"Toxic Environment" Threatens WHO Strategy to Combat Global Obesity Epidemic

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For the first time, the World Health Organization (WHO) has produced an analysis showing the extraordinary importance of both obesity and malnutrition in determining global ill-health (http://www.who.int/whr/2002/en/). And it has proposed a strategy for combating the resulting obesity epidemic worldwide.

Understanding the Nutrition Problem

Perhaps surprisingly, both protein-energy malnutrition (PEM) and obesity coexist in many populations, villages and even families, particularly in Asia, Africa, Latin America and the Middle East. In fact, the two conditions are intimately linked, based on new evidence, which suggests that nutritional deprivation in pregnancy and early childhood makes children much more susceptible to the selective deposition of abdominal fat, with all its enhanced morbid effects, when weight gain subsequently occurs.

Traditionally, childhood malnutrition is prevalent among those with low socio-economic status, and the early phase of economic "development," with its nutrition transition, is linked to the emergence of obesity in women, and then men. Now, however, many parts of the developing, as well as the developed, world reveal poverty-associated obesity.

The deprived and stressful circumstances of urban migration limit physical activity and provide ready access to the cheapest forms of food energy – weight-inducing, energy-dense fats and sugars. Poor access to cheap vegetables, fruits and traditional staples in these urban environments, as well as a universal focus in disadvantaged societies on providing substantial meals and hospitality, amplify weight gain and, consequently, the risk of diabetes, hypertension and coronary heart disease. Therefore, policies geared toward tackling obesity need to incorporate the broader dimensions of the nutrition problem.

Promoting the Obesity Epidemic

The current agricultural, food, trade, marketing and transport priorities, though originally promoted by governments for societal benefit, promote the epidemic of obesity and curtail the chances of eliminating PEM. Governments are therefore primarily, and often inadvertently, responsible for today's global health burdens. Targeting individuals through educational initiatives, by advocating "balanced diets" or more physical activity, is either naïve, or in keeping with the Western food industrial drive to dissemble while continuing to amplify sales, using tactics that remarkably parallel those employed by the tobacco industry.

In fact, unprotected, vulnerable pre-school and school-aged children are targeted to ensure early food brand recognition, which in practice leads to poor eating patterns. Schools and parents are now the focus of marketing schemes, including those touting increased portion sizes, to enhance inappropriate purchases and consumption. Meanwhile, intense lobbying, and heavy political and financial support by industry ensure the maintenance of minimum restrictions on "free trade" and marketing. In effect, food labelling is practically meaningless, except to food technologists, and E.U. and U.S. agricultural subsidies with huge vested interests engage in food dumping of sugar, fat, meat, milk and butter on the developing world.

Preparing to Protect the Vulnerable

The newly proposed WHO strategy (http://www.who.int/gb/EB_WHA/PDF/EB113/eeb11344a1.pdf) is the first to take on board the implications of the innovative WHO 916 technical report, "Diet, Nutrition and the Prevention of Chronic Diseases" (http://www.who.int/hpr/NPH/docs/who_fao_expert_report.pdf), which proposes a life-course (fetus-to-old-age) approach to combating obesity and its resulting health effects, and has engendered intense concern and governmental pleas by soft-drink manufacturers and other food industries. Some scientists are even being encouraged to dispute the WHO findings (http://www.who.int/hpr/nutrition/ExpertConsultationGE.htm).

Evidence suggests that counteracting these barriers to good health requires that governmental policies involve a series of protective measures, with changes in government regulations relating to television advertising, marketing to children, food labelling and school meal provision, not to mention trade, financial, social, agricultural, traffic and urban-planning policies. Legislation in Finland and Norway illustrates the benefits of such protective measures, prompting rapid improvement in national cardiovascular mortality rates in both

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Taking National and Global Action

In short, national goals and objectives with realistic timetables, and measurable process and outcome indicators are needed. Some ministries are already on board with nutrition actions, such as opening appropriately accessible health centres; building school playgrounds and suitable cycling and road systems; re-evaluating taxation and subsidy policies; and promoting physical activity and breastfeeding in the workplace.

Potential actions for health ministries, outlined in the table below and focusing on national and local initiatives, include, among other things: creating groups of specialized health professionals targeting the five life-course categories – fetuses, infants, adolescents, adults and older people; monitoring children's and patient's weights and BMIs; and implementing policies on feeding infants and young children, and on promoting physical activity (especially weight-bearing) via nursing homes, caregivers and community centres.

A LifeCourse Approach to Promoting Health and Preventing Obesity & Malnutrition Policies & Actions for Health Professionals and Health Ministries	
For Pregnant Women and Infants: Audit policies on anaemia, weight gain, the optimum pregnancy diet and breastfeeding Support baby-friendly hospital initiatives Develop policy on feeding infants and young children	Apply optimum techniques for limiting low birth weight, anaemia, gestational diabetes and neural tube defects, and implement breastfeeding strategies Initiate breastfeeding within one hour of birth Inform parents on complementary feeding
For children: Promote physical activity in preschools and schools, nursing homes and community centres Coordinate policies with the education ministry on monitoring children's weight and BMI Train school nurses and canteen staff on healthy diets	Monitor iodine levels; promote consumption of iodized salt with education on intake limits Implement policies to reduce vending machines in schools and to limit availability of soft drinks and sweets in general

For Adolescents: Develop policies on weight control, healthy eating and physical activity in schools and community centres, involving adolescents as decision-makers Educate teachers and health professionals on the dietary and psychosocial needs of adolescents	Initiate projects on diet, physical activity and health Implement policies on anaemia in adolescence and in teenage pregnancy
For Adults and the Elderly: Develop nutrient reference values and food-based dietary guidelines Educate health professionals on dietary needs Develop policies to promote physical activity for older people via nursing homes, caregivers and community centres	Ensure dissemination of consistent information on a healthy diet Monitor BMI, bone density, and micronutrient and macronutrient deficiencies
For the General Public: Develop policies for and monitor public health initiatives in hospitals and the community Develop policy on nutrition labelling and health claims	Promote demonstration projects, e.g., on diet, physical activity and health, including those advocating dietary change in the community
For Displaced Persons: Train volunteers and health staff on monitoring the special dietary and nutritional needs of refugees, internally displaced persons and migrant populations	Support policies to provide oral rehydration therapy and nutrient-rich supplements and foods to refugees in camps Monitor refugees for anaemia, and migrant populations for BMI and micronutrient deficiencies

For Hospitals:	
Develop consistent policies on food and nutrition during illness Create a network of health-promoting hospital	Provide consistent information and advice on diet and physical activity

Adapted from Robertson et al. 2004

The WHO strategy supported by many ministers of health favours development of integrated national programmes to alter both diet and physical activity. WHO also calls for international collaboration within the United Nations system and with bilateral agencies to promote a multisectoral approach, given that many physical, economic, political and socio-cultural factors are involved. Guiding principles consist of: strengthening the evidence for policy, advocating the need for policy change and involving stakeholders so that public interest groups, local government and industry can participate in an integrated action plan. Meanwhile, identified areas for international action include education, food marketing and promotion, food labelling (including health claims) and the development of food and agricultural policies consistent with the new public health agenda. Also important is the promotion of healthier foods, with pricing policies and food programmes for needy families. In addition, emphasis is being placed on investment in surveillance, research and evaluation along with the nurturing of an institutional capacity to promote change and adequate financial support in keeping with the international declaration on the U.N. Millennium Goals.

Bracing for the Future

WHO's strategy has been severely criticised by the U.S. government, which highlights the responsibility of individuals for their own wellbeing and limits any reference to the recent WHO 916 report. While some food groups support the WHO strategy, other, more powerful sectors, including the sugar, soft-drink and fast-food industries, have intensely lobbied against this strategy. Alas, the "toxic environment" generated by governmental policies that permit unregulated marketing, and industrial practices and financial arrangements that promote excess food consumption and limited physical activity threaten the WHO strategy, and may trigger compromise, even before it is presented to the World Health Assembly in May 2004.

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