

Meeting population dietary goals in Scotland and Malta: shared challenges and opportunities for learning.

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1 **MEETING POPULATION DIETARY GOALS IN SCOTLAND AND MALTA: SHARED CHALLENGES**
2 **AND OPPORTUNITIES FOR LEARNING**

3

4 *Commentary*

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24 **Running head**

25 Dietary goals in Scotland and Malta

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31 **Abstract**

32 Scotland and Malta share a high prevalence of overweight and obesity: around two-thirds of adults are
33 overweight (including obese), and one-third are obese. Reducing this burden of overweight and obesity
34 is a priority for both Scottish and Maltese Governments, which involves setting dietary goals and
35 monitoring the progress of the population to meeting those goals, and developing policies to improve
36 health. This commentary summarises the progress of Scotland and Malta to meeting dietary goals,
37 challenges to meeting the goals, and actions being taken. Whilst dietary guidelines are in place in both
38 countries, Malta has yet to estimate average population dietary intakes and is awaiting results from its
39 first national survey. In Scotland however, there are various well established dietary surveys which can
40 be used to inform the development of policy, yet little progress towards the Scottish Dietary Goals has
41 been seen between 2001 and 2015, and the prevalence of overweight and obesity has not changed
42 since 2008. In order for dietary goals to be met, dietary guidelines need to be promoted, understood,
43 and translated into changes in dietary behaviour. However, barriers to behaviour change need to be
44 addressed, with research required to design long-term interventions that are successful and cost-
45 effective in all population groups. Scotland can learn from Malta's dietary guidelines which treat fruit and
46 vegetables as two separate groups, provide serving size and consumption guidelines, and incorporate
47 the positive message to use herbs and spices for flavour. Also, Malta can learn from the methodologies
48 of established Scottish and UK surveys to create their own programme of dietary surveys. The sharing
49 of experiences of researchers, policy makers and health promoters in these countries is therefore
50 beneficial for tackling the current obesity epidemic and promoting a healthier future.

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52 **Keywords**

53 Diet, food, nutrient, goals, Malta, Scotland

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61 **Introduction**

62 Scotland and Malta share a significant obesity problem. In Scotland, the prevalence of overweight
63 (including obesity) and obesity was 65% and 29% respectively in adults aged ≥ 16 years in 2016
64 (Bardsley, 2017). In Malta, the prevalence of overweight was 70% in adults aged 18-70 years in 2014-
65 16, and 37% of men and 31% of women were obese (Cuschieri et al, 2016). Reducing the disease
66 burden from unhealthy diets are priorities for Scottish and Maltese Governments. This involves setting
67 dietary goals and monitoring the progress of the population to meeting those goals, which informs
68 policies to improve health and wellbeing. This commentary summarises the progress of Scotland and
69 Malta to meeting dietary goals, challenges to meeting the goals, and actions being taken. We conclude
70 with recommendations based on the examination of strategies in place in each country.

71

72 **Scottish Dietary Goals and Guidelines**

73 The Scottish Dietary Goals were introduced in 1996 (The Scottish Office, 1996) and were based on the
74 UK Dietary Reference Values (Department of Health, 1991) for selected nutrients and foods. They were
75 originally intended for achievement in 2005, although the timescale was later extended to 2010. The
76 goals were most recently updated in 2016 to “indicate the direction of travel, and the extent of the dietary
77 change needed, to reduce the burden of obesity and diet-related disease in Scotland” and to “underpin
78 diet and health policy in Scotland” (Scottish Government, 2016). The goals are similar to those set in
79 1996 regarding fruit and vegetables, oily fish, total fat, saturated fat, and salt. Goals were also added
80 for red meat, calories, *trans* fatty acids, free sugars, dietary fibre and total carbohydrate.

81

82 Most goals are monitored via secondary analysis of Scottish data from the Living Costs and Food
83 Survey, which collects food purchase data from every person over 7 years of age in each household for
84 14 days. Estimates of food waste are made before estimating consumption for a typical average
85 household member (Barton et al, 2018). The National Diet and Nutrition Survey uses a four day
86 estimated diary to monitor *trans* fatty acid intakes (Bates et al, 2017), and the urinary sodium survey
87 monitors salt consumption (Scottish Centre for Social Research, 2011). The goal for calories is
88 monitored using the Scottish Health Survey’s estimates of overweight and obesity (Bardsley, 2017).

89

90 Table 1 shows recent estimated Scottish average intakes compared with the Scottish Dietary Goals.
91 Energy density, and intakes of total fat, saturated fat, salt and free sugars (as non-milk extrinsic sugars)
92 are considerably higher than recommended, and consumption of fruit and vegetables, oily fish and
93 dietary fibre (as non-starch polysaccharides) is lower than recommended. There has also been little
94 progress towards the goals between 2001 and 2015 (Barton et al, 2018). Therefore, the Scottish
95 population require more support to improve their diet, through a combination of individual behavioural
96 changes, reformulation by the food and drink industry, and changes to the obesogenic environment
97 through a range of initiatives such as taxes on high fat/sugar products and policies to reduce easy
98 accessibility to high fat/sugar foods and drinks.

99

100 Whilst the Scottish Dietary Goals act as a reference for organisations and stakeholders whose actions
101 influence the population's diet, the Eatwell Guide is the key resource for consumers - providing
102 recommendations on the proportions of each food group to achieve a healthy balanced diet (Public
103 Health England, 2016). The Eatwell Guide divides foods into five groups: (1) fruit and vegetables, (2)
104 potatoes, bread, rice, pasta and other starchy carbohydrates, (3) dairy and alternatives, (4) beans,
105 pulses, fish, eggs, meat and other proteins, and (5) oils and spreads. There are also recommendations
106 regarding fluid intake, food label use, and reducing fat, salt and sugar (table 2).

107

108 **Maltese Dietary Guidelines and Nutrient Goals**

109 Malta has long recognised the need for promoting a healthy balanced diet in response to changes in
110 eating behaviours and increased obesity prevalence. The first nutrient goals for Maltese adults were
111 presented in 1986 and included guidelines for 12 nutrients, with recommendations to “eat less meat and
112 have fish and poultry in preference to beef; substitute high-fat dairy products with low-fat alternatives;
113 and eat fewer eggs, more fresh fruit and vegetables and whole grain flour” (World Health Organisation,
114 1986). The first Food Based Dietary Guidelines were launched in 1990 and focused on reducing fat,
115 sugar and salt; increasing fibre; reducing meat with an emphasis on white meat and fish; less high fat
116 dairy and eggs; more fruit and vegetables and wholegrain products; and less alcohol. The Malta Food
117 Pyramid Guide was launched in 2004, recommending the highest daily consumption from starchy foods
118 at the bottom of the pyramid, followed by fruit and vegetables, fewer daily servings of meat and
119 alternatives and dairy products, and the lowest consumption from fats and oils at the top of the pyramid.

120

121 The guidelines were updated in 2015 by the Health Promotion and Disease Prevention Directorate Malta
122 and considered recommendations from the 2015-2020 'Food and Nutrition Policy and Action Plan for
123 Malta' (Health Promotion and Disease Prevention Directorate Malta, 2014). This latest guide, for adults
124 aged 19-65 years, presents 'The Healthy Plate' versus the pyramid image, and depicts six food groups:
125 (1) cereals and cereal products, (2) vegetables, (3) fruit, (4) milk and milk products, (5) lean meat, fish,
126 poultry, eggs, legumes, nuts and seeds, and (6) fats and oils. It includes a focus on the Mediterranean
127 diet, serving sizes for all food groups, and the healthy lifestyle messages below (table 2).

- 128 1. A focus on variety from the different food groups
- 129 2. Using herbs and spices for flavouring, without adding salt
- 130 3. Drinking plenty of water
- 131 4. The importance of keeping active
- 132 5. Limiting intake of saturated and *trans* fats, sugar and salt, and consumption of alcohol and
133 energy drinks
- 134 6. Good oral health
- 135 7. Food safety tips

136

137 It is intended to revise these guidelines once results are available from the first Maltese dietary survey
138 - conducted in 2015-2016 using standardised electronic software (GloboDiet) and 24-hour dietary
139 recalls. However, it is expected that the population will not meet the dietary guidelines. The high
140 prevalence of obesity, and data from general food consumption surveys like the Malta Food
141 Consumption Survey (which used a 5-day food diary), suggest that sweets, biscuits and confectionery
142 remain the most popular snacks, with a low intake of fresh fruit at 1.25 servings/day (Malta Standards
143 Authority, 2010). Similarly the 2014-2015 European Health Interview Survey (which used two lifestyle
144 questionnaires) reported that 58% of Maltese adults consume fruit each day, with only 40% consuming
145 vegetables daily (Gauci et al, 2018).

146

147 **Barriers and solutions to healthier diets**

148 In order for dietary goals to be met, dietary guidelines need to be promoted, understood, and translated
149 into changes in dietary behaviour. However, barriers to behaviour change need to be addressed before

150 the gap between guidelines and practice can be closed. We discuss two examples below: reducing the
151 prevalence of overweight and obesity, and increasing the consumption of fruit and vegetables.

152

153 *Overweight and obesity*

154 Individual, social and cultural, and environmental factors all contribute to weight gain. In a workshop
155 conducted in July 2018 at the University of Malta, stakeholders discussed their opinions on what
156 constituted the main barriers to weight loss. These were numerous and diverse and included time
157 issues, the (higher) cost of healthy food, and taste (individual level), lack of support, cultural barriers and
158 stigma (social and cultural level), and the obesogenic environment, i.e. easy availability of unhealthy
159 food, lack of open spaces (for physical activity) and marketing of unhealthy products (environmental
160 level) (personal communication, 2018).

161

162 In British adults, the most common perceived cause of obesity was the food environment: 'people are
163 overweight because there are so many unhealthy foods around' (61%) (Beeken and Wardle, 2013).
164 Individuals were most supportive of policies involving healthy lifestyle campaigns (71%) and food
165 labelling in restaurants and takeaways (66%), and least supportive of taxes on the sale of unhealthy
166 foods (32%). However, in 2018, the UK Government introduced the Soft Drinks Industry Levy (the 'Sugar
167 Tax') which requires soft drink companies to pay a fee if drinks contain too much added sugar. Since
168 the policy was announced in 2016, over 50% of manufacturers have reformulated their drinks to contain
169 less sugar (HM Treasury, 2018).

170

171 Also in 2018, the Scottish Government published its 'Diet and Healthy Weight Delivery Plan' which aims
172 to achieve its vision for Scotland 'where everyone eats well and has a healthy weight' by working on five
173 outcomes: (1) children have the best start in life – they eat well and have a healthy weight, (2) the food
174 environment supports healthier choices, (3) people have access to effective weight management
175 services, (4) leaders across all sectors promote healthy diet and weight, and (5) diet-related health
176 inequalities are reduced. However, Scottish Government's Obesity Route Map (2010) and Action Plan
177 (2011) had little success: the prevalence of overweight and obesity is unchanged since 2008 (Bardsley,
178 2017). Nevertheless, a review of the Action Plan concluded that the situation may have been worse
179 without the considerable effort in response to the Obesity Route Map (Kerr, 2015).

180

181 The Maltese 'Healthy Weight for Life Strategy' (2012-2020) outlines initiatives relating to the promotion
182 of healthy eating and physical activity and the provision of healthcare services including weight
183 management programmes. Policies to tackle overweight and obesity in Malta include 'A Strategy for the
184 Prevention and Control of Non-communicable Diseases in Malta' and 'A Healthy Weight for Life
185 Strategy' (Ministry for Health, the Elderly and Community Care, 2010 and 2012), and various initiatives
186 to promote healthy lifestyle, as outlined by the Malta Food and Nutrition Policy Action Plan (Health
187 Promotion and Disease Prevention Directorate Malta, 2014), include increasing physical activity, eating
188 more fruit and vegetables, promotion of the Mediterranean diet, and reading of food labels.

189

190 *Fruit and vegetables*

191 The main barriers to increasing fruit and vegetable consumption have been reported to be 'cost' for fruit,
192 but 'food preferences' and 'taste' for vegetables (Glasson et al, 2010). Stakeholders in Malta also
193 identified taste, cost, lack of cooking skills and poor budgeting as individual barriers; stigma and peer
194 pressure as social barriers; and poor marketing (more unhealthy food being advertised) as well as fear
195 of high levels of pesticide residues as environmental barriers to consuming more fruit and vegetables
196 (personal communication, 2018). A Maltese study with stakeholders including farmers and consumers
197 revealed that prices and time to prepare healthy food were the main barriers for healthy, clean and fair
198 food (The President's Foundation for the Wellbeing of Society, 2018).

199

200 The different determinants of consumption of fruit and vegetables, and their differing potential health
201 benefits, support their treatment as two separate groups in health promotion strategies - as in the Malta
202 Healthy Plate, but not the UK Eatwell Guide. In Scotland, the lack of improvement in fruit and vegetable
203 consumption since 2001, and the lower consumption of both fruit and vegetables in more deprived areas
204 (Barton et al, 2018), justifies the need for considerable work to develop long-term interventions that are
205 successful and cost-effective in all population groups.

206

207 **Recommendations**

208 Scotland and Malta require food and drink policies that are effective in order to treat and further prevent
209 overweight and obesity. Policies need to create an enabling environment for all sectors of the population,

210 with priorities being children who need to learn healthy food preferences, and groups in more deprived
211 areas who need to overcome barriers to express healthy preferences. We can benefit by learning about
212 strategies in other countries which share similar challenges, and exploring opportunities for translating
213 these practices into effective policies at home. For instance, Scotland can learn from Malta's dietary
214 guidelines which treat fruit and vegetables as two separate groups, provide serving size and
215 consumption guidelines, and incorporate the positive message to use herbs and spices for flavour. Also,
216 Malta can learn from the methodologies of established Scottish and UK surveys to create their own
217 programme of dietary surveys. The sharing of experiences of researchers, policy makers and health
218 promoters in these countries is therefore beneficial for tackling the current obesity epidemic and
219 promoting a healthier future.

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221 **Conflicts of interest**

222 The authors report no conflicts of interest.

223

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321 **Table 1:** Average food and nutrient intakes in Scotland compared with the Scottish Dietary Goals (Scottish Government, 2016)

Food / Nutrient	Goal	Average Intake	Source
Energy density	Average energy density of the diet to be lowered to 125 kcal/100g	178 kcal/100g	Barton et al, 2018
Fruit & vegetables	Average intake to reach >400 g/day	257 g/day	Barton et al, 2018
Oily fish	Increase to 1 portion per person per week (140 g/week)	34 g/week	Barton et al, 2018
Red & processed meat	Average intake to be pegged at around 70 g per person per day	56 g/day	Barton et al, 2018
Total fat	Average intake to reduce to no more than 35% food energy	38.9% food energy	Barton et al, 2018
Saturated fat	Average intake to reduce to no more than 11% food energy	15.1% food energy	Barton et al, 2018
Trans fatty acids	Average intake to remain below 1% food energy	0.6-0.8% food energy	Bates et al, 2017
Free sugars	Average intake not to exceed 5% total energy	14.4% total energy ¹	Barton et al, 2018
Salt	Average intake to reduce to 6 g/day	8.8 g/day	Scottish Centre for Social Research, 2011
Fibre	Increase in average consumption for adults (≥16 years) to 30 g/day	12 g/day ²	Barton et al, 2018
Total carbohydrate	Average intake of approximately 50% total dietary energy	46.6% food energy	Barton et al, 2018

322 ¹Average intake of non-milk extrinsic sugars

323 ²Average intake of non-starch polysaccharides (main component of dietary fibre)

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Table 2: Comparisons between the UK Eatwell Guide and Malta Healthy Plate

Components	UK Eatwell Guide	Malta Healthy Plate
<i>Within main illustration</i>		
Plate model	✓	✓
Number of food groups	5	6
Fat, sugar and salt reduction	✓	✓
Hydration	✓	✓
Food labels	✓	X
Energy intake	✓	X
Limit alcohol intake	X	✓
Keep active and reduce sitting time	X	✓
Herbs and spices	X	✓
<i>Within full guidelines document</i>		
Vitamin and mineral supplements	✓	X
Oral health	X	✓
Avoid energy drinks	X	✓
Food safety	X	✓
Serving size and consumption guidelines	X	✓