The WHO DPAS consultation on "A framework to monitor and evaluate the implementation of the Global Strategy on Diet, Physical Activity and Health". A joint response from the International Association for the Study of Obesity and the European Association for the Study of Obesity.

We welcome the opportunity to comment on the draft framework document, which has much merit in highlighting the importance of both monitoring and evaluating programmes to combat chronic diseases. It also includes a range of general approaches, which are valuable in highlighting some of the issues, but which require more detailed attention when assessing improvements in chronic diseases rates and their burden.

Given these valuable contributions, IASO and EASO would like to suggest that there are additional points, and sometimes a change in emphasis, which should be made, because it is clear that some of the opinion leaders and analysts in many countries are unaware of the magnitude of the challenge of chronic disease.

The following points deserve consideration:

1. Clearly specifying the different dimensions of primary and secondary prevention. This is important because secondary prevention is often neglected when the evidence is already available from affluent countries that it can make a big difference. Thus the assessment of the prevalence of glucose intolerance and an ability to focus on adults with this problem for the purpose of preventing the development of type 2 diabetes is now in place in some states in Finland. Chinese as well as Scandinavian and US data reveal the extraordinary importance - particularly in older people - of dietary and physical activity interventions. The capability and need to identify glucose intolerance could be considered one issue of prevention, which unless specified, will not occur to most policy makers dealing with health. Similarly the alarming proportion of undiagnosed cases of type 2 diabetes and hypertension - amounting to as many as 89% of cases - reflects an important area of public health policy, which should not be neglected and can be tackled in all sorts of ways. These issues have been addressed in several lower and middle income countries and require different approaches with new screening policies based on changing medical practice.

Another example is the care of the post myocardial infarction patients, where there is already overwhelming evidence that diet and physical activity changes in combination can half the recurrence rate. The question of how this work is being placed into a secondary prevention and care system needs separate consideration depending on the health service systems and communication systems within a country. This aspect should not be dismissed on the grounds that the country cannot afford some initiatives, because these need not be medically focused so the methods for monitoring and evaluating these programmes should allow classic medical policy analyses to be drawn into the wider consideration of primary prevention.

2. The document does not make a very clear distinction between monitoring and evaluation. While it is clear that the evaluation of a problem requires a monitoring system, too often the monitoring becomes a mechanical task which does not then lead to the requirement to increase the breadth of the monitoring process once the evaluation has shown the need to focus on particular aspects of a chronic disease problem. One example of this is the monitoring of the prevalence of hypertension; this should lead to an evaluation of the salt, fat, vegetable and fruit intake of the population as well as rates of physical activity. This often does not happen because the small group struggling to do the monitoring is overwhelmed by work. It might be a useful idea therefore for WHO to help specify how the monitoring systems can be simplified. WHO experts from affluent countries usually set impossible targets for lower income countries and there is a need to develop very simple
quick and reproducible systems for less affluent governments. It might be wise therefore to ask governments to specify their monitoring process, its frequency and their links with other national states - perhaps on a regional WHO basis - to learn different approaches to simplified monitoring. Then a distinction needs to be made where the government might specify how it is evaluating the results of monitoring and taking account of new developments.

3. The monitoring of such things as children's weight gain, the prevalence of obesity and hypertension and even the rates of myocardial infarction at sentinel sites can also be seen as an outcome. This document gives the strong impression that hard endpoints are impossible to achieve, but WHO EURO analyses years ago showed the changes in myocardial infarction rates can change relatively quickly - within a year or two of changes in the saturated/polyunsaturated fatty acid ratio in the national diets. Similarly the alarming escalation of hypertension and diabetes rates in China and elsewhere in Asia is showing changes over a 1-2 year period so the impression with cardiovascular diseases, obesity and diabetes should not be that these are very slow moving endpoints: cancer rates are slow, but not the other major chronic diseases. Furthermore when material gains in strategy are made it can be seen within a year that children's obesity rates can start declining, as seen in both Singapore and Chile where radically different approaches were being used.

4. The specific listing of things to consider on diet and physical activity are rather naïve and disquieting. Thus in physical activity there is still an emphasis on sport as though WHO goes along with the conventional proposition that sport is the answer to the dramatic fall in physical activity occasioned by the advent of private motor cars, mechanised work, TV and the computerisation of everything. The new data, accepted in the WHO 916 report, is that a substantial amount of physical activity is desirable and a distinction needs to be made between short intense activity for cardiovascular benefit, and the amount of energy needed to be expended to limit weight gain on the common diets currently being consumed across the world.

Thus the facilities for children's activity at school need to be documented together with the time for training in physical activity at school; in some major countries e.g. China this is a huge issue given the intense educational drive currently underway. Then the organisation of housing, play groups and facilities for children, when both parents work, is a major policy issue which triggers the question of whether there are nutritional standards for the food and drink allowed in pre-school and school premises. If these are not explicitly set out then countries will not mention them and progress on the global strategy will be severely constrained.

5. Physical activity for adults cannot possibly be met by assuming that all adults in all countries from the age of 20 to 80 years or more will engage in sport. The question is all about transport, urban and work facilities, safe walkways, access to parks and the pedestrianisation of town centres. This draft document should go much further in pushing the well recognised needs for government to become much more pro-active at both a central and local planning level rather than giving the impression that we are back to feeble attempts with health education to combat the chronic disease crisis.

6. On diet it is now well recognised that, as with smoking and alcohol, the major determinants of dietary changes - as distinct from traditional diets - are a) the relative price of different commodities, b) their accessibility to different socioeconomic sectors of the community and c) the marketing of different products. Accessibility is a major issue in the so-called "food deserts" in affluent cities and in the rapid nutritional transition of the lower income countries the absence of town planning to facilitate the transport of perishable foods from the countryside is a big issue. Therefore in this document more attention needs to be drawn to the issues underlying the dramatic changes in nutritional state associated with the hundreds of millions of people moving to towns and cities over the next 5-10 years. By considering the three determinants of population food changes, a much clearer set of priorities for governments should emerge.

7. It is well recognised that in the post Doha negotiations over agricultural products there are major issues for countries in terms of the conditions for the importation of inappropriately
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high fat, sugar and salt products from Western manufacturers. So some credence should be given to considering the setting of nutritional standards for particular products, as has been undertaken by Ghana when attempting to restrict the importation of very fatty meats. By having a standard nutritionally-based set of criteria for home, as well as imported foods, this then complies with the WTO trade agreements in favour of public health. This means that the fundamental sourcing of foods and the setting of criteria for home produced food products of high nutritional value, given the traditional quality of Asian, African, and Latin American diets, needs to be considered by any strategist. The current document is far too vague on these issues.

8. There is insufficient reference to cost-benefit analyses for determining the most appropriate portfolio of changes in policy for improving diets and physical activity. Cost effective analyses are essential because much of the current efforts, based on individual approaches to behaviour change, are inordinately expensive and ineffective. Unless governments are encouraged to use this cost-benefit approach, then in 5 years time there might well be little to show for their efforts.

9. There seems little mention of demonstration projects as a means of assessing different options and galvanising the community. There should be an explicit question relating to this issue in the document as there are many community demonstration projects already underway, and there is a danger that these will not be assessed in a sufficiently coherent manner.

In conclusion WHO should establish benchmarks of minimum indicators of actions to be taken to implement the global strategy by each country, including effective monitoring of overweight and obesity prevalence, and regularly assess progress of Member States against these indicators to allow countries to be ranked in a similar way to the UN Human Development Index.

Prof Philip James, Chair, International Obesity TaskForce, on behalf of the International Association for the Study of Obesity and the European Association for the Study of Obesity.

i Programme For The Prevention Of Type 2 Diabetes In Finland 2003-2010.
iii Diabetes Prevention Program Research Group, Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin. N Engl J Med 2002 346: 393-403