World Health Organization

European Region

# Seventeenth meeting of the WHO Action Network on Salt Reduction in the Population in the WHO European Region

Dublin, Ireland
30 September – 1 October 2025

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## Meeting report

## Abstract

To help facilitate progress towards the globally agreed target to cut salt intakes by 30% by 2025, the WHO Action Network on Salt Reduction in the Population in the WHO European Region, also known as the European Salt Action Network (ESAN), was established in 2007. The seventeenth ESAN meeting took place in Dublin, Ireland, on 30 September – 1 October 2025, and was attended by representatives of 13 Member States. Participants heard a detailed update on national salt (sodium) reduction activities and/or studies in nine countries. Through presentations on country experience and discussion, the meeting further explored mandatory measures for salt reduction, the role of salt reduction in cardiovascular disease prevention policy and salt reduction in the out-of-home and public sectors. Participants were also updated on the WHO Regional Office for Europe's work and activities related to salt reduction.

# Contents

# Abbreviations

| | |
|---|---|
| AESAN | Spanish Food Safety and Nutrition Agency |
| ALADINO | Estudio de Vigilancia des Crecimiento, Alimentación, Actividad Física, Desarrollo Infantil y Obesidad en España (Study on Nutrition, Physical Activity, Child Development and Obesity in Spain) |
| CVD | cardiovascular disease |
| DALY | disability-adjusted life year |
| DGS | Directorate-General of Health of Portugal |
| DTU | Technical University of Denmark |
| EFSA | European Food Safety Authority |
| ESAN | WHO Action Network on Salt Reduction in the Population in the WHO European Region |
| EU | European Union |
| FABLE | Food and Beverage Labels Explorer |
| FIC | Food Information to Consumers |
| FOPNL | front-of-pack nutrition labelling |
| FSAI | Food Safety Authority of Ireland |
| FSVO | Federal Food Safety and Veterinary Office |
| GIFNA | WHO Global database on the Implementation of food and Nutrition Action |
| GS1 | Global Standards 1 |
| INSA | National Institute of Health Dr Ricardo Jorge |
| JACARDI | Joint Action on Cardiovascular Diseases and Diabetes |
| JA PreventNCD | Joint Action Prevent Noncommunicable Diseases |
| JRC | Joint Research Centre |
| NAPV | Dutch National Approach for Product Improvement |
| NCD | noncommunicable disease |
| NGO | non-governmental organization |
| RIVM | Rijksinstituut voor Volksgezondheid en Milieu (Dutch National Institute for Public Health and the Environment) |
| SSB | sugar-sweetened beverages |
| UPF | ultra-processed food |
| WHO | World Health Organization |

# Background and introduction

The WHO Action Network on Salt Reduction in the Population in the WHO European Region (hereafter referred to as ESAN or "the network") was established in 2007 under the auspices of WHO and with the support of the Food Standards Agency of the United Kingdom of Great Britain and Northern Ireland. Since May 2013, Switzerland has chaired ESAN.

The network was established as a response to concern about the increasing salt consumption of the population, in line with the WHO Regional Office for Europe's designation of salt reduction as a priority intervention for tackling noncommunicable diseases (NCDs) in the European population *(1)*. The main aims and objectives of ESAN are to:

- establish, within the WHO European Region, a network of countries committed to reducing salt intake and building international action on salt reduction;
- provide opportunities for information exchange on the implementation of salt reduction strategies, as well as on related activities and achievements;
- provide opportunities for information exchange on technological progress and developmental processes related to salt reduction; and
- develop guidance for Member States wishing to develop salt reduction strategies and provide technical expertise on the different aspects of a salt reduction strategy, such as setting salt targets, monitoring levels of salt intake and salt in products, and communicating with the public.

## Organization of the network

Since May 2013, the Federal Food Safety and Veterinary Office (FSVO) of Switzerland has chaired the network. As of September 2025, the network consisted of 35 of the WHO European Region Member States. Participants include governmental institutions (or those nominated by government) and representatives of WHO and WHO collaborating centres. The network usually meets once a year, at a meeting organized by the country that chairs ESAN, in close collaboration with the Regional Office. The network meeting is an important arena for sharing and discussing experiences in salt reduction strategies.

The seventeenth ESAN meeting took place in Dublin, Ireland on 30 September–1 October 2025.[1] The meeting was co-organized by the Food Safety Authority of Ireland (FSAI) and the Regional Office. The meeting welcomed 34 participants, including representatives of 13 Member States, invited speakers and WHO staff.[2]

# Welcome and opening remarks

Sinead O'Mahony, manager of the Food Reformulation Task Force at FSAI, welcomed participants to Dublin and the meeting.

Mary Horgan, Chief Medical Officer (CMO) at the Department of Health in Ireland delivered opening remarks. The network has gone from strength to strength since its establishment in 2007. Ireland welcomed the opportunity to share its knowledge and experience of decade-long salt reduction efforts with other countries. This is a key objective of the network meetings, to facilitate face-to-face exchange

[1] See Annex 1 for the programme.
[2] See Annex 2 for the list of participants.

of experience. The goal remains to promote health and prevent disease across the European Region, despite a very unstable geopolitical environment. The CMO wished all participants a fruitful and enjoyable meeting.

Wayne Anderson, Director Food Science and Standards, FSAI, added words of welcome, noting that Ireland – which has been a member of the network from the very early days – is honoured to host the seventeenth meeting of the network. The high level of participation from both experts and policy-makers is very welcome, a key reminder of a shared commitment to improving population health by way of salt reduction, thus addressing one of the most significant dietary risk factors for cardiovascular health, excessive salt consumption. The network has served as a vital platform for Member States to exchange knowledge and align strategies. Ireland has been engaged in a salt reduction programme for many years and is now implementing a food reformulation roadmap to reduce salt, fat and sugar levels in food and drink products. He underlined the importance of the planned discussions during the meeting to examine mandatory and voluntary measures for salt reduction, and to explore salt reduction in public and private services. These discussions will be critical to driving progress and overcoming the many shared challenges that countries face. He thanked the Department of Health for its support of the meeting, the Chief Medical Officer for her participation and all involved in the organization of the meeting for their efforts.

Michael Beer, Chair of the network, FSVO, Switzerland, followed up with some further introductory remarks on behalf of the Swiss government. He thanked Ireland for hosting the meeting and welcomed the rich programme, with considerable scientific input. He noted with sadness that a former friend of the network, Professor Graham McGregor, has passed away. He invited any countries interested in taking over as chair of the network to get in touch.

Finally, Kremlin Wickramasinghe, WHO Regional Office for Europe, welcomed participants on behalf of WHO. He thanked the Chief Medical Officer for her warm words and for the public health leadership. He emphasized the shifting geopolitical environment for public health, as reflected by the fact that the recent discussion on NCDs at the UN General Assembly had not led to unanimous adoption of the Political Declaration, thus requiring a vote.[3] Participants were encouraged to speak freely to outline the challenges they face and make the most of the opportunity to learn from others' experience and to come up with common solutions.

There are 1.8 million avoidable deaths from NCDs in the WHO European Region every year. These deaths are avoidable because 60% of them could be prevented and 40% of the cases could be treated. While many countries have now used the evidence to reduce as far as possible *treatable* mortality, the evidence on how to reduce *preventable* mortality is not applied consistently across countries to realise the full potential. Thus, there is large variation in preventable mortality between countries. It is important to carefully examine what is hindering implementation of the effective prevention measures. Ministries of finance, for example, want to know what the return on investment will be on the costs of implementing prevention policies. Often the results will only be visible in 10 years, or later, which is a problem for politicians on short electoral cycles. WHO has recently highlighted, therefore, some of the "best buy" policies which can deliver measurable results within five years, one electoral cycle *(2)*. Nonetheless, there is often pushback against effective policy from vested interests. High-level political leadership is critical. It is important to showcase positive examples and to convince political leaders that prevention policy is an important priority for government action.

He thanked colleagues from Ireland and Switzerland for organization of the meeting.

[3] The *Political Declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being* was finally adopted in December 2025.

# Country updates

## Sweden

Åsa Brugård Konde, Swedish Food Agency, presented an update on monitoring of salt reduction using data from Global Standards 1 (GS1) in Sweden. Between 2020 and 2024 the Agency had the assignment to investigate the possibilities for voluntary agreements on sugar and salt reduction with the food industry. Having concluded that there are good conditions for such agreements, the Agency is now pursuing that work, but with very limited resources. The work is guided by a model that the food industry had developed for voluntary industry agreements, which set out the intention to develop common reformulation goals during 2024. Those goals, however, had not yet been published. Thus, the Agency has invited industry representatives for a meeting to exert some pressure to drive progress and also to discuss the Agency's plans for monitoring.

The Agency plans to use nutrition facts data from GS1, which is the global organization that manages barcodes and linked product information. To give a more complete picture of the potential public health impact, the GS1 data will be combined with sales data to monitor the salt levels in the top 10 products on the market. This approach was inspired by work carried out by the Swedish Consumers' Association in 2013 and 2016, checking the salt content of more than 300 items. As of September 2025, GS1 data had been collected on four different food items (*Falukorv* sausage, pie, crispbread and fish fingers). These data show the lowest, highest and median salt content levels and can be compared with the salt criteria for Sweden's Keyhole labelling system. These data reveal the large variations between products in the same category.

One of the challenges identified with this approach is that some products on the GS1 database are no longer on the market. Another challenge is the cost of sales data to be able to identify the top 10 products. One further issue is how to present the results (e.g. highlighting good examples, shaming those products with the highest levels), knowing that consumers do not always consider a lower salt content to be a positive attribute.

*Discussion*

There was clarification that all companies provide the information to GS1 to get the bar code. However, some products are not actually on the market, so that is a problem. In addition, if the information on the package is not correct then the information on GS1 and in the analysis would not be correct.

There was clarification that there is a plan to revisit the KeyHole criteria. The new criteria will probably be in place in April 2027.

The question of whether the GS1 data includes supermarket own-label data (private brands) was raised. In Sweden, the retailer own-label data are included.

There was some discussion of the high costs of sales data, and this is an area where countries could usefully discuss potential collaboration.

## Belgium

Laurence Doughan, Federal Public Service of Public Health, Belgium, gave an update on the Belgian situation, with results from the Belgian Food Survey 2024.

Sciensano, the Belgian Health Institute, conducted the Food Survey in 2024 among a representative sample of 3020 people, aged from 3 to 64 years. Data collection took place over 12 months, from 2022 to 2023, using a 24-hour recall food frequency questionnaire and a general questionnaire. The results are available on the Sciensano website *(3).*

First, the results suggest strong public support for government public health policy actions. Support for "Impose food reformulation" was expressed by more than 70% of respondents.

Habitual intake of sodium was analyzed using the SPADE programme (which does not systematically include salt added during food preparation or at the table). The key results are as follows:

- on average, the population sodium intake is 2077 mg/day, with 52% of the population exceeding the recommended intake level;
- men have a higher mean sodium intake (2318 mg/day) than women (1840 mg/day);
- mean sodium intake increases with age in men, while it stays stable across age groups in women;
- individuals in Wallonia have lower mean sodium intakes (1958 mg/day) than those in Flanders (2164 mg/day);
- the mean sodium intake in the population aged 3-64 years decreased from 2299 mg/day in 2014-2015 to 2079 md/day in 2022-2023; and
- cereals and cereal products contribute 25% to sodium intake followed by meat, meat products and substitutes (24%), milk, milk-based products and substitutes (13%) and condiments, spices, sauces and yeast (12%).

In conclusion, the results indicate that, despite starting to implement a food reformulation strategy 15 years ago, daily sodium intakes of the Belgian population continue to exceed the WHO recommendation – without taking into account the salt added in the food preparation and at the table, the average is already above the recommended maximum daily intake of 5 g of salt.

A new estimation of the salt intake of the Belgian population through an analysis of sodium in 24-hour urine samples is needed. The last study was performed in 2018, resulting in estimates average daily salt intakes of 8.3 g/day with the Tanaka equation and 9.4 g/day with the Intersalt equation.

There is a need to continue to push for less salt in the food chain by encouraging reformulation by food and beverage companies. The front-of-pack labelling system Nutri-Score is playing an important role in that respect. Further investment in effective promotion campaigns is also required.

Finally, participants were notified about a meeting, jointly organized by WHO Regional Office for Europe and the Iodine Global Network on 3 December 2025. This is a follow-up to the important WHO report published on iodine status in Europe in 2024 that highlighted the challenges hindering use of iodized salt in food production *(4).*

# Portugal

Maria João Gregório, Directorate-General of Health (DGS in its Portuguese acronym), Portugal, gave an overview of the final results of the Portuguese food reformulation plan.

The broad commitment to reformulate food products was formalized in 2019, building on a dialogue with the food industry and the food retail sectors that started in 2018. To recap, the government had proposed a tax on high salt food products but this was not approved by the Portuguese parliament, which, in turn, recommended that the Ministry of Health use a different approach including voluntary reformulation. The results have been monitored since 2019 and the final report was published in 2025.

For the reformulation plan, the Ministry of Health partnered with the Portuguese Food Industries Association, the Portuguese Food Distribution Association and, for the monitoring process, NielsenIQ.

Targets were set for six food categories, with some expressed as a percentage reduction and others as a particular levels of salt per 100 g (Table 1.)

**Table 1**. Salt targets in the Portuguese food reformulation plan

| **Food categories** | **Salt target (by target year)** |
|---|---|
| Potato crisps and other salty snacks | 12% reduction (2022) |
| Breakfast cereals | 10% reduction (2022)<br>1 g per 100 g (weighted average)<br>Maximum 1 g per 100 g (infant cereals) |
| Bread | 1 g per 100 g of bread (2021) |
| Pizza | 10% reduction (2022) |
| Pre-packed ready-to-eat meals | 0.9 g per 100 g of meal (2023) |
| Pre-packed ready-to-eat soups | 0.3 g per 100 g (2023) |

For some other food categories that are major contributors of salt to the Portuguese diet – such as processed meat and cheese – it was not possible to reach an agreement with the food sectors on voluntary targets.

There was external and independent monitoring by NielsenIQ, with support from INSA and follow up from the DGS. The indicators were: weighted averages of salt content for each food category per year; percentage reduction in salt content for each food category per year; and total volume of salt reduced per year. Foods that were monitored account for at least 80% of the total sales.

Over the period 2018-2023, the results for pizza, potato crisps and other salty snacks, and breakfast cereals are shown in Table 2.

**Table 2.** Salt levels in pizza, salty snacks and breakfast cereals

| **Food categories** | **Weighted average salt content (g/100 g)** | | | | | |
|---|---|---|---|---|---|---|
| | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Potato crisps and other salty snacks | 1.25 | 1.25 | 1.17 | 1.16 | 1.08 | 1.04 |
| Breakfast cereals | 0.71 | 0.64 | 0.61 | 0.60 | 0.58 | 0.51 |
| Pizza | 1.78 | 1.54 | 1.43 | 1.45 | 1.42 | 1.43 |

In relation to the targets, there was a 19.5% reduction in the pizza category (compared to the 2022 target of 10%), a 27.9% reduction in breakfast cereals (compared to 10%) and a 17.3% reduction in potato crisps and other salty snacks (compared to 12%).

By 2023, almost 99% of Portuguese bread was below the national salt target and the majority was below level of the WHO sodium benchmark. The average salt level in bread is now 0.86 g/100 g.

For ready-to-eat soups, the average salt content was 0.36 g/100 g, slightly higher than the national target but below the WHO sodium benchmark level.

Three types of ready-to-eat meals were also monitored (chilled and frozen). The average salt content was around 0.7 g/100 g for chilled meals and 0.87 g for frozen meals. For the frozen meals, around 19% were above the level of the WHO sodium benchmark.

Overall, an average gradual reduction of 14.8% was achieved in the products covered by the reformulation plan between 2018 and 2023. This represents a reduction of 18.3 tonnes of salt over the period.

The voluntary approach to reformulation is likely to be continued, but a revision to the Portuguese law on the salt content of bread is also envisaged – reducing the maximum level from 1.4 g to 1.0 g of salt per 100 g of bread.

*Discussion*

It was noted that the progress realized in Portugal is very impressive. The question was posed as to whether the availability of sales data enabled understanding of whether the changes in salt levels had led to any change in consumer purchasing. On the basis of available data, it was not possible to answer this question.

The differences observed in salt levels between the frozen and chilled products were raised. When questioned about this, the manufacturers replied that these differences were due to variations in the recipes, but this does not clarify the situation. It was noted that similar differences were observed in Spain. One possible theory is that the differences are due to the variation in water content between chilled and frozen meals, even though it would seem more logical that there is a greater technological need for salt in the chilled versions.

There was clarification that Nielsen provides the results of the data analysis rather than providing the whole dataset. So, the DGS cannot conduct its own further analyses of the dataset.

There was clarification that the main arguments against the proposed salt tax law was general opposition to additional taxes on the population – particularly in the context of cost-of-living crises – and the argument that the same results could be achieved with different approaches (e.g. reformulation). The parliamentary process was also affected by the political context, which was in the run-up period to a general election.

# Finland

Satu Männistö, Finnish Institute for Health and Welfare, presented an update on salt status and trends in Finland.

There are three key pillars of dietary monitoring and nutrition policy in Finland: the Finnish Nutrition Recommendations (2024) *(5)*; the Fineli national food composition database; and the national FinDiet study for long-term monitoring of adult diets. The national recommended maximum intake of salt is less than 5 g per day.

Finland has a long history of health monitoring through health examination studies, dating back to the 1960s and 1970s. The two most recent relevant studies are the Fin Health 2017 study and the Healthy Finland 2022-23 study.

Trend data show that urinary salt excretion and estimated daily intakes decreased (from a high starting point of 15 g for men and over 10 g for women) in both men and women between 1977 and 2007. The 2017 FinHealth study found that the average daily intake was 9.5 g for men and 6.9 g for women. Almost all men and women had intakes above the recommended 5 g per day. The Healthy Finland 2023 study found no change in urinary sodium excretion (g/day) between 2017 and 2023 – preliminary results found

that mean daily excretions were equivalent to 10 g of salt per day for men and 7 g for women. There were no differences between age groups.

Thus, despite the strong need to reduce salt intakes in Finland, there is no positive trend since 2007 and most adults consume more salt than recommended. Processed foods are the main sources and the main food category sources of salt in the diet are meat dishes, cereal products (especially bread) and cheese. Attention is also needed to salt content in ready meals, semi-prepared foods and new plant-based protein products. In addition, public catering services should promote low salt options.

*Discussion*

It was suggested that the levelling off in Finland mimics what was seen in the United Kingdom and there may be many reasons. It is important to note that since 2007 there have been huge misinformation campaigns about sodium and health, and this might have contributed to governments reducing efforts on salt reduction.

It was noted that many of the new plant-based sources of protein – which are part of a shift to more climate friendly diets – are high in salt. It is important to raise awareness of the salt content of many of these products.

# Ireland

Sinéad O'Mahony, Food Safety Authority of Ireland, presented an update on salt reformulation under the *Roadmap for Food Product Reformulation in Ireland (2021-2025) (6)*.

To recap, the estimated salt intakes in Ireland in 2021-2022 were 9.5 g/day for men and 7.5 g/day for women (both down from 2008-2010). Salt reduction is being progressed under a Roadmap developed by a food product reformulation sub-group of the Obesity Policy Implementation Oversight Group. A Food Reformulation Task Force was established, as a strategic partnership between FSAI and Healthy Ireland at the Department of Health. The role of the Task Force is to implement the roadmap and to drive and monitor industry progress towards achievement of the roadmap.

Forty priority food categories were identified for food reformulation, and 25 of those are targeted for salt reduction (reduction of 10%). Thresholds have also been introduced for new product development in nine of the priority categories – these thresholds are at the median level of salt in that food category – and further thresholds will be defined for new products in other categories in due course. Salt and sodium targets have been defined for baby and toddler foods, while also specifying that no salt or salt-containing ingredients (except cheese) should be added to commercially available complementary foods. The Task Force is also implementing a programme of work for the food service sector, starting with definition of maximum serving salt targets for pizza sold in food service outlets and for children's meals sold in the food service sector.

Monitoring of composition of processed foods has been carried out for 21 years. In general, the monitoring data show decreases between 2003 and 2013, followed by less consistent trends (including some increases). The latest results are from 2024, demonstrating that the salt content of breakfast cereals has decreased notably since the last data collection in 2015 *(7)*. Analysis of cinema popcorn also found that salt levels are high (2.72 g per 100g, 1.93 g per portion) – these values are higher than pre-packaged popcorn and all above the WHO sodium benchmark level, highlighting that there is considerable scope for reformulation.

In order to set the children's meals targets, a survey to identify popular children's meals choices was conducted among managers of 197 outlets – restaurants, takeaways and pubs – that served food for children 1-12 years old. Five subcategories of meals were then sampled and analyzed for salt content: chicken nuggets and chips; chicken curry and rice or chips; beef burger and chips; pasta and sauce; and sausage and mash or chips. The results highlighted variation both between and within meal categories, with the highest median values found in the sausage and mash or chips category (4.66 g per meal) and the highest maximum found in the pasta and sauce category (10.26 g per meal). FSAI then published benchmarks and guidance for the reformulation of children's meals sold in food service outlets *(8)*.

Monitoring in 2021 of the proportion of commercially available complementary foods compliant with the FSAI targets (no added salt and total sodium targets) found, in general, a high degree of compliance. The savoury meal category, however, requires reformulation, with only half (51%) of products meeting the target of no more than 50 mg per 100 g of sodium. The Task Force is engaging with this group of manufacturers to request further reductions in both sodium and sugar.

Other recent efforts by the Task Force include commissioning research to fill knowledge gaps, publication of progress and monitoring reports, stakeholder engagement and communications and development of a learning portal with content to help food businesses meet their training requirements. Future work will include continued monitoring of salt content, setting of additional targets for new product development and sampling of further food service food categories. The period for implementation of the Roadmap has been extended to the end of 2027.

*Discussion*

There was some discussion of whether the industry had pushed back on the idea of targets for new product development in Ireland. Such resistance had been experienced in other countries on the basis that such targets would stifle innovation. In Ireland, a consultation on the new product development targets was published, and some feedback was received. As the targets were based on median levels, they were easy to justify – since half of the products were already meeting the target.

# Hungary

Eszter Sarkadi-Nagy, National Centre for Public Health and Pharmacy, provided an update on monitoring and interventions toward salt reduction in Hungary.

There is currently no strategy, action plan or roadmap on nutrition, reformulation or salt-reduction. There will be some reformulation related actions in the forthcoming diabetes strategy.

Awareness activities were carried out in 2010, with the STOP SALT! campaign. A further campaign is planned for 2026. A web-based tool called MÁRTA – a searchable branded food website – is in development. In addition, a series of dialogues for reformulation (focus group meetings) are planned for 2025 and 2026.

In relation to regulation, Hungary introduced the Public Health Product Tax in 2011 and this has been useful in driving reformulation. In 2014 a decree on the nutritional regulations of public catering was issued. Development of guidelines for public food procurement is in process. Minimum and maximum salt content of bread and the maximum content for processed meat, as set out in Codex Alimentarius Hungaricus, were reduced in 2018. Unfortunately, in one category the salt level has now been increased.

The 2025 National Diet and Nutrition Status Survey was underway at the time of the meeting. This round does not include 24-hour urine collection – this was previously done in 2010 in adults and in 2019 with older people.

Between 2020 and 2025, branded food data has been collected and this is ongoing. These and other countries' branded food data are now included in the European Commission's Food and Beverage Labels Explorer (FABLE) database. This enables country comparisons of salt content of specific foods. Hungary, for example, has one of the highest median levels of salt in pre-packaged breads among the countries for which data is available. The aim of the branded food database is to monitor the processed food supply at the national level, support data-based policymaking, facilitate the reformulation of food products and empower consumers to make informed, healthy food choices by sharing the data with consumers through the MÁRTA website.

Another ongoing area of work is the development of procurement guidelines in public catering, with a focus on dairy products and meat products. This work has involved stakeholder engagement through intersectoral meetings, definition of food categories, setting of nutrient thresholds and use of descriptive statistics of salt and sugar levels. There has been opposition from the agricultural sector. Publication of the guidelines was imminent at the time of the meeting.

Throughout 2025 and 2026 a series of dialogues on reformulation are bringing together academia, young professionals, decision-makers and representatives from different sectors in six to eight focus group meetings. The expected outcome of these dialogues is a jointly developed roadmap outlining the next steps to advance food reformulation in Hungary.

*Discussion*

There was clarification that the food categorization in MARTA is adapted to the Hungarian context. There was also clarification that the data are open access and brand names are also included. Before creating the database, legal advice confirmed that these data are publicly available and, thus, the database can be open access even with the brand names. This is a tool to exert some pressure on the industry to reformulate their products.

It was noted that Hungary is the only country in the Region that has a food and beverage tax, beyond sugar-sweetened beverage (SSB) taxes. The Public Health Product Tax is very unpopular with the food industry and there is continuous pressure pushing for its repeal. One reason that the Ministry continues to support the tax is because of the considerable tax revenue that it generates. This could be an interesting lesson for other countries. A previous analysis of food categories high in salt and/or sugar in Hungary and other countries suggests that the Public Health Product Tax is the reason that there are some categories where levels are lower in Hungary than in other countries. However, above the thresholds of the Tax there is no incentive to reformulate – levels of sugar in sugar-sweetened colas, for example, are higher in Hungary than other countries, arguably because above the sugar threshold of 8 g per 100 ml in the Public Health Product Tax there is no need to reduce sugar levels.

## Switzerland

Steffi Schluechter, FSVO, Switzerland, provided an update on salt content monitoring.

Around 75% of the salt consumed in Switzerland is consumed through processed foods, and ready-to-eat dishes have become an integral part of modern lifestyles. Switzerland had engaged with the food industry, on a voluntary basis, through the Milan Declaration to reduce sugar in five food groups. There was an attempt in 2023 to introduce salt reduction for salad sauces and soups into the Milan Declaration

approach, but this was not successful. In 2025, armed with data from the monitoring findings, there was a second attempt to introduce salt reduction, with a focus on pizza and ready-to-eat meals, into the approach. However, this attempt also failed.

FVSO asked food companies to provide an Excel worksheet with the required data on a voluntary basis. Data sets were provided for 913 ready-to-eat products and, finally, 834 were included in the evaluation. Semi-finished products, parts of a meal, side dishes and instant meals were excluded, along with duplicates and meals from retailer restaurants. Data were collected on pizza, ready-to-eat meals, sandwiches, snacks, small dishes and rich salads. Each category was pre-defined.

**Table 3.** Salt content of ready-to-eat dishes in Switzerland

| Category | Salt content (g per 100 g) | | |
|---|---|---|---|
| | **Median** | **Minimum** | **Maximum** |
| Ready-to-eat meals (*n*=167) | 1.1 | 0.5 | 1.6 |
| Rich salads (*n*=29) | 1.1 | 0.7 | 1.9 |
| Snacks and small dishes (*n*=95) | 1.2 | 0.7 | 2.6 |
| Pizza (*n*=156) | 1.3 | 0.7 | 1.9 |
| Sandwiches (*n*=387) | 1.5 | 0.6 | 2.8 |
| Total (*n*=834) | 1.3 | 0.5 | 2.8 |

The highest median value was in the sandwiches category, and this was also the category with the widest variation – the lowest value was 0.8 g/100 g and the highest was 2.8 g /100 g (for sandwiches with raw or dried ham). The results were also broken down within the categories.

Companies were also asked to provide information about use of iodized salt. Over half (56%) of the products were reported to be made with iodized salt. Forty-four per cent (n=365) did not contain iodized salt, of which 109 products contained sea salt which contains significantly less iodine than conventional table salt.

Anonymized data sets for each product group are available online (in German).[4]

*Discussion*

Further detail was sought on the objections that were voiced to resist the salt reduction agreement on pizza and bread meals. A range of commonly used industry arguments were presented, including the risk of reduced sales and/or revenue, as well as denial of the need to reduce population salt intakes. Many of the companies refusing to sign the salt declaration are those that had already signed a similar agreement on sugar reduction, and were, therefore, well aware that stepwise reduction is possible and does not have to lead to reduced sales. Nonetheless, they resisted the same approach for salt. This prompts reflection on whether the limits of what can be achieved with the voluntary approach have been reached in many countries in the Region.

There was clarification that these are self-reported data, from the nutrition declaration labels. It is important to note that these figures are based on calculations from the recipe and not analysed data. It was also clarified that it had not been possible to produce sales weighted averages.

[4] https://opendata.swiss/de/dataset/salz-in-fertiggerichten/resource/1868fa02-6917-4881-9c99-c8343ac06328

# Netherlands (The Kingdom of)

Maria Van Delft, Ministry of Health, presented an update on product improvement in the Netherlands.

The National Approach for Product Improvement (NAPV in its Dutch acronym), which was started in 2022, is based on motivating producers to improve the composition of their food products by reducing salt, sugar and/or saturated fat and increasing fibre content. Currently, it is focused on products sold by supermarkets and wholesalers. For each product group, three limits – low, medium and high – have been set for salt, sugar and/or saturated fat. For bread there are also three levels for fibre. The aim is to improve all products on the market, step by step. The goal is that, by 2030, 50% of the products in every product group are in the best category and that no more than 10% are in the worst category. The first monitoring report is due in 2026.

To implement this approach, the guidelines and methodology were published in 2022, calling on food and beverage companies to improve their products. In 2023, the approach was evaluated by Wageningen University, which indicated companies' need for more guidance and support from the government to create a level playing field. To achieve this a network coordinator was nominated in 2024 to issue stronger guidance and support coordinated action within each product group. The product group meetings with producers and supermarkets seek to arrive at agreements about step-by-step product improvements (including, for example, interim goals), with the aim of creating a level playing field. So far, agreements have been reached on salt reduction in ready meals and meat substitutes. Agreements for 10 food groups should be in place by the end of 2025. A number of challenges have been encountered including: how to reduce salt in meat products without reducing the expiration dates too much; and how to collaborate to motivate internationally operating businesses to improve their recipes in all countries where they are active?

Bread is a major contributor to salt intakes in the Netherlands and currently bread contains iodized "*bakkerszout*" (Bakers' salt). The sector has developed a salt substitute (Bakers' salt 2.0) which has been reformulated to reduce the quantity of sodium (-43%), increase potassium, magnesium and chloride and maintain iodine content. The Ministry of Health will decide under what conditions this salt substitute will be permitted. To enable this, the Dutch public health institute (RIVM) examined whether the use of Bakers' Salt 2.0 could have adverse health effects. Findings suggest that use of the salt substitute in bread would not have any adverse effects in healthy adults, but that it could pose a problem for people with kidney failure or taking certain heart medication. For young children and pregnant women there is insufficient information. The RIVM report included several recommendations:

- information on the packaging of a food product is needed (which minerals, quantity of potassium);
- care professionals and at-risk groups should be informed, and low-potassium food products must remain available for people with a potassium-restricted diet;
- intake of the three minerals and the quantity consumed that has been added to food products needs to be monitored;
- further research into possible adverse effects of the three minerals is necessary; and
- the laws and regulations with which the use of salt substitutes must comply have to be determined.

Input from experts and other Member States on this issue, particularly those that have experienced similar situations, would be welcome.

Finally, she shared some links to useful resources:

- Practical guide: product reformulation and innovation for better health by Food Valley *(9)*;
- Healthier food community – information about the healthier food community partners *(10)*; and
- the NAPV platform for sharing of information, sectoral agreements and inspiring examples of product improvement *(11).*

*Discussion*

Clarification was sought on whether the approach asks major international food producers to share their recipes and intellectual property. The approach does not, in fact, ask manufacturers to share their recipes, but they are asked to make a commitment to reduce their portfolio by the agreed proportion. Given the levelling off in progress witnessed in the UK and Ireland, some concern was expressed that the industry might not meet their targets, thus delaying progress. WHO would be happy to bring countries together to support joint targets and a common approach, as had been done for the hospital medicine initiative.

There was clarification that the Ministry has a budget for the food products improvement work, and this includes paying the network coordinator.

# Spain

Maria Jose Yusta Boyo, Spanish Agency for Food Safety and Nutrition (AESAN), provided an update from Spain on the use of food composition databases as a tool for the design, implementation and monitoring of policies to reduce salt intake.

AESAN has been working on food composition since 2004 to support different public health initiatives. Recently ASEAN has created a branded food database. The database can be downloaded in Excel format[5] and an interactive visualization tool is available. The first report of the database, containing the main statistical analyses, was published in 2025 *(12)*.

In 2022, under the aegis of the Observatory for Nutrition and the Study of obesity, an extensive food compositional study was carried out to assess the available food products on the Spanish market. Data were collected between August and November 2022 on 29 575 products – representing 85% of the total market – classified in 20 food categories and 94 sub-categories. The data included product identification, mandatory nutrition information, ingredients list and the market share (for November 2021-2022).

The food categories with the higher market share were: processed meat, poultry and fish (12.44%); fresh and frozen fruit and vegetables and legumes (8.5%); cakes, biscuits and pastries (7.61%); bread and crisp bread (6.19%); ready-made and convenience foods (6.09%); savoury snacks (5.65%); and yogurts and similar products (5.61%). The distribution of salt content (g/100 g or 100 ml) was plotted for each category, and the mean and weighted averages calculated. The mean and weighted averages were higher than 1.5 g/100 g in the following categories: ready-made foods; processed meat, poultry and fish; sauces and dressing; and cheese. In two categories – ready-made foods and savoury snacks – the weighted average was higher than the mean. Within the processed meat, poultry and fish category, there are nine subcategories – of these, smoked and salted fish had the highest average and median salt contents, followed by air-dried and cured meat products.

[5] https://www.aesan.gob.es/AECOSAN/docs/documentos/seguridad_alimentaria/bases_datos/BasedatosWeb.xlsx

The Spanish experience suggests that branded food composition databases are a relevant tool for many objectives in the field of public health and nutrition, because they reflect the variability of products in the market to which consumers have access in their purchasing choices.

It is important to consider *all* foods and beverages in the design, implementation and monitoring of public health measures aimed at improving diets. Analysis of the Spanish data shows that products with the largest market share are not always those with the best/worst nutritional profile and that many products together have a significant weight in the overall purchases of the Spanish population.

Transparency, open access data and new technology applications are helpful for user-friendly dissemination of data, generation of scientific evidence and raising awareness of the need to improve food environments.

*Discussion*

Clarification was sought on the costs of accessing this data. The Agency had decided to invest at this point in purchasing the data, in order to have information on a wide range of products available on the Spanish market, to design and implement public health initiatives aimed at improving food composition and facilitating choices that promote a healthy diet. This does not mean, however, that commercial data will be bought on a continuous basis. It was noted that the United Kingdom has been purchasing commercial data since 2007, and – given the high costs – is now reviewing whether to purchase fewer data to reduce the costs.

Further information was sought on how the supplier of commercial data has reacted to ASEAN making the data purchased publicly available. There was clarification that this use was set out in the initial contract, and it was noted that the nutrition data is already in the public domain. Data on sales, for the calculation of sales weighted data, are more sensitive, particularly relating to individual businesses. In the United Kingdom, permission was granted by the commercial data provider to publish the percentage change in sugar reduction in a particular food category for each business, provided that the company in question also agreed. The possibility of pursuing common purchasing of sales data is another important issue for WHO and the network to explore.

# Session 3: Mandatory measures for salt reduction

## Mandatory thresholds: setting the scene

Jack Reeves, Department of Health and Social Care, United Kingdom, presented an overview of some new policy developments, with a particular focus on possible mandatory measures.

The backdrop to these efforts is the increasing prevalence of overweight and obesity in both children and adults. At the start of school, 9.6% of children are living with obesity and by the end of primary school 22.1% of children are living with obesity. The latest data point to a three-percentage point increase since 2013/14. Among adults, 64% are currently living with overweight or obesity, with rates having doubled since 1993.

The government has recommended use of front-of-pack nutrition labelling (FOPNL) – in the form of multiple traffic light labels – on a voluntary basis since 2013. This is in addition to mandatory back-of-pack information for all pre-packaged food. Around 60% of products now carry a front-of-pack label and

research suggests that the label is widely used by consumers across socioeconomic groups. There is, however, some debate on whether the labelling actually influences food purchasing decisions. In addition, the products where there are no traffic light labels tend to be the less healthy.

In 2020, the then government conducted a consultation exploring how to build on the recommended voluntary system, including exploring the possibility of a mandatory system or using other types of front-of-pack labels (e.g. Nutri-Score or warning labels). This was in response to concerns about the limits of a voluntary approach and questions about whether other labels might be easier for consumers to understand than relatively complex traffic lights. The potential health benefits of mandating FOPNL are considerable, and can be estimated in terms of reductions in obesity prevalence, prevention or postponement of cardiovascular deaths, energy intake and – due to food industry reformulation – energy content of packaged food.

The United Kingdom is bound by the Food Information to Consumers Act. The stated principle of closer alignment with the EU is likely to impact in future on any FOPNL legislation. One interesting option is to use a derogation from the Act/the Food Information to Consumers (FIC) Regulation 1169/2011 to implement mandatory FOPNL, based on article 39 if this can be justified on the grounds of the protection of public health. Ireland is introducing health warnings on alcoholic beverages using this Article 39 derogation to the FIC Regulation. Ireland's experience with alcohol health warning labelling may be an interesting precedent for mandatory FOPNL, particularly given that efforts to introduce standardized EU-wide FOPNL have stalled.

Another important aspect of the United Kingdom's policy work is the regulation of promotions and advertising of less healthy foods and drinks. This work is underpinned by the country's nutrient profile model, which is based on a simple scoring system where points are allocated on the basis of the nutrient content of 100 g of a food or non-alcoholic beverage. New restrictions on promotions and advertising on television and online will come into force in January 2026. Restrictions on product placement and volume promotions on less healthy foods are also now in place (after some delays).

One particularly exciting area of work, under the 10 Year Health Plan for England *(13)* is the introduction of mandatory reporting and targets, requiring large food businesses to report on sales of healthy products. This mandatory reporting requirement will be introduced before the end of the current Parliament (no later than spring 2029). In the following Parliament (2029–2034) targets will also be set for increases in the healthiness of sales for the largest food businesses.

This is intended to set full transparency and accountability around the food and drink that businesses are selling and to encourage company portfolios towards healthier products. Publishing the reported data will also support investors to invest in healthy companies, thus encouraging further action. Businesses will have the freedom to decide how they achieve the target, through improving products, changing shop layouts and introducing new healthy products or changing incentive/loyalty schemes to make healthier products cheaper and available to all.

*Discussion*

There was some discussion of the reasons that consumers might have difficulty understanding the traffic lights labels and applying them to their food purchase choices. It was noted that the traffic lights labelling was introduced 20 years ago, when Nutri-Score and front-of-pack warning labels did not exist. Traffic light labelling has promoted reformulation of food products. The question of whether the United Kingdom is considering implementation of Nutri-Score was raised. There was clarification that the government is considering changing the approach to FOPNL and is still exploring whether to implement mandatory FOPNL and, if so, whether to adopt a different type of label, such as Nutri-Score.

There was clarification that the measures on placement, volume and price promotions will be evaluated. It is important to acknowledge that the industry will find methods of circumventing the restrictions and it is vital to monitor the situation on the ground.

## Exploring EU Member States' legal avenues for adopting national front-of-pack labelling schemes on a mandatory basis

Nikhil Gokani, University of Exeter, further explored EU law regulating FOPNL and the options for implementation of mandatory FOPNL in EU Member States.

Knowing that EU-wide mandatory FOPNL is, for now at least, unlikely, the question of whether Member States can themselves introduce mandatory FOPNL has been raised. WHO requested a legal opinion on what, if anything, EU Member States can do.

The EU governs certain information and has specific rules on some topics, but other issues are left to Member States. When the EU says nothing on a topic, there are no rules (meaning that rules in that specific area have not been harmonized), and Member States are able to act within reason and in compliance with certain other rules). Food information, however, is a field that has been harmonized. In this case, Member States are prohibited from doing anything to the extent the EU has acted.

There are two key laws:

- the FIC Regulation 1169/2011; and
- the Nutrition and Health Claims Regulation 1924/2006.

The main piece of legislation relevant to the options that exist for Member States to make FOPNL mandatory is the FIC Regulation. This sets out mandatory elements that industry must include on the label of prepackaged foods (e.g. list of ingredients; name of manufacturer; legal name of the food; nutrition declarations). It also regulates voluntary information – the information that industry can put on labels voluntarily. One item of voluntary information that is particularly relevant is repeated nutrition information – article 35 provides for Member States to recommend how companies repeat elements from the back-of-pack nutrition declaration on the front-of-pack.

The more specific law is the Nutrition and Health Claims Regulation – setting out the claims that can be used or allowing for the European Food Safety Authority (EFSA) to approve other claims.

Any action would also have to comply with the general rules of the Treaty on the Functioning of the European Union etc, such as the principle of proportionality.

In summary, it is complicated, and there are no easy options, but there are nonetheless some options for Member States to explore further. There is a need to be creative. There would be a clear role for one or more Member State to take action to lead the way.

Several references were provided for further reading on how EU food law regulates food labelling *(14)*, how FOPL is regulated in EU law *(15)*, and how the FIC Regulation derogation can be used by EU Member States *(16)*.

*Discussion*

There was clarification that WHO's intention in commissioning the legal opinion was to stimulate discussion and exploration of the options at the national level.

The trade implications of a non-EU Member State adopting a mandatory FOPNL scheme were raised. Countries like Switzerland, for example, are aligned with EU legislation. New legislation imposing mandatory FOPNL may be challenged at the World Trade Organization, which could cause some difficulties and delays – but these difficulties are not insurmountable if the Member State has the political will.

## Exploring maximum salt thresholds in bread

Eileen Gibney, Institute of Food and Health, University College Dublin, presented findings of a study exploring the potential impact of maximum thresholds for salt in bread.

A case study was conducted to explore the impact of potential legal thresholds for salt in one single food category – bread – sold on the Irish market on the dietary salt intakes of adults living in Ireland. The study was conducted in collaboration with FSAI and using national data.

Bread and bread products was chosen as a category, because it contributes almost a fifth (19.3%) of the sodium in adult diets in Ireland according to the most recent data. Two categories – "white sliced bread and rolls" and "wholemeal and brown bread and rolls" – have been prioritized by FSAI for reformulation.

As a first step, composition and nutrition information was collected from supermarkets on the available breads (covering 70-85% of the market share). The products were then categorized into two food categories – "white bread and bread products" and "wholemeal and brown bread and rolls" – with some subcategories within each category. These categories are aligned with the national food composition database.

The next step was calculation of the median salt values. The results highlighted the variation between subcategories, particularly in the wholemeal and brown breads, where subcategory median values ranged from 1.1 to 1.3 g/100 g.

These median values were then compared with existing legal thresholds from other countries and some reformulation targets from other countries. The median values were actually at or below the values that have been mandated in the other countries (Bulgaria, Croatia, Portugal and Spain), but were higher than the more ambitious targets set by the United Kingdom and the WHO sodium benchmarks.

A number of scenarios were then modelled to assess the impact on average adult diets of the different scenarios, representing potential legal thresholds:

0. baseline – mean daily intake of salt in Irish adults;
1. scenario 1 – substituted all breads with a level of salt at the median salt value of the two bread categories as per gathered market information;
2. scenario 2 – substituted with the median salt value of the six most consumed types of bread;
3. scenario 3 – scenario 2 and a 10% reduction of the 25 Irish priority food categories for salt reduction; and
4. scenario 4 – achievement of the ambitious targets (United Kingdom target of 0.9 g/ 100 g and WHO 0.925 g/ 100 g).

The results suggest that scenarios 1 and 2 could result in an increase in mean daily intake of salt from bread, while the best practice in scenario 3 would result in a very small (2%) reduction and scenario 4 would result in a 16% reduction in salt from bread. The impact on mean daily intake of salt would be greatest for scenario 3.

The results of the modelling suggest that scenarios 1 and 2 could be useful in preventing new products coming on to the market from increasing the average level for the categories. These scenarios would need additional measures to be effective. Scenario 3 – which combines both voluntary and mandatory approaches – would be most effective at reducing daily salt intakes.

Care needs to be taken to avoid unintended consequences when introducing legal thresholds. If the threshold were set at the current median, for example, there could be no effect or increases in salt content of some products and small increases in mean daily salt intakes. Setting thresholds at the level of more ambitious targets would be necessary to ensure an impact.

*Discussion*

It was noted that artisan and bakery bread is not dominant in the Irish market.

# Update from Joint Action Prevent Noncommunicable Diseases (JA PreventNCD) Work package 5

On behalf of JA PreventNCD, Maria João Gregório gave an update on the joint efforts from work package 5 of the Joint Action which are most relevant to mandatory measures for salt reduction.

Four main areas of work are particularly relevant:

- *Food monitoring system* – implementation of a monitoring tool focusing on food nutritional composition – including sugars, saturated fat and salt – at the country level. Data are included on 19 countries, enabling comparisons between countries and international guidelines (e.g. WHO sodium benchmarks). The latest data collection was in 2022. The data are integrated into the Food and Beverage Labels Explorer (FABLE) database, hosted by the European Commission's Joint Research Centre (JRC), which also includes data from the Best-ReMaP Joint Action. The data will be used, for example, to identify best in class for each category, monitor reformulation and model the impact of different scenarios.
- *Harmonized nutrient profile model* – working with WHO and the University of Oxford, the Joint Action intends to develop a nutrient profile model to be applied as a tool for all nutrition policy actions. This will be done by first mapping the existing nutrient profile models, designing a harmonized nutrient profile model approach, analysing the possibility of including sustainability criteria and modelling the health benefits of implementing the model in different policy actions.
- *Public food procurement* – another area of work will be the development of criteria for public food procurement, working with the JRC. Under the farm support strategy, the JRC published a report on *Development of criteria for the sustainable public procurement of food, catering services and vending machines (17)* and the Joint Action provided some contributions to the stakeholder consultations. This document includes some criteria for salt – specifically on monitoring salt content of food and beverages offered, use of standard recipes with a calculated salt content, cooking vegetables and boiled starchy foods without salt or salted broth/bouillon, ensuring that

salt is not available on tables and providing menus with age-specific salt content. These criteria can be used as a reference for Member States

- *Food taxation* – in collaboration with Imperial College London, the project will: (i) review current EU and national health taxation policies; (ii) evaluate current policies and identify strengths, weaknesses and best practices; (iii) develop robust data and modelling infrastructure to support and facilitate policy development; and (iv) simulate tax policy developments, relating to tobacco use, unhealthy foods and drinks.

*Discussion*

There was some discussion of the inclusion of environmental aspects in the models. It was noted that there had been attempts to integrate these aspects into the Nordic KeyHole label, but it has been found to be extremely complicated.

There was some clarification that Member States were sent a questionnaire in early 2025 to identify which countries were interested in participating the simulation of tax policy. WHO has been very careful to specify that there is no recommendation to increase the overall tax burden, rather to reorganize existing taxes.

# Session 4: Salt reduction as a prevention strategy in cardiovascular disease policy

## Cardiovascular disease policy priorities in Joint Action JACARDI

Benedetta Armocida, Italian National Insititute of Health and the Coordinator of the Joint Action on Cardiovascular Diseases and Diabetes (JACARDI), presented an overview of the CVD policy priorities in JACARDI.

CVD policy matters in Europe because a total of 60 million people currently live with CVD in the EU. CVD is responsible for one in every three deaths in the EU, amounting to 1.7 million deaths annually. There have been a number of important EU actions on cardiovascular health, including the *EU Council conclusions on improving cardiovascular health* in 2024 *(18)*. These Council Conclusions highlighted a specific focus on primary prevention, early detection and screening. The Conclusions invited Member States to implement actions designed to reduce nutritional risk factors – such as high intakes of salt, saturated fat and sugars – through, for example, food reformulation, public health campaigns and tackling marketing.

JACARDI aims to reduce the burden of CVD and diabetes, both at the individual and societal level, while assuring health system sustainability and equity. It seeks to do this by enhancing the implementation of best practices and pilot testing of innovative practices. JACARDI's comprehensive approach involves 143 pilot projects across 18 European countries, with a budget of 66 million euros for a period from November 2023 to October 2027. The project addresses CVD and diabetes within a single framework, comprising health promotion and prevention, early detection and screening, and integrated and continuity of care.

One of the first JACARDI initiatives was a context analysis of national legislation and strategic frameworks and current national practices relating to CVD, in order to identify the gaps and to implement pilots of specific activities to help close those gaps.

One of the work packages focused on data availability, quality, sharing and harmonization. A conceptual framework has been developed to define the key information needed to assess the status of CVD and diabetes across the EU. This conceptual framework is intended to enable harmonized data collection across pilots, enhance data comparability and interoperability and provide a model to strengthen integrated health information systems at the EU level.

Another area of work is screening and early detection. JACARDI strongly recommends the establishment of a centralized EU platform to guide countries in screening programmes for CVD and diabetes, ensuring scientific validity, data protection, ethical standards and strategic coordination. JACARDI has developed a protocol which could form the basis of this platform and to guide decisions on the implementation of screening.

An interesting pilot project conducted under JACARDI is the CUORE pilot project in Italy. This aimed to continue the periodic, national Health Examination Survey to monitor the health of Italy's adult population, combining direct clinical measurements, biological samples and questionnaires. As part of this survey, 24-hour urine samples are being collected in all Italian regions (seven screened within JACARDI) to assess salt intakes. The preliminary data for 2023-2025 based on 17 regions (out of 20) from the ongoing survey suggest that the current average daily salt intake is 9.3 g for men and 7.1 g for women, and that about one in 10 men (10.6%) and one in four women (23.6%) are meeting the WHO target of lower than 5 g per day. In the 2018-2019 survey, the mean daily population salt intake was 9.5 g for men and 7.2 g for women, which was a 12% relative reduction since 2008-2012, going in the direction of the WHO target of a 30% relative reduction in mean population salt/sodium intake by 2030 *(19)*.

A key priority of JACARDI is the application of an equity lens and equity tools across all EU health initiatives. The aim of the equity lens is to cross-cuttingly integrate cultural and ethnic diversity, other social determinants and commercial determinants in pilot actions. Specific tools, along with capacity building and expert consultations have been implemented to provide practical support to this process.

JACARDI is also promoting a strong gender-sensitive lens, following the Lancet Commission on women and cardiovascular diseases *(20)* which underscored the need to embed sex- and gender-specific data into every level of policy and practice. This work is being advanced through two pilot projects: development of an interactive gender health atlas in Spain; and analysis of French national health system data on sex and socioeconomic differences in CVD and diabetes to inform action to reduce inequalities.

Finally, JACARDI is clearly demonstrating the importance of a multi-sectoral approach and of multistakeholder collaboration. The Joint Action is fostering collaboration across diverse sectors and countries and embedding equity, inclusion and evidence at every stage and, thus, strengthening collective impact for preventing CVD and reducing health inequities.[6]

*Discussion*

It was noted that the earlier Italian data show that there are socioeconomic inequalities in salt intakes and it is important to track the impact of policy on inequalities. It was suggested that in the United Kingdom, for example, the overall average salt intake reduced but the socioeconomic gap in salt intakes

[6] For more information see https://jacardi.eu/ or follow on LinkedIn (https://www.linkedin.com/company/jacardi/).

was not reduced. Further exploration of the latest Italian data provides an opportunity to better understand the socioeconomic data, and ascertain whether the inequalities have been reduced.

The importance of gender-sensitive research and policy responses was underlined, and this will be an increasingly important issue to explore in coming years. It was noted that Ireland was one of the first countries in the world to introduce a men's health strategy.

## Developing cardiovascular health policy for Ireland

Joanne Uí Chrualaoich, Department of Health, Ireland, presented some background to health policy in Ireland, with a focus on cardiovascular health policy.

Cardiovascular disease is responsible for 26% of all deaths in Ireland, equivalent to 9000 deaths per year. One in four Irish adults has high blood pressure and 40% of stroke patients with atrial fibrillation were diagnosed after their stroke.

The Department of Health's vision for the people of Ireland is: a healthier Ireland, with improved health and wellbeing for all, and with the right care delivered in the right place at the right time.

In the Irish civil service, there are five steps for developing policy ("the 5 Ds"), Namely:

1. demand for policy (clarifying the specific policy demand, assessing the legality and making a recommendation);
2. deepening understanding (reviewing existing data and evidence, commissioning new data and evidence, consulting and evaluating);
3. design with best advice (analysing policy options and implications, engaging with stakeholders, making policy recommendations);
4. decide policy proposals (conducting political and legal review, seeking ministerial approval, submitting a memo for government approval); and
5. deliver policy (project and risk management, monitoring and reporting and planning to evaluate).

A *National stroke strategy 2022–2027 (21)* is in place and funding allocated to the Strategy has supported the expansion of the general practitioner contract to include opportunistic case finding of high blood pressure among people with access to free primary care.

A recent national review of cardiac services *(22)* included recommendations relating to the screening and management of hypertension and highlighted the specific risks of cardiovascular disease among women, particularly post gestation. The recommendations are now being integrated into policy development and there are six projects aimed at improving women's cardiovascular health being implemented through the *Women's health action plan (23)*.

Policy on primary prevention has been shaped by collaboration with civil society stakeholders, including, for example, a roadmap of best practices and lessons for Ireland prepared by the Irish Heart Foundation.

EU health policy is also, of course, important. The Council conclusions on the improvement of cardiovascular health in the European Union, published in December 2024, specifically call for action on salt *(18)*. The conclusions highlight actions such as, among others, an EU salt reduction programme, joint initiatives to enhance food reformulation activities, tackling commercial determinants of health and changing the attitudes of consumers at an early age.

Ireland is in the process of developing a national plan for cardiovascular health, in line with a commitment in the *Programme for government, 2025 (24)*.

*Discussion*

The fundamental importance of helping politicians to understand the vital need for primary prevention was emphasized in discussion. Ensuring an adequate health workforce is another challenge – and one that is high on the agenda of health ministers. Modelling work on sustainability of the health workforce is showing that no EU country can produce enough health professionals to deal with the increased NCD burden. Thus, prevention really needs to be part of the workforce planning process.

Ireland is very strong on a robust annual evidence review of screening programmes by the National Screening Advisory Committee, which makes recommendations for improvements. Another strength is the implementation of brief interventions in primary healthcare, with the aim of making every contact with the health system count.

## Developing, implementing and tracking communication campaigns: case study on a food environment campaign and lessons learned

Joana Caldeira Fernandes da Silva, Safefood Ireland, presented an overview of a recent public health campaign on healthier food environments. This was guided by the vision of inspiring and empowering a societal movement so that healthy eating is within reach of every child in the community by changing the food environment.

Previous survey results suggest that the public largely feel that they themselves are mainly responsible for food-related ill-health in children, rather than food manufacturers and food retailers. Only one in three adults (34%) believe that the food environment has a negative impact on food choices, and 45% consider that it makes no difference. The idea behind the campaign was to change this imbalance, taking the responsibility away from the individual and putting greater responsibility on those who produce and sell food, as well as raising awareness of how the food environment impacts negatively on food choices and health.

The campaign focused on building healthy food environments to protect kids' health. Short ads, from the perspective of a child, emphasized the ubiquity of unhealthy foods in children's environments and how these foods are often placed at children's eye level. The strap line was "it's time we talk about our food environment".

A face-to-face, in-home survey was carried out among a nationally representative sample of adults aged 15 or over in the Republic of Ireland and 16 and over in Northern Ireland in May-June 2025. A total of 817 interviews were completed. Where possible, comparisons were made between 2025 and 2024 results.

The survey revealed low levels of awareness of the food environment – with only 25% of respondents having ever heard the term "food environment" before. However, those that recalled the advert had more awareness of food environment. Overall, respondents in 2025 were less likely to say that the food environment makes no difference to the food choices that they make (13 percentage points lower than in 2024) and more likely to say that food environments negatively affect their food choices (plus five percentage points compared to 2024). The proportion believing that the food environment negatively

affects the health of children, however, decreased between 2024 and 2025 (three percentage points lower).

Almost half (47%) did not recall seeing or hearing any advertisements about food environment topics. One in five (20%) recall seeing or hearing adverts about how unhealthy foods are placed at children's eye level, and this rose to 35% among those that recalled seeing or hearing the Safefood advert.

Further findings on understanding of the term food environment, highlight a major difference in understanding between lower and higher socioeconomic groups. This is valuable data for planning the future of the campaign, and a greater focus on areas of deprivation will be needed.

The ad was mainly perceived as easy to understand (94%) and effective in prompting people to think about the unhealthy food environment (88%). Respondents considered that it encourages reflection about how unhealthy food is always at children's eye level and the majority disagreed that the ad was patronising to parents. The proportion saying that they have thought about doing something to try to bring about a change in the food environment increased between 2024 and 2025 by seven percentage points across the island of Ireland (with increases observed in both the Republic of Ireland and Northern Ireland).

In conclusion, understanding of food environment is varied, and one in five people are still unsure about what food environment means. Nonetheless, an increasing proportion seems to understand that the food environment has some influence on the food choices that people make and the majority believe that it negatively impacts the health of children.

*Discussion*

Clarification was sought on whether a question about who is responsible for changing the environment was asked. There was clarification that this question was not asked. The value of campaigns in the long term was recognized in discussion – acknowledging that even if short-term changes in behaviour are not achieved, changes in attitudes and the public discourse can happen and these will, in turn, make it easier for policy-makers to implement measures.

# Reflection and Day 1 closure

Kremlin Wickramasinghe delivered some reflections on the first day's proceedings. Given the overarching need in the current context to prioritize activities, one option might be to produce a report on everything that has been learned from all the voluntary approaches over the last 20 or 25 years. Member State participants were asked to consider the utility of such a report and provide feedback

Another issue for consideration is whether it would be useful to bring together multinational companies for a dialogue with all countries, and, if so, reflect on what be useful to include on the agenda. To prepare for this it is important to collect the main arguments that governments have faced from industry to hinder salt reduction.

# Session 5: WHO updates on work and activities related to salt

Kremlin Wickramasinghe, WHO Regional Office for Europe, provided an update on WHO initiatives and activities related to salt reduction.

Unfortunately, there continues to be a need to raise awareness of the burden of unhealthy diets and to tackle unhealthy diets and create healthier food environments. In the WHO European Region, 11% of disability-adjusted life years (DALYs) lost to NCDs are attributable to dietary risks, while 10% are attributable to high body mass index, 15% to high systolic blood pressure and 8% to high fasting plasma glucose.

The date for achievement of the nine voluntary global NCD targets has now been extended to 2030. Although there has been some progress in the Region in reducing NCD mortality, there is still much more to be gained by reducing preventable mortality and the Region is not on track to meet the targets in relation to risk factors. The updated targets include a target for a 40% relative reduction in mean population intake of salt/sodium.

The WHO Regional Office for Europe has identified 25 quick buys for NCD prevention and control *(2, 25)*. These proven, cost-effective policies and interventions deliver measurable public health improvements within just one to five years. In relation to healthy diet, these include reformulation policies, front-of-pack labelling and behaviour change communication and mass media campaigns for healthy diets. Between 2025 and 2030 there is an opportunity to avoid an extra 1.3 million NCD deaths in the Region by implementing these quick buys. This would help to get the Region back on track to meet the SDG target 3.4 for NCDs.

To help countries drive salt reduction, a theory of change has been developed for a 100-week challenge, setting out processes and outputs to be completed at 25, 50 and 100 weeks. In addition, a framework for the Race to the Finish (2030) also sets out the implementation outcomes and long-term outcomes feeding in to the long-term goal of reducing NCD mortality. Countries are encouraged to adopt different types of indicators, including process, output and outcome indicators. WHO is keen to work with Member States to document what has been done, particularly in countries where mean salt intakes have been reduced. The public health non-governmental organization (NGO) Resolve to Save Lives is also keen to hear from countries about their experience to build some positive case studies to inspire action elsewhere.

Country action is reported in the WHO Sodium Country Score Card on the WHO Global database on the implementation of Food and Nutrition Action (GIFNA) *(26).* This is based on data provided to WHO in response to the country capacity survey, and are not always comprehensive or up to date. The database is a useful resource for published policy documents.  Fig. 1 shows the progress on selected sodium reduction measures in the Region, based on the GIFNA data.

**Fig. 1.** Summary of sodium reduction policy situation in the European Region

| National policy commitment to reduce sodium intake | Voluntary measures to reduce sodium | Mandatory measures adopted for sodium reduction | Multiple mandatory measures adopted for sodium reduction, and implementation of all related WHO Best Buys for tackling NCDs |
|---|---|---|---|
| Albania, Armenia, Kyrgyzstan, San Marino, Tajikistan | Azerbaijan, Belarus, Bosnia and Herzegovina, Denmark, Georgia, Germany, Iceland, Italy, Kazakhstan, Luxembourg, North Macedonia, Norway, Republic of Moldova, Russian Federation, Slovenia, Sweden, Switzerland, Turkmenistan | Austria, Belgium, Bulgaria, Croatia, Estonia, Finland, France, Greece, Hungary, Ireland, Israel, Latvia, Malta, Montenegro, Netherlands (Kingdom of the), Poland, Portugal, Romania, Serbia, Slovakia, Türkiye, Ukraine, United Kingdom, Uzbekistan | Czechia, Lithuania, Spain |
| 5 (9%) | 18 (34%) | 24 (45%) | 3 (6%) |

The NCD progress monitor reports on implementation – full, partial or no/unknown – of measures to reduce unhealthy diets. More specific information on whether countries have mandatory reformulation targets and/or mandatory front-of-pack labelling would be more helpful, but it was not agreed globally to report on such indicators. It can be useful for nutrition focal points to discuss these issues with their country's health attachés, to inform them about which data are most useful for driving policy implementation in advance of the upcoming discussions on targets beyond 2030.

The WHO country support package to accelerate salt reduction in Europe has been available since 2020 *(27)* and the second edition of the WHO global sodium benchmarks was published in 2024 *(28).* These benchmarks are intended to be useful for countries in setting national policies and strategies.

Following on from the briefing that the network heard at the 2024 meeting, WHO published the guideline on use of lower-sodium salt substitutes in January 2025 *(29).* This includes the conditional recommendation "*if choosing to use table salt, WHO suggests replacing regular table salt with lower-sodium salt substitutes that contain potassium*". This recommendation is intended for adults (not pregnant women or children) in general populations, excluding individuals with kidney impairments or with other circumstances or conditions that might compromise potassium excretion.

The Regional Office has been developing a food reformulation manual – developed in collaboration with Wageningen University and the Technical University of Denmark (DTU) – to support countries to reformulate processed foods to healthier nutrition profiles, and this will be published in due course, along with an interactive platform.

A literature review is being drafted, which compares voluntary versus mandatory approaches to reformulation, to clarify the evidence on the different approaches. This found that voluntary reformulation agreements have some success in increasing healthier options but have limited impact on leading products due to inconsistent compliance and no accountability. When countries decide to implement policies with mandatory reformulation targets, these have a greater public health impact through required compliance and enforcement, and can reduce harmful ingredients at scale.

WHO has also highlighted the importance of integrating behavioural and cultural insights into salt reduction communication campaigns, while recognizing the practical challenges that implies. This is an issue that could be considered at a future ESAN meeting, drawing on the expertise of the WHO behavioural and cultural insights team and potentially involving country behavioural and cultural insights focal points.

The work described at the 2024 Network meeting to develop template nutrient profile model(s) for FOPNL is ongoing. Testing of the prototype template models will be done in conjunction with the JA PreventNCD. Participants were invited to let WHO know if they are interested in testing the prototype models against their national food composition databases. Development of a model law for front-of-pack labelling is also underway. A draft should be issued for consultation by the end of 2025.

The issue of ultra-processed foods (UPF) has gained traction with policy-makers and the public. A growing body of evidence suggests that consumption of UPF is associated with negative health outcomes *(30)*. WHO recognizes the urgent need to curb the global dietary shift towards UPF that is driving negative health outcomes *(31)*. The Regional Office is preparing a factsheet on the current state of knowledge on UPF. WHO headquarters is working with an expert group to refine the operational definition for UPF by the end of 2026 and, if possible, issue guidance on UPF consumption.

Work is ongoing on how to implement food taxes for a healthy diet, building on the positive evidence from experience with SSB taxes. Food taxes should be based on overall nutritional quality, and require careful design, implementation and monitoring – to ensure that they do not increase the tax burden on consumers. Aligning existing food taxes with health goals can promote healthy diets without raising the overall tax burden. The Regional Office published a policy brief, *Food taxes for a healthy diet: time for action*, in September 2025 *(32)*. The document aims to help Member States overcome some of the barriers to implementing food taxes for health. Participants are encouraged to use the policy brief and to use it as a basis for dialogue with counterparts in ministries of economy or finance.

In relation to food marketing to children, an important development is the introduction of legislation in many countries to regulate digital services. While these laws are not being introduced because of concerns about unhealthy commodity marketing to children, they do create a regulatory framework that can be helpful for protecting children from harmful food marketing. That is because they may require digital platforms to recognize children online or introduce age verification tools. Governments are also defining the online harms caused by big digital platforms. Further advocacy is needed to provide officials with evidence on the harm caused by digital marketing of products containing alcohol, salt and sugar, so that these get included in the definitions of harms. Nutrition focal points are encouraged to initiate dialogue and share evidence with risk assessment teams in competent media regulatory bodies.

*Discussion*

There was some discussion on the merits of singling out salt reduction as a factor for action, rather than more comprehensive action on unhealthy diets. The view was expressed that action on salt reduction is relatively simple because it can just be removed/reduced and this can be done immediately to achieve results in the next five years, compared to more complicated actions to reduce sugar, calories and saturated fat. On the other hand, it was argued, it can lead to unnecessary duplication of efforts if countries first work on salt reduction initiatives (e.g. labelling, public procurement) and then have to work on the same types of initiatives for other aspects of healthy diet. Rather, it would be more resource efficient for countries to develop policy initiatives which target unhealthy diets.

The question was raised on whether the network could should play more of a role in specifically pushing faster progress the agenda on salt reduction specifically. The reality for officials, however, is that they are subject to the policy priorities of their elected leaders. In the last 10-15 years, for example, the focus of elected politicians in many countries has shifted towards obesity, possibly because of the costs to health services and other societal costs, driving action on sugar and calories. To overcome these challenges, officials need to devise policy that will be impactful in multiple ways on multiple health conditions.

The possibility of using child rights as a lever for change was raised. Ireland, for example, has a comprehensive constitution which has been amended to strengthen children's rights. The EU's Child

Guarantee Scheme, which includes the guarantee for every child to have a school meal, is another potential opening. It is very difficult for industry to oppose measures when they are framed in terms of child rights. Children and adolescents' mental health is another key concern in European countries. Social media is obviously a key issue in this field. The health sector needs to gather and present evidence on food-related online harms affecting children and young people.

The importance of communication campaigns to support reformulation and other healthy diet measures was reiterated. However, the major costs of running such campaigns are a challenge in times of reduced budgets. WHO collaborating centres working with the behavioural and cultural insights team have relevant research on health messaging that could be very useful to inform national campaigns. If helpful. WHO can create a platform to connect these WHO collaborating centres and interested countries. Member States interested in participating are invited to inform WHO.

It was suggested that the forthcoming evidence and guidance on UPF will be very welcome for Member States. Clarity is needed on the mechanisms of UPF-related health outcomes and the best messaging to inform consumers.

# Session 6: Salt reduction in the out-of-home private and public sector

## Salt thresholds in public sector procurement systems

Ivan Perry, University College Cork, Ireland, provided an overview of policy developments on salt and health in recent decades and explored the issues and challenges in public sector healthy food procurement.

An early reference to salt in an Irish government health policy document was in the 1999 cardiovascular disease prevention strategy, which explicitly acknowledged the contribution of diet and salt intake to blood pressure levels and recommended that FSAI should advise on the national policy on salt. This led to development of the *Salt and health report* in 2004, which was updated in 2016 *(33).* This report has informed FSAI's engagement with the food sector on salt content and the food reformulation activities. There have now been 21 years of monitoring sodium content in prepacked food. Despite the limitations of what can be achieved through a voluntary programme, some progress has been made across major food categories, such as bread and breakfast cereals, over that period. There have been small reductions in estimated average population daily salt intake – from 8.8 g in 2008-2010 to 7.5 g in 2021-2022 among women and from 11.6 g to 9.5 g among men over the same period (based on spot urine samples as part of the Irish Universities Nutrition Alliance National Adult Nutrition Surveys). Further salt reduction policy initiatives were carried out under the obesity policy and action plan *(34)* and the *Roadmap for food product reformulation in Ireland* (6).

To complement these efforts, the potentially significant role of public sector food procurement as a driver of food and drinks reformulation has been highlighted. Public sector food procurement refers to the purchasing of food and the contracting out of catering services, fully or in parts, by public bodies. This can include public hospitals, schools, childcare facilities, prison services and government workplaces, as well as food venues such as canteens, vending machines and food programmes. Public institutions serve a significant portion of daily meals, especially for children, and public food procurement can, therefore, influence consumption and production patterns, promote healthier diets and support local economies. The process is governed by minimum harmonized public procurement

rules set by EU Directives that are transposed into national legislation to ensure transparency, non-discriminatory practices and value for money.

The Best-ReMaP Joint Action explored public food procurement and identified wide variation in practices across EU countries. There remains an overwhelming tendency for institutions to prioritize price over quality, limiting the nutritional value of procured food. Some countries – such as Finland, Portugal and Slovenia – have implemented quality-based procurement tools and working groups. The lack of harmonized legislation was highlighted, as well as the high degree of administrative complexity in implementing healthier public food procurement. At the same time there is limited capacity at the local level, exacerbated by limited training opportunities for procurement officers and catering staff. The difficulty of integrating sustainability and health criteria into procurement processes was also highlighted.

To support countries to take action in this area, WHO produced an *Action framework for public food procurement and service policies for a healthy diet* in 2021 *(35).* One of the policy levers identified in this action framework is the use of mandatory standards in public procurement. The *WHO Global sodium benchmarks* (revised in 2024), which define maximum sodium targets for different food categories can be useful as thresholds for public sector food *(28).*

In 2020, an assessment of the Irish healthy food environment policy found that the country rated poorly against international benchmarks in relation to public sector food procurement. Currently, there is no overarching national policy for nutrition in public food procurement. There are some standards in place in hospitals and public health services, early learning facilities and for school meals. However, these standards are fragmented and are mostly not mandatory. Gaps have been identified in local government, defence, higher education, prisons, food banks and community centres.

As Ireland moves forward with standards for public food procurement, it can learn from the United Kingdom's *Government buying standard for food and catering services*, which are mandatory and contain detailed criteria relating to salt *(36).* The Best-ReMaP Joint Action recommended a harmonized EU framework for action for public food procurement and highlighted key actions at EU and national level. These recommendations are useful for countries interested in taking action on public food procurement. There is likely to be opposition from vested interests and it will be important to build public support for such action, highlighting the simple and compelling narrative that taxpayers' money should not be spent on unhealthy food.

*Discussion*

In discussion, the point was reiterated that salt reduction is best done slowly and gradually over time, rather than going for a large reduction in a short timescale. Further advice was sought on how incremental reductions on salt can be integrated into procurement and the tender process (rather than just ultimate targets). This was recognized as a challenge for procurement officers, where support is needed. WHO is keen to learn from any Member States who have achieved incremental salt reduction in public food procurement, and to document these best practices.

There was some discussion of setting salt targets based on the median of the existing products on the market. This is often recommended in the literature, but when Ireland modelled the effect of this, the situation could be made worse if the products that are below a median-based target *increase* their salt levels. In the Netherlands, the low category is at the 25$^{th}$ percentile and the medium target is equal to the median.

# Addressing salt in Royal Decree 315/2025 for the promotion of healthy and sustainable eating in educational institutions

Continuing with the theme of healthy food in public institutions, Maria Jose Yusta Boyo, AESAN, Spain, provided an overview of a new Royal Decree (315/2025) on the promotion of healthy and sustainable eating in educational centres.

According to the Study on Nutrition, Physical Activity, Child Development and Obesity in Spain (ALADINO) more than one in three (36%) 6-9-year-olds were affected by overweight (including obesity) in 2023 *(37)*. Although the prevalence of both overweight and obesity remains high, the values have fallen since 2011. Among low-income families, however, prevalence of overweight remains practically unchanged over the same period.

The political and legal framework for healthy educational environments in Spain includes:

- the *National strategic plan for the reduction of childhood obesity (2022 – 2030) Spain (38)* which includes a measure to ensure that the food offered in all educational centres meets minimum criteria to promote a healthy and sustainable diet;
- the implementation in Spain of the European Child Guarantee, which includes a healthy meal each school day and improving the implementation of the school fruit, vegetable and milk scheme *(39)*;
- Guideline on health-promoting schools *(40);* and
- the 2011 law on food safety and nutrition (Law 17/2011) which includes an article of special measures aimed at schools and an article on public procurement.

The Royal Decree 315/2025 established implementing regulations for Law 17/2011. The Decree is comprised of four chapters: general provisions; nutrition and sustainability criteria for the procurement, purchase and provision of food and beverages in educational centres; measures aimed at school menu planning; and monitoring and penalty system.

Realization of the Decree has been a lengthy process, starting with publication of a consensus document on food in educational centres in 2010. This was implemented to differing degrees at the regional level, with its legal status varying from recommendations to regional regulations. For the first time and since the *National plan for the official control of the food chain 2021-2025 (41)*, one of its strategic objectives is to "*promote healthy and sustainable eating through the fostering of nutritional quality and control thereof in school meals and in food and drink in vending machines and cafeterias*". Programme 16 relates to school meals, vending machines and cafeterias in schools. Building on this national plan, the Royal Decree 315/2025 makes the official control actions mandatory. The Decree was issued for public consultation in April-May 2022, and this was followed by a public hearing procedure in September-October 2022. In March 2025, the Council of State issued a favourable opinion. A communication campaign on school meals was launched.

The Decree applies to public, private and state-subsidized educational centres providing early childhood, primary, special, compulsory secondary or upper secondary education or basic or intermediate vocational training.

Chapter II sets out nutritional and sustainability criteria for the procurement, purchase and provision of food and beverages in educational establishments. Article 4 establishes general nutritional quality and sustainability criteria, including some relating to salt: iodized salt should be used and the amount added

to preparations should be reduced; use of stock concentrates or other flavour enhancers in food preparation shall be limited and, if used, commercially available options with 25% less salt shall be used; and use of single-dose containers shall be reduced and, in any case, single-dose containers shall contain a maximum of 0.8 g of salt. Article 5 prohibits the sale of food and beverages high in saturated or trans fats, salt and sugar in vending machines and cafeterias. In relation to salt, this applies to foods with more than 0.5 g of salt per packaged portion. Article 7 sets out additional requirements for food offered in vending machines, including that they shall not be located in areas accessible to nursery and primary school pupils and they shall not display any food or drink advertising. Article 8 sets out measures to promote access to drinking water.

Chapter III sets out measures aimed at school menu planning, including that iodized salt should be used, in a reduced manner. According to the annual reports on the *National plan for the official control of the food chain*, the proportion of school canteens using iodized salt has increased from 30.3% in 2022 to 51.3% in 2024.

It is noteworthy that in the framework of the *National plan for the official control of the food chain* some stakeholders expressed the opinion that the recommendation on the use of iodized salt in school canteens should not be understood as mandatory. In response to this and other comments received during the public hearing relating to iodized salt, the rationale for inclusion of the recommendation on iodized salt was clearly set out, referencing documents from WHO, UNICEF and the International Council for the Control of Iodine Deficiency Disorders *(*35,*42*,*43)*, the Spanish dietary guidelines *(44)* and the Ministry of Health's document on the prevention of iodine deficiency disorders *(45).* The case for use of iodized salt in Spain – within the context of salt reduction – was also set out in two key academic papers, emphasizing that although iodine nutrition in Spain has improved in recent years, the problem is not completely resolved *(46*,*47)*.

The Royal Decree has been positively received for improving quality and transparency, representing a step forward in nutrition and the prevention of obesity.

Another current area of work is development, by the Standing Committee on Nutrition, of a consensus document on healthy and sustainable food in the first stage of early childhood education (0–3 years). In relation to complementary feeding, the document is clear that salt is not recommended before the first year of age and thereafter, if used, it should be in small amounts and iodized (1 g per day). The use of other seasonings, stock cubes or packaged broths is also not recommended. The maximum amount of salt (both added and present in food) for children aged 1 to 3 years is 2 g per day.

Finally, another important area of work is the draft Royal Decree for the promotion of healthy and sustainable food in public administration contracts and in centres for dependent people or those with special needs. A consultation on the draft was carried out in May–June 2025. This states that minimum nutritional quality and sustainability criteria will be established to guide the contracting, procurement and supply of food and beverages in food services dependent on public administrations. It also seeks to improve food in centres and services that are not necessarily managed through public procurement, but which care for dependent people and those with special needs, such as hospitals and nursing homes.

*Discussion*

Clarification was sought on the political drivers that had made this action possible. Concern about obesity, overweight and type 2 diabetes, particularly among children, has been growing and has fostered the political will for mandatory measures. High profile and influential champions – such as Her Majesty Queen Laetizia and the former basketball player Pau Gasol – have also played an important role.

The question of whether food in educational settings is prepared on site or if it is delivered pre-prepared was raised. In fact, some schools have kitchens, while others get meals delivered from a central kitchen, but all of them fall within the scope of the application of the Royal Decree 315/2025.

The plans for monitoring compliance were clarified, noting that this will be part of official school inspections.

## Approach to reducing salt in foods served in Irish public settings

Fiona Ward, Department of Health, Ireland, presented an overview of the approach to reducing salt in foods served in Irish public settings.

The *Healthy Ireland Framework 2013-2025* established the framework for improved health and wellbeing, and set a series of clear objectives *(48)*. This was complemented by the Obesity Policy and Action Plan, *A healthy weight for Ireland (*34*)*. The Department of Health commissioned FSAI to develop national dietary guidelines for the general population *(49)*, young children *(50,51)* and older adults *(52*,*53)*. The FSAI recommends that adults consume no more than 6 g of salt per day.

Health services are the largest employer of public servants and have broad reach (more than 7 million contacts with people per year). In relation to nutrition, several standard or policy documents exist:

- Nutrition standards for food and beverage provision for staff and visitors in healthcare settings *(54)*;
- Food, nutrition and hydration policy for adults accessing disability services *(55)*;
- Food, nutrition and hydration policy for adult patients in acute hospitals *(56)*;
- the Health Service Executive *Healthier vending policy*, which sets a maximum of 1.5 g per 100 g for the "better choice" products that are supposed to represent 60% of the products in a vending machine *(57)*; and
- Health Service Executive calorie posting policy.

In relation to educational establishments there are also some standards and guidance available:

- Nutrition standards for school meals *(58)*;
- Nutrition standards for hot school meals *(59)*;
- Nutrition standards for early learning and care services *(60)*;
- Menu plan for early learning care and care services *(61)*; and
- the healthy food made easy educational programme for marginalized groups.

In addition, the free school meal programme, managed by the Department of Social Protection, sets out that every child in Ireland will be eligible to have a hot school meal by 2030. There was rapid expansion of provision between 2019 and 2025, and hot school meals are now available to all primary schools in the country. An interdepartmental group has been established to examine implementation of the programme and, from September 2025, a dietitian has been engaged to evaluate compliance with the nutrition standards.

The nutrition standards for pre-school children were developed by the Health Service Executive and Safefood, following a successful pilot in 2023, and were launched in October 2024. These are aligned with the food-based dietary guidelines for 1–5-year-olds. The menu plan also complies with the nutrition standards, so there is no salt added. Feedback from preschool services suggests that the service

providers really valued having the opportunity to discuss menu planning, shopping and food preparation with a dietitian. A dietitian or registered nutritionist is going to be employed, therefore, to work with preschool services across the country on the implementation of the standards.

For workplace health, a *National framework for healthy workplaces in Ireland* is in place *(62)*. Healthy Ireland has designed a website with resources and tools to help employers improve the health and wellbeing of their staff, and this includes a section on provision of healthier food options in the workplace and use behavioural nudges and food choice architecture to encourage healthier choices.

A key challenge to promoting healthier food procurement is the tension between the quality of food and the cost. When food production is outsourced, and has to be transported to the point of consumption, salt levels are likely to increase. It is vital to fully engage with all stakeholders and to provide ongoing training and education to public service providers and food service companies.

*Discussion*

It was suggested that it is often easier to get good nutrition standards adopted in early childcare and learning settings, than in schools. This might be that the former are perceived as care settings, while the main objective of schools is to educate. Other factors that may be relevant include more availability of on-site kitchen facilities in early learning settings and that – at least in the case of Ireland – the early years sector has been able to learn some lessons from the experience in implementing schools meals.

It has been challenging to reduce the salt content of menus while aligning with the general healthy eating guidelines – because, for example, the guidelines suggest that processed meats can be consumed up to once per week. Alignment of the menus with guidelines on high fat and high sugar foods is more straightforward since the guidelines recommend that 1–5-year-olds do not have any foods high in sugar and fat.

Cost/price has been highlighted as a challenge for healthy food procurement. This may be due to the limited budgets available or to procurement officers tending, by default, to think of price and value for money first. In the Irish situation, the procurement systems presented a list of available products, from which procurement officers or facilities could choose, and price would be a determining factor in the selection of products for inclusion in this list.

# Discussion on the leadership of ESAN

There was a discussion on the future of the ESAN network. Volunteer countries are sought to take forward chairing the network and hosting the meetings. One option is for countries to volunteer to host the annual meeting, without taking on the role of chairing the network. In such situations, the current chair, Switzerland, would support the host country in organizing the meeting. The added value of having different organizing countries has been evident in the variety of local speakers and different perspectives covered in this meeting hosted by Ireland. Another option could be for the network chair and meeting host to rotate annually. However, it would be desirable for a new country to take over the leadership of the network.

In 2026, a joint meeting on reformulation with the Sugar and Calorie Reduction Network is planned in Copenhagen. The advantages and disadvantages of having joint meetings of ESAN with the Sugar and Calorie Reduction Network were discussed. Some concern was expressed that it is difficult for participants to attend meetings that last for three or four days. It was clarified that the 2026 meeting will probably be 1.5 days, since there is a lot of content overlap on the two issues. It was also noted that in

2027 the two networks will meet separately again. At that point there will be further discussion and agreement will be sought on whether to have further joint meetings every other year.

Representatives from Member States that might be interested in hosting a meeting or chairing the network were encouraged to contact WHO for informal discussion.

# Reflections from meeting participants

The participants offered individual reflections on the meeting. Many participants expressed a high level of appreciation for both the content and the opportunity to network with peers and experts. Countries were congratulated on their efforts and achievements, and for providing inspiration to others. At the same time, some frustration was expressed about the slow pace of progress. The continued high level of participation in the network is testament to the ongoing commitment to reduce salt intakes, and the network's facilitation of exchange of information and insights on reformulation, public procurement, food marketing and monitoring is highly valued. There was considerable interest in a report documenting the collective European experience with voluntary and mandatory measures over the past two decades.

Interest was also expressed in having a WHO-facilitated joint dialogue (involving several Member States) with multinational food companies.

Another theme to emerge repeatedly was appreciation for the legal perspective provided by Nikhil Gokani. It was suggested that further input from public health lawyers – and possibly also experts from business and other areas – could be valuable in future. It was noted that the Netherlands had similarly presented a legal opinion to the network two years ago, and that it may be valuable to recirculate that paper.

# Closure of the meeting

To close the meeting, Sinead O'Mahony thanked WHO and Switzerland for the support in organizing the meeting and their continued leadership. She thanked the Department of Health for its support of the meeting and thanked the Chief Medical Officer for her leadership. Finally, she expressed gratitude to all those who attended and contributed to the meeting.

Kremlin Wickramasinghe also delivered some closing remarks, undertaking to further explore the proposed actions for WHO, including the publication of a report on progress with voluntary and mandatory approaches. He thanked Ireland for its generous hosting and for organization of a successful meeting with very rich content. Handing over to Michael Beer, he reiterated WHO's gratitude to Switzerland for its ongoing leadership of the network.

Finally, Michael Beer closed the meeting. The policies and approaches of countries vary considerably and he urged participants to reflect on how countries can better work together to drive progress on salt reduction. He added his words of thanks to the host team in Ireland and thanked all participants for their presence and contributions.

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# Annex 1. Programme

**European Salt Action Network 2025** 8/12/2025

30 September – 1 October 2025 Original: English
The Spencer Hotel
Excise Walk, International Financial Services Centre, Dublin 1, Ireland
D01 X4C9

## Provisional Programme

| Time | Session / Speaker |
|---|---|
| **Day 1 – Tuesday 30th September 2025** | |
| 09:00–09:30 | **Registration** |
| 09:30–09:35 | Housekeeping |
| 09:35–10:00 | Welcome and introductory remarks |
| 10:00–11:15 | **Session 1: Country updates**<br>WHO |
| 11:15–11:45 | Break |
| 11:45–13:00 | **Session 2: Country updates** |
| 13:00–14:00 | Lunch |
| 14:00–15:15 | **Session 3: Mandatory measures for salt reduction**<br>Presentation exploring maximum salt thresholds in bread - Prof Eileen Gibney, UCD<br>Country presentations / moderated discussion |
| 15:15–15:35 | Break |
| 15:35–16:50 | **Session 4: Salt reduction as a prevention strategy in cardiovascular disease policy**<br>Developing communication strategies and implementing and tacking communication campaigns |
| 16:50–17:00 | Reflection and meeting close – WHO |
| 17:00 onwards | Participants leave |
| 18:30 onwards | Dinner: Fallon and Byrne, 11–17 Exchequer Street, Dublin 2, D02 RY63, Ireland |
| **Day 2 – Wednesday 1st October 2025** | |
| 08:30–09:00 | **Registration** |
| 09:00–09:15 | Welcome and introductory remarks |
| 09:15–10:15 | **Session 5: WHO updates on work and activity related to salt** |
| 10:15–10:45 | **Session 6: Research project updates** |
| 10:45–11:15 | Break |
| 11:15–12:45 | **Session 6: Salt reduction in the out-of-home private and public sector**<br>Keynote presentation salt thresholds in public food procurement systems – Prof Ivan Perry, UCC<br>Salt in the Royal Decree on food security and nutrition, for the promotion of healthy and sustainable eating in educational centres in Spain – M José Yusta<br>Approach to reducing salt in foods served in Irish public setting – Fiona Ward |
| 12:45–13:00 | Meeting reflection and closing remarks |
| 13:00–14:00 | Lunch |
| | **Participants leave** |

# Annex 2. List of participants

**Belgium**
Laurence Doughan
Federal Public Service of Public Health

**Denmark**
Kirstine Hartvig Mahler
Danish Veterinary and Food Administration

**Estonia**
Janne Lauk
National Institute for Health Development

**Finland**
Satu Männistö
Finnish Institute for Health and Welfare

**Hungary**
Eszter Sarkadi-Nagy
National Center for Public Health and Pharmacy

**Ireland**
Aideen McCann
Food Safety Authority of Ireland

Aisling Dunphy
Food Safety Authority of Ireland

Colette Dunne
Food Safety Authority of Ireland

Fiona Ward
Department of Health

Joana Caldeira Fernandes da Silva
Safefood

Joanne Ui Chrualoaoich
Department of Health

Mary Horgan
Department of Health

Matthew Doyle
Department of Health

Sinead O'Mahony
Food Safety Authority of Ireland

Wayne Anderson
Food Safety Authority of Ireland

**Lithuania**
Ieva Gudanaviciene
Ministry of Health of the Republic of Lithuania

**Netherlands (kingdom of the)**
Elisabeth Temme
National Institute for Public Health and the Environment

Maria van Delft
Ministry of Health

**Portugal**
Maria João Gregorio
Directorate-General of Health

Mariana Coelho Santos
National Institute of Health Dr Ricardo Jorge

**Spain**
Maria Jose Yusta-Boyo
Spanish Food Safety and Nutrition Agency

**Sweden**
Åsa Brugård Konde
Swedish Food Agency

**Switzerland**
Michael Beer
Federal Food Safety and Veterinary Office

Steffi Schluechter
Federal Food Safety and Veterinary Office

**United Kingdom of Great Britain and Northern Ireland**
Jack Reeves
Department of Health and Social Care

Nikhil Gokani
University of Exeter

Victoria Targett
Department of Health and Social Care

**Invited experts**

Francesco Cappuccio
University of Warwick
United Kingdom

Eileen Gibney
University College Dublin
Ireland

Nikhil Gokani
University of Exeter
United Kingdom

Ivan Perry
University College Cork
Ireland

**WHO Regional Office for Europe**

Kremlin Wickramasinghe
Regional Adviser, Nutrition, Physical Activity and Obesity

**The WHO Regional Office for Europe**

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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**World Health Organization**
**Regional Office for Europe**
UN City, Marmorvej 51,
DK-2100 Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00  Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.who.int/europe