intervention group B, $n = 1308$) were drawn. Participants completed a questionnaire, underwent a health examination and received a life-style consultation. Those at high risk of CHD in group A were furthermore offered lifestyle counselling in groups over a 6-month period. Individuals at risk in group B were referred to their general practitioner.
From the remaining 48 285 individuals a random sample of 5264 individuals was drawn (group C) and followed by questionnaires. Outcome measures were reported changes in the intake of fish, fruit, vegetables and fats measured by a 52-item food frequency questionnaire.
Results
At 1-year follow-up group A, compared to group C had significantly increased their intake of vegetables ($P = 0.0069$) and decreased the intake of saturated fat ($P = 0.0003$) and total fat ($P = 0.0025$). Group A decreased the intake of lard ($P = 0.0034$) and olive oil ($P = 0.0118$) more than group B. Group B decreased the intake of margarine ($P = 0.0239$) more than group C.
Conclusions
In a general population it was possible to promote significant greater positive dietary changes than in the reference population. The high intensity group showed superior results compared to the low intensity group. Long term effects and refining the intervention strategy are relevant subjects for future research.

Track 8: Workshop: Influenza pandemic preparedness: from national to local level

Chairpersons: MI Esveld
Organiser: Joint workshop EUPHA section IDC and Dutch association of Community Health Services

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Objective
To share experiences on influenza pandemic preparedness (PP), particularly with respect to local implementation of national. plans. Attention will be paid on collaboration with local health care and emergency services, progress support and benchmarking.
Added value
PP is one of the most active topics in public health and one of the major challenges of the 21st century. Pandemic spread of a new virus will most probably affect all countries. The management of such an event requests thorough preparation at all levels and a clear chain of decision making. We will explore the choices that were made by countries within national contingency plans and the translation of those plans to the local level. We will provide the 'state of the art' in PP and bring together policy makers and professionals.
Programme
(i) Dr A.Wirtz—Ministry of Health, Hessen—Germany
(ii) Dr H.Pickles—Nat. Health Service Borough of Hillingdon—UK
(iii) Dr A.Timen—Nat. Coord. Centre Infectious Disease Control-Holland
(iv) Discussion

From a national to a regional plan

Angela Wirtz

A Wirtz
Hesse Department of social welfare, Division of health, Section head for public health services, Hesse, Germany

Issue
Description of the approach and the crucial issues involved in implementing the German 'national influenza pandemic preparedness plan' at the state and county levels – discussion of the situation in Hesse, Germany
Description
By 2000, the conference of state health ministers in Germany decided to begin with influenza pandemic planning. A task force was installed and it submitted a scientific report in early 2004 on risk assessment, delineating options for taking action in the event of an influenza pandemic. It took 1 year of discussion between the federal and state governments to agree on common recommendations and a national action plan. The action plan focuses primarily on the decisions related to vaccine production and stockpiling of antiviral drugs. In parallel, the 'national influenza preparedness plan' was developed and published in January 2005. From that date onwards, the state governments began implementation of this plan by setting up working groups on specific issues, involving multiple state and local government agencies, professional health associations, NGOs, health insurance plans, and church delegates.
Lessons learned
Influenza preparedness planning can and should build on existing plans. For example, in 2002 Hesse set up a regulation defining roles and responsibilities for dealing with biological danger—delineating the terms for cooperation between various public administration bodies. The highest level of danger as defined in this regulation, is deemed to be an epidemic with easy human-to-human transmission and great disease impact—and could thus be applied to an influenza pandemic. Under these circumstances, a clear distribution of tasks, a clear decision structure and strong coordination of measures, and risk communication are needed. Leadership in decision-making lies with the health administration.

But some crucial aspects of influenza differ significantly from other epidemics, such as SARS or smallpox.The main points are: possibly low efficacy of infection control measures, the need for hospital and outpatient care for a mass number of infected patients, and the need to react with limited resources. Mass immunisation within a short time period and the vaccination of priority groups have already been planned in Hesse—but only in circumstances with a sufficient amount of vaccine. This may prove not to be the case in the event of influenza pandemic. These issues have to be discussed involving all key players, including local agencies and non-government experts, to gain a broad societal consensus on how best to overcome the challenges. Only if consensus can be reached can it be expected that centralized, state-level control of all necessary measures on infection control and patient care will be broadly accepted and carried through.

The discussion of the necessity of centralized hospital and outpatient care for infectious patients in Germany is not clear-cut—responses are ambivalent for multiple reasons. Another sensitive issue is state-level control over the distribution of special drugs, particularly of drugs with a high risk of shortages.
Conclusions
At this preliminary stage, the Hesse government stance is to promote the state-level measures in the areas discussed above

in order to achieve a flattening of the transmission rate, to maintain control over the distribution of limited resources and, last but not least, to obtain an optimal assignment of the medical personnel of which the state also faces potential shortages. An update of the progress made in Hesse as of the autumn of 2005, will be presented.

Pandemic preparedness—not just a responsibility for health

Hilary Pickles

H Pickles
Director of Public Health, Hillingdon, UK

Issue
Awaiting the development of national guidance, the community of Hillingdon Borough started making local provisions to cope with the impact of a pandemic flu. Experiences turned out to be useful for national planning. The objective of the presentation is to share experiences of:

- engagement of a local community in understanding' flu pandemics
- thinking through planning for a whole community response

Description
Hillingdon Borough has 250 000 residents. In 2001, workshop sessions were held where leaders from the health sector and local government heard about pandemic flu and thought through the potential local impact. This was based on attack rates and mortality as in 1918, in the early pandemic phase without vaccines and with limited anti-viral drugs. Various technical questions were raised, and sent to national experts for answers.

The local plan that resulted was based on a combination of emergency planning and communicable disease approaches, enhancing existing local structures and accountability, and including all the key public sector, private and, voluntary local bodies.

Much of this work predated national guidance but was used to help influence it.

Lessons learned
The effect on the local workforce was recognized as crucial, and potentially affected by decisions in different sectors, e.g. school closures. Although much would need to follow national plans, difficult local decisions would need to be made. Potentially, this meant shifting priority for limited health services, which would have severe implications for the most vulnerable of our citizens, and create difficult dilemmas for healthcare and social care staff. Hence, how decisions were taken was seen as vitally important in maintaining cohesion of the community and resilience for the longer term.

Conclusions
Whilst undertaken for pandemic flu, the plan that resulted potentially could be adapted for other scenarios, such as managing the consequences of terrorist atrocities. It would also have been of value had SARS spread locally.

From paper to practice—how to support and evaluate local implementation

Aura Timen

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Issue
Only after the outbreaks of avian influenza in Southeast Asia, the Netherlands managed to develop a national plan for pandemic preparedness. However, more is needed to make the plan work in practice. In this paper we describe the Dutch approach to local implementation.

Description
At the beginning of 2004, countries in Southeast Asia reported infections with a HPAI virus (AI/H5N1) in birds and humans. As the risk of a pandemic, according to the WHO, was increasing, a national pandemic plan was issued in August 2004. It consists of 3 chapters dealing with: management of avian influenza outbreaks, early recognition of incidental introduction of a new virus, and pandemic preparedness. As guidelines do not implement themselves, an implementation plan was worked out for the 25 regions of the Netherlands. It provided progress indicators, targeted at all layers of professionals within the health system and even at partners in other sectors. This resulted in a sustainable system of quality management. In the short period between August 2004 and February 2005, all regions started 'translating' the national guideline into practice. On the basis of the quality indicators, the Inspectorate of Health carried out a survey resulting in a benchmark of local implementation. The results will be included in the presentation.

Lessons learned
Ongoing outbreaks of avian influenza increase the risk of reassortment. This sense of urgency should be used to work out plans for pandemic preparedness. In these guidelines, risk assessment, and management are crucial, providing answers to the question whether public health action is warranted. The distance from paper to practice can be narrowed by involving the field in implementing the guidelines and by defining clear progress indicators.

Conclusions
Pandemic preparedness is time consuming, but efforts are justified by the changing epidemiological patterns of avian flu. Although reluctant at the beginning, (para)medical professionals will benefit from working together with contingency planning professionals in preparing regional, practice-based plans.

Track 9: Mental health aspects and overweight in children and adolescents

Overweight and health-related quality of life in Portuguese adolescents

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Background
Overweight and obesity may interfere with social, psychological, and physical activities. The objective of this study was to analyse the association between obesity and health related quality of life (HRQOL) in adolescents.

Methods
In a cross-sectional study we evaluated 7563 students (54.4% females) aged 12–18 years (14.8 ± 1.8) from twenty-six public schools of Viseu, Portugal. Participants completed a self-administered questionnaire. Body mass index (divides weight in kilograms by the square of height in metres) was calculated from self-reported height and weight and classified into three groups: 'normal weight' (<25.0), 'overweight' (25.0–29.9), and 'obese' (> or = 30.0) according to cut-off points for overweight and obesity by sex and age proposed by Cole et al. HRQOL was assessed by SF36 (ranging from 0 to 100) which includes