shaping policy. In this respect, participants argued that consultation processes need to be more inclusive and comprehensive and that policies need to have more of a grassroots approach and be better communicated to citizens. The need to include patient representatives and professionals who practice or conduct research in the field, in the private and public sector, throughout the consultation process, was mentioned by NGO and professional association representatives. One NGO representative questioned whether the consultation processes undertaken are genuinely intended to integrate feedback into the drafting process or simply exercises to ensure compliance with regulatory obligations. A representative of a professional association argued that more consultation with employers was required, to enable the introduction of various initiatives at the workplace that promote healthy eating and an active lifestyle. The Malta Chamber of SMEs advocated for communication with private sector stakeholders early on in the process, to explore different possible initiatives and ensure buy-in.

5.8.15 On being questioned as to whether their organisation was consulted or directly involved in identifying possible solutions for the address of obesity, the Commission for the Rights of Persons with Disability, the Office of the Commissioner for Older Persons, the Malta Council for Economic and Social Development and the Malta Chamber of SMEs replied in the negative. However, the Malta Council for Economic and Social Development did note that their lack of direct involvement as a Council does not preclude the direct consultation with social partners, civil society and NGOs. The MFH noted that the position of the Commissioner for Older Persons was only instituted after the publication of the Strategy. On the other hand, ERA explained that the precursor of this Authority, the Environment Protection Directorate within the former Malta Environment and Planning Authority, was consulted on the draft Strategy and had provided feedback. ERA also noted that feedback was also submitted on the draft Food and Nutrition Policy and Action Plan 2014-2020 when this was published for public consultation.

5.8.16 Various stakeholders, most prominently academics, emphasised the importance of research to guide policy decisions. The Office of the Commissioner for Children similarly advocates for further research to be carried out on how best to address childhood obesity. An NGO representative described the consideration of research studies conducted by academics or professionals in the field as another positive consultative process by proxy, which would allow policy makers to capitalise on available resources and knowledge. In this respect, some academics noted that academia undertakes ample research that can inform policy development, and yet these studies are not being considered by administrators, policy makers and politicians. An academic observed that, sometimes policy makers make reference to research studies more as a tokenistic gesture rather than because the true value of research is being elicited. These academics argued that the drafting of policies and the monitoring of the implementation of policies needs to be informed by research that evaluates the impact of specific initiatives in creating more awareness and changing behaviours, and ultimately lowering the prevalence of overweight. In this respect, an academic noted that local research focused on evaluating the impact of the strategy and specific initiatives aimed at reducing overweight is lacking. An NGO representative and two academics acknowledged that while international studies may shed light on the determinants of overweight and effective initiatives to address this phenomenon, local studies that take into consideration the particular context and factors at play are required.

5.8.17 The MFH representatives acknowledged that, on the flip side, other ministries do not always directly request feedback from the MFH when drafting new policies, possibly contributing to the lack of consideration of health matters in such policies. Alternatively, MFH officials are given limited time to provide feedback once a policy has been drafted and is open for public consultation, and are not provided with any account of the integration or otherwise of their feedback. Various stakeholders argued that a health-in-all-policies approach is required to ensure horizontal coherence across Government sectors, such that the wider policy framework is conducive to creating an enabling environment that facilitates healthy choices. Despite its promotion by the MFH, this concept was noted to still not be widely adopted, and needed to be further developed and nurtured. Providing training to policy makers in different sectors to ensure they consider health implications when drafting new policies was considered vital in this respect. A member of the Advisory Council suggested that health and obesity considerations should form part of the impact assessment framework for new policies or legislation [more details in 'Legislation and enforcement']. Similarly, an MFH representative suggested that, across Government, public health specialists should be responsible for vetting policies to assess

their impact on the health and wellbeing of the population, possibly by having public health specialists placed within different ministries and entities. The MFH representative argued that developing one-to-one relationships through such a representative may be instrumental in affecting the required change.

The future development of policies

5.8.18 According to the MFH representatives, in 2019, a review of the obesity strategy was commenced to plan for follow-up after 2020. It was agreed that, rather than having a new obesity strategy, various strategies intended to prevent non-communicable diseases and promote healthy lifestyles would be integrated into one streamlined and focused prevention framework. It was agreed that a holistic strategy that promotes a healthy lifestyle in general be drafted, and to have two supplementary strategies that target healthy nutrition and physical activity separately. This approach would eliminate the need for multiple distinct policies (Healthy Weight for Life Strategy, the Food and Nutrition Policy and Action Plan for Malta, the National Breastfeeding Policy and Action Plan, the Strategy for the Prevention and Control of Noncommunicable Disease in Malta and the National Strategy for Sport and Physical Activity in Malta). The approach in the future is to target lifestyle factors (such as good nutrition, uptake of physical Activity, smoking cessation) rather than individual diseases or conditions, as in effect, lifestyle choices have an impact on various conditions and diseases, including obesity and cancer. The work on policy development in this respect took somewhat of a secondary priority because of the COVID-19 pandemic, since all public health experts were involved in the response thereto. The Advisory Council explained that regarding the content of this framework, that relating to obesity will build on the Healthy Weight for Life Strategy 2010-2020.

5.8.19 An MFH representative suggested that a new obesity strategy should consider targeted actions for different socio-economic groups, rather than maintaining generic interventions for the whole population. Various stakeholders emphasised the need to strengthen strategy implementation, partly through buy-in and commitment from various stakeholders and the allocation of adequate financial and human resources, and to concentrate efforts on monitoring and enforcement [more details in 'The implementation and monitoring of policies']. Academics and representatives of professional associations suggested including short-, medium- and long-term targets in the strategy. A representative of a professional association recommended for the new strategy to not only include outcome targets, as is the case in the Healthy Weight for Life Strategy, but to also include structure and process targets, such as targets relating to budget allocation, legislative amendments, human resource allocations and minimum health-professional patient interaction times.

The wider policy framework

5.8.20 Besides the obesity strategy, stakeholders mentioned other policies that also influence efforts against overwieght. A representative of the MAFA and the Director Sustainable Development observed that an important policy development is the drafting of the national food policy, following the issuance of the EU farm-to-fork strategy. The strategy aims to promote better food sources, organic produce, less use of pesticides, the consumption of seasonal produce, clearer labelling, financial support to

local farmers and eating close to source. The strategy considers the food supply chain, starting from producers, to processors, traders, restaurants, and finally consumers, and identifies required changes in the legal and policy framework in connection thereto. The local national food policy will aim to empower consumers, stimulate businesses, and support producers, with the ultimate objective of having healthier food systems. Preparatory work relating to the drafting of the policy includes consideration of issues related to food, including obesity.

5.8.21 The National Strategic Policy for Poverty Reduction and for Social Inclusion 2014-2024 and the National Children's Policy were also noted by the MSPC as contributing to the address of obesity. NGO representatives noted that policies related to trade and taxes, economic development, infrastructure and the built environment, transport, environment and education also highly influence consumer lifestyle behaviours and choices. It was argued that, at times, government policies in areas other than health may actually be exacerbating the overweight problem, and this was partly explained by the fact that health and wellbeing are not at the centre of policy making. For example, economic development policies are pushing economic growth at the expense of the environment, social cohesion and the wellbeing of citizens, and employment policies are favouring higher employment rates and work intensity at the expense of adequate time for families to prepare healthy food and engage in active lifestyles. In further feedback provided, the MFH noted that the wider policy framework contributes to most of the determinants of obesity. Consequently, stakeholders proposed that health should be an overarching priority for all policies, that policies are aligned and that the impact of various policies on health and specifically overweight must be assessed and taken into consideration when planning policy changes across government sectors.

5.8.22 ERA noted that environmental policies may contribute indirectly to the address of obesity, by addressing the environmental aspects which contribute to this national challenge. The Authority considered that the most relevant policy areas that may need attention are those related to urban planning and transport, which are not directly within its responsibility. Nevertheless, the Authority acknowledged that due to their indirect contribution, ERA's policies may also provide a policy framework for actions in the areas of spatial planning, including urban design, road infrastructure and transport features that enable active lifestyles. Specific mention was made of the relevant forthcoming environmental policy – the National Strategy for the Environment (NSE) 2050 – which aims to provide the strategic direction for improving the environmental quality and liveability of our towns and villages, by increasing and improving open spaces and enabling active mobility options. The Authority also referred to air quality and environmental noise policies, including the National Air Pollution Control Programme, the Air Quality Plan (under development) and the Noise Action Plan (under development), which policies promote the uptake of active mobility over car use. Additionally, policies related to biodiversity were also considered relevant in the context of protecting or creating green spaces conducive to physical activity. Relevant policies in this regard include the 2030 update to the strategic National Biodiversity Strategy & Action Plan 2012-2020 (under development), Investing in the Multi-Functionality of Green Infrastructure (GI), Information Document to support GI Thinking in Malta, and the Green Paper on Greening Buildings in Malta: Initiatives for Green Walls and Roofs for Residential, Commercial, and Industrial Buildings.

5.8.23 The PA noted that as the Authority responsible for development and planning, it gives due consideration to quality of life (which in turn has an indirect impact on obesity), evidenced through its policies and the initiatives undertaken. The Authority explained that the planning system follows a hierarchy of plans, with the Strategic Plan for Environment and Development, 2015 (SPED), as the national strategic document providing direction to the other subsidiary plans within the hierarchy, including Local Plans and other policy documents. The SPED document, which provides the national strategy for the Maltese islands with regard to land use and the environment, directs attention to human health and wellbeing through its various thematic and spatial objectives and related policies. The strategy aims to protect and enhance rural areas, beaches and swimming zones, environmentally sensitive areas and heritage sites, increase green open spaces, implement an integrated transport strategy that facilitates active mobility, improve walking and cycling infrastructure and pathways in rural and urban areas, promote alternative modes of travel and improve the accessibility and affordability of public transport to coastal promenades. Additional aims include the protection, enhancement and improved accessibility of existing recreational facilities and the provision of new ones and the provision of further community facilities including ones specifically targeting vulnerable communities.

5.8.24 The PA also noted that Local Plan policies support several measures that are intended to promote a healthier lifestyle and that can assist in tackling health issues such as obesity. The Local Plans in effect identify numerous walking trails and routes as well as other sports/recreational areas. Such land use designations facilitate public recreation, encourage the enjoyment of the countryside and enable the improvement of the local lifestyle through a healthy regime of walking. In line with the other SPED and Local Plan policies that aim to provide space where recreation and physical exercise can take place, Policy 1.2I of the Rural Policy and Design Guidance 2014 safeguards the country pathways that characterise rural areas.

5.8.25 The Health Policy and Strategy Board mentioned other strategies that help promote a health-in-all-policies approach across sectors. These include the National Health Systems Strategy for Malta (2023-2030), which aims to improve the safety of urban design through traffic calming measures, pavements for safe walking and bicycle lanes, and the Road Safety Strategy Malta 2014-2024, which aims to provide safe footpaths and improve the standard of cycling. The Board also referred to the five strategic themes underpinning the National Strategy for Sport and Physical Activity in Malta (2019) – building a more active and healthy nation, stimulating a new sporting culture, enhancing the competence of all stakeholders, transforming Malta into a centre of sporting excellence and achieving competitive success. Additionally, the Board noted that a Health Enhancing Physical Activity policy/ strategy and action plan is currently being drafted by the Superintendence of Public Health and that a Non-Communicable Disease Prevention Framework is also being outlined in collaboration with the technical team from the WHO as part of the country cooperation strategy.

The implementation and monitoring of policies

5.8.26 The MFH representatives explained that following the launch of the Healthy Weight for Life Strategy, an action plan template that outlines the implementation efforts to be undertaken to implement the strategy across the years was created. Additionally, the Advisory Council explained that, periodically, a

mapping exercise is carried out to identify the measures, projects and initiatives being implemented that address the various areas for action outlined in the strategy and a log of these implementation efforts is kept. When queried as to whether a more formal monitoring and reporting structure, such as that utilised by the MSPC for the poverty policy, could be adopted for the obesity strategy, no opposition was voiced by the Advisory Council members.

5.8.27 Other stakeholders placed emphasis on the importance of strengthening strategy implementation, and on concentrating efforts on monitoring and enforcement. Some stakeholders recognised the lack of adequate structures, commitment, workforce and financial resources to implement and monitor the implementation of this policy. Some stakeholders, especially academics, commented outright that implementation has fallen short of plans and expectations, or that any implemented actions are not resulting in the expected improvement. An NGO representative pinpointed the numerous areas for action of the strategy as one of the reasons behind limited implementation, suggesting that a more focused strategy with limited priority areas, similar to the approach taken in the Food and Nutrition Policy, would have yielded better results. The MFH representatives did note that the implementation of the strategy does not depend solely on the effort and drive of the Ministry and the Advisory Council (considering its advisory role as opposed to having any implementing powers), but on the commitment and action of several other stakeholders. Various stakeholders acknowledged that the MFH has limited influence on many aspects of the enabling environment. In this respect, an academic questioned whether the obesity strategy would have better prospects of effective implementation if the MFH was not the ministry tasked with responsibility for seeing it through. Similarly, in further feedback provided, the MFH argued that if multiple ministries took ownership of the obesity strategy, rather than just the MFH, then this could possibly lead to better coordination of efforts.

5.8.28 Besides comments related specifically to the implementation of the obesity strategy, other comments related to the implementation of transport and environment policies. Academics noted that there are several policies and plans that aim to improve the pedestrian environment and active travel, and promote a sustainable built environment, that have yet not been implemented or alternatively major projects in the sector are designed in a way that jars with existing policies. Lack of political will, competing priorities and changing governance structures were identified as possible explanations for this shortcoming. An academic argued that, for example, the transport masterplan includes various measures for developing a pedestrian infrastructure plan, reducing the impact of cars on urban areas and designing streets to create a balance between pedestrians, cyclists and cars, and yet investment is mostly focused on expanding the arterial road network infrastructure and on road resurfacing to accommodate cars. The Msida flyover project was mentioned as an example of a project that is at odds with current policies. To ensure that major projects are not at odds with existing pro-health and pro-environment policies, an academic suggested that all major projects should be scrutinized by a group of experts who are independent of Government. This group of experts can suggest amendments to proposed projects to secure an enabling environment that facilitates healthy lifestyles.

5.8.29 Academics emphasised the need for monitoring efforts and evaluation research throughout the implementation period that consider the progress made and the impact of implementation efforts against feasible targets and plans, something which was considered to be lacking in the local context.

For this evaluation work, an NGO representative suggested having a separate team responsible for evaluation from the one responsible for implementation. An academic commented that pushing specific initiatives at all costs can be counterproductive, as some might prove not to be effective in the local context, and that ideally what is needed is a resilient capacity and a process that integrates monitoring with implementation allowing for changes to plans as necessary. It was suggested that to facilitate implementation the next strategy should clearly outline the areas of responsibilities of different ministries and stakeholders and the expected outputs for specified short-term, medium-term and long-term timeframes, to encourage ownership and accountability and enable more effective monitoring. Similarly, the Malta Chamber suggested that efforts should be measured through key implementation steps that are sequential, quantifiable and effective.

5.9 Targeted interventions

5.9.1 One of the issues explored was whether interventions aimed at reducing overweight should be targeted for specific groups within the population, and possibly even for vulnerable groups. Mixed feedback was obtained in this respect.

5.9.2 Specifically with respect to information campaigns, some respondents were against the targeting of information in health promotion campaigns for different population groups or vulnerable groups, as this could involve omissions or mistakes in messaging, possibly have a stigmatising effect and might be received with resistance. Instead, it was suggested that public health campaigns should focus on promoting healthy lifestyles and not the reduction of excess weight, and be nation-wide, as the same information is applicable to all. On the other hand, the National Youth Agency of Malta representative noted that young people respond to motivations that appeal to their here and now, such as their improved appearance, and not to warnings of possible morbidities in a decade, and in this respect health promotion campaigns need to be tailored accordingly. A health promotion campaign against tobacco use that appealed to youth, which had a 'would you kiss an ashtray?' slogan, was mentioned as an example of effective targeted marketing.

5.9.3 With respect to more general interventions for addressing overweight, many stakeholders were in favour of targeted measures. An MFH representative commented that the existing strategy assumed that generic interventions would equally reach and affect all social groups and advised that instead an obesity strategy should consider targeted actions for different socio-economic groups. A few stakeholders argued that since habits are formed at home, legislation, policies, health promotion campaigns and other measures should be designed in such a way as to appeal to and target families. In supplementary feedback, the MFH explained that most initiatives should be targeted at populations rather than specific groups, in line with WHO recommendations; however, acknowledged scope for life course specific initiatives tailored to vulnerable groups. The Advisory Council was in favour of targeting vulnerable groups in future interventions, such as the groups disproportionately affected by multiple lifestyle risk factors identified by the ESF project aimed at identifying the social determinants of health. Stakeholders observed that empirical research has shown that several social factors are associated with pre-obesity and obesity. There are differences in the lifestyle behaviours, as well as in the pre-obesity and obesity prevalence levels across gender, age and socio-economic status categories, categorised in

terms of the level of education, income, housing type and size, household composition, employment status and job type. Those engaging to a greater extent in unhealthy lifestyle behaviours are at higher risk of morbidities, which in turn worsens their work status, work intensity and income – leading to a vicious cycle. An inter-generational effect, with vulnerabilities persisting from one generation to the next, was also noted. While recognising these vulnerabilities, an MFH representative observed that overweight is not just a problem of vulnerable groups. Elaborating in this respect, in additional feedback provided by the MFH, the Ministry explained that while vulnerable groups are more likely to be affected, pre-obesity and obesity is not exclusive to them.

5.9.4 Persons of low socio-economic status, most especially those with low income and low educational attainment, children and youth from families burdened with social and emotional problems and adulthood obesity, children from deprived neighbourhoods, migrants, and persons with disabilities, were mentioned by different stakeholders as persons more susceptible to, and therefore vulnerable in terms of, overweight. It was argued that low-income families, but even families with a median income, that is, the working poor, may struggle to consistently choose healthier food due to financial restrictions and such food being more expensive than low-nutrient, processed and convenient food options. Moreover, health concerns may not be a priority for these families, considering their other more imminent struggles. On the other hand, some academics noted that even high-income earners could be experiencing malnutrition, due to the fact that they do not have the time or will to plan, prepare and cook meals.

5.9.5 The Commission for the Rights of Persons with Disability highlighted the fact that since persons with disability are at a greater risk of poverty, they may be more likely to opt for less healthy food choices, on the basis that such foods tend to be less expensive than healthier options. Additionally, some persons with disability may not have the necessary skills or do not have the necessary support to prepare home-cooked meals, leading them to opt for less healthy ready-made meals or take-out food.

5.9.6 Some proposals for targeted interventions were put forward during the focus group discussions. In reference to tax incentives or income supplements or free services, such as voucher schemes (to be redeemed when buying healthy food or enrolling in exercise programs), two academics were of the opinion that such schemes should be targeted towards low-income earners, as economic instruments are less elastic and therefore less effective among high-income earners. However, attention is required to avoid stigmatising beneficiaries. Alternatively, other academics proposed staggering the quantum of financial support based on family size or household income. In this respect, an academic noted that from a public health point of view, experience has shown that there is a role for universal and targeted interventions. Universal interventions avoid situations of people falling through the net, as eligibility criteria may still exclude some people who are in need and keep the administrative burden of the scheme low. An academic also noted that due consideration must be given on introducing any new taxation, such as universal sugar tax, not to further disadvantage persons with low income, as such measures will affect them disproportionately. It was argued that unless such taxation is coupled with subsidies for healthier options and intense educational outreach and support, such measures would simply drive certain strata of society deeper into poverty and deprivation.

5.9.7 Other suggestions for targeted interventions included ones tailored for older persons and foreign nationals working locally. An academic suggested a scheme offering a delivered basket of fruit and vegetables to older persons, possibly as an extension of the meals on wheels service and possibly basing eligibility on a means-test. The Office of the Commissioner for Older Persons recommended promoting activities and sports suitable for older persons. A service provider noted that in their practice they are coming across an increasing number of cases of foreign residents developing gestational diabetes. In this respect, outreach initiatives encouraging foreign workers to participate in targeted weight management initiatives were suggested. However, another MFH representative commented that human resources and training on cultural sensitivity are lacking for such targeted interventions.

5.9.8 The Commission for the Rights of Persons with Disability advocated for the need for activities and programmes aimed at preventing and addressing obesity to be planned in such a way as to ensure that individuals with different needs are provided with the support they require. More specifically, information provided on websites must be accessible for all and information should be accessible in an easy-to-read format. Moreover, professionals and practitioners should be trained to communicate effectively with persons with intellectual impairment and physical exercise trainers should be well versed in working with persons with disability, especially individuals with physical disability, to ensure the safe and proper execution of physical exercises. Finally, services ought to be provided at venues that are in conformity with the national standards on accessibility within the built environment.

5.9.9 Examples of existing targeted interventions mentioned in the focus groups included exercise programmes catering specifically for children of certain ages, parent and child groups, older persons as well as prisoners and persons battling addictions separately, the provision of free school lunches for children coming from lower socio-economic backgrounds and a youth programme for vulnerable youth intended to teach life skills, including cooking skills and personal self-care. Also mentioned were health promotion components of social services provided, such as the distribution of nutrition booklets with food distribution schemes, BMI assessment and education on healthy lifestyles for minors living in alternative care, as well as health promotion within support and empowerment programmes for lone mothers. Additionally cited was an afterschool programme for children coming from lower socio-economic backgrounds during which nutritious snacks are provided, food preparation activities carried out, and lessons in food budgeting and opportunities for physical activities delivered – the Move 360 pilot project. This programme was praised for achieving substantial changes in body composition in terms of fat and lean mass ratio and better educational outcomes for the participating children, and its reintroduction encouraged. The Office of the Commissioner for Older Persons praised the screening initiative launched by the Ministry for Active Ageing (MFAA), targeting persons ages 65 years and over, providing them an assessment of the heartbeat, blood pressure, BMI and blood glucose level to identify risk factors associated with stroke. The MSPC commented that the measures implemented by Government served to address the specific needs of identified vulnerable groups, such as children, the elderly community and persons at risk of poverty or social exclusion.

5.9.10 Age was mentioned most frequently as a sensible grouping variable for disaggregating the population to target interventions. The Advisory Council explained that from a strategic point of view, based on the scientific evidence available, interventions targeting children are more likely to be effective and

impactful than those aimed at adults. It is very difficult to change behaviour of adults, so it is worth investing more on behaviour at the paediatric level as children are more malleable and this helps prevent excess weight in children in the first place. Healthy habits, attitudes and behaviours should be taught and formed from an early age. This focus on children is reflected in the work undertaken by the MFH, which is mainly investing in a cohort effect. The Council explained that there is a family concept to addressing obesity – children's knowledge and views have a greater impact on the family's decisions and behaviours than public health campaigns aimed at adults. This argument was supported by many other stakeholders who also noted that, in view of limited resources, targeting children is a sensible use of resources due to the ripple effect within their family and social environment. It was noted that children have encouraged their parents to stop smoking and to take precautions during the COVID-19 pandemic, and similarly they can encourage healthier eating and active lifestyles in their parents and others. The focus on childhood obesity was also considered sound because obese children are likely to retain their excess weight in adulthood, and therefore addressing or preventing childhood obesity now is an investment in reducing adult obesity in the future.

5.9.11 The feedback provided by the Office of the Commissioner for Children supports this focus on children, in light of the increasing prevalence of childhood obesity. The Office of the Commissioner for Children explained that the UN Convention on the Rights of the Child recognises the right of the child to the enjoyment of the highest attainable standard of health, undertakes to combat disease and malnutrition through the provision of adequate nutritious food and advocates for access to education and support on child health and nutrition. In this respect, the Office of the Commissioner for Children asserted that there is a responsibility for action in enabling children to improve their lifestyle to the greatest possible degree, and empowering them with the means to make sustainable, healthy and responsible choices.

5.9.12 The Advisory Council explained that despite the focus on children, the obesity strategy takes on a life-course approach to obesity. This approach, as promoted by WHO, considers the individual's experience throughout life, including pre-conception stage, as impacting the likelihood of that individual having excess weight at all ages. The mother's weight during pregnancy has been found to impact the child's likelihood of having excess weight throughout his/her life. An academic explained that the control, motivations and environment that impact one's lifestyle vary across the life stages. For example, food availability and consumption varies across life stages, particularly in terms of the extent of control of one's food intake, as well as who is preparing and providing the food and where it is eaten. Similarly, different life stages or events may prompt a revision of one's diet, physical activity levels and lifestyle, such as when one starts cohabitating with a partner or spouse, has children, or develops some health problems.

5.9.13 Despite the strategy's life-course approach, a few stakeholders criticised the fact that while ample work has been done targeting children, actions targeting adults, such as those focusing on the workplace, are lagging. A member of the Advisory Council acknowledged that while the Council considered diverse interventions that target different age groups, there is scope for greater work addressing older age groups. The Office of the Commissioner for Older Persons observed that current initiatives, especially awareness campaigns, are more focused on children and younger adults, and that older persons, particularly those over 65 years of age, have not been adequately targeted.

5.9.14 Some argued that solely targeting children, without also targeting the parents, produces limited results, since parents make most of the decisions about the children's food intake and activity levels, and children spend more time away from the school environment than within it. A few stakeholders argued that the effectiveness of measures focused on educating children are dependent on the education of parents and their willingness to make healthy choices. While children, especially as they grow older, do have some control over their food intake and physical activity levels, healthy choices will come easier for them if they find a supportive environment at home. In this respect, a public sector representative commented that habits are formed and home and can only be reinforced at school. Similarly, a representative of the MEYR argued that while schools have a duty to provide education on healthy lifestyle choices, yet schools are not the solution to every problem and the school's input cannot replace the parent's role and influence. In further feedback provided, the MFH commented that schools can and should contribute in efforts aimed at addressing overweight; however, the limitations of this area of government intervention was also acknowledged. Academics noted that research has shown that overweight parents are more likely to have overweight children, and while there could be genetic, social and environmental factors explaining this correlation, there is also an element of behavioural determinants. For this reason, it was proposed that interventions targeting children should be coupled with interventions targeting parents or the wider family unit. In further feedback provided by the MFH, the Ministry recognised the importance of introducing further programmes targeting parents, recognising that parents' time is limited and that they need guidance on food planning, budgeting, food preparation and on ensuring that informal carers also provide the same quality of food to the children being cared for.

5.9.15 The need for a whole-family approach to tackling overweight was also mentioned in the context of weight management programmes. A service provider noted that, in her experience, weight management programmes that are attended by the entire family often lead to better outcomes in terms of behavioural change and weight loss.

5.10 Physical activity

5.10.1 The WHO health expert explained that while physical activity helps to maintain a healthy weight, the body is so efficient that it is mostly one's food intake that determines one's BMI, rather than how physically active a person is. However, being fit gives protective benefits against non-communicable diseases, such that someone who is slightly overweight and is physically active may be less likely to suffer from certain chronic diseases than someone with normal weight but who is not physically active. Physical activity therefore protects against acute cardio-vascular events and chronic non-communicable diseases. Health professionals explained that they encourage patients to incorporate physical activity, even simply opting to walk to get errands done, throughout their day.

5.10.2 Various positive measures to encourage physical activity were acknowledged. The Advisory Council recognised that aerobics classes organised in collaboration with local councils offer accessible physical activity opportunities for the community, as they are free and held in proximity within the locality. Representatives of professional associations noted that many people have benefitted from infrastructural developments, such as the embellishment of promenades and the introduction of walk

and cycle lanes. Others mentioned positive measures, including tax rebates for child enrolment in sports clubs and the purchase of sports equipment, funds for fitness instructor training, efforts by local councils to provide open spaces within villages and towns, the promotion of various mapped walking trails, the inclusion of gym equipment in recreational parks, efforts by ERA to improve pathways in the countryside, and sports programmes organised by SportMalta.

5.10.3 The Health Policy and Strategy Board mentioned the 2023 Budget commitment to complete the construction of sports facilities, including a sports complex, at the Santa Luċija School, and the pledge to increase the tax rebate for child enrolment in sports, artistic or cultural activities from €100 to €300 per year. The Board also made reference to the guidance documents issued by the HPDP relating to physical activity, namely, the Be Active 18-65 years and Be Active 65 plus. The MFH also acknowledged the work undertaken by the Ministry to train health care workers to include specific preventative physical activities within any treatment plan, in line with the Swedish practice model. The Health Policy and Strategy Board explained that the Physical Activity on Prescription model is a method that involves counselling and prescription of exercise in an individualised manner based on the client's health circumstances, stressing the important role that physical activity has in the management of several non-communicable diseases. As part of this project, various types of physical activity opportunities (suiting different needs, abilities and preferences) in different localities were mapped. The Office of the Commissioner for Children referred to its active participation in the BeSmartOnline! campaign, led by the Foundation for Social Welfare Services in collaboration with the MEYR and the Malta Police Force, which aims to encourage children to limit their online sedentary activity and further engage in physical activity.

5.10.4 Many stakeholders recognised that modern lifestyles – sedentary work, heavy workloads, hectic schedules, restricted leisure time that has become less active in nature – do not encourage physical activity. An academic noted that participating in nursery sports is expensive, and that many families may not be able to afford the expenses involved. Many argued that physical activity needs to be ingrained as a way of life and a cultural norm, and its inception must start from childhood. In promoting physical activity, various stakeholders recognised that physical activity is not limited to the gym or sports or competitive activities, but it is the daily incorporation of moderate exercise that impacts the heart rate, which can include active transportation and fun non-competitive physical activities, such as gardening or walking animals. This message was recognised as important to make physical activity approachable and feasible for many. The Malta Chamber similarly commented that the promotion of walking and take-up of a sport for fun, as opposed to competitive sports, can be more effective than focused exercise programmes that many drop out of after a short span.

5.10.5 Various suggestions were put forward by stakeholders to facilitate the further uptake of physical activity, such as the further development and promotion of water sports and exercise, the allocation of gym membership vouchers by employers, the inclusion of short breaks at the workplace for exercising and additional Government vouchers for sports activities. Two members of professional associations criticised the education system for not sufficiently prioritising physical education, and eliminating physical activity classes from the curriculum at a certain point in the pandemic, when it was argued that, with careful planning, safe controlled outdoor activities could have been organised. Various

stakeholders put forward recommendations for changes to be made within the education system to provide more time and enable further uptake of physical activity among children [more details in 'Tackling overweight – a joint effort']. The Malta Chamber suggested including physical activity facilities at mass events, noting that such events are full of food stalls, most of which are selling junk food, but do not feature any physical activity areas. The Chamber argued that these facilities, such as basketball hoops, skateboard ramps, trampolines, darts, air hockey, table tennis and bocci, could be easily set up.

5.10.6 The need for and the subsequent health benefits of creating safe and pleasurable environments that enable walking and cycling as well as open spaces within built environments for active recreation were recognised by many stakeholders [more details in 'Spatial planning']. The Malta Chamber noted that the promotion of physical activity needs to be accompanied by facilities that people can actually use to walk, run or play sports for leisure. In additional feedback provided by the MFH, the Ministry argued that in line with discussions held with SportMalta, it was of the understanding that there are facilities available for sports. However, the utilisation of these facilities is not optimal due to lack of cooperation from facility administrators, such as head teachers in relation to school sports complexes. An academic argued that urban greening, that is, introducing more vegetation in the built environment, can improve air quality and also make the environment more pleasant for walking and exercising. Another academic argued that safety for pedestrians and cyclists can only be improved if driving and parking regulations are enforced and if a study is carried out to identify the systemic factors that are causing so many accidents on our road.

5.11 Spatial planning

5.11.1 Many stakeholders acknowledged that efforts aimed at addressing overweight need to seriously consider the built environment, an element which is often overlooked or not given its due importance. Various stakeholders noted that busy roads, narrow footpaths, dense construction/overcrowding, scarce long stretches of level pathways, potholes and unsafe driving, discourage people from undertaking physical activity in their localities, or to walk or cycle as a means of transport to get to work/school or to run daily errands. An NGO representative criticised recent major infrastructural projects that introduced cycle lanes, noting that the planning and design work lacked adequate input from cyclists, or failed to integrate their feedback at conceptualisation, resulting in unsafe cycle lanes that terminate abruptly and which are mostly unused. Additionally, there are limited open and green spaces for recreation and exercise in urban areas and issues relating to access with respect to rural pathways that intersect private agricultural land. An academic asserted that our urban spaces have been taken over by construction and cars, with little priority given to pedestrians and cyclists. Some stakeholders noted that within parks, such as at Ta' Qali, the use of bicycles and skates is prohibited, enabling a culture of meeting up in such spaces to sit down and have a picnic, rather than exercising. Another academic also noted that the land use planning system has not maintained services, such as sport amenities, at the community level, therefore necessitating the use of a car to access such services. In this way the infrastructure was noted to discourage rather than encourage active lifestyles, in terms of physical activity for its own sake and mobile transportation.

5.11.2 On the other hand, promenades such as the ones found in Buġibba, Sliema, Marsascala, Birżebbuġa and Żurrieq, and pedestrian pathways such as the 1km stretch between Żejtun and Żabbar introduced in recent years, were noted to be highly frequented by locals. The inclusion of such areas when planning road infrastructure within villages and towns, as well as the maintenance of walk pathways in rural areas, was encouraged. An MFH representative asserted that it is the responsibility of local councils to ensure that residents have access to safe and pleasant areas for physical activity. An MFH representative and a few academics suggested that each village and town should have a pedestrian zone to encourage further physical activity and create a pleasant environment for recreation and socialisation.

5.11.3 Various academics spoke of the centrality of including health considerations, including overweight, in spatial planning, built environment and transport policies, and of implementing such policies and ensuring that any major projects are consistent with the applicable policy framework. Academics suggested that greater support for these efforts could be achieved by emphasising the health and economic benefits of a healthier environment and by other sectors pushing for these efforts alongside spatial planners. More specifically, academics suggested that our policies need to stop prioritising car use and overdevelopment. Instead, policies must promote sustainable development, support urban regeneration (which accommodates pedestrians and active travel) and place importance on the environment's attractiveness, safety, and the availability of public spaces for recreation and physical exercise.

5.11.4 An academic mentioned the need for policies that allow for land use zoning that enable walking distance access of facilities close to residential hubs. Another academic explained that integrating transport and land use planning can further encourage active transportation. For example, if childcare centres or primary schools are easily accessible or within walking distance and the immediate environment of the centre/school during drop off and pick up times is sealed off to cars, then more children may opt to walk to school. Similarly, having pedestrian zones within village or town centres and providing various centralised parking facilities outside of this pedestrian zone (so that all areas not accessible to cars are within walking distance of a parking facility) can also encourage active transportation. Other academics objected to these proposals arguing that such closures may cause further congestion and that they would not be politically acceptable. On the other hand, an academic argued that we cannot improve our built environment by keeping the status quo with respect to vehicle use and parking management, and if change is desired then we must disincentivise such use and make alternative means of transport more appealing.

5.11.5 ERA considered that, from an environmental perspective, the obstacles that need to be addressed to tackle obesity include the creation of a safe environment that is more conducive to physical activity, while enabling active mobility. The creation of safer roads and safer playgrounds, which are ideally located away from traffic-congested areas, and the promotion of green infrastructure, including the planning for greener corridors and areas in our localities, may encourage more physical activity and the consideration of a modal shift from the private car to cycling and walking, while also having various psychological and emotional health benefits. Such an environment would have the added benefit of improving air and noise quality, supporting urban biodiversity and result in more green

open spaces. The Authority expressed its commitment to continue its efforts to integrate these environmental aspects and push for a concerted approach with the relevant competent entities to implement effective measures related to transport and spatial planning. Moreover, ERA noted that the National Strategy for the Environment 2050 and the Strategic Objectives thereunder, will provide the strategic direction for a range of initiatives that would contribute to the address of obesity. These include investing to make open spaces safer and more attractive and improving existing spaces through reorganisation to ensure their appropriate use, while creating new open spaces, giving priority to areas where such spaces are currently lacking. Other examples provided include various traffic calming and management measures, coupled with the facilitation of active and alternative mobility options, implemented through collaboration and consultation with the community.

5.11.6 IM acknowledged that some of the country's arterial road links are already saturated, and that population and economic growth projections indicate that existing public infrastructure will be in greater difficulty to meet the country's requirements within a few years. In this context, IM recognised that the development of improved facilities for alternative modes of travel can alleviate the country's dependence on private car travel. IM stated its commitment to invest in an optimised and sustainably expanded infrastructure, to develop safer spaces for all road users and to introduce measures that promote active mobility. In addition, IM noted that in designing and planning new roads, when technically feasible, new roads were to incorporate safe footpaths and cycle lanes. In the first three years of its operation, IM included 16 kilometres of cycle lanes in Malta's main arterial roads. In the major projects, like the Marsa Junction Project and Central Link Project, separate cycle lanes and footpaths were included, creating a safe network to encourage an active lifestyle. Where it is not technically possible to include separate cycle lanes, IM introduced signage warning of shared infrastructure and limiting speed limits. Apart from such cycle lanes and footpaths, IM also introduced access through subways and pedestrian bridges.

5.11.7 The PA outlined the various development policies [more details in 'The wider policy framework'] and projects in place that indirectly help to alleviate obesity. The Authority was a key player in an EU-funded project titled 'Healthy Cities Project', which was undertaken in collaboration with the Health Department and the Department of Local Government. One of the main aims of this project was to combat obesity. Additionally, as part of its contribution towards a better quality of life, the Authority undertook another EU-sponsored project titled 'An integrated Action Plan for Senglea, Malta', which aimed to promote healthy lifestyles.

5.11.8 The Advisory Council noted that, internally, the Council had considered initiating conversations with property developers to explore ways in which development can be more conducive to healthy living, through village and town planning and the provision of open spaces. However, this avenue was deemed too difficult to pursue as developers had no appetite for this kind of planning. Nevertheless, the Council suggested that Government could explore areas which it owned within villages and towns that could be utilised as open spaces for families, such as was the case with the recent opening of Park ta' San Klement in Żabbar.

5.11.9 The Advisory Council and an MFH representative also discussed the possibility of introducing a health impact assessment (which goes beyond environmental considerations) for development applications,

to ensure open spaces within developments and the consideration of health aspects. Similarly, an MFH representative commented that requirements for green spaces and open spaces for physical activities should be applicable for all developments. The Advisory Council acknowledged that mega projects already carry the requirement to include open spaces. An academic suggested that representatives of the MFH, or specifically the Advisory Council, could be listed as required statutory consultees for major infrastructural projects.

5.12 Food considerations

5.12.1 Ample discussions centred around food – local consumer tastes and dietary habits, food accessibility and affordability as well as various interventions to incentivise healthy eating and discourage unhealthy eating, food and menu labelling, portion sizes, food reformulation efforts and the use of pesticides and food quality considerations.

Consumer taste

5.12.2 An Advisory Council member acknowledged that, often times, processed food includes additives which may be more appealing to one's palate but that are harmful for one's health. A public sector representative explained that taste is acquired, with infants first acquiring a taste for sweet foods, and subsequently a taste for savoury food. Often, infants and older children are exposed to food which is sweetened or full of additives, skewing taste buds to find processed food more palatable, and other healthy foods and drinks, like water and vegetables, unappealing. NGO representatives argued that this leads to children with homogenous taste buds, who reject foods which deviate even slightly from their narrow spectrum of acceptable food and who have tried a limited variety of food items. Moreover, another NGO representative argued that the lack of understanding of food sources and the gap between food production and food consumption contributes to a lack of appreciation of fresh produce. This preference for sweetened and processed food is frequently extended into adulthood. In fact, an academic noted that many patients she comes across in her clinical practice have very poor diets, which include high carb sweetened foods, sweetened beverages and processed food like chicken nuggets, despite having chronic conditions like diabetes.

5.12.3 NGO representatives noted that, despite being an island in the Mediterranean Sea, our diet is more heavily influenced by British cuisine, such that the most locally consumed fish, cheese and legumes are salmon, cheddar and baked beans and butter is favoured over olive oil. For this reason, the MFH representatives explained that part of health education needs to include exposure to healthy food and natural produce, to allow a person to acquire a taste for such food and to appreciate its flavours and textures [more details in 'Health education, health literacy and health promotion']. Additionally, an NGO representative noted that due to language preference, the local population often seek recipe ideas from British or American websites, which do not necessarily promote a healthy Mediterranean diet, and that alternative sources need to be created and promoted.

5.12.4 An MFH representative and a representative of a professional association noted that there is a need to repeat the Food Consumption Survey occasionally, to better understand consumption patterns and

changing trends over time in consumer taste, portion sizes and popular food items. It was noted that the report of the only Food Consumption Survey conducted in Malta has not yet been published.

Food accessibility and affordability

5.12.5 Various stakeholders acknowledged that in view of time limitations and lack of cooking skills, ready-made meals and convenient snacks and food delivery are becoming more commonplace, as opposed to home cooked meals [more details in 'Lifestyle and culture']. An MFH representative commented that the liberal licensing of fast-food outlets has led to the prolific accessibility of unhealthy food within our villages and towns. This accessibility and the price advantage of unhealthy food as compared to healthier options translates into a disproportionate consumption of processed, fattening food.

5.12.6 The WHO health expert acknowledged that, across the globe, national policies and the environment generally favour energy-dense food. The affordability, availability and marketing of energy-dense foods is a force that acts against any efforts aimed at reducing pre-obesity and obesity. Companies that sell energy-dense food are producing greater volumes of this food at more advantageous prices, and heavily marketing them. The business model consists of using the cheapest ingredients to attain the greatest markup and utilising ingredients which are addictive, thereby sustaining high levels of consumption. The national food policy currently being drafted, following the issuance of the EU farm-to-fork strategy, with its objective of having healthier food systems, is expected to impact food accessibility and affordability [more details in 'The wider policy framework']. Importers also play a significant role in determining the availability of food products, since the majority of food items consumed locally are imported. Noted in this respect was that importers' decisions can be influenced through taxation and food reformulation legislation [more details in 'Fiscal measures' & 'Food reformulation'].

5.12.7 Stakeholders also observed that food consumption choices are highly influenced by one's means, since healthier food is more expensive than low-nutrient, processed and convenient food options [more details in 'Targeted interventions']. More specifically, stakeholders noted that presently local fresh produce and healthier meals are often offered at a price point that is not sufficiently competitive to entice consumers to choose these products over foreign produce or more processed alternatives, or may not even be financially accessible to some consumers. Current inflation exacerbates this situation. An academic explained that a Caritas research project has indicated that low-income families must spend around 50 per cent of their disposable income to obtain a basic but decent and healthy basket of food.

5.12.8 The MSPC noted that the Fund for European Aid to the Most Deprived (FEAD) and the State Funded Food Distribution, which distribute food boxes to families who are most in need or vulnerable, contribute to the address of obesity by providing healthy nutritious food to low-income households. A service provider noted that schools face the reality of children being sent to school without a lunch, and the provision of free school lunches for children coming from lower socio-economic backgrounds was introduced to address this situation. In further feedback provided, the MFH noted that the omission of a packed lunch is not limited to any specific socio-economic strata. An MFH representative and a service provider asserted that the introduction of universal school lunches is a costly yet worthwhile

endeavour in the fight against overweight, as it would ensure children consume at least one healthy meal a day and also ensure that they are exposed to different nutritious food and acquire a taste for healthy produce. Some academics commented about the progress registered in France with respect to childhood obesity, noting that in France children are provided with school meals. An academic acknowledged that universal provision would avoid situations of people falling through the net, and would help keep the administrative burden low. Another academic suggested that to keep the cost of such an initiative manageable, but at the same time avoid stigmatising those who are subsidised, lunches can be offered to all students and a smart card system could be introduced to charge for food, with subsidies being credited to the accounts of those who fulfil a means test. The Malta Chamber suggested providing free fruit and salad bars within schools, where children can select the items they want to consume and be served into their reusable containers.

5.12.9 The health expert explained that a highly effective environmental approach to promoting a healthy body weight is the introduction of guidelines or legislation regulating the procurement and preparation of food in specific settings, such as schools, hospitals, and mass catering establishments in workplaces and residential homes. Through legislation or guidelines, if well enforced, boundaries are established on the food choices of a whole vulnerable population group. This measure helps by either directly providing healthier food, or by limiting the choices that are available to those populations, as would be the case with respect to tuck shops/canteens. In this respect, the legislative changes relating to food procured within the school environment have helped restrict children's access to unhealthy food within this setting. The Malta Chamber suggested that the regulation of food provision within school canteens should be extended to other settings attended by children, including sports nurseries and kiosks within children's playgrounds.

5.12.10 Similarly, the MFH representatives noted that the guidelines the Ministry has issued relating to tender specifications for patient and staff meals within hospitals and elderly homes and for shops and other canteens within hospitals regulate the food options available within these settings. A representative of a professional association suggested that such guidelines or regulations should be extended to other settings, including workplaces. On the other hand, a few public sector representatives argued that the approach taken within schools, of restricting access to unhealthy foods, is not the correct approach, and instead more emphasis should be placed on educating and empowering children to make moderate decisions about their diet, since children have access to unhealthy food once outside the school gates. However, this view was not shared by all public sector representatives. In further feedback provided, the MFH asserted that both approaches – that of restricting access to unhealthy foods, and that of educating and empowering healthy choices – are required.

5.12.11 Stakeholders recommended improving the affordability and accessibility of local fresh produce and healthier meals, through different fiscal measures aimed directly at the consumer, the farmer, the producer/manufacturer and the restauranteur [more details in 'Fiscal measures']. The Commission for the Rights of Persons with Disability advocated for greater consideration of the provision of affordable healthy options for people who are at risk of poverty, including persons with disability. The possibility of buying directly from the food producer, including pick your own activities, was also discussed by NGO representatives as a way to bridge the gap between food production and food consumption.

Facilitating farmers markets by establishing them within more localities or providing free transportation from villages and towns to a centralised location was also suggested by academics, noting that farmers markets offer more advantageous prices as the cut of various middlemen is eliminated. A member of the Advisory Council noted that local councils face difficulties in accommodating additional vendors within the open market setup due to lack of space, and that instead efforts should be focused on marketing local produce. As food producers in their majority may not have the time, skill or interest to undertake projects that deviate from their main activity, other stakeholders may be involved in planning and executing these visits and purchasing opportunities. In supplementary submissions, the MFH suggested possibly facilitating buying from food producers through a website, which initiative could possibly be government-led.

5.12.12 Also proposed by various stakeholders was the promotion of short chain food systems and educating consumers to opt for local, seasonal and fresh produce, as well as underutilised cheaper produce [more details in 'Health education, health literacy and health promotion']. The availability of healthy food stalls at national events was proposed by a public sector representative. Other suggestions to improve accessibility to healthy options included the introduction of potable water through water fountains, the addition of healthy snacks in vending machines, the choice of healthy food options within work canteens and at work meetings (particularly those within the public sector), and the choice of healthy food options within sixth forms and university canteens.

5.12.13 The Advisory Council noted that Government's strategy must steer people away from constantly eating out or ordering food delivery, but must help them develop the skills and tools to be able to prepare healthy meals for themselves and their families. Any measures intended to make healthy ready-made meals affordable and more widely available should be introduced with programmes intended to encourage and teach people how to cook.

5.12.14 Another aspect of food accessibility relates to ease of breastfeeding. The Health Policy and Strategy Board noted that the HPDP will continue working towards the implementation of the Baby Friendly Hospital Initiative to help mothers to breastfeed babies and provide lactation support training for health professionals.

Food and menu labelling

5.12.15 Various participants discussed the benefit of front-of-pack labelling, noting that it guides healthier food choices by shoppers by providing them with accessible and easy to use information, while also encouraging food manufacturers to make their products healthier through food reformulation [more details in 'Food reformulation']. The front-of-pack labels would supplement the nutritional information and reference intake information, usually found at the back or side of the packaging of pre-packed food. The front-of-pack labels can either be interpretive, such as in the case of the nutri-score introduced in France, or binary, such as the green keyhole of Scandinavia or the tick mark of Australia and New Zealand. The binary labelling includes the presence or absence of a symbol or text-based warning (indicating that the product contains excessive amounts of critical nutrients), whereas the interpretive labelling provides the consumer with graded information about the nutritional quality of the product,

through a star rating or a traffic light system. The Advisory Council asserted that this initiative should be considered for the local context and appropriate legislative measures introduced to regulate any such scheme. The Malta Chamber emphasised the need to supplement any front-of-package labelling initiatives with an education campaign on the adverse effects of unhealthy food.

5.12.16 Reference was made by some participants to the significant resistance from industry to the introduction of front-of-pack labelling and accompanying political pressure against such schemes. For this reason, front-of-pack labelling schemes are generally optional for companies, and therefore companies decide whether to join the scheme on a voluntary basis. Conflicting views regarding whether such a scheme would operate effectively if implemented on a voluntary basis were provided by the MFH. The Malta Chamber of SMEs commented that while businesses aren't opposed to such labelling, one had to recognise that such legislative requirements create logistical problems with substantial costs for businesses and implications on their competitiveness. Importers would be required to produce and affix labels to products, raising issues on which party is responsible for the information produced.

5.12.17 However, local efforts in relation to front-of-pack labelling may be shaped by EU-level efforts aimed at introducing a harmonised mandatory labelling system, possibly through the unilateral adoption of the French nutri-score system. The Health Policy and Strategy Board also mentioned efforts within the EU Commission on the harmonisation of 'Front of Pack Nutrition Labelling', and noted that since most of the products sold and consumed in the local market are imported, these efforts will be of major benefit. An academic advised that, should the EU legislation allow for country-specific labelling, rather than a standardised system, research should be undertaken to evaluate which kind of label the Maltese are more responsive to.

5.12.18 A representative of a professional association commented that the public health laboratory needs to be strengthened to ensure adequate monitoring of any labelling (front-of-pack and other nutritional labels). On this note, the WHO health expert explained that the introduction of a front-of-pack labelling system requires a lab set-up dedicated for monitoring and control. Interested companies would have to apply and submit the food samples, which would then be tested independently. The lab would monitor food over time by periodically collecting and testing samples.

5.12.19 A public sector representative and an academic suggested including basic nutritional information for food prepared by restaurants and catering establishments, similar to what is available in some states in the USA. This information could be provided on the menu, or on a board within say a fast-food outlet. There was some disagreement in the focus group discussions as to whether such a scheme should be introduced locally on a voluntary or mandatory basis. One public sector representative argued that in view of current adversities in the market, imposing an obligatory scheme would not be prudent and could possibly result in false claims and recipe manipulations that may evade monitoring efforts. Considering the prolific use of food delivery applications, a service provider commented that this information would need to be included on the application to have the desired coverage and effect. Similarly, an academic suggested having nutritional information available for perishable food items such as local bread, possibly to be made available on request by those who require this information, such as persons with diabetes taking insulin.

5.12.20 Also discussed by an academic was the need for clear labelling of the provenance of fresh food items, such as fish, meat and fruit and vegetables. Consumers cannot support local producers and eat closer to the source unless this information is accurately provided.

5.12.21 The Commission for the Rights of Persons with Disability noted that packaging information is usually not accessible to visually impaired persons, due to small print, and to persons with intellectual disabilities, who may not be well-versed in technical terms.

Portion sizes

5.12.22 The WHO health expert explained that controlling portion size, such as through using smaller bottles in the manufacturing of sweetened beverages, is promoted by WHO as an effective strategy for the address of overweight. The Health Policy and Strategy Board explained that the Health Authorities have consistently recommended moderation in food sizes and have issued guidelines on this issue, titled 'Your Guide to Healthy Portion Sizes'. On providing further feedback, the MFH noted that weight management programmes promote moderation in portion sizes and include tips on eating out. The Board noted that Health Authorities were pleased to note that a new tender issued by the Active Ageing and Community Care unit for the provision of meals in residential care homes has implemented changes to encourage and improve healthy eating in older persons living in residential care homes.

5.12.23 An academic argued that decreasing portion sizes with respect to plated food within restaurants should be feasible to implement as it is not politically controversial, and has been successfully done in Italy, where an educational initiative in Italy targeted restaurateurs to control portion size. However, the Advisory Council explained that it may not be in the interest of the manufacturers to opt for smaller portion sizes, and in effect larger portions may be more desirable as they justify price increases. This happened in the past with respect to a local sweetened beverage manufacturer, with direct discussions to encourage the use of smaller sized bottles proving futile. Similarly, with respect to restaurant food, the local customer prefers large portions and therefore restaurant owners may be unwilling to decrease portion sizes for fear of losing their market share. NGO representatives argued that local consumers tend to prefer larger portion sizes to quality and nutritious food, and that changing this preference may be key in addressing overweight. However, an academic argued that should business catch on to this agenda of providing healthier food in smaller portions, and should such changes benefit them in terms of increased sales or fiscal incentives, uptake could be successful.

Food reformulation

5.12.24 Food reformulation refers to initiatives undertaken to reduce salt and calories from sugar and saturated fat in processed foods, thereby directly contributing to improvements in the population's diet. Since the majority of products consumed by the local population are imported, Malta has limited control and influence over the formulation of consumed products. However, efforts at food reformulation were being undertaken at the EU level, and Malta will inevitably benefit from any such efforts. The Health Policy and Strategy Board noted that Malta is currently participating in the Best-ReMap Food for a Healthy Future project, which targets food monitoring and reformulation. Moreover, the Board

referred to a seminar held on this subject between the authorities, NGOs and relevant actors in the private sector.

5.12.25 With regard to locally manufactured products, the Advisory Council indicated that while Government discussions with certain industry leaders were futile, others had reaped benefits, as was the case with the salt reduction in local bread and sugar reduction in yoghurts. The Health Policy and Strategy Board asserted that full collaboration from the private sector is required to achieve the desired goals. The Board noted that this was achieved with a prominent local cooperative when it decided to reformulate its products to reduce sugar content in yoghurts to be in line with the food for procurement for schools standard. While recognising that local efforts at reformulation are difficult due to business interests and strong lobby groups, the Advisory Council affirmed its intention to continue supporting discussions with industry aimed at product reformulation. Nevertheless, a representative of a professional association noted that locally there is no strategy that regulates food reformulation despite this representing an important public health policy for the reduction of overweight.

5.12.26 The Advisory Council also noted that the formulation of established brands vary by country of production. For example, the sugar content of a specific cereal manufactured and consumed in one European country might differ from the same cereal manufactured and consumed in another European country. Which formulation is imported into the local market is determined by the import agents, who base their decision on logistical and financial considerations, rather than health and nutritional considerations.

5.12.27 The WHO health expert explained that government may also use nudges to directly influence industry towards food reformulation. For example, a tax can be introduced for certain foods, with thresholds of application, stimulating industry to reformulate its product to fall under the specified threshold to avoid taxation. This happened in Hungary when a fat tax was introduced a few years back.

Pesticides/Food quality

5.12.28 An academic and an NGO representative discussed endocrine disruptors – plastics, fuel and pesticides and other chemicals present in our environment and food which interact negatively with our endocrine and immune system, and which are also contributing to the overweight epidemic. The academic noted that this is an area of increasing interest within the EU, and encouraged applying for EU funds to support any initiatives aimed to address endocrine disruptors. With specific regard to pesticides, an academic made reference to media reports claiming high pesticide use in local agricultural products, and commented that if a Mediterranean diet is to be promoted, then efforts must be undertaken to ensure minimal pesticide use in local products. Similarly, this academic questioned whether fish being sold is mainly wild or farmed. Regarding these media reports, an NGO representative noted that reports of Malta ranking highest for pesticide use was a one-off event that had resulted from issues with the sampling methodology undertaken, which was inconsistent with the harmonised methodology at European level. In this respect, information campaigns may be required to address any association in public perception between local products and high pesticide use. Another academic argued that local importers and supermarkets have vested interests in promoting misconceptions about local pesticide

use, since foreign produce yields greater profit. Two academics and an NGO representative argued that we should not solely be concerned with pesticide use by local farmers, but also with the pesticide levels of produce imported from abroad. In this respect, an NGO representative explained that the EU has very strict protocols regarding which types of pesticides are allowed, the levels considered acceptable and the timing of their use in terms of the preharvest interval. Locally there is generally a good level of compliance with these regulations. On the other hand, produce imported from say South America or Africa are not regulated in the same way. Similarly, an academic noted that whereas every litre of milk utilised locally is tested for antibiotics and discarded in the event that any traces are found, abroad such milk may be used for cheese production.

5.13 Weight management

5.13.1 Weight management considerations included reflections on the adequacy and effectiveness of available services, the extent of collaboration between different service providers, possible strategies for overcoming the lack of awareness of services and service evaluation needs. Additionally, a case was made for the inclusion of glucagon-like peptide 1 (GLP-1) analogues as part of the Government formulary list of medication provided free of charge to the user.

Available services

5.13.2 Addressing overweight must also include initiatives that treat excess weight, that is, measures that seek to attain weight loss in those who are pre-obese and obese. Weight management programmes are available for members of the public who need to lose excess weight. Bespoke programmes for persons who have been diagnosed with various non-communicable diseases who also need to lose weight are also available.

5.13.3 The Primary HealthCare offers one-to-one interventions with dieticians, which may be preferrable in the case of a patient with chronic conditions, and group interventions with a nutritionist. The HPDP offers weight management programmes that include a nutritional element and physical activity sessions. To ensure accessibility, community weight management programmes are provided from health centres and local councils, as well as from specific workplaces. Dar Kenn għal Saħħtek provides a residential inpatient programme (followed by outpatients follow-up consultations) as well as an outpatient programme for more complex cases of morbid obesity or eating disorders that need more intensive interventions. The programme offered by Dar Kenn għal Saħħtek includes nutrition and motivation counselling, psychological support, occupational therapy, and physical activity. The Health Policy and Strategy Board noted that Dar Kenn għal Saħħtek has been offering services for the past nine years, with a €300,000 budget allocated for obesity programmes every year.

5.13.4 Within secondary care, the MDH offers the service of a dietician, bariatric surgery and, more recently, an obesity clinic, which clinic seeks to offer a medical (non-surgical) approach to the treatment of complex obesity. The obesity clinic will screen patients for other conditions and factors instigating, exacerbating or arising as a consequence of the excess weight, advise on required lifestyle changes and referral to nutritionists and dieticians, prescribe medication and if necessary refer for bariatric

surgery. Willingness to engage with lifestyle changes will be a prerequisite for attendance. The focus of the clinic is to treat obesity as a disease, and not solely focus on the complications arising from obesity, as other clinics, such as cardiac, respiratory and musculoskeletal, would. At present there is only one bariatric surgeon and one obesity physician offering these specialised services within the MDH. This limited pool was partly explained by the lack of specialised clinicians in this area.

5.13.5 While some service providers spoke of the joint service provision and the functional communication and referral system between hospital services and community services and between Dar Kenn għal Saħħtek and community services, others, especially those working within the hospital setting, expressed concern about the dwindling communication and cooperation within the sector over recent years. An NGO representative commented about the lack of coordination between different service providers, specifically the Primary HealthCare and the HPDP, with both offering similar programmes targeting the same audience. Service providers acknowledged this overlap and the need for greater communication between these entities. A service provider explained that, originally, the HPDP was the only entity that provided community weight management programmes, and as the Primary HealthCare started providing this service there were some issues in identifying distinct roles and areas of cooperation. One service provider recommended that, in terms of work dissemination, ideally applications for normal weight management programmes (not those provided for persons with specific conditions such as diabetes) should all be centrally received by the HPDP, in view of its central role in health promotion, which would then assign clients to different services according to their specific needs and availability. In further feedback provided, an MFH representative suggested that the HPDP could possibly set standards and coordinate services, while other service providers could be responsible for service provision. On the other hand, another MFH representative stated that coordination was being tackled through targeted services. On providing further feedback, the MFH explained that this issue is being addressed to ensure that both entities target specific groups in a multidisciplinary team.

5.13.6 Various participants acknowledged the role of the private sector in offering weight management programmes and the services of nutritionists, dieticians and lifestyle coaches. Some noted that certain private sector practitioners are promoting unhealthy and unsustainable weight loss practices and commercial products that instigate short-term quick fixes and often lead to repeated weight loss and weight gain. The high volume of Maltese nationals resorting to bariatric surgery overseas was also mentioned by an academic and a service provider.

5.13.7 Several participants acknowledged the role of various health professionals, including general practitioners and pharmacists, in transmitting information, raising awareness and providing tailored advice regarding healthy lifestyles. Their role extends to referring patients to specialists, such as dieticians and nutritionists, or to specific services, such as weight management programmes, when necessary. However, an NGO representative and professional association representatives recognised that this role is somewhat restricted by time constraints, competing priorities, limited knowledge and support, resistance from the patients, capacity shortages and long waiting lists for specialised services. A representative of a professional association suggested consolidating and supporting this role through structured initiatives, training and financial and other means. Another representative of a professional association advised that a collective effort from all healthcare professionals to motivate patients on their weight loss journey and follow-up on their progress is required.

Awareness of services

5.13.8 During the focus group discussions held with representatives of professional associations and service providers, it became apparent that there were some misconceptions and a lack of knowledge regarding the availability of certain services as well as the eligibility criteria for access thereto. This was explained in terms of the lack of communication between different health service providers and the silo mentality within the medical sector. Service providers similarly noted that there is lack of awareness of the services available in the sector among various professionals and the public. It was suggested that professional associations be used as a channel to divulge information regarding new services to various professionals. A representative of a professional association noted that such notifications are already being sent to public officials through email, and this proposal would simply involve extending the dissemination to the private sector. The continuation of face-to-face information sessions for professionals (at the time halted due to the COVID-19 pandemic) as well as published reports outlining the extent of services offered, was also considered beneficial. Despite these identified lacunas in the awareness of services, there were also positive narratives of service knowledge, communication and referrals, such as in the case of educational practitioners referring children with eating disorders to Dar Kenn għal Saħħtek. Similarly, a service provider explained that representatives of Dar Kenn għal Saħħtek do outreach work within schools to raise awareness about nutrition, eating disorders, healthy weight and the services they offer.

5.13.9 The Advisory Council suggested that it would be opportune to assess the reasons why there is lack of knowledge of services among professionals and the public. Dar Kenn għal Saħħtek commissioned a study specifically to obtain a snapshot of the level of awareness of various professionals, including health professionals, teachers, and counsellors, of the services they offer. This study was intended to inform future action on awareness raising. An MFH representative commented that such a study, but with a wider scope, is required to assess awareness of different professionals of all available services related to weight management.

5.13.10 An Advisory Council member and an MFH representative suggested introducing public campaigns to raise awareness about the health and social services being offered free at point of use. One such campaign that has been successful is the outreach undertaken by Dar Kenn għal Saħħtek within secondary and post-secondary schools and promotion on the media. On providing further feedback, the MFH highlighted an extensive campaign organised in 2023, “this is us”, which included various media and the door-to-door distribution of a leaflet to promote the free services being provided by the HPDP. An MFH representative indicated that newsletters had been sent out in the past by the Primary HealthCare to entities and healthcare workers who interact with patients on a day-to-day basis, to inform them of all the services available. In the near future another similar leaflet will be distributed door-to-door to the general public. The Primary HealthCare also organises seminars at different workplaces to inform them of the services available.

5.13.11 A few participants suggested the creation of a common directory or database listing all services available to the public categorised by theme, which is to include a search function to facilitate its use. The Chair Advisory Council explained that such a project had already been envisaged and been

conceptually planned, and it was to be a live system that incorporates services and certain products (such as bed rental for the elderly) being offered by the public and private sector. In the area of weight management, such a database would help to distinguish between certified professional nutritionists and dieticians, and amateurs. An MFH representative explained that discussions are underway with servizz.gov to feature health services in their one-stop-shop concept and the 153 centralised phoneline.

Service evaluation

5.13.12 According to the information provided by the focus group participants, the weight loss programmes offered by the public sector are evaluated, with feedback provided utilised to revise and improve the service. However, follow-up studies to determine whether weight loss was maintained at specific time intervals after the programmes are not undertaken. An academic explained that the success of short-term interventions, such as a 12-week weight loss programme, is often not maintained in the long run, and that visibility on the long-term outcome is required in this respect. A service provider suggested that reports should be drawn up providing statistics on the uptake and the immediate and long-term outcomes of the various weight management services, of those programmes provided by the public as well as those provided by the private sector. The service provider also noted that the introduction of the electronic patients records and the future integration of lab results within the system will allow this administrative data to be analysed to determine the effect of the weight loss on various blood test results, at the individual and population level. These reports could justify the further expansion of weight loss programmes and the recruitment of additional human resources such as dieticians, nutritionists, physiotherapists and fitness instructors.

5.13.13 Despite current programme evaluation exercises, an NGO representative commented that there is a need for in-depth consultation with patient representatives to better improve services. Similarly, a service provider referred to the need for national research initiatives to identify successful interventions and barriers to uptake or the achievement of set individual targets. A service provider suggested that the measure of programme success could also be adapted individually to the person-centred goals set by each participant at the start of the programme. With regard to other initiatives, the MFH noted that all major undertakings in this respect are preceded and followed by an assessment (of for example knowledge), to measure its impact and make necessary improvements.

Medication

5.13.14 Besides lifestyle changes and bariatric surgery, medication was considered as another effective strategy to aid weight loss in obese patients. A service provider explained that for some obese patients, especially those whose BMI exceeds 40, lifestyle interventions, though always important and to be maintained, are not sufficient to ensure the desired weight loss outcome. The weight loss brought on by medication or surgery can help these patients adhere to the lifestyle interventions, without which the medication and surgery cannot be successful. Two representatives of professional associations and a service provider strongly encouraged Government to consider including such medication as part of the Government formulary list of medication provided free of charge to the user. At present, such medication is available to purchase from community pharmacies at the patient's own expense,

which can present a substantial impediment to uptake for some who simply do not afford it. For this reason, a representative of a professional association explained that for years there has been lobbying for general practitioners and community pharmacists to be part of the Government Formulary List Advisory Committee.

5.13.15 The service provider explained that nowadays there is an injectable medication on the market that is primarily indicated for use in diabetics to control blood sugar levels, while at the same time resulting in weight loss and is cardioprotective, that is, GLP-1 analogues. The GLP-1 analogues have only recently been developed and work by modifying the neural gut circuit mechanisms thereby suppressing hunger. This medication, which is disease modifying, is used worldwide as the primary treatment for obese patients with diabetes, and is licensed within the United Kingdom for use by patients who are not diabetic, but solely need to achieve weight loss, since this medication does not cause drastic reductions in blood glucose levels but controls these levels. The service provider noted that medication is not a substitute for lifestyle changes, but needs to be supplemented by important diet and physical activity changes. Moreover, eating disorders must also be treated and managed appropriately, independent of the administration of this medication.

5.13.16 With the start of the obesity clinic within the MDH, which seeks to offer a medical service to patients with complex obesity [more details in 'Weight management'], the availability of this medication on the national health service was considered imperative. It was suggested that initial eligibility could be limited to persons with obesity and diabetes, or potentially patients with these conditions as well as heart disease, and later further expanded to include more patients. Eligibility would also be subject to the patient being willing to engage with lifestyle modifications. Eligibility criteria for free medication would be clearly stipulated and prescription rights would be limited to diabetologists and physicians working within the obesity clinic. From the private market this medication was estimated to cost around €160 monthly, which was prohibitive for many patients. A service provider argued that the correlation between obesity and poverty further justifies the need for this medication to be made available on the national health service. The service provider noted that Government incurs exponentially increasing substantial costs treating the target damage and health consequences of obesity, as well as supporting disability, inactivity and social isolation, among others. However, the root cause, that is, obesity, is not being effectively addressed. This strategy is neither cost-effective, nor sustainable, nor does it optimise patient wellbeing.

5.14 Health education, health literacy and health promotion

5.14.1 While acknowledging that health education and health promotion cannot instigate and sustain behavioural changes unless accompanied by wider policy changes that create an enabling environment, stakeholders also recognised that having the right knowledge is the first step in conducting a healthy lifestyle. Knowledge of the negative impact of energy-dense and low-nutritional value food, sedentary lifestyles and obesity on health and quality of life, as well as knowledge about healthy choices and alternatives, was considered necessary – though alone insufficient – to enable the public to make the right choices for their own wellbeing. An NGO representative asserted that research has confirmed that education without a supportive environment is a failing strategy, but on the other hand education

strengthens the positive impact of an enabling environment. Many stakeholders were in agreement that a greater emphasis on health promotion is required to educate the public and provide them with the necessary tools to sustain healthy choices and behaviours. The MFH representatives argued that a focus on prevention and health promotion, rather than reactive secondary healthcare would yield better outcomes.

5.14.2 Health education was considered particularly important in the context of a free market that does not in any way penalise harmful products. Education in the early years, which is reinforced within the family environment, was considered essential in preventing and addressing excess weight in the younger generations. An NGO representative emphasised the importance of making education applicable to all and accessible by all. The various health promotion campaigns organised by the MFH, and specifically the HPDP, were also noted as impactful interventions aimed at informing the public and instigating positive behaviours. The media presence of public health officials was noted to be important but currently limited, hampered by the high costs involved and limited budgets [more details in 'Marketing and advertising']. The role of several health professionals, including general practitioners and pharmacists, in transmitting information, raising awareness and providing tailored advice, was acknowledged by multiple stakeholders. A few stakeholders also recognised the potential for a greater input from these health professionals [more in Weight Management].

5.14.3 With respect to health promotion campaigns, a representative of a professional association explained that there is a need for more consistent and regular health promotion initiatives, rather than one-off campaigns. Various stakeholders spoke of the need for additional funds to sustain different health promotion initiatives, such as Fonzu l-Fenek, a Maltese character who promotes healthy living. Academics spoke of the need for consistent and correct messaging across the board. A representative of the National Youth Agency of Malta spoke of the importance of market segmentation and targeted communication efforts that appeal to the sub-population being targeted. The representative noted that young people are more likely to be motivated by things that affect their present, such as their appearance, than future consequences, such as possible morbidities, and that health campaigns should reflect such considerations [more details in 'Targeted interventions']. An academic suggested organising in-store promotions for healthy food products, including manned information booths where trained personal can prepare and hand out tasty healthy food samples together with informative brochures to shoppers.

5.14.4 Another recommendation regarding health promotion campaigns, put forward by the Advisory Council and an NGO representative, was for coordinated messages and one iconic champion or character, such as the Xummiemu character utilised for environmental matters, rather than fragmented campaigns. In additional submissions, the MFH commented that professional marketing is required for this endeavour. A public sector representative suggested the possibility of Government sponsoring influencers to promote healthy lifestyle choices, in view of their popularity among youngsters and their influence, and to compensate for those influencers who are being sponsored by capitalist ventures including fast food companies. NGO representatives suggested that health promotion campaigns should focus on promoting healthy lifestyles and not focus on the prevention and address of overweight, to minimise stigmatisation and resistance from those most affected by excess weight and to widen the audience.

5.14.5 Several stakeholders spoke of the need to improve health literacy, specifically nutrition education and food literacy, including cooking skills and the interpretation of food labels, which were noted to be diminishing over time and lacking in many, so that people have the knowledge and skills to make healthier affordable choices. In further feedback provided, the MFH explained that healthy literacy is linked to literacy and entails people's knowledge, motivation and competencies to access, understand, appraise and apply information to make judgements and take decisions in their everyday life concerning healthcare, disease prevention and health promotion, to maintain and improve quality of life during the life course. Moreover, health literacy motivates and sustains lifestyle changes. Stakeholders envisaged health and food literacy education to be delivered within the education system and also through nationwide community programmes, possibly also involving the participation of academics and non-health professionals, including teachers, senior scout members, church leaders and community educators [more details in 'Capacities'] to divulge simplified basic nutrition guidelines. The Commission for the Rights of Persons with a Disability recommended the introduction of health literacy programmes targeting persons with disability, to equip these individuals with knowledge about how their impairment can affect their health, including their risk of developing comorbidities, and provide them with information and support to address any health issues, including dietetic advice and personal training.

5.14.6 MFH and NGO representatives and an academic suggested creating awareness regarding the seasonality of produce, promoting the idea of buying short chain, in season produce in bulk and minimally processing it to store it, as well as opting for underutilised and cheaper produce (such as specific smaller fish, cuts of meat and pulses). Also suggested was the dissemination of healthy recipes to use such produce and teach cooking skills. An NGO representative similarly advised that the gap between food production and food consumption needs to be narrowed, and for consumers to obtain better knowledge of their food sources and production processes, to be better able to appreciate wholesome food and fresh produce. One suggested way to bridge this gap was to organise visits by the public to food producers, including farmers, fisherman and animal farmers, to provide the public with a greater understanding of food production and create a connection with their food source [more details in 'Food accessibility and affordability'].

5.14.7 Multiple positive initiatives being undertaken which promote food literacy were noted by various stakeholders. A service provider mentioned the nutrition helpline run by the HPDP. The Health Policy and Strategy Board noted that the HPDP does provide advice on how to read food labels as part of every campaign it carries out, to increase the public's awareness and knowledge. Moreover, it was also noted that this Directorate has issued several guidance documents related to nutrition – Dietary Guidelines for Maltese Infants and Young Children Aged 6 months to 3 years, A Guide for Parents; Dietary Guidelines for Maltese Children 3 to 12 years: the Mediterranean Way; and Healthy eating the Mediterranean Way: Dietary Guidelines for Maltese Adults. An MFH representative noted that the Ministry is already undertaking awareness campaigns, promoting the habit of taking time to plan and prepare food shopping and meal preparation. An academic referred to various courses being organised through local councils by Caritas, the MSPC and the Home Economists in Action (an association of home economics teachers) to promote healthy sustainable lifestyles which covered food sourcing, budgeting and cooking. An NGO representative praised the Għaqal id-Dar programme, organised

by the University of Malta, for delivering an awareness programme that provides participants with skills to eat healthily within a modest budget, while an academic commended the work done by the Mediterranean Food Platform within the University of Malta to promote healthy Mediterranean eating. A representative of a professional association made reference to a health promotion initiative organised by the Chamber of Pharmacists within private schools, with the support of the Foundation for the Wellbeing of Society.

5.14.8 A few stakeholders referred to the current role of home economics classes in teaching children to budget, shop, plan and prepare healthy meals, though the limited time and wider subject curriculum was also noted. The extension of the entitlement to home economics, or alternatively the introduction of food education and food literacy, into the last three years of secondary school as well as in primary school and post-secondary institutions was recommended by some academics. Also mentioned was the one-off initiative by home economics students who had set up a stall at the farmers market, prepared a demonstration of how to blanche fruit and vegetables for freezing, and presented different meals that could be prepared with the products on offer at the market. An academic suggested that this initiative should be a recurrent event organised by permanently employed extension educators. The nutritional guidelines issued by the MFH for children and elderly, which are based on the Mediterranean diet, outline adequate portion sizes and provide practical tips on healthy and sustainable eating, and were noted as important tools for educating the public on healthy eating.

5.14.9 The Health Policy and Strategy Board referred to a successful health promotion campaign – an ESF project titled 'The Social Determinants of Health Awareness Campaign' by the Social Determinants Unit within the Superintendence of Public Health. This included posts on social media platforms, TV infomercials and radio adverts, published articles on culinary magazines and the development and dissemination of 50 recipes adhering to a budget of €10 or less were developed. The aim was to promote healthier lifestyles for individuals and families, to create a more enabling environment for healthier food choices and eating habits. Stakeholder meetings as well as capacity building sessions were held across various sectors within the public service and with NGOs for general awareness on nutrition and physical activity and on the social determinants of health.

5.15 Fiscal measures

5.15.1 The possibility and potential positive impact of introducing various economic instruments to address the issue of overweight was acknowledged by several stakeholders. An academic explained that multiple economic instruments can act as behavioural nudges, making the healthy choice an accessible, attractive, social and timely option and the unhealthy choice more difficult, unattractive and costly. Another academic suggested that in considering fiscal measures, including whether to tax unhealthy foods or subsidise healthy food, attention must be given to empirical evidence as to each measure's impact on food consumption and physical activity levels. In this respect, a member of the Advisory Council commented that one-off subsidies will most likely not result in a culture change in buying and consumption patterns. Commenting in this respect, an academic argued that allocating funding to the problem through fiscal incentives will not yield the desired effect unless such intervention is accompanied by strong health education campaigning. In the absence of education there may be

backlash, as was the case with the schemes for the installation of renewable energy technology, which resulted in higher consumption patterns within the households who benefitted from the scheme.

5.15.2 Some stakeholders suggested introducing further fiscal measures to incentivise physical activity and active transportation. A representative of a professional association and an academic suggested making subsidies payable on target achievement, such as loss of excess weight. The Advisory Council explained that it had put forward various recommendations for budgetary measures to encourage uptake of physical activity, for example financial subsidies for gym equipment or bicycles. The Council noted that various schemes had already been issued, while others may be included in subsequent budgets, which were not initiated by the Council. Subsidies for gym memberships had been considered but were deemed more difficult to implement. However, Government had reduced the VAT rate on gym memberships, with the intention of encouraging further uptake.

5.15.3 Other stakeholders acknowledged the high prices of fruit and vegetables compared to the low prices of low-nutrient and processed food, encouraging an imbalance in consumption, especially among low-income households. Various stakeholders acknowledged that busy lifestyles result in less time available to prepare meals and source healthy quality ingredients, with many resorting to ready-made meals or eating out or ordering take-outs, with such options generally containing higher contents of fat, sugar and salt than home-made meals. An MFH representative noted that the local Food Consumption Survey indicated low levels of fruit, and most especially, vegetable consumption. In this scenario, the availability of price-accessible healthy meals as well as affordable fresh produce, and incentives to enable this, were considered desirable by various stakeholders.

5.15.4 An academic acknowledged that due to the size of the market, efforts to reduce production costs are limited, as these require economies of scales. Instead, various measures, such as free promotion exchanges, reduction in taxes, subsidies and voucher systems were proposed. These measures would seek to encourage consumers to opt for healthier foods and incentivise and support business to make healthier foods more accessible and affordable. Some measures could be directed specifically to the end consumers, such as voucher schemes and subsidised or free lunches within schools, while others could be aimed towards business, such as financial support for farmers or grants for restaurants offering healthier options. A representative from the MAFA argued that policies and legislation should encourage healthy choices rather than ban less healthy or unhealthy options. An Advisory Council member recognised that banning unhealthy food items could be problematic in terms of barrier to trade considerations.

5.15.5 With respect to subsidies and voucher systems, different views were expressed regarding eligibility, with some suggesting that such interventions should be universal, others recommending that it be based on income, while others suggesting that the subsidy or voucher value could be dependent on family size or household income [more details in 'Targeted interventions']. An MFH representative explained that a voucher scheme was considered when the obesity strategy was first drafted, but was shot down immediately due to the complexity involved in administering such a scheme and its possible abuse. The MFH representative explained that one cannot compare a health scheme to the pandemic situation, where there was ample economic pressure to intervene to prompt economic regeneration. However,

the MFH representative did not completely dismiss the possibility of implementing such a measure, though it was emphasised that the scheme would have to be managed to avoid disadvantaging the small trader and to ensure that market forces work in favour and not against that intended. An academic suggested that the meals on wheels programme for older persons can be augmented to also offer subsidised fruit and vegetables.

5.15.6 Regarding the proposal relating to the subsidy of healthy food, a member of the Advisory Council noted that it would be difficult for Government to determine which healthy products or businesses to include in the scheme, and there may be contention from food producers and restaurateurs. Additionally, such subsidies would distort the market and raise competition issues as well as state aid issues, given the sector's heavy regulation by EU directives. Additionally, there were uncertainties regarding the plausibility and sustainability of such measures, and their logistics, including the frequency of such subsidies, that is, whether they were to be one-off instances or repeat occurrences, and to what extent one-time measures would alter buying and consumption patterns. Additionally, with regard to business incentives, the challenge was to ensure that the support provided trickles down to the end consumer rather than resulting in super profits for the business. In this respect, a representative from the MAFA argued that such an initiative could possibly increase competition and therefore lower prices for consumers. Another Council member argued that measures intended to make healthy meals accessible and affordable were to be considered with caution, as Government did not want to further promote a culture where persons did not prepare their own meals.

5.15.7 The MFH representatives noted that they had received feedback from catering establishment owners and chefs indicating that while they would like to provide healthier meals, they also want to keep producing food that people want and to continue registering adequate profit margins. Some businesses need financial support to make certain changes, as otherwise they risk becoming unsustainable. The Malta Chamber of SMEs noted that healthy and fresh produce is more expensive and more logistically difficult to source than less healthy alternatives, and therefore financial incentives may be necessary to instigate businesses to move towards the provision of more healthy options that are financially accessible for consumers. The Chamber was of the opinion that increased financial and physical accessibility may in turn translate into higher uptake of healthy products by consumers.

5.15.8 Similarly, the MFH representatives suggested that financial incentives provided to catering establishments that produce healthy options should be considered, possibly by Malta Enterprise, to encourage businesses to provide healthier options at a price point that is accessible by many. The private sector would most likely only act once there is a financial incentive for them to do so or once legislation forces them to, as in the case of product reformulation. This was the case with the issuance of the EU directive relating to trans fats, with businesses now having to abide by the established thresholds. A representative from the MAFA suggested the provision of funds for businesses who voluntarily opt to offer healthy products for say those who are restricting their calorie intake or those who are diabetic, with the food offered being certified through a front-of-pack labelling scheme.

5.15.9 Representatives of the MFH and of the Sustainable Development Directorate spoke of the need to financially support farmers and producers of healthy produce, such as local milk and ricotta, through

tax rebates or grants, to also ensure sustainability in terms of pricing and availability of fresh local produce. The Malta Chamber of SMEs spoke of the importance of producing certain basic food items such as wheat, in view of lessons learnt from the pandemic in terms of logistic channel disruptions and food shortages in times of crises. This would necessitate subsidies to make such endeavours commercially viable. An academic suggested that incentives could be provided for producers and farmers who opt for healthier production methods. Another academic argued that support for farmers would also contribute to the better use of land and the preservation of our environment. Subsidies or vouchers to be used on specific produce from any vendors or specifically within farmers markets could also support farmers by making these products affordable for many. Regarding the possibility of subsidising farmers' products, a member of the Advisory Council noted that farmers are already receiving substantial financial assistance through national and EU funds, and that consumer prices are inaccessible for some mainly due to middlemen costs of pitkali, hawkers and supermarkets. It was recognised that in this particular case the free market was not acting in the interest of consumers. The member questioned whether Government should consider controlling the prices of certain basic produce items, as is the case with the price of milk and Maltese bread. An NGO representative advocated the provision of fiscal incentives for manufacturers of food products, to encourage them to undertake simple processing of Maltese produce, such as blanching and freezing excess produce in peak season.

5.15.10 Some stakeholders proposed the introduction of taxation on specific food items, mostly focusing on sugar, but also more generally of food high in sugar, fat and salt content, or highly processed food. An MFH representative noted that the local Food Consumption Survey indicated excessive sugar consumption levels, which needed to be addressed. Disincentive measures, specifically taxation, were considered by the Malta Chamber of SMEs to be administratively burdensome to implement, requiring monitoring and enforcement efforts and to often be ineffective. An academic asserted that taxation would have to be implemented on locally produced food items and on imported ones, to avoid state aid issues. Similarly, the Malta Chamber was of the opinion that taxing sugar directly would not be a viable standalone option, in view of the fact that sugar is an ingredient, in varying degrees, in many food items. In additional feedback provided by the MFH, the Ministry noted that research has shown that taxation on sugar-sweetened beverages has been shown to decrease sales and consumption proportionately, with a 10 per cent taxation resulting in a 10 per cent decrease in sales and consumption. Furthermore, the MFH noted that research has also shown that tiered taxation on sugar-sweetened beverages based on sugar content decreases overall purchasing volume, indicating that manufacturers are successfully reformulating their products. The Malta Chamber also cautioned against taxing local products with a high sugar content since parallel importation tends to slip in undeclared and would render the prices of local manufacturers of the same products uncompetitive.

5.15.11 The MSPC argued that proposing a different direction in fiscal policy, mainly through tax incentives, may push lower socio-economic groups to healthier consumption. However, a tax introduction on certain commodities, such as sugary drinks and fatty foods, might affect low-income families disproportionately in comparison to other socio-economic groups. To mitigate this effect, a representative of a professional association and an academic suggested that taxation was to be coupled with incentives such as subsidies for fruit and vegetables, in line with a carrot and stick approach. In further feedback, the

MFH recommended mitigating this effect by encouraging consumers to opt for alternative cheap healthy food, including millet and seasonal fruit and vegetables, as well as providing consumers with knowledge on how to explore cheaper shopping options and how to evaluate the benefits of certain products. With respect to the introduction of such taxation, the Advisory Council acknowledged that this option had been discussed and explored within the Council. In principle, this measure was considered to be a positive one, yet its implementation was fraught with difficulties.

5.15.12 The Advisory Council observed that taxation measures require strong political will, since opposition from industry was a given. Pressure from industry and the veiled threat of the possible impact of such taxation on employment levels within large manufacturing companies explained why such taxation, irrespective of its potential benefit on health, was unlikely to be implemented. In the case of sugar, it was noted that on joining the EU, Malta had secured a derogation on sugar allowing for its purchase at a low price, and that this fact highlighted the powerful lobby groups that would oppose this measure. Additionally, it was argued that such taxation would create distortions in the local market, as the cost of raw material for a local bakery that uses sugar in its bread production would be higher than overseas production, and consequently the imported bread products would be cheaper to buy by the consumer. An MFH representative suggested that tax could be introduced on products that exceed a certain threshold of sugar content, rather than on the raw material itself, to mitigate such issues. An academic argued that there was lack of political will to introduce taxation in view of objections not solely from the business sector but also from the public, and that political and economic incentives were easier to introduce. Similarly, another MFH representative noted that taxation on sugar has not been very popular in many countries, and Malta does not tend to be at the forefront in implementing highly-opposed measures.

5.15.13 The WHO health expert explained that price can be used to try and influence consumer choice and food product reformulation; however, acknowledged that it is a blunt instrument, and it is very limited in its application. For example, a tax can be introduced for certain foods, with thresholds of application, stimulating industry to reformulate its product to fall under the specified threshold to avoid taxation, and encouraging consumers to switch to healthier less expensive alternatives. Nevertheless, taxation comes with its own problems. The industry will resist its introduction with all its force and bring to the table a lot of objections. Industry will claim that it is regressive, that it will affect poorer people more and that it will lead to substitution, that is people switching certain types of foods with other foods which may be equally unhealthy or with more unhealthy alternatives. This makes the implementation of tax on sugar and fat very difficult. In supplementary feedback given by the MFH, the Ministry argued that leaving low-income families with easy access to cheap unhealthy diets is doing them a disservice, predisposing them to more health issues that in turn lead to a higher utilisation of sick leave and absenteeism and a vicious cycle of bad health.

5.15.14 The tax on fat in Denmark had to be repealed because it was very difficult to determine on which part of the food chain to tax the fat. In the case of beef, tax could be applied on the cow (before the animal is slaughtered), at slaughter, at the wholesale process, at the meat packaging stage or at the retail stage. The main dilemmas are who should pay the tax and how one can ensure that the tax then carries over into the price for the consumer to ensure that there is an influence on the

consumer choice. There are issues of regressivity, substitution, overheads of administration and pass-through effects to the consumer. All these issues are one reason why WHO mostly focuses on the cost effectiveness of taxing sugar-sweetened beverages, rather than a whole set of food products. In the case of sugar-sweetened beverages, the tax is much more easily controlled, and it is a much cleaner intervention. The WHO health expert recommended that at the very least though, a country should be taxing sugar-sweetened beverages (not just soft drinks). The Advisory Council noted that Malta introduced excise duty on sugar-sweetened non-alcoholic beverages of four cents per litre, and that this was considered the fairest sugar taxation avenue, as local producers and importers of foreign-manufactured products would be taxed equally. The Malta Chamber of SMEs commented on this tax, stating that the tax imposed was marginal, and therefore unlikely to affect consumption patterns.

5.15.15 An NGO representative and an academic suggested that any money collected from such taxation should be ring-fenced for health promotion and disease prevention activities or to subsidise healthy food. This suggestion was also put forward by the Malta Chamber of SMEs. In further feedback, the MFH argued that taxation is better received by the public if funds collected are earmarked for health-related initiatives.

5.16 Measuring Progress

5.16.1 Feedback regarding the measurement of progress included discussions regarding the limitations of existing data sources, the possibility of using administrative data from electronic medical health records, and the progress, or lack thereof, achieved so far, including the impact of the COVID-19 pandemic on efforts aimed at reducing overweight.

Prevalence data

5.16.2 Stakeholders recognised the importance of data for measuring progress on the specified targets. The WHO health expert noted that three of the goals are based on self-reported data (HBSC and EHIS), which are known to provide an underestimation of the true prevalence rates, while the other goal is based on anthropometric measurements (COSI), which represent the gold standard for measuring BMI and for comparing rates across countries. Despite the bias found in self-reported data, stakeholders noted that this is still useful to analyse trends over time. Besides HBSC, EHIS and COSI, the MFH representatives referred to another survey being undertaken among children of all ages in collaboration with the MEYR, partly funded by the EU. A representative of a professional association also referred to the Health Examination Survey that was carried out once, which like COSI in the case of children, is an anthropometric study. The representative proposed that this study should be repeated periodically. An MFH representative recommended including socio-demographic variables in surveys and studies intended to estimate prevalence rates, to allow for further analysis into the various associations and determinants of overweight.

5.16.3 The Health Policy and Strategy Board referred to all of the above-mentioned studies of body composition and food and physical activity data, as well as the Social Determinants of Health Survey study. The

Board noted that the MFH has acknowledged that the surveillance and monitoring of socioeconomic status will help to inform and monitor policy action to address the social determinants of health. To achieve this aim, the Social Determinants of Health Unit was set up to support, guide and strengthen the intersectoral capacity across government and society to develop, implement, monitor, and evaluate initiatives to promote health equity through addressing the social determinants of health.

5.16.4 A representative of a professional association suggested using administrative data from electronic medical health records, once the public and private sector practitioners can access and update the records, to obtain prevalence rates for overweight as well as non-communicable diseases and health complications. However, another representative of a professional association and the WHO health expert warned that the use of height and weight measurements collected by health professionals and inputted in the patient record database cannot replace survey measurements because of issues relating to the accuracy and representativeness of the data. The protocols for height and weight measurements for clinical practice and anthropometric studies differ. In clinical practice, the patient is not asked to remove their clothes for example, and measurements are not subject to protocols or stringent rigour. In anthropometric studies, the same weighing scales, calibrated in the same manner, are used for all participants, and training on the use of these weighing scales and the measurement of height is provided. The standardisation in anthropometric studies allows for comparability across countries. Additionally, clinics are generally attended by persons who are ill or who are susceptible to illness, and therefore the patients accessed by general practitioners are not representative of the general population. On providing further feedback, the MFH argued that despite limitations relating to the accuracy and representativeness of the data, such an endeavour would still be useful. An MFH representative suggested introducing screening measures within public health centres – having weight and height measurements taken for every person that accesses these centres. While this approach could allow for standardised measurements, it does not address the issue that the population of health care centres attendants is not a representative sample of the general population. In additional feedback provided, the MFH explained that weighting this data to census statistics for age, sex and district of residence could improve the data.

5.16.5 The representative of the Sustainable Development Directorate argued that one of the limitations of the existing data is its periodicity. More frequent data collection and assessment of progress was considered necessary in view of the mapping of national targets to budgetary measures. To this end, discussions were undertaken between the Directorate for Sustainable Development and the Superintendent of Public Health to conduct the HBSC more regularly. Discussions to this effect were put on hold due to COVID-19. On the other hand, the MFH representatives noted that obesity prevalence rates change very slowly and that in the case of the NAO review focusing on the assessment of the progress relating to the 2020 targets, the fact that the latest reference years for the ECOSI and HBSC data are 2019 and 2018 would not be an issue. An opposing stance to that expressed by the representative of the Sustainable Development Directorate was put forward by an NGO representative and a representative of a professional association, who argued that in the context of limited resources money spent on collecting data would be better spent on initiatives aimed at addressing the problem. The NGO representative added that currently available data clearly show the extent of the problem and offers sufficient information on where action is required.

Progress achieved

5.16.6 Quoting worsening or consistently high prevalence rates, various stakeholders were of the impression that progress with regard to the tackling of overweight had not been achieved and that in effect Malta has been moving farther away from its set targets. An academic noted that though various efforts have been made, little progress or effect has been registered, and that could be explained by either ineffective interventions or possibly because of barriers which neutralise or impede the progress of effective interventions. On the other hand, NGO representatives questioned whether discussions, institutional governance structures and strategies are resulting in concrete implemented actions, and whether such actions are providing the required results.

5.16.7 The WHO health expert explained that the world is facing problems with overweight, and that the lack of progress registered in Malta with respect to reductions in pre-obesity and obesity prevalence rates is not unique to our island. Very few countries have registered success with reduction in rates for sub-populations and less so for the whole population. France, New Zealand and Canada were mentioned as countries that have been successful in tackling obesity. Additionally, the WHO health expert noted that international targets aim for a slowing down of the upward trend or plateauing of rates, and in this respect Malta's ambitious targets can be at best described as aspirational. On the other hand, an academic noted that in considering progress made, statistics should be disaggregated at cohort-level and separately analysed for young children, adolescents and adults, reflecting the fact that different cohorts are varying in terms of responsiveness to interventions.

5.16.8 On the other hand, the MFH representatives noted that while prevalence rates in adults have increased over time, stabilised rates were noted for children. As of 2012, there was a sharp rise over time in childhood obesity, so aiming for reductions in childhood obesity rates was not practical. Instead, the target was a practical one – a resting rise. The HBSC data shows a drop in the obesity prevalence rates for girls, but constant rates for boys. ECOSI statistics show consistent figures for 2014 and 2017. It was argued that the target for children has therefore been reached, in that the prevalence rate did not increase, as was previously the case in 2012.

5.16.9 Various stakeholders, including members of the Advisory Council, an NGO representative, the MFH representatives and other public sector representatives, academics and representatives of professional associations, acknowledged that the COVID-19 pandemic drastically curtailed health promotion work, including that focused on overweight. In effect the Advisory Council did not meet for a period of time, as the Chair, who also holds the role of Superintendent of Public Health, had other pressing priorities at the time. A member of a professional association commented that implementation and monitoring efforts to be undertaken by the Advisory Council are weak and have been further weakened by the pandemic. The Health Policy and Strategy Board commented that the efforts aimed at addressing excess weight will regain momentum following the pandemic.

5.16.10 Specific examples provided of the disruptive effect of the pandemic included the halting of the obesity programme and the SportMalta sports promotion work within schools, public sector sports events as well as a diabetes weight management programme for newly diagnosed diabetics jointly managed by

the HPDP and the Endocrine Centre within MDH, and the cessation or curtailing of physical activity lessons and the daily mile initiative within schools. Efforts at limiting fast food vendors in the vicinity of schools were also disrupted by the pandemic. Community weight management programmes were either only provided online, and plans to conduct the HBSC more regularly, in view of the more regular assessment of progress required for the mapping exercise being done with respect to budgetary measures and SDG national targets, were postponed. Regarding the HBSC, on providing further feedback, the MFH noted that this study is carried out in coordination with an international consortium, and hence its frequency is determined according to international standards. Moreover, the MFH stated that there was continuity in data collection during the pandemic. Also acknowledged was that the COVID-19 pandemic impacted overweight prevalence rates through the price inflation of basic nutritious food such as fruit, vegetables, grains and nuts, increased food consumption, including the greater use of food delivery services, and a more sedentary lifestyle.

5.16.11 Some positive influences of the pandemic were the staggering of break time for different cohorts and the consolidation of the two breaks into one longer break to maintain bubbles within schools, which was found to encourage more physical activity due to the longer time and less crowded space. For this reason the Education Department was considering extending this day break structure into a post-pandemic scenario. Similarly, online weight management classes by the HPDP proved to be successful and will continue being offered in the future.

5.16.12 An Advisory Council member explained that in view of the fact that tackling overweight requires a change in culture, lifestyle and behaviour, changes in the pre-obesity and obesity prevalence rates are unlikely to be observed in a short-time span. The impact of collective efforts on these prevalence rates as well as other health metrics, such as the prevalence of non-communicable diseases, is most likely to be observed in a decade or two, same as observed in the case of efforts against tobacco use. This long-term timespan must be considered when monitoring and auditing efforts aimed at addressing overweight.

5.17 Other feedback

5.17.1 The Health Policy and Strategy Board mentioned several programmes across various Ministries that help in promoting a health-in-all-policies approach across sectors. These include:

a. Għaqal id-Dar, Ħajja Aħjar – a 10-session community course, free of charge, aimed to help adults make better use of their resources to improve their and their family's quality of life;

b. Nibqgħu Attivi – an educational programme aimed at senior citizens to avoid falls. The Active Ageing and Community Care unit offers educational programmes for members of active ageing centres, among which are programmes on nutrition.

c. The Active Ageing and Community Care unit is also encouraging more physical activities for senior citizens, including physical exercise sessions led by qualified tutors, such as Tai Chi, pilates, yoga, aerobics, line dancing, a programme including a variety of sports adapted for senior citizens, and

swimming sessions held in collaboration with SportMalta. Some centres also organise walking and trekking activities for members on a regular basis;

d. Dawra Durella (2014-2020) – this project was aimed for children that are between 7 to 11 years, which apart from cooking, focuses on life skills, and other sessions where the children can learn to be independent;

e. Kuluri and Kuluri Sajf (2016-2018, 2020) – this programme was aimed for children between 5 and 10 years and focused on bringing together the children of the community, improve their skills and creativity, address values and promote self-growth. This programme also focused on enhancing the parent-child relationship. Apart from cooking, the sessions included crafts and games; and

f. The Looked After Children Health care Service – established in 2021 within the Directorate for Alternative Care, giving the opportunity to assess children living in alternative care. As part of ongoing holistic assessments, these minors have their weight, height and BMI calculated.

5.17.2 Other initiatives mentioned by the Health Policy and Strategy Board relate to those implemented within the school environment. These include the free breakfast during the breakfast club service in primary state schools, free lunches for means-tested schoolchildren, initiatives that encourage the uptake of fruit and vegetables, nutrition education as part of the Personal, Social and Career Development and the Home Economics curriculum, the revision of the Healthy Eating Lifestyle Plan document and the introduction of the new policy 'A Whole School Approach to Healthy Eating and Physical Activity.' Finally, the Board provided an overview of other strategies [more details in 'The wider policy framework'] and investments relating to the uptake of physical activity.

5.17.3 The MSPC noted that, in conjunction with other key stakeholders, it had implemented numerous measures, initiatives and projects with a view to tackle obesity, and that these had been successful in terms of uptake and participant satisfaction. These included the Għaqal id-Dar, Ħajja Aħjar course, the Nibqgħu Attivi programme, the activities organised by the Active Ageing and Community Care unit, the Looked After Children Health Care Service and Kuluri and Kuluri Sajf, also mentioned by the Health Policy and Strategy Board. Additionally, the MSPC also mentioned the following:

a. Tikka u Tajba Video Series – In line with their commitment to community development for sustainable, healthy living, in 2020, Home Economists in Action collaborated with the Local Councils Association to develop the Tikka u Tajba Video Series, with a number of these videos focused on different aspects of food and healthy eating, always in adherence with national dietary guidelines. The videos had thousands of views and are still available for the public;

b. The LEAP project – It was through this project that the national food distribution in relation to the FEAD programme and the State Funded Food Distributions was implemented. Several documents have also been disseminated as part of this measure;

c. Proġett Familja – This project aimed to empower lone mothers to achieve the skills required to improve their life situations. It was opened to residents from the Cottonera area and aimed to provide formation in home management (which includes healthy eating), self-care and employability; and

d. Healthy Eating Seminars – A set of informative sessions organised by the LEAP Project on healthy eating, including healthy eating for children.

Chapter 6| Analysis and conclusions

6.1 Has progress been achieved?

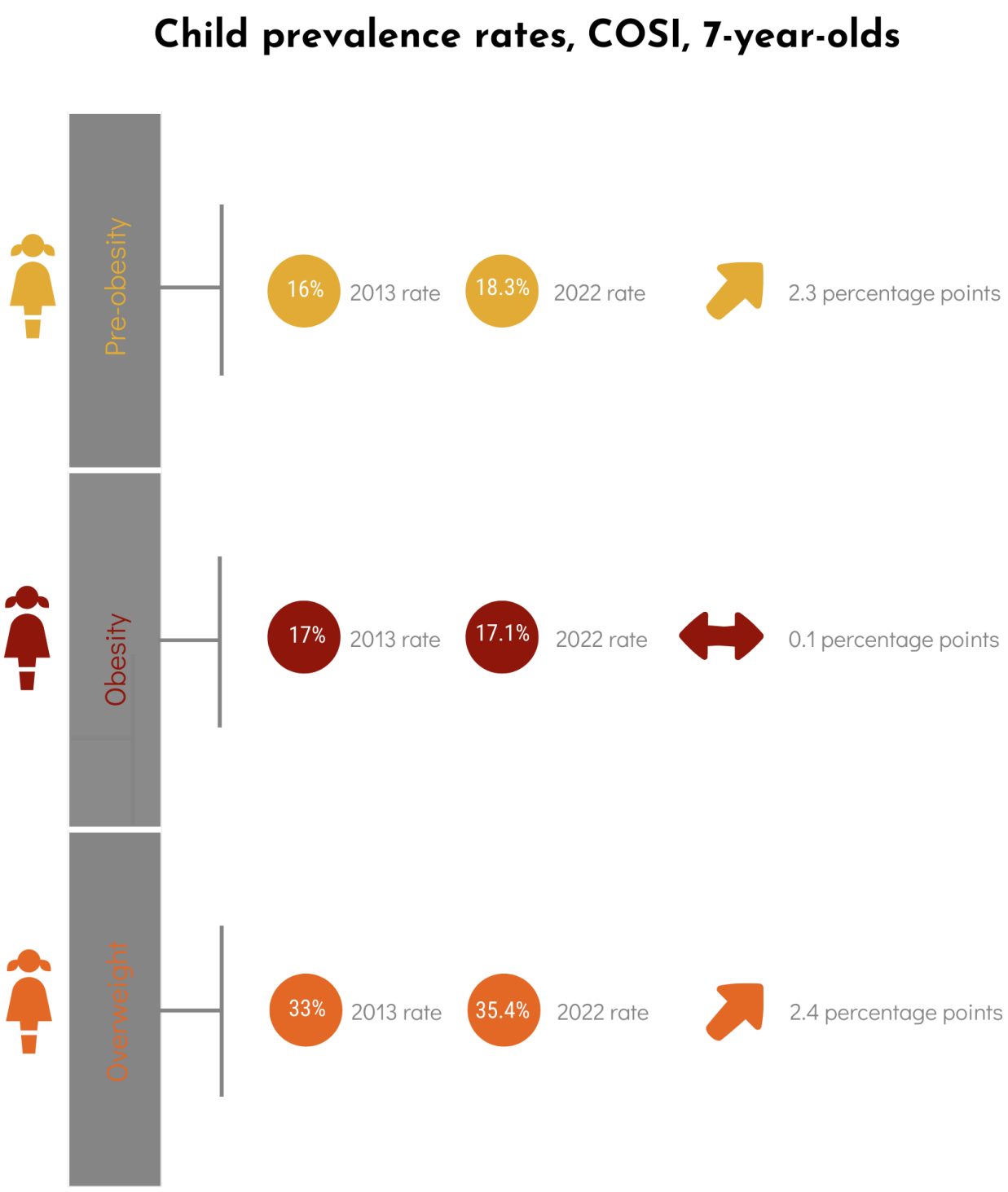
6.1.1 The first question the NAO sought to answer through this review is whether progress has been registered with respect to the reduction in the prevalence of pre-obesity, obesity and overweight. Prevalence rates for children (7-year-olds, based on COSI data), adolescents (11-, 13- and 15-year-olds, using HBSC information) and adults (15+-year-olds, through reference to EHIS records) in Malta were compared over time to generate insight as to the trend in prevalence in recent years. Specifically, this Office sought to ascertain whether an increase or decrease in pre-obesity, obesity and overweight was registered. Results indicated no progress, and in most cases provided evidence of regression in rates over time in recent years.

6.1.2 Aside from analysing trends in prevalence rates across time, the NAO considered whether the targets set in 2012 in the Healthy Weight for Life Strategy were reached by the implementation period deadline, that is, 2020. The NAO's overall assessment is negative, with only one of the four targets set, that relating to adolescents, having been met. In the case of the adult pre-obesity target, the envisioned reduction in prevalence was not secured and instead the rate of pre-obese adults remained constant. As regards the adult obesity target and the child overweight target, not only were the envisioned reductions not realised, but prevalence increased substantially when compared to the rates at the start of the implementation period.

6.1.3 In considering the lack of progress registered, the NAO takes cognisance that failure to reduce pre-obesity and obesity prevalence rates is not unique to Malta, a perspective also put forward by the WHO expert. Moreover, this Office acknowledges the complex nature of overweight, the pervasive and strong presence of an obesogenic environment that is not entirely within the control of the Government, as well as the element of personal responsibility and choice.

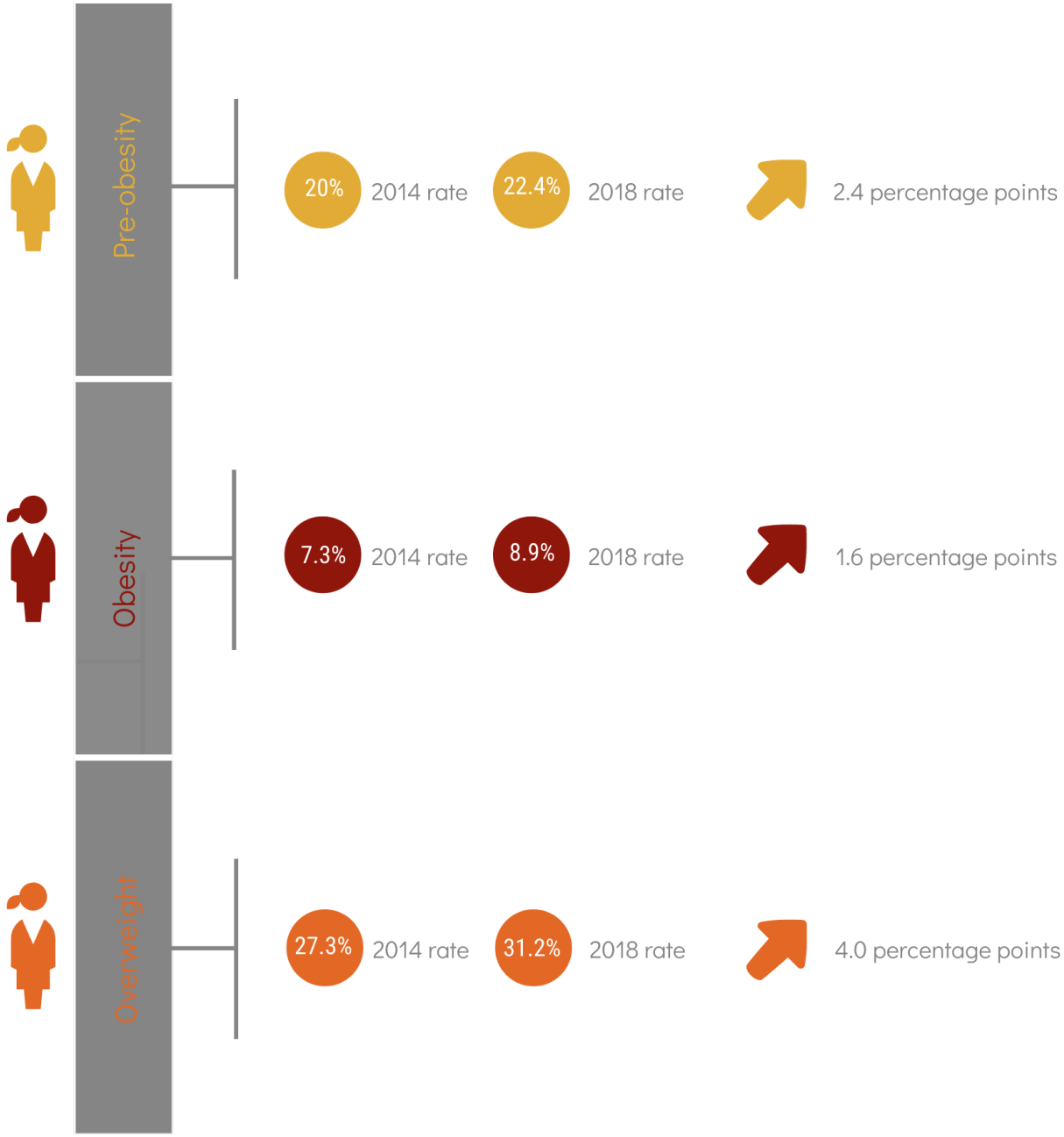
Trend analysis

6.1.4 In the case of child prevalence rates, COSI statistics for the period 2013 to 2019 indicate stable rates for the obesity indicator and an increasing trend in pre-obesity and overweight. Obesity rates for seven-year-olds showed a monotonic improvement from round three to round five (2013 to 2019), reducing from 17.0 per cent to 16.5 per cent to 14.9 per cent. However, the improvement registered in this period is lost in the last round, with the round six (2022) rate being approximately equal to the round three (2013) rate, 17.1 per cent as compared to 17.0 per cent, respectively. Pre-obesity rates show fluctuations in the period under review (2013 to 2022), but overall an increase of 2.3 percentage points (equivalent to a 14.4 per cent increase) is noted when comparing the 2022 rate to the 2013 rate (round six versus round three), 18.3 per cent as compared to 16.0 per cent, respectively. The same fluctuations and overall increase in prevalence rates are noted for the overweight indicator, with the rate having increased by 2.4 percentage points (equivalent to a 7.3 per cent increase) from 2013 to 2022 (round three to round six), from 33.0 per cent to 35.4 per cent.

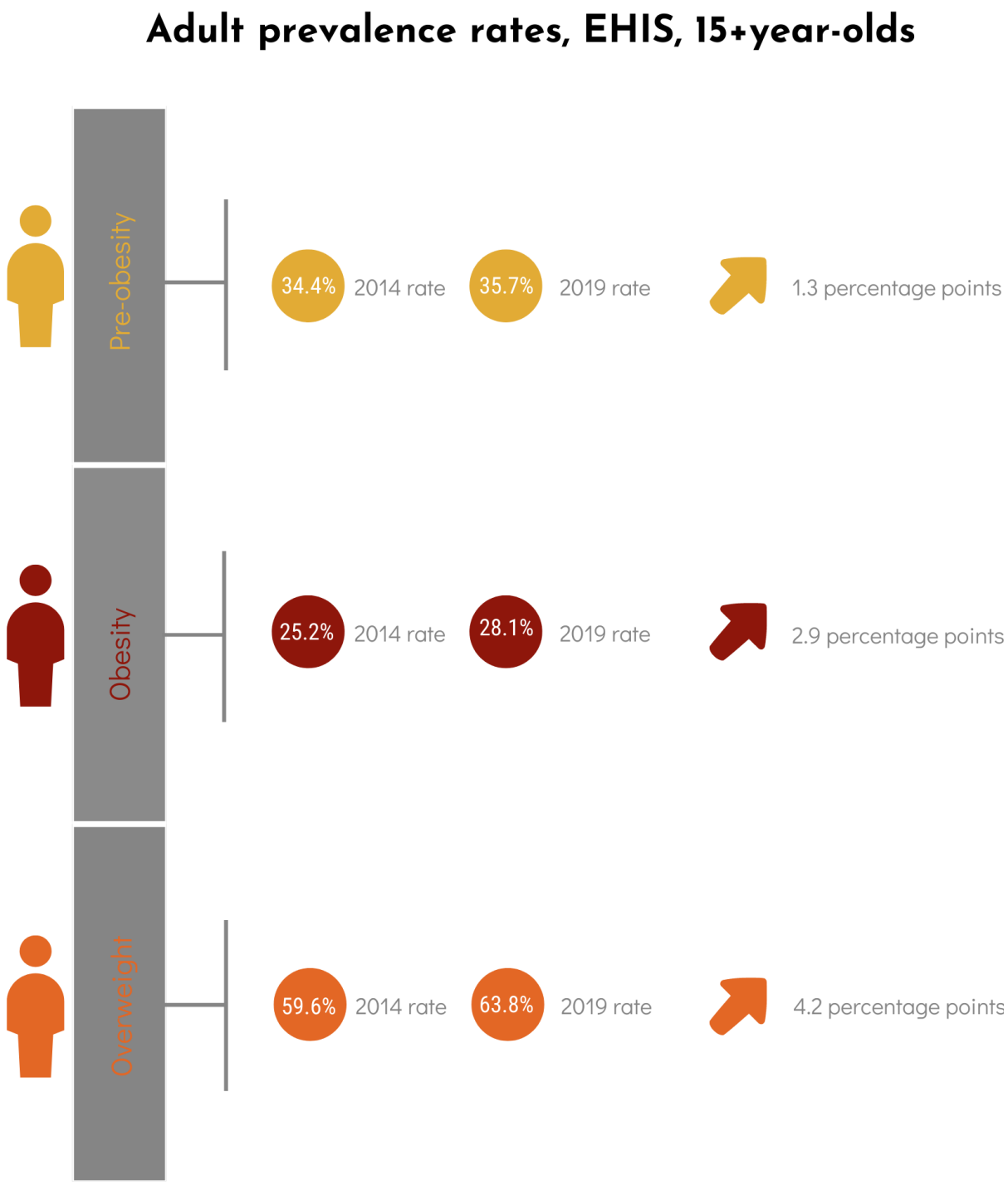


6.1.5 As regards adolescent rates, HBSC statistics for the period 2014 to 2018 indicated an increasing trend for all three indicators for Malta. In 2018, Malta's pre-obese, obese and overweight prevalence rates were 22.4, 8.9 and 31.2 per cent, respectively, representing an increase when compared to the 2014 rates, which stood at 20.0, 7.3 and 27.3 per cent, respectively. Malta therefore registered a 2.4, 1.6 and 4.0 percentage point increase in adolescent pre-obesity, obesity and overweight rates, equivalent to a 12.0, 21.3 and 14.5 per cent increase for the period 2014 to 2018.

Adolescent prevalence rates, HBSC, 11-13-15-year-olds



6.1.6 Similar results were obtained with respect to adult rates, as EHIS statistics for the period 2014 to 2019 indicated an increasing trend for all three indicators for Malta. The 2019 pre-obese, obese and overweight prevalence rates were 35.7, 28.1 and 63.8 per cent, respectively, up from those of 2014, which stood at 34.4, 25.2 and 59.6 per cent, respectively. More specifically, the change in percentage points for Malta for the period 2014 to 2019 was equal to 1.3, 2.9 and 4.2 for adult pre-obesity, obesity and overweight, equivalent to a percentage increase of 3.8, 11.5 and 7.0 per cent, respectively.



Target achievement assessment

6.1.7 Available statistics from the various data sources, COSI, HBSC and EHIS, were instrumental in determining whether the following targets were met:

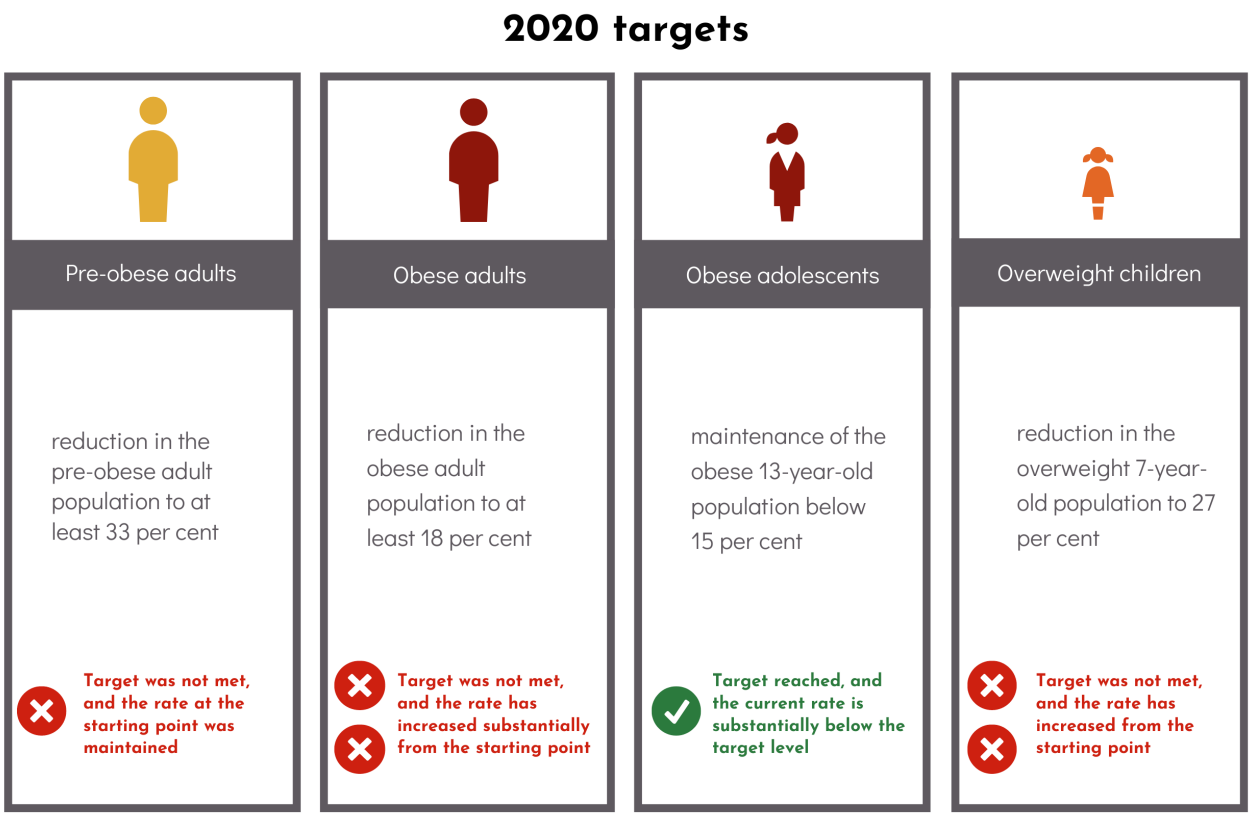
a. a reduction in the pre-obese adult population from 36 per cent to at least 33 per cent;

b. a reduction in the obese adult population from 22 per cent to at least 18 per cent;

c. the maintenance of the proportion of 13-year-olds who are obese below 15 per cent; and

d. a reduction in the overweight seven-year-old population from 32 per cent to 27 per cent.

6.1.8 The NAO's overall assessment is negative. Only one of the targets set, that relating to adolescents, was met. The envisioned reductions of the other three targets were not secured, and instead, prevalence rates remained constant or increased substantially when compared to the rates as at the start of the implementation period.



6.1.9 The two targets relating to adults were not met. The Healthy Weight for Life Strategy envisaged a reduction of three percentage points for the adult pre-obesity rate, from the 36 per cent reported in the EHIS 2008 to 33 per cent, and a reduction of four percentage points for the adult obesity rate, from the 22 per cent reported in the EHIS 2008 to 18 per cent. In the case of pre-obesity, no progress was registered and a constant level maintained, with EHIS 2019 reporting adult pre-obesity prevalence at 35.7 per cent. As regards obesity, an increase of around six percentage points was observed, with 28.1 per cent of the population aged 15+ being classified as obese in the EHIS 2019.

6.1.10 Regarding children, a reduction of five percentage points was envisaged for the overweight rate, from 32 per cent to 27 per cent; however, the contrary occurred, with an increase in rates observed over the implementation period. In 2010 (round two of COSI), the overweight rate stood at 32.1 per cent, which rate increased to 33 per cent in 2019 (round five of COSI) and to 35.4 per cent in 2022 (round five of COSI – preliminary results).

6.1.11 The target relating to adolescents was set as the maintenance of the proportion of 13-year-olds who are obese below 15 per cent. The HBSC 2018 data sourced by the NAO indicates that 7.4 per cent of 13-year-olds are obese as at 2018, and therefore, not only has the target set been reached, but the obesity prevalence rate among adolescents effectively halved in the period 2006 to 2018. The NAO acknowledges that the substantial reduction in the prevalence of obesity among 13-year-olds is deemed as indicative of significant progress registered. However, this Office noted an aspect of concern when considering changes in overweight prevalence as reported in the international publications of the HBSC. In 2018, 38 and 35 per cent of boys and girls, respectively, were reported to be overweight, compared to the 31 per cent of boys and girls separately reported to be overweight in 2006. This indicates a regression in overweight prevalence rates for both genders. This result provides a bleaker picture for adolescents than observed when solely focusing on the obesity indicator. The decrease in the obesity rate, when considered in the context of the simultaneous increase in the overweight rates implies that a larger percentage of the 13-year-old population is now classified as pre-obese.

6.2 Have Government's efforts been sufficient, effective and did they address all vulnerable groups?

6.2.1 The second aspect of analysis that the NAO sought to address related to whether the Government's efforts to address pre-obesity and obesity were sufficient and effective and whether they addressed the needs of all vulnerable groups. In considering these matters the NAO took into account the latest prevalence statistics, the views of stakeholders on the matter, the records of work of the Advisory Council on Healthy Lifestyles, the Healthy Weight for Life Strategy and information regarding its implementation. In assessing whether the needs of vulnerable groups have been met, the NAO also analysed pre-obesity, obesity and overweight indicator data disaggregated by demographic categories to determine variations in prevalence.

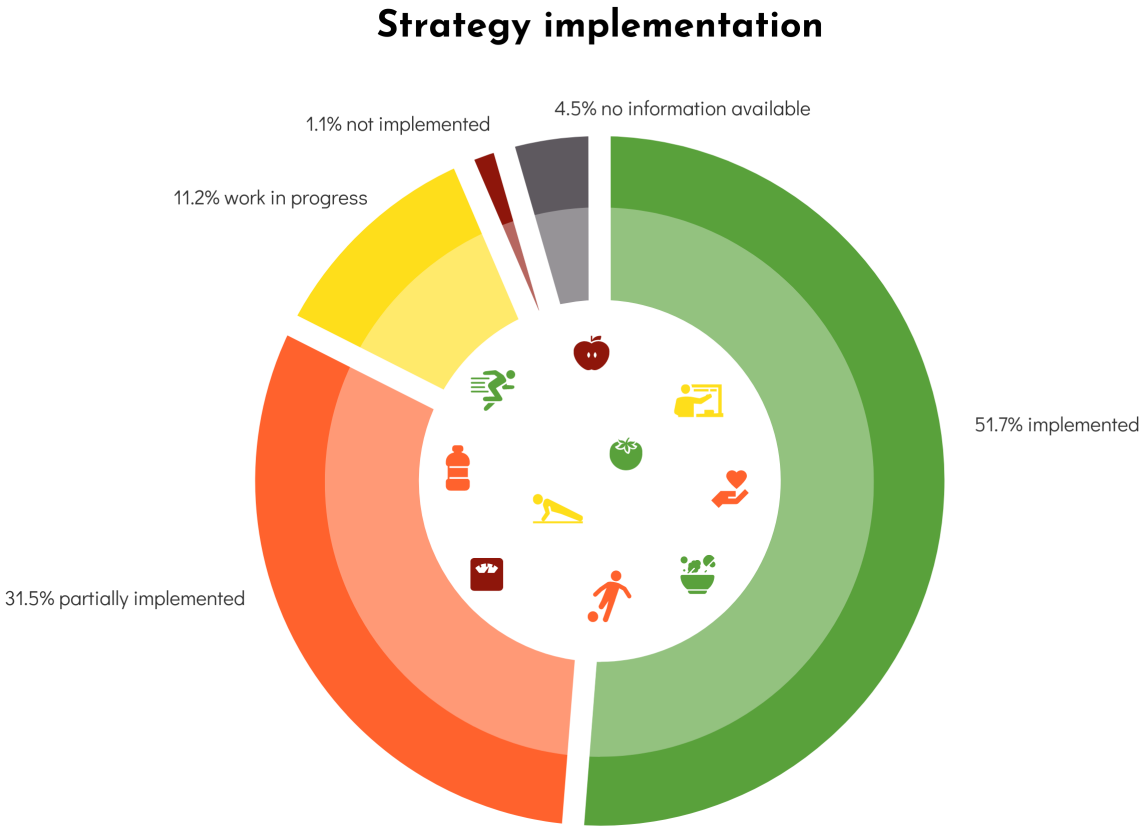
6.2.2 The NAO acknowledges the investment and efforts undertaken by the Government in its drive to reduce pre-obesity and obesity, including legislative changes, policy developments, as well as implemented projects, measures and initiatives. The work undertaken by the Advisory Council is particularly commended by this Office. However, current statistics for pre-obesity and obesity in themselves provide enough evidence that these efforts are not sufficiently comprehensive and effective. The assessment of implementation of the Strategy also identified areas of unknown or no progress. In addition, the analysis of data relating to food consumption patterns and physical activity indicate the need for further efforts to motivate, enable and sustain healthier food consumption and more active lifestyles. Feedback from stakeholders also highlights gaps in funding, human resources and service provision, as well as a current state of affairs where the address of overweight is not an overarching priority across the different sectors of the Government. Also of concern to the NAO is the limited legislative changes implemented, far reduced in scope than those originally intended in the original submissions tabled in Parliament to address obesity. This Office advocates for strengthened political will to make the address of overweight a national priority across sectors, and for the allocation of appropriate resources and funding, as well as the undertaking of sufficient efforts commensurate with the gravity of the issue at hand. The NAO encourages Government to consider the multiple suggestions put forward by the many stakeholders consulted in this review, to inform future plans and actions to create an enabling environment that facilitates healthy choices.

6.2.3 The NAO is of the opinion that while the Government has undertaken several measures that positively address the vulnerabilities of particular groups, more varied and sustained efforts are required to effectively reach all vulnerable groups. The review of the Advisory Council meeting minutes indicated that the Council was cognisant of the importance of addressing the specific needs of vulnerable groups and of assessing the impact of planned interventions in this respect. Vulnerability was mainly considered in terms of one's financial means. Various targeted interventions were identified by stakeholders and by the NAO in its review of the implemented actions. However, disaggregated statistics and the feedback sourced from stakeholders provide insight into the systemic disadvantages of specific demographic groups, which insight can further direct Government in the design of efforts to reduce pre-obesity and obesity. The NAO also noted that while some targeted efforts were envisaged in the Healthy Weight for Life Strategy, most areas for actions included proposed generic interventions intended for specific age groups or settings, with no provisions specifically designed for particular socio-economic groups. This Office commends the Advisory Council's favourable disposition to further target vulnerable groups in future interventions, and to consider the information produced by the ESF project aimed at identifying the social determinants of health to identify groups disproportionately affected by multiple lifestyle risk factors for targeted efforts. The NAO recommends Government to consider the several suggestions for targeted interventions put forward by stakeholders in planning future action to target the needs of groups with heightened susceptibility to gaining and retaining excess weight.

Positive development registered

6.2.4 The assessment of the implementation progress for the 89 areas for action included in the Healthy Weight for Life Strategy undertaken by the Strategy Development and Implementation Unit, within the Office of the Superintendent of Public Health, Health Regulation Department, following the collation of information from various stakeholders, yielded mixed results. This exercise provided evidence of substantial resources and efforts invested and progress registered in specific areas, while also highlighting some gaps. 51.7 (n=46), 31.5 (n=28), 11.2 (n=10) and 1.1 per cent (n=1) of areas for action have been implemented, have been partially implemented, are a work in progress, and have not been implemented, respectively. For 4.5 per cent (n=4) of areas for action, no information was provided by the stakeholders. Regarding progress on the implementation of the Strategy, the MFH noted that partially implemented areas for action include some areas that require sustained efforts and are therefore ongoing.

6.2.5 Implemented actions related to healthy eating addressed different life stages, including early years up to the age of four, with special emphasis on the promotion of breastfeeding, school years and adulthood, and specific settings, including workplaces, hospitals, institutes and homes for older people. These included actions relating to the issuance of policies, various dietary guidelines, action plans and legislative provisions, implementation and enforcement efforts, changes in food procurement specifications and menu provision in various settings, health education and promotion activities, training and capacity building initiatives, food reformulation and food labelling efforts, the appointment of additional specialised human resources, food distribution initiatives and service provision.



6.2.6 Positive efforts highlighted by stakeholders relating to healthy eating included initiatives that promote food literacy, specifically the nutrition helpline run by the HPDP, the various dietary guidelines issued by the Directorate, the contribution of home economics within the school curriculum, as well as several promotion campaigns organised by the MFH, the University of Malta, the Chamber of Pharmacists with the support of the Foundation for the Wellbeing of Society and Caritas, the MSPC and the Home Economists in Action. Stakeholders also referred to changes in tender specifications for the provision of meals in residential care homes and hospitals, the tax introduced on sugar-sweetened beverages, the guidelines issued by the Broadcasting Authority to regulate what can be advertised during children's programmes, and food distribution schemes within schools and in the wider community. Also mentioned were various legislative acts or amendments that helped foster a healthy food environment, including the Nutrition Labelling for Foodstuffs Regulations (Subsidiary Legislation 449.20), the Procurement of Food for Schools Regulations (Subsidiary Legislation 550.01), the Healthy Lifestyle Promotion and Care of Non-communicable Diseases Act (Chapter 550) and the Infant Formulae and Follow-on Formulae Regulations (Subsidiary Legislation 449.52). Malta's participation in the Best-ReMap Food for a Healthy Future project, which targets food monitoring and reformulation, was mentioned as a positive initiative in terms of efforts aimed at healthy eating.

6.2.7 The Strategy implementation assessment exercise provided evidence of progress registered with respect to implemented actions promoting physical activity in schools. This included embellishment and upgrading projects, in-service training for teachers, various physical activity programmes and initiatives, the procurement of physical education equipment and commitments to increase the physical

education lessons within obligatory schooling years. In terms of spatial planning, efforts undertaken include the issuance of policies that protect open spaces and support infrastructure that promotes physical activity and active mobility, the development of gym and training facilities, and the provision of funds for the maintenance and development of local infrastructure and the availability of more green spaces, playing equipment and sports facilities. Also undertaken were infrastructural projects that have introduced new footpaths, improved existing cycle lanes and created further networks, training initiatives for policy makers and administrators, and awareness raising initiatives on safety on shared roads. Specific implemented efforts were aimed at providing opportunities and incentives to encourage stakeholders to provide physical activity classes, active play and sports that are accessible and affordable to the general population. Also undertaken were various educational activities and awareness raising campaigns highlighting the health benefits of exercise, providing guidelines on the types and quantities of physical activity required in different age groups and training health care professionals to prescribe exercise in an individualised manner.

6.2.8 Stakeholders highlighted several initiatives that provide accessible and affordable opportunities for physical activity and active transportation. These include sports programmes organised by local councils and SportMalta, tax rebate schemes and the investment in sports facilities and equipment. Also mentioned were the embellishment of promenades, the introduction of cycle lanes and footpaths, the inclusion of subways and pedestrian bridges in major projects by IM, efforts by ERA to improve pathways in the countryside, and EU-funded projects undertaken by the PA. Other initiatives that promote active lifestyles which were cited include the guidance documents relating to physical activity issued by the HPDP, the training provided by the MFH to health care workers on the Swedish practice model, awareness campaigns promoting the benefits of physical activity, funds for fitness instructor training and the ad hoc fund for special initiatives enabling physical activities for local councils.

6.2.9 Stakeholders praised efforts within schools that have contributed to greater nutrition-related knowledge and better food choices, greater awareness of the positive impact of physical activity, and a supportive and enabling environment with respect to food consumption and active lifestyles. Specific initiatives mentioned include legislative amendments regulating the procurement of food within schools, the introduction of potable water through water fountains in schools, the fruit, vegetable and milk scheme, the increase in the number of physical education classes for children in compulsory schooling, the introduction of home economics as a compulsory subject in the first two years of secondary school in state schools and health promotion initiatives targeting students, teachers and parents, lectures by TM promoting active transportation, and training sessions for teachers.

6.2.10 Other implemented actions identified in the Strategy implementation assessment exercise related to the re-orientation of health services and the development of community-level services and specific services. The national health service offers assessment and referral to specialist services, various weight management programmes, a nutrition and dietetics service, and bariatric surgery. Stakeholders also referred to the newly established obesity clinic within the MDH, which seeks to offer a medical (non-surgical) approach to the treatment of complex obesity. With respect to the training of health care professionals, it was noted that healthy lifestyle and behaviour change strategies as well as health promotion and disease prevention content are addressed in various healthcare undergraduate courses,

continuous professional development training programmes and national guidelines for healthcare workers. Undergraduate and postgraduate programmes in nutrition and dietetics have been greatly expanded to ensure that the human resource pool in the sector is increased. Various initiatives relating to the setting up of cookery clubs or delivery of cookery lessons at the community level were also cited.

6.2.11 Other initiatives cited in the Strategy implementation assessment exercise included structural action, economic instruments and research initiatives and prevalence surveillance mechanisms. Structural action included the setting up of the Advisory Council, the finalisation of the revision of the Malta Food and Nutrition Policy and the launch of the corresponding action plan in 2014, as well as the establishment of the Social Determinants of Health Unit and the ensuing partnerships across different ministries in Malta and Gozo. Other structural action mentioned by stakeholders relates to ERA's participation in a working group with the Superintendence of Public Health and the Environmental Health Directorate, which group was set up to develop a national portfolio of actions on the environment and health. Economic instruments relate to the various schemes introduced by the MFE for tax rebates, intended to incentivise the uptake of physical activity. Ongoing discussions with the MFE are being undertaken to analyse the impact of subsidies and taxes on people's behaviour and income redistribution, the feasibility of incentives to increase the availability of healthy food outlets and restrictions related to fast food outlets, and the potential for further employer tax incentives to motivate employee healthy lifestyle choices. Research included a doctorate study mapping potential drivers of obesity in Malta, while prevalence surveillance mechanisms included surveys and anthropometric studies to measure pre-obesity and obesity prevalence data and assess the nutritional status and eating habits of the Maltese population.

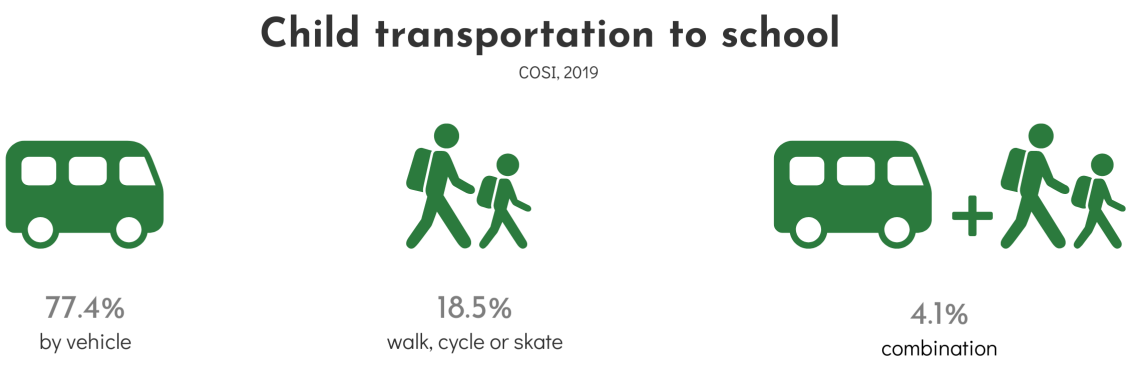
6.2.12 The review of the Advisory Council meeting minutes provided an insight into the areas of action and achieved output of the Council. The minutes shed light on the efforts invested by the Council to identify, consult with and secure the cooperation of relevant stakeholders. From a strategic and local governance perspective, the Advisory Council's focus was directed towards ensuring policy coherence through a health-in-all-policies approach, exploring the introduction of different fiscal measures, spurring legislative change and aiding compliance thereto. In addition, the Council sought to identify and source budgetary allocations to support relevant initiatives and projects, with training measures an essential component of efforts in this regard. The Council also considered factors extraneous to local governance, by following the work being done at an EU level on several matters, cautiously exploring possible partnerships with the private sector and reflecting on the impact or reaction of market forces on various decisions and interventions. In addition, the Council discussed the content, funding sources, envisaged collaborations and possible avenues for the dissemination of educational campaigns. Several strategies to encourage physical activity and healthy food choices featured prominently in the minutes of the Advisory Council meetings. Efforts focused on addressing obesity in children were prioritised and evident progress was noted in this respect. Also noted in the minutes of the meetings held by the Advisory Council was reference to multiple identified research needs and implementation monitoring and evaluation requirements, as well as plans to expand weight management services.

6.2.13 The latest statistics, which show almost a third of the child and adolescent population and two-thirds of the adult population being overweight, unequivocally show that efforts so far have not been sufficiently comprehensive or effective (Figure 57 refers). This assessment was shared by some stakeholders, mostly academics, who commented that the implementation of the Healthy Weight for Life Strategy has fallen short of plans and expectations, or that implemented actions are not resulting in the expected improvement. Some stakeholders recognised the lack of adequate structures, commitment, workforce and financial resources to implement and monitor the implementation of the Strategy. They advocated for strengthened strategy implementation through buy-in and commitment from multiple stakeholders and the allocation of adequate financial and human resources, as well as concentrated efforts on monitoring and enforcement. The assessment of progress on the implementation of the Strategy identified an area for action that has not been implemented (relating to actions intended to promote healthy eating throughout the school years) and areas of unknown progress (relating to human resource issues and surveillance and research), hence highlighting gaps in policy implementation.

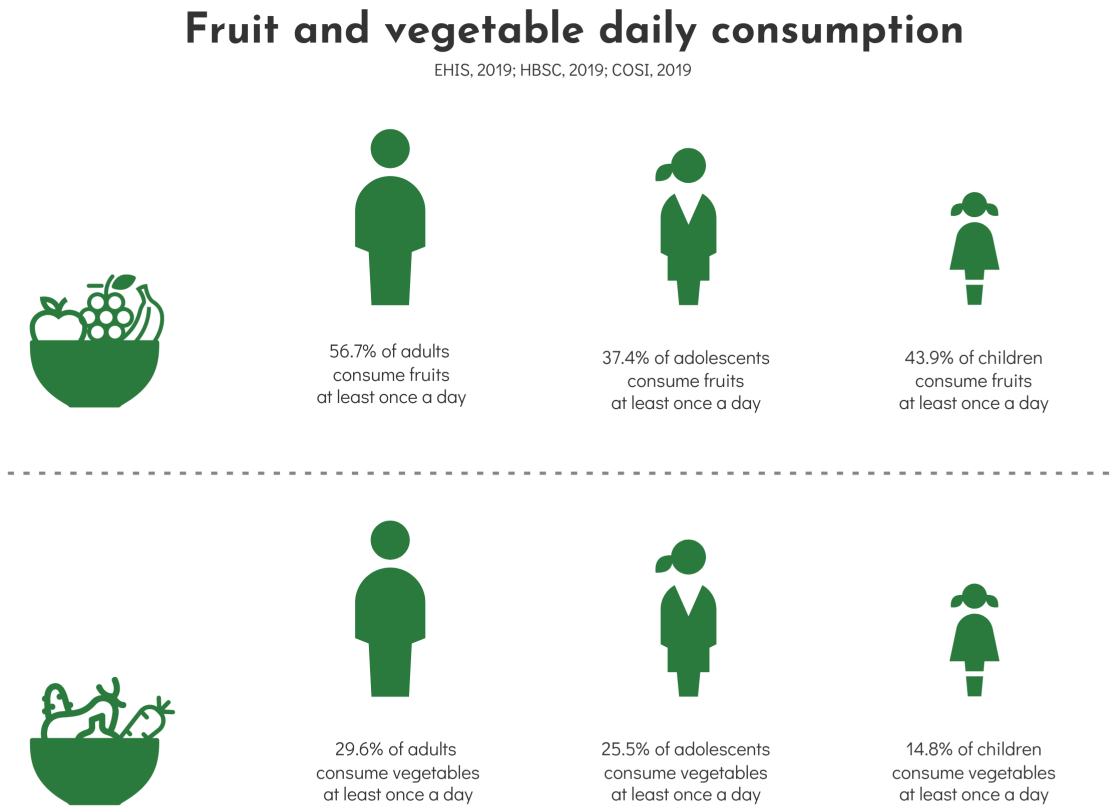
Figure 57 | Malta's latest prevalence rates

Population group	Data source	Pre-obese (%)	Obese (%)	Overweight (%)
7-year-olds (child)	COSI, 2022 (preliminary figures)	18.3	17.1	35.4
11-, 13-, 15-year-olds (adolescent)	HBSC, 2018	22.4	8.9	31.2
15-year-olds and over (adult)	EHIS, 2019	35.7	28.1	63.8

6.2.14 On an individual level, obesity is linked to an increased risk of various noncommunicable diseases that affect multiple body systems, decreased quality of life, mental wellbeing and life expectancy, and experiences of stigmatisation and social isolation. At a national level, obesity is linked to increased pressures on already overstretched healthcare resources and services, additional cost burdens on public expenditure, decreased productivity, the sub-optimal use of human resources and several social problems. Sustained high prevalence rates of overweight and the individual and national implications of obesity motivate some stakeholders' concerns that the gravity of the situation, in terms of scope and severity, is not being fully acknowledged by the Government or the public and that action taken is not commensurate to the scale of the problem.



6.2.15 The analysis of data relating to food consumption patterns and physical activity indicated high prevalence of behaviours that may impact health outcomes negatively and contribute to overweight and obesity. These statistics highlight the need for further efforts to motivate, enable and sustain healthier and more active lifestyles. Overall statistics indicate sub-optimal consumption of fruit and vegetables, more pronounced with respect to vegetables among all age categories. There is still a considerable percentage of the population, within all age groups, that consume soft drinks regularly, this being highest among adolescents. Statistics relating to the consumption of sweets among adolescents (this data is not available for children and adults) also indicate over-consumption. Daily breakfast consumption is not consistent for most adolescents and a substantial proportion of children. Statistics indicate that most adolescents and adults do not partake in the minimum level of recommended weekly physical activity, while physical activity statistics are more encouraging for children.

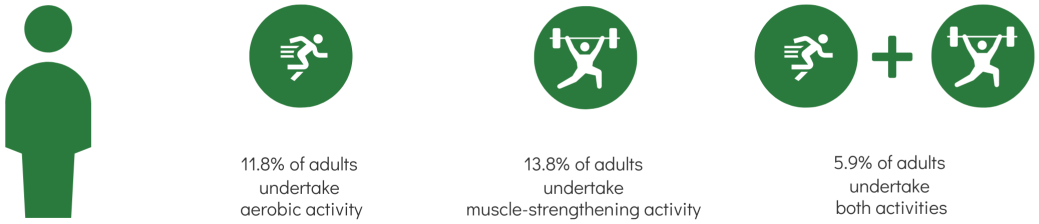


6.2.16 Mixed opinions regarding the sufficiency of funding were expressed by stakeholders, though on balance the views expressed were more negative. Stakeholders acknowledged that local and EU funds relating to finance, sports, youth, education, infrastructure, social services, local councils, agriculture, and health contribute to the fight against overweight. While this funding, including allocations made for specific initiatives and the corresponding human resources participating in relation thereto, was acknowledged, concerns regarding the sufficiency of funding were expressed. More specifically, stakeholders questioned whether tackling overweight was indeed prioritised when allocating funding, and noted that the funds allocated for the obesity vote and for the provision of weight management programmes are consistently substantially lower than the requested amount. Funding for monitoring

and evaluation efforts, and more generally for research, was also acknowledged to be lacking. The MFH representatives and service providers deemed the healthcare vote and staff complement allocated for health promotion and the prevention of non-communicable diseases to be very limited, with priority focused mostly on the treatment of ill health. Various stakeholders stressed the need for more substantial financial allocations and resources, and for financial and resource allocation that prioritises a preventative approach to tackling overweight, as opposed to the current interventionist approach, which focuses mostly on reversing excess weight or managing the complications and comorbidities arising therefrom. It was suggested that if taxation on unhealthy food items was to be introduced, then money collected from such taxation should be ring-fenced for health promotion and disease prevention activities or to subsidise healthy food.

Uptake of physical activity

EHIS, 2019; HBSC, 2019; COSI, 2019



Physical activity recommendation for adults: 2.5 hours of moderate-intensity aerobic physical activity per week
muscle-strengthening activities two or more days per week

Physical activity recommendation for adolescents and children: moderate-to-vigorous intensity exercise for at least 60 minutes a day

6.2.17 Providers of weight management programmes indicated experiencing capacity shortages and struggling to find suitable candidates to recruit, in view of supply issues and funding limitations. Strengthened cooperation and networking between different healthcare providers across the public and private sector and capacity building were considered potential avenues for overcoming capacity shortages. The provision of additional skilled human resources was recognised as imperative to aid efforts intended to reduce the prevalence of pre-obesity and obesity. Specifically mentioned were professionals specialised in relevant fields, such as nutritionists and dieticians, medical physicians specialised in the treatment of obesity, as well as psychologists and psychiatrists with a special interest in eating disorders and weight issues. Additional human resources were considered necessary to increase service provision coverage, reduce waiting times, and to provide a service where currently there is none. Strategic work within ministries was also highlighted by an academic as being hampered by staffing shortages and political pressures. Recommendations were put forward for training for policy makers in different sectors to ensure that they consider health implications when drafting new policies.

6.2.18 With respect to service provision, two representatives of professional associations and a service provider strongly encouraged Government to consider including medication that can assist weight loss as part of the Government formulary list of medication provided free of charge to the user. With the start of the obesity clinic within the MDH, which seeks to offer a medical service to patients with complex obesity, the availability of this medication on the national health service was considered imperative. Currently, this medication is only available to purchase from community pharmacies at the patient's own expense, at a cost that is prohibitive for many patients. While no issues relating to service quality were raised in relation to the various weight management programmes offered by the public health sector, attention was drawn to the fact that follow-up studies that determine whether weight loss was maintained at specific time intervals after programme termination are not undertaken. Visibility on the long-term outcome is required to assess the effectiveness of such programmes, in view of the fact that weight loss is often not maintained in the long run. It was also suggested that the introduction of the electronic patients records and the future integration of lab results within the system will allow this administrative data to be analysed to determine the effect of weight loss on multiple blood test results, at the individual and population level. The need for in-depth consultation with patient representatives to better improve services was also mentioned.

6.2.19 The Member of Parliament who had originally tabled the private member's bill that eventually led to the enactment of the Healthy Lifestyle Promotion and Care of Non-Communicable Diseases Act and the instatement of the Advisory Council criticised the way the original bill was watered down due to a lack of political will to implement the necessary legislative changes. The bill was amended from one focused on obesity to one addressing non-communicable diseases more generally, and excluded many of the original proposals. The Member of Parliament observed that, for many of the proposed legal amendments, no subsequent legal notices were issued to address them. These observations were also reiterated by an academic, who argued that these developments highlight the fact that the address of obesity is given minimal importance at the policy level. Stakeholders mentioned various areas that require further legislation or legislative amendments, including advertising content, product packaging, food labelling, food reformulation, pesticide use, built environment and development planning, the Advisory Council's enabling legislation, as well as food within workplace canteens and

within elderly homes and institutions. Also mentioned was the need to revisit procurement regulations, as the selection of the least expensive technically compliant bid was not considered adequate for the choice of medication, caring services and catering provision in elderly institutions.

6.2.20 Stakeholders recognised that besides individual factors, excess weight is also driven by numerous other environmental and societal factors, including the built-up environment, transport systems, advertising efforts and influencers, culture, lifestyle, as well as the availability and accessibility of different types of food and sports facilities. For this reason, various stakeholders emphasised the need for further cooperation and commitment of non-health stakeholders and sectors, strengthened communication and coordination between sectors, and stronger policy integration to create an enabling environment that facilitates healthy choices. An enabling environment makes the healthy choice with respect to physical activity and food consumption the easy choice – the accessible, affordable and culturally acceptable choice. Specific emphasis was made on the built environment, and the need to ensure that our infrastructure encourages active lifestyles, including physical activity for its own sake and mobile transportation. The Advisory Council and the MFH representatives suggested that with respect to specific remits and initiatives, individual stakeholders need to be identified to take responsibility and be accountable for their implementation.

6.2.21 Lack of political will and competing priorities were identified by stakeholders as factors underlying existing shortcomings in legislative changes, policy coherence and limited efforts by other sectors. Several stakeholders observed how political influence may stall or disrupt progress against overweight, with sustainable mobility mentioned as an area that has registered poor progress due to a lack of political direction and will. Such stalling or disruptions were explained in terms of the citizen's primary interest in increasing one's economic power, politicians' tendency to favour policy that is well liked by the electorate, politicians' hesitancy to tackle issues that have a monetary bottom line, and external pressures on politicians to reject proposals on grounds that it would lead to loss of business, loss of jobs or international implications in terms of trade and other issues.

6.2.22 Stakeholders also put forward other recommendations for future endeavours aimed at ensuring the sufficiency and effectiveness of efforts aimed at addressing pre-obesity and obesity. Health education was acknowledged by various stakeholders as an essential, but alone insufficient, element to motivate change in dietary and physical activity behaviours. Health education needs to be supplemented with measures that motivate and empower behavioural change, and make the healthy choice the easy one. Stakeholders advocated for policy and legislative changes, fiscal measures, nudge-based interventions and other efforts intended to control and improve the physical and food environment, to help further foster an enabling environment, and for political goodwill to back such measures.

6.2.23 Several suggestions related to actions to be taken within the school environment. Some recommendations were specific to the school curriculum, such as extending the entitlement of home economics classes, increasing the time allocated for physical education classes and other physical activity, and changes to the content of the school curriculum. This latter point included the introduction of health literacy and specifically nutrition education, and the placement of greater emphasis on soft skills and life skills, particularly planning skills. Further training for teachers and the recruitment of peripatetic teachers

specialised in health or home economics was proposed to enable these recommendations. Also proposed was the introduction of legal restrictions for a buffer zone around schools with respect to the licensing of food outlets and the introduction of universal school lunches. Other suggestions put forward related to the introduction of specialised training for chefs and waitering staff at the ITS on healthier cooking methods, the design of healthier menus and knowledge of different food options for specific dietary requirements. Recommendations for tertiary education included the design of a module, open to all students university-wide, focused on delivering consistent messaging on healthy lifestyles, the design of a bespoke module, specifically for communication students, to adequately train journalists on health and nutrition and sustainable lifestyles as well as communication science, and the inclusion of infodemic management as part of teacher training.

6.2.24 Multiple suggestions were put forward by stakeholders to facilitate the further uptake of physical activity, such as the further development and promotion of water sports and exercise, different initiatives to be taken up within the workplace, additional Government vouchers for sports activities or equipment and physical activity facilities at mass events. Also recommended was the further development of safe and pleasurable environments that enable walking and cycling as well as open spaces within built environments for active recreation. Many stakeholders suggested that, in promoting physical activities, physical activity should not be limited to the gym or sports or competitive activities, but should include the daily incorporation of moderate exercise that impacts the heart rate, such as active transportation and fun non-competitive physical activities, such as gardening or walking animals.

6.2.25 Other recommendations sought to influence consumer food choices by addressing the accessibility and affordability of different food items. Specific recommendations included the introduction of guidelines or legislation regulating the procurement and preparation of food in particular settings, such as hospitals, and mass catering establishments in workplaces and residential homes. Stakeholders recommended improving the affordability and accessibility of local fresh produce and healthier meals through different fiscal measures (additional or reduced tax rates, tax rebates, voucher systems, price controls, grants and subsidies) aimed directly at the consumer, the farmer, the producer/manufacturer and the restauranteur. Different initiatives for facilitating direct buying from the food producer, including pick your own activities and more accessible farmers markets, were also suggested. Additionally stressed was the importance of educational campaigns to improve health literacy, specifically nutrition education and food literacy, including cooking skills and the interpretation of food labels, so that people have the knowledge and skills to make healthier affordable choices. Awareness raising campaigns regarding the seasonality of produce, the advantage of buying short chain, in season produce in bulk and minimally processing it to store it, as well as opting for underutilised and cheaper produce were also recommended. Other suggestions to improve accessibility to healthy options included the introduction of potable water through water fountains, the addition of healthy snacks in vending machines, the availability of healthy food stalls at national events and the choice of healthy food options within work canteens and at work meetings and within sixth forms and university canteens.

Vulnerable groups

6.2.26 The areas for action proposed in the Healthy Weight for Life Strategy were mainly designed to address target age groups or settings (workplaces, hospitals, institutes and homes for older people). Additionally, one area for action specifically targeted persons with disability, promoting their inclusion in physical activity opportunities. The review of the Advisory Council meeting minutes indicated that the Council acknowledged that interventions must be inclusive of vulnerable groups, for example children in vulnerable situations or those coming from low-income families, or that targeted approaches, such as the targeting of low-income families, may be required. Additionally, the Council noted the importance of considering the impact of fiscal measures, such as taxation, on low-income groups. Social interventions for vulnerable groups that also included health literacy skills programmes, such as cooking, budgeting and nutritional education, were considered positive initiatives.

6.2.27 A review of the information relating to the implementation progress of the Healthy Weight for Life Strategy provided evidence of various targeted interventions that aimed to address the needs of different vulnerable groups, including persons coming from lower socio-economic backgrounds, lone mothers, older persons, persons living in institutions, and persons with disability. The provision of a healthy lunch to eligible students from disadvantaged socio-economic backgrounds, the Fund for European Aid to the Most Deprived, the State Funded Food Distribution Scheme and the LEAP Project, all help alleviate food deprivation among disadvantaged target groups. Additionally, two training programmes – Għaqal id-Dar, Ħajja Aħjar and Proġett Familja 2014-2017 – managed by the MSPC aim to provide participants with basic skills for improving one's quality of life, including home management skills, such as skills to eat healthily within a modest budget.

6.2.28 Efforts have also been undertaken to introduce dietary guidelines and regulations within institutions, to ensure the accessibility and provision of healthy food. The new tender issued for meals provision for residential care homes by the Active Ageing and Community Care unit implemented changes to encourage and improve healthy eating in residential care homes for older persons. The MDH canteen and shop are now only allowed to serve and sell healthy food. Additionally, as part of its role as a regulatory body, the Social Care Standards Authority monitors and regulates the standards of care for residential services for senior citizens, including the quality of food provided, to ensure that older persons received a varied, appealing, wholesome and nutritious diet that is suited to individually assessed and recorded requirements.

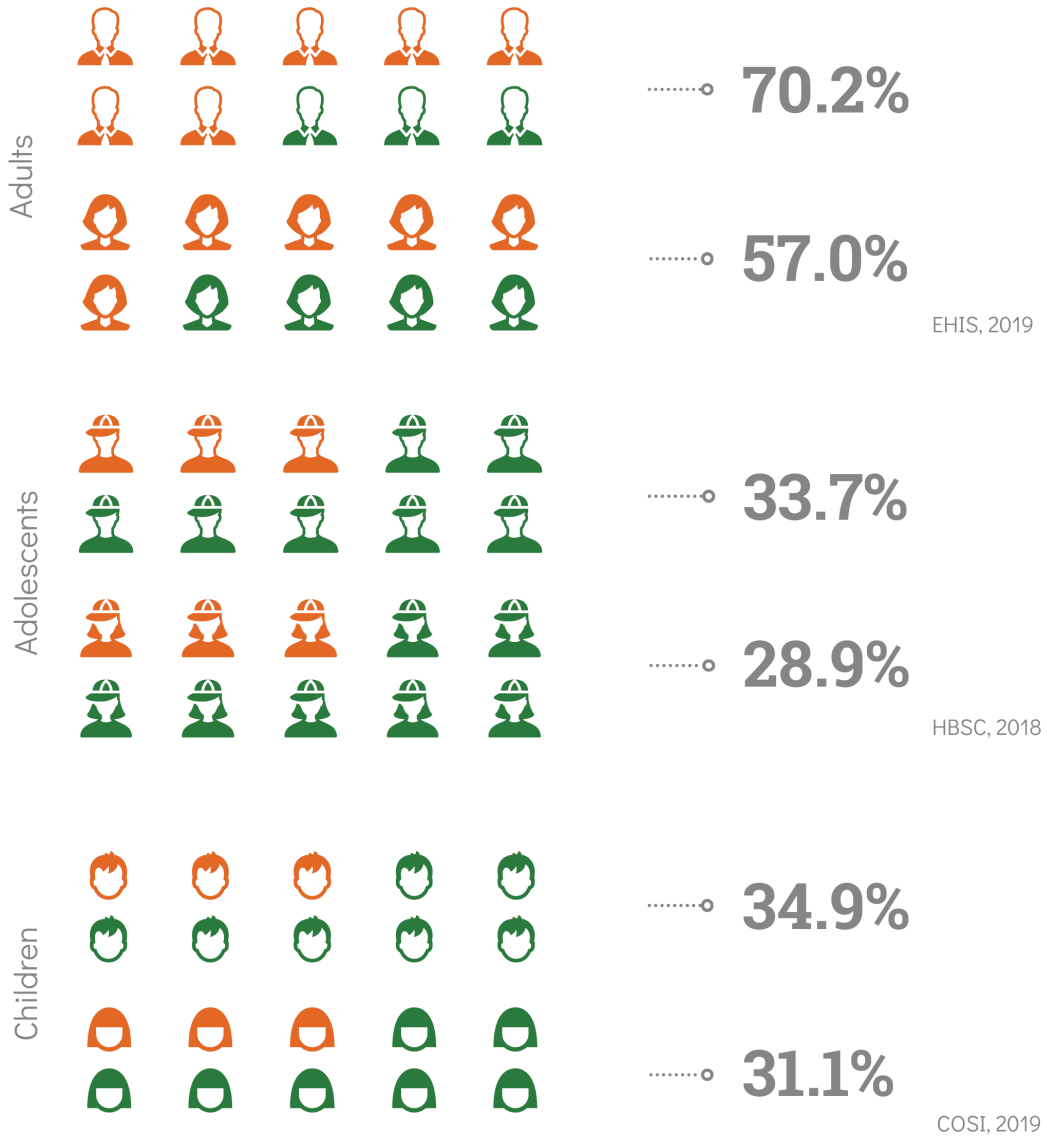
6.2.29 Other efforts are aimed at ensuring the inclusion of persons with a disability and older persons in opportunities of physical activity. The Motor Activity Training Programme is offered to persons with multiple impairments, aiming to provide adaptable physical training and education, whereas the Sharing Lives programme promotes sports activities within different communities in collaboration with several organisations. Several projects have benefitted from funds intended to encourage integration and accessibility. More physical activities for senior citizens are being promoted by the Active Ageing and Community Care unit, including adapted physical exercise sessions led by qualified tutors, and swimming sessions held in collaboration with SportMalta. Furthermore, some community centres organise walking and trekking activities for members on a regular basis.

6.2.30 Stakeholders also mentioned various examples of existing targeted interventions, aiming to address the specific needs of sub-groups in the population. Examples mentioned included exercise programmes catering specifically for children of certain ages, parent and child groups, older persons, as well as prisoners and persons battling addictions separately, the provision of free school lunches for children coming from lower socio-economic backgrounds and a youth programme for vulnerable youth intended to teach life skills, including cooking skills and personal self-care. Reference was also made to the health promotion components of social services provided, such as the distribution of nutrition booklets with food distribution schemes, BMI assessment and education on healthy lifestyles for minors living in alternative care, as well as health promotion within support and empowerment programmes for lone mothers. Additionally cited was an afterschool programme for children coming from lower socio-economic backgrounds during which children are provided with nutritious snacks, carry out food preparation activities, and participate in lessons in food budgeting and physical activities. This programme was praised for achieving substantial changes in body composition in terms of fat and lean mass ratio and better educational outcomes for the participating children. Also praised was the screening initiative launched by the MFAA.

6.2.31 Despite the Advisory Council's consideration of vulnerable groups and the various targeted measures in place, disaggregated indicator statistics indicate specific demographic groups that are more susceptible to excess weight. Consistently, males register higher rates than females, with a more evident pattern in this respect emerging for older cohorts. The only exception to this pattern is noted for the 7-year-old cohort, with the 2019 COSI statistics for the pre-obesity indicator showing higher rates for girls compared to boys, by 1.5 percentage points. Disaggregated prevalence rates by wealth show mixed results; however, despite some anomalies, the general trend is that higher rates are observed for lower income groups. Disaggregated prevalence rates by educational variables show higher prevalence rates for respondents with the lowest level of education, whose parents have the lowest level of education or who do not enjoy attending school, suggesting an inverse association between education level and excess weight. In the case of adults (15+ years), the highest rates for 2019 are observed for respondents with the lowest educational achievement. In the case of children, there is a clear inverse relationship between parental education and the child's likelihood of having excess weight in 2019. In the case of adolescents, marginally higher rates for all three indicators are observed in 2018 for those who do not like school compared to those who do. Family structure information available for adolescent data shows that, for 2018, adolescents pertaining to single parent households had the highest prevalence rates for obesity and overweight among the three categories of family structure, while those adolescents pertaining to other family structures registered the highest pre-obesity rates.

6.2.32 During the focus group discussions, various stakeholders also affirmed the existence of vulnerable groups which have a heightened susceptibility to excess weight. They noted that empirical research has revealed that there are differences in the lifestyle behaviours, as well as in the pre-obesity and obesity prevalence levels across gender, age and socio-economic status categories. Socio-economic variables mentioned included level of education, income, housing type and size, household composition, employment status and job type. Engaging unhealthy lifestyle behaviours contributes to a higher risk of morbidities, which in turn worsens one's work status, work intensity and income – leading to a vicious cycle. An inter-generational effect, with vulnerabilities persisting from one generation to the next, was also noted. Persons of low socio-economic status, most especially those with low income

Overweight prevalence rates by gender



and low educational attainment, children and youth from families burdened with social and emotional problems and adulthood obesity, children from deprived neighbourhoods, migrants, and persons with disabilities, were mentioned by different stakeholders as persons more susceptible to, and therefore vulnerable in terms of, excess weight. For this reason, many stakeholders were in favour of targeted measures.

6.2.33 Proposals for future targeted interventions were put forward during the focus group discussions. In reference to tax incentives or income supplements or free services, such as voucher schemes, two academics were of the opinion that such schemes should be targeted towards low-income earners, as economic instruments are less elastic and therefore less effective among high-income earners. However, attention is required to avoid stigmatising beneficiaries. Alternatively, other academics

proposed staggering the extent of financial support based on family size or household income. In this respect, an academic noted that from a public health point of view, experience has shown that there is a role for universal and targeted interventions. Universal interventions avoid situations of people falling through the net, as eligibility criteria may still exclude some people who are in need, while simultaneously keeping the administrative burden of the scheme low.

6.2.34 Other suggestions for targeted interventions included ones tailored for older persons, foreign nationals working locally and persons with disability. Specifically suggested were the provision of fruit and vegetable supplies to older persons, possibly as an extension of the meals on wheels service and possibly basing eligibility on a means-test, the promotion of activities and sports suitable for older persons, and outreach initiatives encouraging foreign workers to participate in targeted weight management initiatives. Also recommended was for activities and programmes aimed at preventing and addressing overweight to be planned in such a way as to ensure that individuals with different needs find these accessible and are provided with the support they require. More specifically, it was suggested that information provided on websites must be accessible for all and information should be accessible in an easy-to-read format. Other recommendations were for professionals and practitioners to be trained to communicate effectively with persons with intellectual impairment, for physical exercise trainers to be knowledgeable in working with persons with disability, to ensure the safe and proper execution of physical exercises, and to provide services from venues that are in conformity with the national standards on accessibility within the built environment.

6.2.35 The Advisory Council was in favour of targeting vulnerable groups in future interventions, such as the groups disproportionately affected by multiple lifestyle risk factors identified by the ESF project aimed at identifying the social determinants of health.

6.3 Is there sufficient communication, coordination and cooperation within Government?

6.3.1 Through this review, the NAO also sought to assess whether there is sufficient communication, coordination and cooperation within Government in its efforts to reduce pre-obesity and obesity. This assessment considered strategic level issues and aspects relating to service provision. At the strategic level, the NAO considered the adequacy of the governance structure and the strategy implementation framework, as well as whether a whole-of-government approach and policy coherence has been secured. At the service provision level, the extent of cooperation and overlap between different weight management services as well as educational campaigns is considered. In addressing whether the communication, coordination and cooperation within Government is sufficient, the NAO considered the feedback provided by stakeholders, the minutes of meetings held by the Advisory Council and information in connection with the implementation of the Healthy Weight for Life Strategy.

6.3.2 The NAO is of the opinion that the Advisory Council provides an adequate framework for enabling communication, coordination and cooperation within Government and for promoting a whole-of-government approach to addressing overweight. In this respect, while the NAO is not opposed to the consideration of other alternative governance structures as suggested by stakeholders, this Office is of the opinion that strengthening the Council – possibly through the inclusion of other key

ministries, the allocation of a supporting staff complement, additional resources and a separate research body – could help secure more impactful outputs and positive outcomes in terms of the set targets. Additionally, the NAO recognises the need for the Council to further widen its consultative processes to include more stakeholders from various sectors, public and private, and to introduce a more robust monitoring and implementation framework.

6.3.3 The NAO notes the efforts undertaken to promote whole-of-government cooperation and a health-in-all-policies approach to tackling overweight. This is evident in terms of the inter-ministerial and multi-sectoral approach put forward in the Healthy Weight for Life Strategy and other health strategies, the cross-sectoral measures developed by the Advisory Council and the collaboration encouraged by it, as well as through the health considerations included in agricultural, transport, environment, planning and social policies and initiatives. On the other hand, this Office acknowledges the concerns raised by stakeholders regarding elements of incoherence in the wider policy framework, with economic considerations at times superseding or even conflicting with health-related priorities. The NAO agrees that additional efforts are required to further develop and nurture a health-in-all-policies approach to policy-making across Government, and proposes that recommendations made by stakeholders in this respect are considered by the Government. This Office also acknowledges the concerns raised by stakeholders relating to policy implementation shortcomings and inconsistencies between policy frameworks and major projects design, and advocates for strengthened political will and prioritisation of health considerations.

6.3.4 With respect to concerns raised regarding the silo mentality fostered within the MFH and across Government, the NAO recognises the need for further cooperation across ministries and entities at the level of policy implementation and service provision. Recognising the complexity of obesity, the NAO advocates for coordinated efforts by all sectors to ensure lack of replication and enhanced endeavours through more synergistic and impactful activities and initiatives. The NAO agrees with various stakeholders that the MFH alone cannot be held responsible for addressing overweight since most of the compounding parameters within our environment that contribute, sustain or exacerbate obesity are outside the control of the Ministry.

6.3.5 More specifically in relation to service provision, the NAO recognises that there is unclear differentiation between the programmes offered by the Primary HealthCare and the HPDP, and further efforts are required to identify distinct roles and areas of cooperation. In response to concerns raised regarding dwindling communication and cooperation within the sector over recent years, the NAO advocates for improvements in this regard to ensure optimised utilisation of resources, knowledge sharing and ultimately better outcomes for patients. This Office agrees with the proposals put forward intended to ensure greater awareness of the available services and the eligibility criteria among the healthcare professional community. In terms of the fragmented educational campaigns, the NAO recognises the validity of coordinating efforts for a unified, consistent message. This Office supports the consideration of the various recommendations put forward by stakeholders to improve cooperation within the healthcare sector.

Governance structure

6.3.6 Members of the Advisory Council recognised that the strength of the Council lies in the inter-ministerial discussion and cooperation, and in its role of providing advice and empowering other stakeholders to take ownership and invest resources in actions that contribute to the creation of an enabling environment. The members of the Advisory Council representing ministries other than the MFH were deemed instrumental when advocating for change within their respective ministries. Acknowledged was that, through this platform, substantial achievements were registered within schools, including the introduction of water fountains, food regulation and the provision of free school meals for children in need. Additionally, the Council reaches out to other ministries or public sector entities, other officials of the ministries represented on the Council, or other stakeholders when required, for consultation and to foster areas of cooperation for implementation. For the future, the Advisory Council was in favour of further extending invitations to ministries with which there has been little to minimal contact so far, to consult with them and explore possible areas of collaboration.

6.3.7 The NAO's review of the minutes of the Advisory Council provided evidence of the Council's commitment to identifying relevant stakeholders for specific initiatives, consulting with them, integrating their feedback in its plans and recommendations, and liaising with them to explore funding options and securing implementation. This Office noted several instances where relevant experts and stakeholders were invited to attend Council meetings, provide their views during discussions and their input in the formulation of recommendations.

6.3.8 While some stakeholders were content with the current institutional set-up, deeming it adequate and inclusive, others criticised the Advisory Council for having managed to secure little progress in terms of the targets set. However, an academic argued that although the Council had not attained the expected results, this did not necessarily mean that the governance structure was not fit for purpose. Some stakeholders suggested improvements to the current set-up, including extending the resources and powers of the Council and changes to the member composition, while others suggested a completely different governance structure.

6.3.9 One of the major concerns expressed about the institutional set-up was the fact that the Advisory Council has limited powers, with three stakeholders even describing the Council as 'toothless'. More specifically, stakeholders mentioned the fact that the MFH heads this governance structure, rather than other ministries, such as the MFE, which have the resources and influence to effect change, the Council's advisory role, with no legal means to become an effective implementing body, the Council's weak accountability, monitoring and implementation frameworks, the competing priorities and workload of its members and the Council's limited resources and lack of supporting teams responsible for research and implementation.

6.3.10 In this respect, a few stakeholders suggested that the Advisory Council should be allocated a budget and implementing powers. The Council acknowledged that their advisory capacity has certain limitations in terms of expediency and power to execute; however, it operated within the parameters set at a political level. Moreover, the Council noted that having executive or regulatory powers would hamper

its strategic approach of empowering different stakeholders to assume ownership and implement changes within their respective sector to create an enabling environment. The envisaged implications of allocating such powers included possible infringements on the autonomy of ministries, the duplication of work and a costly administrative set-up.

6.3.11 Some stakeholder feedback also related to the members constituting the Advisory Council, with suggestions put forward to include representatives of TM or IM and the MAFA, as well as academics as additional members on the Council. However, the Advisory Council was more amenable to widening its consultative processes rather than adding more members and making the Council more cumbersome. Other stakeholder feedback related to the work practices of the Council. Suggestions included the widening of consultative practices, participation as a statutory consultee in planning processes for major infrastructural projects, the vetting of all new policies or projects across government to ensure coherence, direct reporting to Parliament, and making public the Council's meeting minutes to strengthen accountability, transparency and implementation efforts. Another proposal, put forward by an academic, was for the Council to propose a programme of work to Parliament every year or electoral cycle, within the budgetary measures and electoral manifesto framework, delineating the governmental stakeholders responsible for each measure.

6.3.12 Different alternative structures were proposed by stakeholders, including a commissioner for obesity with a supporting team, a parliamentary group similar to that set up to address diabetes and the introduction of new medication, and a task force, similar to that established to enable appropriate school nutrition environments, which focuses exclusively on addressing overweight. A few academics also proposed introducing a supplementary structure, separate from the implementing arm, responsible for research and innovation. The Advisory Council was not in favour of additional governance structures, as this was thought to potentially lead to further fragmentation, duplication and the stretching of resources. The Council emphasised that efforts need to be coordinated and consolidated, and that the Council can fulfil this coordinating role.

Strategy implementation monitoring framework

6.3.13 The MFH representatives explained that following the launch of the Healthy Weight for Life Strategy, an action plan template was created, which template was intended to outline the implementation efforts that were to be undertaken to implement the Strategy over the implementation period. The Advisory Council explained that, periodically, a mapping exercise was carried out to identify the measures, projects and initiatives being implemented that address the various areas for action outlined in the Strategy and a log of these implementation efforts was kept. Despite this set-up, some stakeholders recognised the lack of adequate structures, commitment, workforce and financial resources to implement this Strategy and monitor progress. In this respect, the need to strengthen strategy implementation and dedicate additional resources and efforts on monitoring and enforcement was highlighted.

6.3.14 In reviewing the log of implementation efforts undertaken with respect to the Healthy Weight for Life Strategy, as gathered, collated and organised by the Strategy Development and Implementation Unit, within the Office of the Superintendent of Public Health, Health Regulation Department, the NAO

noted several instances where the identified implemented actions were at best tokenistic or tangential in their address of the respective area for action, or limited in scope, and in a few cases could be argued to be unrelated. For this reason, this Office is of the opinion that status updates submitted by stakeholders ought to be assessed by the MFH with greater rigour. Moreover, it is suggested that, to facilitate implementation, the next strategy should clearly outline the areas of responsibilities of different ministries and stakeholders and concrete expected outputs specified for the short-, medium- and long-term, to allow for more valid and effective monitoring.

Whole-of-government approach and policy coherence

6.3.15 Various stakeholders recognised that overweight is not solely the responsibility of the MFH and emphasised the need for coordinated efforts across Government to create an enabling environment that facilitates healthy choices. An enabling environment requires a whole-of-government and even a whole-of-society approach, and sustained commitment from the highest levels of the Government to adopt a health-in-all-policies approach. The MFH representatives provided multiple examples where it endeavoured to include other governmental actors in its fight against overweight, guiding and encouraging others to take action and providing them with tools and knowledge on possible actions. Examples of such endeavours included collaborating with the MAFA to promote healthy food, encouraging local councils to apply for funds for sustainable health-related projects and initiatives, and collaborating with the Water Services Corporation to install more water dispensers to make potable water cheap and more easily available. Another successful collaboration mentioned was that with the ministry responsible for recreational parks, which resulted in the provision of fitness equipment and the organisation of physical activity events at these sites.

6.3.16 Examples of the current collaborations and niche contributions by stakeholders outside the health sector were mentioned by stakeholders. The MSPC noted that it collaborates with local councils for the Għaqal Aħjar Training programmes, with the HPDP for the Looked After Children Health Care Services, and with SportMalta for the Nibqgħu Attivi sessions. SportMalta promotes physical activity within the education sector, workplaces, sports organisations and the community. The Strategy implementation assessment exercise also provides examples of the contribution of non-health sectors in the address of overweight. Non-health contributors included the Active Ageing and Community Care unit, Aġenzija Sapport, the MHSR, the Local Government Division within the MHAL, the MEYR, the MSPC, the MTIP and the Social Care Standards Authority.

6.3.17 The Healthy Weight for Life Strategy recognises the need for a whole-of-government approach and promotes an inter-ministerial and multi-sectoral approach to enable changes within the living environment that promotes healthy choices and a healthy weight for all. The review of the Advisory Council meeting minutes similarly highlighted these strategic considerations. The Council encouraged cross-sectoral measures aimed at tackling overweight and the consideration of health aspects in other policy areas – consistent with a health-in-all-policies approach – as well as in local councils' decisions and projects. Similarly, the Advisory Council discussed the possibility of including an obesity impact assessment in planning decisions for large new developments. The Council considered the impact of non-health policies on the health of the nation and specifically on overweight and discussed the importance of a safe and enabling environment, including safe roads and open spaces conducive to

physical activity. Additionally, the Health Policy and Strategy Board mentioned various health strategies that help promote a health-in-all-policies approach across sectors. On a separate note, the MAFA, the MSPC, ERA and the PA all provided examples of policies in their sector that promote healthy lifestyles and can assist in tackling overweight.

6.3.18 Despite the Strategy's direction, the MFH's and the Advisory Council's efforts and intentions of securing a whole-of-government approach and policy coherence across different sectors, and the existing non-health sector policies and initiatives that include health considerations, the MFH noted that the health-in-all-policies approach was still not widely adopted, and consequently needed to be further developed and nurtured. Recommendations in this respect included providing training to policy makers in different sectors, including health and obesity considerations as part of the impact assessment framework for new policies or legislation, tasking public health specialists with the vetting of policies across Government, and designating an officer within each department/ministry to undertake such vetting.

6.3.19 Some stakeholders argued that, at times, government policies in areas other than health may actually be exacerbating the overweight problem. The fact that health and wellbeing are not at the centre of policy making across all sectors was considered central to this state of affairs. For example, economic development policies at times were considered to push for economic growth at the expense of the environment, social cohesion and the wellbeing of citizens, while employment policies were considered to favour higher employment rates and work intensity at the expense of adequate time for families to prepare healthy food and engage in active lifestyles. With respect to spatial planning, the built environment and transport policies, academics noted that these policies tend to prioritise car use and overdevelopment, instead of promoting sustainable development, supporting urban regeneration that accommodates pedestrians and active travel and placing importance on the environment's attractiveness, safety, and the availability of public spaces for recreation and physical exercise. Consequently, stakeholders emphasised the importance of including health as a central overarching priority for all policies, ensuring alignment thereto, and of considering the impact of various policies on health, and specifically overweight, when planning policy changes across government sectors.

6.3.20 However, stakeholders also discussed instances where although the policy framework is conducive to healthy living, actual implementation falls short of the ideals set, due to implementation shortcomings. Cited as an example were major projects designed in a way that is at odds with the overarching policy framework. Academics noted that there are several transport and environmental policies and plans that aim to improve the pedestrian environment and active travel, and promote a sustainable built environment. However, there are areas of these policies that have not been implemented yet and major projects in the sector that jar with the policy framework. The lack of political will, competing priorities and changing governance structures were identified as possible explanations for this shortcoming. Additionally, limited collaboration within the Government was explained by a few participants in terms of the silo mentality within the MFH and across government.

Service provision

6.3.21 Various weight management programmes and services, offered by the Primary HealthCare, the HPDP and Dar Kenn għal Saħħtek and the MDH, are available free at the point of use for persons who need to lose excess weight. Some service providers spoke of the joint service provision and the functional communication and referral system between hospital services and community services and between Dar Kenn għal Saħħtek and community services. On the other hand, other service providers, especially those working within the hospital setting, expressed concern about the dwindling communication and cooperation within the sector over recent years. An NGO representative commented about the lack of coordination between different service providers, specifically the Primary HealthCare and the HPDP, with both offering similar programmes for the same target population. Service providers acknowledged this overlap and the need for identifying distinct roles and areas of cooperation and fostering greater communication between these entities. The discussions held with representatives of professional associations and service providers shed light on some misconceptions and a lack of knowledge regarding the availability of certain services as well as the eligibility criteria for access thereto. To address these gaps in awareness, it was suggested that professional associations be used as a channel to disseminate information regarding new services to various professionals, face-to-face information sessions for professionals be reinstated, reports outlining the extent of services offered be published, campaigns to inform the public of the services available be launched, and a common directory listing available services created.

6.3.22 Besides the overlap in the weight management programmes provided within the public sector, the existence of small-scale fragmented educational campaigns with different marketing characters was noted as another example of the lack of communication and coordination within the health sector. Integrated health patient records, a comprehensive database of available services, established information dissemination channels and educational seminars for professionals were considered helpful in improving cooperation within the healthcare sector.

6.4 Is Government providing an enabling and positive environment for other actors to contribute?

6.4.1 The final aspect of review considered by the NAO related to whether the Government provided an enabling and positive environment for other actors, including business stakeholders, NGOs, academics, professionals in the field and affected groups, to contribute to efforts aimed at reducing the prevalence of pre-obesity and obesity. The elements assessed by the NAO in this respect relate to whether the Government took into consideration other stakeholders when designing policy and action, the extent to which the Government consulted with various non-governmental stakeholders in the design of legislation, policy, initiatives and services, and the extent to which positive developments, including areas of cooperation for implemented actions, have been secured. In assessing these elements, this Office considered the feedback provided by stakeholders, the records of work of the Advisory Council and the information relating to the implementation of the Healthy Weight for Life Strategy. Looking forward, the NAO also reviewed various recommendations put forward by stakeholders regarding

efforts that could be undertaken by the Government to better facilitate the contributions of other actors.

6.4.2 The NAO is of the understanding that the first step in providing an enabling and positive environment that is conducive to the contribution of other stakeholders is the consideration of the stakeholders one seeks to involve. Attention in this regard is directed towards how stakeholders influence behaviours that contribute to excess weight in the population, their potential contribution in addressing this issue, possible areas of collaboration and envisaged pushback to intended actions. This Office's review of the Healthy Weight for Life Strategy, the records of work of the Advisory Council and focus group discussions suggests that such considerations are central to Government's approach to tackling overweight, and recommends for these considerations to be sustained in the future. The NAO acknowledges that the Healthy Weight for Life Strategy envisages NGOs and the private sector as part of the solution. The review of the Advisory Council meeting minutes confirms that the Council considered potential collaborations and the influence of the EU, market forces, and marketing and advertising in its deliberations. Stakeholder feedback also confirms that public sector representatives, including representatives of the MFH, are cognisant of the influence of other stakeholders, most especially business, on people's behaviours, the political will to act, and the successful implementation of Government interventions. Additionally, stakeholders recognised the potential of encouraging and incentivising external stakeholders to contribute to the efforts aimed at reducing overweight.

6.4.3 The NAO recognises the various efforts undertaken by the Advisory Council to consult and foster cooperation with actors external to the Government; however, contends that there is scope for wider and more impactful consultative practices. In this respect, the NAO supports the Council's resolution to undertake further consultation with other stakeholders going forward, to secure additional feedback and commitment from different sectors.

6.4.4 With respect to policy consultation, the NAO commends the wide-ranging consultation undertaken in the process of drafting and finalising the Healthy Weight for Life Strategy. Nevertheless, considering the feedback of certain stakeholders regarding their lack of involvement, this Office is of the opinion that scope for improvement in terms of the breadth of stakeholders consulted when drafting the upcoming strategy still exists. The scope for wider consultative practices also applies more broadly to the drafting of legislation, policy formulation and service design, delivery and evaluation across sectors, to allow for a more inclusive, comprehensive and grassroots approach to governance.

6.4.5 The NAO commends the progress registered, albeit limited, in private sector settings and with non-governmental stakeholders. Specifically, this Office notes the positive developments relating to healthcare practitioners working in the private sector, sports non-profit organisations, food reformulation of local products, and within school and workplace settings. The NAO acknowledges that there is ample scope for additional collaboration with non-governmental stakeholders to capitalise on all available resources, overcome capacity shortages and ensure a holistic approach towards tackling obesity. This Office subscribes to the view expressed by several stakeholders that businesses should be integrated as part of the solution, as they can be instrumental in affecting the required changes.

It is within this context and for this reason that the private sector ought to be more broadly and intensely consulted to explore areas of cooperation and incentivised and supported to offer healthier products and services. The NAO supports the Government's consideration of proposals put forward by stakeholders for increased collaboration with NGOs, academics, business operators, including employers, and professional associations and health care professionals operating in the private sector.

Considering external actors in the formulation of policy and action

6.4.6 NGOs and the private sector, collectively comprising workplaces, private sports clubs and gyms, and private health care practitioners, are included in some areas for action outlined in the Healthy Weight for Life Strategy. More specifically, the Strategy proposes establishing partnerships with the wider community and in association with NGOs for the provision of more nutrient-dense food and beverage options in the community, providing opportunities and incentives to encourage NGOs and the private sector to provide physical activity initiatives that are accessible and affordable to all, and the setting up of cookery clubs in workplaces and day care centres. Another area for action included in the Strategy is the issuance of guidelines on messages to be delivered in weight management courses, to be disseminated to practitioners working in the private and the public sector.

6.4.7 The review of the Advisory Council meeting minutes indicated to the NAO that the Council considered the private sector as a possible partner in its work towards enabling healthier lifestyles. In this respect, the Advisory Council acknowledged the private sector's corporate social responsibility as a channel through which focus on healthy lifestyle projects could be realised, and cautiously sought to explore the possibility of working with industry through public-private partnerships.

6.4.8 The Advisory Council also considered the influence of the EU and market forces, and marketing and advertising. The Council followed the work being done at EU level on various matters including the banning of trans fats, the setting of fiscal policies, food reformulation, the procurement of healthy food for schools, the audio-visual marketing directives, front-of-pack labelling and school lunches. The Advisory Council acknowledged that Malta could benefit from the experience of the joint research committee at the EU level, EU experts and other member states that have introduced several related measures. The Council often considered the impact or reaction of market forces on various decisions and interventions. By way of example, the Council identified the need for a positive approach and prescriptive guidelines to ensure cooperation and compliance from school tuck shop operators in view of complaints raised following the enactment of legislation regulating food in schools. Similarly, feedback from industry was sought and considered when discussing food reformulation. Other considerations included food product reformulation by industry as a response to healthier specifications in procurement requirements, market availability and local market considerations, market acceptance and profitability considerations for healthier options in restaurant menus, the impact of legislation regulating food on small industry and small countries with large amounts of imported goods and possible price spikes by industry following the introduction of fiscal measures. Similarly, the influence of advertising of unhealthy food on consumer behaviour, especially in the case of children, was discussed by the Advisory Council.

6.4.9 The role of external actors also emerged in the focus group discussions. Various stakeholders, including public sector representatives, recognised the need for further united, aligned and coordinated efforts across diverse sectors in the public and private spheres. The participation of the private and NGO sectors in the address of overweight were highlighted in this respect. Special emphasis was directed towards the private sector, recognising that its actions influence the health of consumers and society at large by directly determining product availability and pricing, thereby shaping the diet and lifestyle of the local community. Nevertheless, the challenge of fostering cooperation with the private sector was acknowledged, for business remains primarily motivated by profit. The opposition exerted by powerful lobby groups in reaction to legislative and policy changes perceived as having an impact on their commercial interests, and their significant influence on policy makers at the European and local levels, was also recognised.

6.4.10 Stakeholders also discussed the need to further legislate on the advertising and marketing (including packaging) of unhealthy food and weight loss products and regimes. Additionally, stakeholders were aware of coordinated efforts at EU level regarding advertising regulations, food labelling, food reformulation, pesticide use and the management of market forces.

Consultation

6.4.11 The NAO's review of the minutes of the Advisory Council provided evidence that consultation and cooperation was sought not only with experts and stakeholders internal to the Government, but also with other actors external thereto, including representatives of industry, private enterprises, an international organisation and a professional association. During focus group sessions, the Advisory Council referred to several discussions held with business leaders on key issues, such as in relation to food reformulation and portion sizes of sweetened beverages with manufacturers, and on spatial planning with developers, with the aim of finding possible areas of agreement and cooperation. Going forward, the Council recognised that more feedback and commitment was to be secured from different sectors to better inform its decisions on future action and ensure ownership and commitment in respect of specific remits and initiatives.

6.4.12 As regards policy consultation, the MFH explained that the process of developing the Healthy Weight for Life Strategy included initial consultation meetings with many stakeholders at the start of the process. A working group, which included stakeholders from across government, business representatives and an NGO, had drafted the Strategy that was subsequently issued for public consultation. The Strategy was launched after effecting the necessary revisions following feedback received. Despite the wide-ranging consultation undertaken, some officially appointed bodies engaged with by the NAO indicated not being consulted or directly involved in identifying possible solutions for the address of obesity. Similarly, some representatives of NGOs and professional associations claimed that they were not involved in the process of drafting the Healthy Weight for Life Strategy and, in some cases, had no knowledge of the published Strategy.

6.4.13 Although the Government has consulted with various stakeholders in its efforts to reduce the prevalence of pre-obesity and obesity, several stakeholders highlighted the scope for greater consultation in the drafting of legislation, policy formulation as well as in weight management service design, delivery and evaluation. In terms of the wider policy context affecting overweight, stakeholders criticised the consultation process for not seeking direct input at an earlier stage in the drafting process, and on grounds that feedback provided is not sufficiently shaping policy. In this respect, participants argued that consultation processes need to be more inclusive and comprehensive. A grassroots approach was considered paramount in designing effective solutions that translate into the desired results. The need to include patient representatives and professionals who practice or conduct research in the field, in the private and public sector, throughout the consultation process, was mentioned by NGO and professional association representatives. Specific reference was also made to the need for wider and more meaningful communication with employers and private sector stakeholders to explore areas of possible collaboration and ensure buy-in.

Positive developments registered

6.4.14 Examples of successful collaboration were mentioned by a few stakeholders. The MFH representatives indicated working with NGOs, medical and dental students' associations and various health professionals to promote healthy eating and physical activity. Several participants acknowledged the role of the private sector in offering weight management programmes as well as the services of nutritionists, dieticians and lifestyle coaches. Additionally, several participants acknowledged the role of health professionals, including general practitioners and pharmacists, in transmitting information, raising awareness and providing tailored advice regarding healthy lifestyles. These health professionals also played a central role in referring patients to specialists, such as dieticians and nutritionists, or to specific services, such as weight management programmes, when necessary.

6.4.15 The MFH representatives also referred to negotiations undertaken with food manufacturers to encourage them to reformulate their products to decrease fat, sugar and salt content. Regarding food reformulation, the Advisory Council indicated that Government's discussions with certain industry leaders had reaped benefits, as was the case with the salt reduction in local bread and sugar reduction in yoghurts. The issuance of guidelines for the procurement of healthy foods in various institutions was considered as a possible new entry point for food reformulation, with bidders for tenders having to provide healthier alternatives to be compliant with the technical specifications set.

6.4.16 Positive developments were also registered within the workplace context. The guidance document 'Improving Employee Health in the Workplace: Guidelines for Employers', introduced in 2022 by the HPDP, was intended to support the adoption of healthy behaviours in the workplace by means of several recommendations. Through the Healthy Workplace Scheme many workplaces consult with and obtain the support of the HPDP on implementing positive changes targeting the wellbeing of employees. The MFH also has ongoing partnerships established with workplaces to increase awareness on nutrition and physical activity as well as on other areas of health. Additionally, weight management programmes offered by the HPDP are sometimes offered from specific workplaces to ensure accessibility, while the Primary HealthCare organises seminars at different workplaces to raise awareness and disseminate information regarding the weight management services that are available.

6.4.17 Certain elements of the progress registered within the school environment, such as the issuance of relevant policies and legislation regulating the food types made available to children in canteens and during activities, is also applicable to private schools. In relation to sports non-profit organisations, the financial assistance provided to these organisations by SportMalta through various schemes was positively acknowledged. Parish priests were mentioned as playing a central role in identifying low-income families or families facing difficulties in a dignified and effective manner for targeted interventions.

Further actions required

6.4.18 Stakeholders put forward recommendations for enhanced collaboration with, among others, NGOs, academics, business operators, professional associations and health care professionals operating in the private sector. The stakeholders argued that this would allow the Government to capitalise on all available resources, overcome capacity shortages and ensure a holistic approach to tackling obesity.

6.4.19 In relation to food, stakeholders spoke of the need to educate, encourage and incentivise importers to include healthier products in their range; for supermarkets to prominently display and promote healthy food products on their point-of-sale displays; for catering establishments to opt for healthier cooking methods and ingredients, decrease portion sizes, provide the option of healthy meals and present nutritional information in their menus; and for food producers to introduce front-of-package labelling and provide healthier formulations and options. Proposed incentives included a reduction in taxes, subsidies and voucher systems, all intended to encourage consumers to opt for healthier foods and to incentivise and support businesses in making healthier foods more accessible and affordable. While some of these measures targeted the end consumer, such as through the voucher schemes and subsidised or free lunches within schools, other measures were designed for implementation further up the chain, as would be the case with financial support for farmers or grants for restaurants offering healthier options. Regarding such incentives, the Advisory Council noted that the challenge was in identifying the products or businesses to include in a given scheme to ensure that the support provided trickles down to the end consumer rather than resulting in super profits for the business and to avoid the further promotion of the practice where persons do not prepare their own meals. These incentives were proposed partly in recognition that businesses may require financial support to implement certain changes, as otherwise they risk becoming unsustainable, and partly in hope that the agenda to address obesity is subscribed to by them and considered a profitable endeavour, thereby substantially aiding Government's efforts. Moreover, some businesses are interested in providing healthier, local and more sustainable products, and in having a positive impact on society's wellbeing, and may be responsive to any nudging provided by fiscal incentives, funding and voucher schemes. Other proposals relating to food included facilitating the direct selling of produce from the farmer to the consumer and educating consumers to opt for local, seasonal and fresh produce, as well as underutilised cheaper produce.

6.4.20 Another area where scope for further collaboration with the private sector was envisaged relates to physical activity and active transportation. Sustained initiatives for government vouchers for sports activities, schemes for tax rebates for child enrolment in sports clubs and the purchase of sports equipment, as well as funds for fitness instructor training were proposed to further support business

enterprises in the sports and fitness industry, while simultaneously encouraging physical activity. A SportMalta representative commented about human resource shortages in sports non-profit organisations, where volunteers are often responsible for the management and operation of the organisation, service provision and for ensuring compliance with bureaucratic requirements. SportMalta suggested that Government ought to consider ways of facilitating and streamlining adherence to such requirements. Additionally, ERA commented on the need for further collaboration with NGOs and private businesses that focus on active mobility.

6.4.21 A few stakeholders were of the opinion that actions targeting the workplace were lagging, thereby recognising the need for efforts focused on workplace settings and on securing the cooperation of employers. Greater awareness from employers as regards the positive impact of healthy lifestyles on physical and mental wellbeing, and by consequence on employee focus, sick leave utilisation and productivity, was considered necessary. It was proposed that employers should be encouraged and supported to accommodate further health promotion activities, possibly during break time, make available healthy snacks and meals at work canteens and events, allow time for exercise breaks, include gym allowances as part of the remuneration package, or provide gym facilitates on site and organise sports events. Additionally, a service provider noted that employers should be encouraged to support employees who require residential weight loss programmes by sponsoring their leave to attend such programmes.

6.4.22 The important role of various health professionals, including general practitioners and pharmacists, in transmitting information, raising awareness, providing tailored advice regarding healthy lifestyles and referring patients to specialists was recognised as somewhat restricted by time constraints, competing priorities, limited knowledge and support, resistance from patients, capacity shortages and long waiting lists for specialised services. For this reason, proposals were put forward to consolidate and support this role through structured programmes, training and financial and other means and possibly through public-private partnerships. Such initiatives would help mitigate capacity shortages and strengthen outreach efforts by making better use of and better supporting existing private health care resources that are accessible to the public in a more systematic manner. Providing general practitioners in private practice with access to the public health system medical records was considered imperative to strengthening their role in health promotion and disease prevention, and to improve coordination efforts across the public and private sectors in the area of obesity and more holistically in health care. Additionally, it was suggested that professional associations be used as a channel to disseminate relevant information to professionals working in the private sector to ensure that they are informed of any new developments.

6.4.23 Strengthened cooperation and networking between the public sector and academics was considered essential for maximising the effectiveness of current resources and ultimately attaining the desired reductions in pre-obesity and obesity rates. Several academics discussed their potential contribution in terms of research and evidence-based proposals for further action, capitalising on their strength at multidisciplinary work, expertise in various disciplines and research capabilities. Academics advocated for administrators, policy makers and politicians to consider research undertaken as the basis to informing policy development. Other proposals featuring the involvement of academics included

the setting up of a multidisciplinary forum or platform to identify and propose initiatives intended to address overweight, as well as the provision of a funding stream to encourage research in the area.

6.5 Overall conclusion

6.5.1 Regarding whether progress has been realised, the NAO ascertained that, over recent years, the pre-obesity, obesity and overweight indicators for children, adolescents and adults registered increasing trends. The only exception is the child obesity indicator, which remained stable. The NAO's overall assessment of the achievement of the targets set in the Healthy Weight for Life Strategy is similarly negative, with only one of the four targets set, that relating to adolescent obesity, met. In considering the lack of progress registered, the NAO takes cognisance that the failure to reduce pre-obesity and obesity prevalence rates is not unique to Malta. Moreover, this Office acknowledges the complex nature of overweight, the pervasive and strong presence of an obesogenic environment that is not entirely within the control of the Government, as well as the element of personal responsibility and choice.

6.5.2 As to whether the Government's efforts to address pre-obesity and obesity were sufficient and effective, the NAO recognises the investment and efforts undertaken by the Government, including legislative changes, policy developments, as well as implemented projects, measures and initiatives. However, sustained high prevalence rates of overweight and the individual and national implications of obesity raise concerns about whether the Government is fully cognisant of the scale of the problem and taking sufficient action. The NAO acknowledges feedback from stakeholders highlighting gaps in funding, human resources and service provision, and issues related to lack of policy coherence. Of concern to the NAO are the limited legislative changes implemented, far reduced in scope from that intended in the original private member's bill tabled to address obesity. This Office advocates for strengthened political will to make the address of overweight an overarching priority across the different sectors of the Government, and for the allocation of appropriate resources and funding, as well as the undertaking of sufficient efforts in this respect. The NAO is of the opinion that while the Government has undertaken several measures that positively address the vulnerabilities of particular groups, disaggregated statistics and the feedback sourced from stakeholders provide insight into the systemic disadvantages of specific demographic groups, which in turn highlight the need for more varied and sustained targeted efforts to effectively reach all vulnerable groups.

6.5.3 The NAO is of the opinion that the Advisory Council provides an adequate framework for enabling communication, coordination and cooperation within Government and for promoting a whole-of-government approach to addressing overweight, and that the strengthening of the Council could help secure more impactful outputs and positive outcomes in terms of the set targets. This Office also recognises the need for the Council to further widen its consultative processes to include more stakeholders from various sectors, and to introduce a more robust monitoring and implementation framework. While the NAO notes the efforts undertaken to promote whole-of-government cooperation and a health-in-all-policies approach to tackling overweight, this Office acknowledges the concerns raised by stakeholders regarding elements of incoherence in the wider policy framework, shortcomings in policy implementation and inconsistencies between policy frameworks and major projects design.

The NAO therefore advocates for strengthened political will to prioritise health considerations and further cooperation across ministries and entities within the MFH and across Government at the level of policy implementation and service provision.

6.5.4 The final element of review is whether the Government is providing an enabling and positive environment for non-governmental actors to contribute to the address of pre-obesity and obesity. The NAO noted that the consideration of non-governmental stakeholders when designing policy and action is central to Government's approach to tackling overweight, and recommends for these considerations to be sustained in the future. Moreover, this Office recognises the various efforts undertaken by the Advisory Council to consult and foster cooperation with actors external to the Government; however, contends that there is scope for wider and more impactful consultative practices. The scope for such practices also applies more broadly to the drafting of legislation, policy formulation and service design, delivery and evaluation across Government sectors, to allow for a more inclusive, comprehensive and grassroots approach to governance. With respect to successful areas of cooperation for implemented actions, the NAO commends the progress registered, albeit limited, in private sector settings and with non-governmental stakeholders. The NAO acknowledges that there is ample scope for the Government to further collaborate and partner up with non-governmental stakeholders, to capitalise on all available resources, overcome capacity shortages and ensure a holistic, effective and sustainable approach towards tackling obesity. Specifically, this Office supports the view that by involving businesses as stakeholders, through consultation, as well as incentive and support schemes, it becomes possible to leverage their expertise, resources, and reach to effect positive change.

Annex | Methodological considerations

1. This review, which focuses on SDG target 2.2, and more specifically the reduction of overweight, be it in terms of pre-obesity and obesity, is consistent with the role assigned to SAIs in respect of the successful realisation of the SDGs – that of conducting reviews that measure progress on particular goals. The International Organization of Supreme Audit Institutions (INTOSAI) included SAIs' contribution to the achievement of the UN Agenda 2030 as one of the five key priorities in its Strategic Plan 2023-2028. INTOSAI encouraged member SAIs to "contribute to audits of the UN Sustainable Development Goals within the context of each nation's specific sustainable development efforts and SAIs' individual mandates." The Moscow Declaration of the 2019 INTOSAI Congress captures the centrality of this function, wherein it is stated that the future direction for public auditing is dependent on the strong commitment by INTOSAI and SAIs to provide independent external oversight on the achievement of nationally agreed targets, including those linked to the SDGs.

2. SDG target 2.2, as defined by the 2030 Agenda for Sustainable Development, aims to end all forms of malnutrition. According to the WHO, malnutrition refers to deficiencies or excesses in nutrient intake, imbalance of essential nutrients or impaired nutrient utilisation. The double burden of malnutrition consists of undernutrition, pre-obesity and obesity on one hand, and diet-related noncommunicable diseases on the other.

3. The IDI's SDGs Audit Model (ISAM) was used as guidance to plan and execute this review. ISAM shed light on the importance of considering various elements of Government's efforts to address the issue of overweight, including the legal and policy framework, the governance structure, the available financing and resourcing, the measures, projects and initiatives undertaken, as well as the monitoring and data collection system for measuring prevalence. In line with ISAM, in appraising these elements of Government's efforts, consideration was given to horizontal and vertical coherence, collaboration and coordination, multi-stakeholder engagement and the leave no one behind principle.

4. It is within this context that this review focuses on Government's efforts at addressing overweight, particularly considering whether efforts undertaken were comprehensive, effective and inclusive, and the extent of progress achieved with respect to the nationally set targets. More specifically, the NAO enquired whether:

   a. progress has been achieved;

   b. Government's efforts are sufficient, effective and address all vulnerable groups;

   c. there is sufficient communication, coordination and cooperation within Government; and

   d. Government is providing an enabling and positive environment for other actors to contribute.

5. The fieldwork undertaken in this review was structured in four main components. The first component entailed the engagement of various stakeholders during the conducting stage of the review. This component was intended as a source of gathering relevant evidence. The perspective of the stakeholders helped in obtaining greater insight into the complexity of the issue of overweight, its contributing factors and its consequences. Moreover, stakeholders provided their views regarding the positive efforts undertaken by Government, as well as any perceived shortcomings and recommendations necessary to address them. The stakeholders engaged in this respect comprised several ministries and public sector entities, the Advisory Council on Healthy Lifestyles, various NGOs, professional associations, service providers and academics, as well as business stakeholders and numerous governmental officially appointed bodies.

6. The NAO held focus groups with academics, service providers, the Advisory Council, and representatives of the MFH, NGOs, professional associations and the public sector, separately. The NGOs were recruited through the distribution of an open call by the Malta Council for the Voluntary Sector to all organisations working in the areas of health, education or fitness. This effort was supplemented through direct contact made by the NAO with several NGOs. Academics were recruited through direct email submissions to known lecturers and researchers who have a special interest in obesity. The Malta Obesity Association, the Malta Health Network, the Federation of Organisations of Persons with Disability, the Anti-Poverty Forum, the Għaqda Bdiewa Attivi and the Arthritis and Rheumatism Association Malta were the participating NGOs. Prof Maria Attard, Dr Maresca Attard Pizzuto, Dr Therese Bajada, Dr Patricia Bonello, Dr Marie Briguglio, Ms Sina Bugeja, Dr Noel Buttigieg, Prof Sandra Buttigieg, Prof Neville Calleja, Dr Claire Copperstone, Dr Andrew Decelis, Prof Julian Mamo, Dr Wendy Jo Mifsud, Dr Karen Mugliett, Prof Suzanne Piscopo, Dr Anthony Sacco, Dr Sarah Scheiber and Prof Josanne Vassallo were the participating lecturers and researchers, referred to hereunder as the academics. Another two academics, Mr Edgar Galea Curmi and Dr Joseph Vella, provided their feedback in writing. Representatives of the Superintendence of Public Health, the HPDP, the Primary HealthCare, Dar Kenn għal Saħħtek and the Diabetes and Endocrine Centre within the MDH were the participating service providers. The Association of Private Family Doctors, the Malta Association of Occupational Therapists, the Malta Association of Public Health Medicine, the Malta Chamber of Pharmacists, the Malta Exercise Health and Fitness Association and the Maltese Association of Social Workers were the participating professional associations. MAFA, the MEYR, the MFE, the MTIP, Aġenzija Żagħżagħ, SportMalta and TM, were the participating public service ministries and public sector entities. The MSPC provided a written submission.

7. Several officially appointed bodies and business stakeholders were also contacted for written feedback. The Commission for the Rights of Persons with Disability, ERA, the Health Policy and Strategy Board, IM, the Malta Council for Economic and Social Development, the Office of the Commissioner for Children, the Office of the Commissioner for Older Persons, the PA and the Malta Chamber provided feedback in writing. The Malta Chamber of SMEs provided its feedback through an interview.

8. In addition, interviews were held with the MFH, the Director Sustainable Development Directorate, the Hon. Robert Cutajar and a WHO health expert.

9. In the case of academics, service providers, NGOs and professional associations, to encourage open participation, focus group participants were assured confidentiality. This was to be achieved by collective reference to the academics, service providers, NGOs and professional associations instead of the linking of individual submissions to specific participants.

10. The stakeholder feedback comprises the basis of Chapter 5. A thematic analysis was undertaken of the transcripts of the various focus groups and interviews held, and of the written submissions.

11. The second component of fieldwork entailed the sourcing and analysis of information obtained regarding efforts undertaken by Government to address overweight and obesity. This comprised the review and analysis of the minutes of meetings held by the Advisory Council on Healthy Lifestyles for the period 2016 to 2021 (Chapter 2), as well as the presentation and assessment of the information collated by the Strategy Development and Implementation Unit within the Office of the Superintendent of Public Health, regarding the measures, project and initiatives implemented across ministries and entities aimed at addressing the 89 areas for action included in the Healthy Weight for Life Strategy (Chapter 3).

12. A thematic analysis of the minutes of the Advisory Council on Healthy Lifestyles meetings was undertaken, eliciting salient points relating to the operational dynamics, areas of action, achieved output and factors influencing the work of the Council.

13. The information provided by the Strategy Development and Implementation Unit was part of a wider monitoring and evaluation exercise intended to assess implemented initiatives focusing on reducing non-communicable diseases. Consequently, to reduce the administrative burden on ministries and entities, and to avoid the duplication of work, the NAO utilised this available data instead of sourcing the information directly from governmental stakeholders. The Strategy Development and Implementation Unit provided an assessment of the implementation progress of each of the 89 areas for action, and details of the efforts undertaken by multiple stakeholders to address these areas for action. In this respect, the NAO included its opinion on the validity and comprehensiveness of the identified implemented actions in relation to the corresponding area for action and its assessment of implementation progress.

14. The third component of fieldwork comprised the analysis of data. This is presented in Chapter 4. To measure progress and better understand the patterns of pre-obesity, obesity and overweight over time and across demographic groups, to gauge Malta's prevalence severity in comparison to other countries, and to assess the pervasiveness of health determinant behaviours that contribute to excess weight, the NAO sourced COSI, HBSC and EHIS data for analysis. For ease of reference COSI data was referred to as child data, HBSC data as adolescent data and HBSC data as adult data. It is to be noted that the data cited may be subject to small rounding errors. The Directorate for Health Information and Research were instrumental in understanding the available data and establishing the necessary connections to source the data from the respective international offices.

15. The prevalence rates for pre-obesity, obesity and overweight for children aged six to nine for countries across the WHO European Region, including Malta, for rounds one to six (2007/2008-2021/2023) were provided to the NAO by the WHO European Office for Prevention and Control of Noncommunicable Diseases (NCD Office). International data was only available for rounds one to five (2007/2008-2018/2020), while data for rounds one to six (2008-2022) were available for Malta. The WHO NCD Office noted that round six (2021-2023) figures for other countries were not yet available to be made public, and that round six (2022) data for Malta (provided in March 2023), for which data collection was undertaken in the period April to May 2022, were to be considered preliminary. The WHO NCD Office explained that different countries sample different age groups – six-year-olds, seven-year-olds, eight-year-olds or nine-year-olds – with some countries sampling multiple age groups within the range indicated. However, age-combined estimates are not computed for countries that sample multiple ages groups, as COSI data show that estimates tend to increase with age. Since not all countries target all age groups, the practice assumed by the WHO NCD Office is to avoid comparing countries using estimates of children of different age profiles. Similarly, in comparing trends over time for Malta, attention must be directed towards the fact that rounds one and two sampled six-year-olds, while seven-year-olds were sampled for subsequent rounds. Sex-combined estimates were only produced for the fifth round of data collection, and while the WHO NCD Office was able to produce sex-combined estimates for all rounds for Malta, the same could not be done for other countries since these statistics were not published or shared with principal investigators of the respective countries.

16. Prevalence rates for pre-obesity, obesity and overweight for adolescents aged 11, 13 and 15 for countries across Europe and North America, including Malta, for 2014 and 2018 were sourced by the NAO from the HBSC Data Management Centre. The Centre noted that although Malta was part of the network in 2009, data was not included in the international report and the datafile was not stored in its repository. Of note is that for the HBSC and COSI data, pre-obesity, obesity and overweight (including pre-obese and obese persons)[13] are determined based on the cut-offs indicated in the WHO growth reference for age.

17. Prevalence rates for pre-obesity (BMI 25 to 29), obesity (BMI 30+) and overweight (BMI 25+) for the population aged 15+ for the 27 countries of the EU[14], including Malta, for 2014 and 2019 were accessed from the EUROSTAT website in February 2023.

18. Prevalence rates for children (6–9-year-olds, COSI), adolescents (11-, 13-, 15-year-olds, HBSC) and adults (15+-year-olds, EHIS) were compared across participating countries and over time. The analysis across countries allows for an assessment of the scale of the obesity and overweight problem in Malta relative to other countries. The analysis over time provides an insight into the trend in prevalence rates.

[13] The HBSC uses the term overweight to define those children who have excess weight but are not obese. This category is generally referred to as pre-obese in other data sources. For comparability in terminology, pre-obese, obese and overweight (pre-obese and obese) are also being used for the reporting of HBSC data in this report.

[14] Data for Ireland was not available for 2019 due to unreliable estimates.

19. Further analysis focused on salient indicators by demographic characteristics, namely gender, educational level, wealth and family structure, assessing patterns in prevalence rates across socio-demographic categories and identifying vulnerable groups that are more susceptible to excess weight. This analysis was undertaken for the most recent available data for each data source, that is, 2019 data for COSI, 2018 data for the HBSC and 2019 for the EHIS. The choice of demographic variables for each data source was dependent on its availability and ease of access. For the HBSC, data was provided by the HBSC Data Management Centre in Bergen. For the EHIS and COSI, the information presented in the analysis was publicly available and accessed from the EUROSTAT website in the case of the EHIS and extracted from the supplementary data tables in the latest COSI publication. The only exception in relation to COSI data is that relating to perceived family wealth, which information was provided by the WHO NCD Office in respect of all third graders (as opposed to 7-year-olds), to allow for narrower confidence intervals.

20. Statistics for health determinant behaviours, specifically food consumption and physical activity levels, for COSI 2019, HBSC 2018 and EHIS 2019, were also reported. These statistics provided insights into the prevalence of behaviours that may impact health outcomes, including overweight and obesity. For the HBSC, this data was provided by the HBSC Data Management Centre in Bergen, and valid percentages[15] are quoted in the relevant section. For COSI and the EHIS, the information cited was publicly available, extracted from the supplementary data tables in the latest COSI publication and accessed from the EUROSTAT website, respectively.

21. Finally, available statistics were considered to determine whether the targets specified in the Healthy Weight for Life Strategy for the implementation period 2012-2020 were met.

22. The fourth and final component of fieldwork related to review. In this regard, the views of the MFH were obtained at the reporting review stage to ensure a comprehensive and accurate representation of the views held by this primary stakeholder. Important comments that were deemed as further enriching the review undertaken were captured. The final draft, including the comments incorporated at reporting review stage and the analysis and conclusions of the NAO, were also made available to the MFH as part of the exit process.

[15] Missing data are excluded from calculations and therefore the total count includes only valid cases.

2022-2023 (to date) Reports issued by NAO

NAO Annual Report and Financial Statements

June 2023	National Audit Office Annual Report and Financial Statements 2022

NAO Audit Reports

July 2022	Performance Audit: Procuring the Public Transportation Service
October 2022	Performance Audit: The COVID-19 pandemic- Business continuity within the public administration
October 2022	Performance Audit: A Follow-up on the 2018 Strategic Overview of Mount Carmel Hospital
November 2022	Follow-up Audits Report by the National Audit Office Volume II 2022
November 2022	Report by the Auditor General on the workings of Local Government for the year 2021
November 2022	Performance Audit: Care for the Elderly in Gozo
December 2022	IT Audit: Online Malta Census of Population and Housing 2021
December 2022	Report by the Auditor General on the Public Accounts 2021
February 2023	IT Audit: Active Ageing and Community Care – Ministry for Active Ageing
April 2023	Performance Audit: An assessment of capital projects at the University of Malta
April 2023	Performance Audit: Ensuring fair Non-Contributory Social Benefits and safeguarding against related fraud
May 2023	An audit of matters relating to the concession awarded to Vitals Global Healthcare by Government Part 3 | Steward Health Care assumes control of the concession
May 2023	An audit of matters relating to the concession awarded to Vitals Global Healthcare by Government Part 3 | Steward Health Care assumes control of the concession [Abridged]
June 2023	Follow-up Audits Report by the National Audit Office Volume I 2023
June 2023	IT Audit: Food Agency