



March 26, 2003

Mrs Amalia Waxman
Project Manager
Noncommunicable Diseases and Mental Health
World Health Organization
Geneva, Switzerland

Dear Mrs. Waxman:

RE: your request for “consultation” on WHO’s global health strategy as invited on <http://www.who.int/hpr/NPH/docs/consultationdocument.pdf>.

We have attached the document with our comments embedded. In addition, for your ready reference, I’m attaching the Statement by the UNICEF-WHO Joint Committee on Health Policy on “World Summit for Children – Mid-decade Goal: Iodine Deficiency Disorders (IDD).

Thank you for this opportunity to provide feedback for your efforts.

Sincerely,

A handwritten signature in black ink that reads 'Richard L. Hanneman'.

Richard L. Hanneman
President

Attachments

TA7261



JCHPSS.pdf

Salt Institute comments embedded in red type.

CONSULTATION DOCUMENT TO GUIDE DEVELOPMENT OF A WHO GLOBAL STRATEGY FOR DIET, PHYSICAL ACTIVITY AND HEALTH

This document provides a framework for the elaboration of a WHO Global Strategy on Diet, Physical Activity and Health, within the WHO integrated approach to prevention and control of chronic diseases. It outlines the main public health issues and provides a rationale and background for the strategy. This document also includes several key discussion points, which policy-makers may wish to consider when developing inputs to the Global Strategy or when stimulating and revising their national strategies. The regional consultations to be held in 2003 will serve as an important platform for refining and agreeing on the full text of the Global Strategy. Additional inputs will be sought from industry, NGOs and consumer groups, and United Nations agencies.

1. The goal

The overall goal of the WHO Global Strategy on Diet, Physical Activity and Health will be to guide the development of actions at local, national and international levels that, when taken together, will lead to measurable improvements in risk factor levels with reduced disease and death rates due to chronic diseases related to diet and physical activity in populations.

The Salt Institute supports this worthy goal.

2. Background

Chronic diseases dominate the burden of disease in developed countries and now increasingly affect low- and middle-income countries. Concern about these trends led the Fifty-third World Health Assembly in May 2000 to adopt a resolution emphasizing the need to prevent and control noncommunicable diseases and requested WHO to maintain this area as high priority (WHA53.17). In May 2002 the Fifty-fifth World Health Assembly also requested the Director-General to develop a Global Strategy on Diet, Physical Activity and Health in consultation with Member States and the United Nations system (WHA55.23)

The development and implementation of a strategy to address diet and physical activity complements and reinforces work already under way under WHO leadership in relation to infant and child nutrition, child development, healthy ageing and tobacco control. Alcohol strategies will be considered in a future process. Responding to Member States' call for action, WHO has embarked on a number of focused initiatives to address the major risks for chronic diseases. Evidence shows that population groups can live healthily into their 7th and 8th decades, provided that they are on an optimal diet, maintain physical activity and don't use tobacco. A strategic life-course approach will enable populations to be spontaneously active as well as to obtain appealing and affordable foods of an appropriate nutritional composition.

Discussion Points:

What is the status of your country's legislative, regulatory and national policy in the area of diet and physical activity? (e.g. are there food labelling, marketing codes) Do policies involve different sectors, such as health, transport and agriculture? Does the agriculture policy address

issues such as national food security, trade and exports and agri-environmental issues? Has your country investigated barriers to access to healthy foods?

An additional consideration is the declining public confidence in public health nutrition advisories. Public opinion polls confirm that the public is increasingly confused. We believe this is due to the strained credibility of organizations, like WHO/FAO in its current draft report Series 916 “Diet, Nutrition and the Prevention of Chronic Diseases.” Rather than rely on evidence-based approaches, WHO jeopardizes its credibility and the public acceptance of its recommendations by relying, instead of on the evidence, on the opinions of its self-selected scientific committee. Our area of familiarity is with the science regarding health impacts of dietary salt intake. In that area, publication within the past two months of two powerful evidence-based Cochrane Reviews, reaching diametrically opposite conclusions from the empanelled WHO/FAO “experts” illustrates your problem.

3. The problem

A profound shift in the major causes of death and disease pattern is under way in most countries. For some developed countries where chronic diseases (defined here to include noncommunicable diseases such as cardiovascular disease, cancer, chronic respiratory disease, diabetes, osteoporosis and dental caries) have dominated the national burden of disease profile, age-specific death and disease rates have been slowly declining. Although progress is being made in reducing premature death rates from coronary artery disease, stroke and some smoking-related cancers in many developed countries, the overall burden remains very high and many of these countries are experiencing a rise in overweight and obesity in children and adults and closely linked increases in type 2 diabetes.

Of even greater concern are the effects of rapid nutrition transition and the decline in physical activity in the developing world, where there are escalating rates of cardiovascular diseases and cancers, as well as increasing rates of obesity and type 2 diabetes. There are now far more people with cardiovascular diseases, cancer and type 2 diabetes in developing than in developed countries.

The ageing of populations also has a strong impact on morbidity and mortality patterns in developed countries, in developing countries, an up to 400% increase for the population 60 years of age and over is foreseen in the next two decades. For many developing countries this will mean an increased burden of chronic diseases along with the persisting burden of infectious diseases.

Furthermore, in the poorest countries of the world, even though infectious diseases and under-nutrition dominate their current burden, the known risk factors for chronic diseases are increasing. These risk factors have a more dramatic impact when infants and young children are stunted and deficient in micro-nutrients during what should be their rapid growth periods.

For all countries, the underlying broader determinants and role of specific risk factors for chronic diseases, both independently and for specific diseases, and in combination, are largely the same. These include: urbanization, globalization, increased marketing and consumption of tobacco and foods high in fats and/or sugar and low in micronutrients, and reduced levels of physical activity at home and at work for recreation and transport. Many of these factors overlap, but some benefits of physical activity are independent of nutrition or obesity and some nutritional risks have nothing to do with obesity. Variation in outcomes at the population level is mainly due to the timing and intensity of changes.

The *World Health Report 2002*¹ describes in detail how a few major risk factors account for a significant proportion of all deaths and disease in most countries. For chronic diseases, the most important include tobacco, overweight and obesity, physical inactivity, lack of fruits and vegetables, alcohol and intermediate biological outcomes such as raised blood pressure, serum cholesterol and blood glucose levels.

In all countries, chronic diseases have a major impact on the demand for health services. High costs of treatment, lost productivity and premature death negatively impact on economies. Several trends suggest that the problem will grow steadily worse unless urgent action is taken. Some of these trends include: increased consumption of animal fats and unhealthy hydrogenation of fats; widespread displacement of nutrient-rich foods (such as fruits, vegetables and legumes) by energy-dense nutrient poor foods; global marketing and consumption of salty, sugary and fatty snacks—all occurring within a context of reduced levels of physical activity.

While death rates may be higher initially in more affluent sectors of society and in urban areas, global experience suggests that in time all major harmful risks for health would cluster among the poorest communities - even in many rural areas – and become the major contributor to inequities by social class.

Discussion Points:

What are the levels and trends of the major risk factors and determinants for chronic diseases in your country?

Many medical experts have a fundamental disagreement with the way WHO approaches risk factors. They believe blood pressure is an important measurement, but it is simplistic to conclude that, because blood pressure is important, that any and all methods to reduce elevated BP are desirable. Hypertension may be a risk factor, but WHO should be trying to prevent chronic disease. In that regard, HBP is an indicator of a problem, a surrogate marker, but not a useful indicator of the appropriate intervention to lower the incidence of CV incidents. Preventing myocardial infarctions and strokes is the objective, not simply lowering BP.

We are dismayed at the virtual absence of any discussion of the problems associated with iodine deficiency disorders – a priority health concern identified by WHO’s sister agency, UNICEF, at its 1991 World Summit for Children. We are making gratifying progress – and WHO is part of the international network, with the salt industry and other public health groups – in virtually eliminating IDD through the iodization of salt. In fact, the attached UNICEF-WHO Joint Committee on Health Policy statement to a Special Session in Geneva in 1994 emphasizes WHO’s commitment to “advocacy for universal salt iodization” and “a sustained commitment to permanent iodisation.” Prevention of birth defects and mental retardation is very clearly linked to inadequate nutrition and should be squarely within the scope of the WHO Global Strategy on Diet, Physical Activity and Health. Please review your own URL and see if you don’t agree: <http://www.who.int/nut/idd.htm>.

4. The solution

Extensive research carried out over the past years provides us with information on optimal diets and minimum thresholds for physical activity levels, as well as the most successful public health interventions (both individual and population-based), which are effective to achieve them. The specific diet and physical activity recommendations include:

- Increase consumption of fruit and vegetables as well as legumes, whole grains and nuts.
- Substantially increase levels of physical activity across the life span.
- Shift consumption from saturated fats and trans-fatty acids towards unsaturated fats and, in some settings, reduce levels of total fat intake.
- Encourage fish, lean meats and low-fat dairy products when consuming animal-based foods.
- Reduce the intake of “free” sugars.
- Reduce salt consumption from all sources and ensure salt is iodized. **As stated earlier, your conclusion does not reflect the “extensive research...over the past years.” The Cochrane Reviews found that the quality evidence in this area does not support the conclusion that the population would benefit from reducing salt consumption. We agree that all salt in areas of iodine deficiency must be iodized and active public education efforts should augment salt producers’ iodine fortification of sodium chloride.**
- Provide appropriate food information to consumers to allow them to make “healthy choices”. **Again, “healthy choices” will not include consumer food information that advises general sodium intake reductions as the Cochrane analysis has determined that a population-based strategy is not supported by the available CVD outcome measures as well as the surrogate BP.**
- Reduce heavy marketing of foods high in fat and/or sugar to children.
- Support exclusive breast-feeding for 6 months and healthy infant and child feeding practices, combined with breastfeeding, up to 2 years.

The translation of these recommendations (together with effective tobacco control) into supportive national and local policies and actions will take time, sustained political commitment and the collaboration of many stakeholders. The work could lead to one of the largest positive shifts in population health ever undertaken and should put populations on pathways to lifelong and sustained improvements in their health.

Discussion Points:

Do you anticipate that gaining increased political commitment on implementing strategies to reduce levels of chronic diseases and obesity, will encounter any obstacles, such as policymakers not seeing NCDs as a priority, or cultural constraints? What other potential obstacles do you envisage?

One “potential obstacle” impeding the strategy for reducing salt intake is the accelerating erosion of scientific support for universal sodium restriction. As long as organizations like the Cochrane Collaboration – more credible if not better known than WHO – identify no scientific foundation for this intervention, adoption of policies will be difficult to accomplish – and, if achieved, lead to uncertain results.

5. Principles for action

Based on experience with successful policies and strategies in a number of countries and communities, the following working principles are proposed for developing the WHO Global Strategy for Diet, Physical Activity and Health:

- The Strategy should be *comprehensive*, addressing all major risks for chronic diseases together; should be multisectoral and take a long-term perspective.
- Each government should select the *optimal mix of policies and programmes* that are in accord with its national capabilities and economic realities.

- *Governments have a central steering and stewardship role* in initiating and developing the strategy, ensuring it is implemented and monitoring its impact over the long-term. When governments act decisively and with long-term commitment, changes are possible. Local government action is critical to operational success.
- *The Health Ministry has a crucial convening role* among many other ministries that need to be actively involved. These include: ministries with responsibility for food and agriculture policy; youth, sports policies; education policies; commerce, industry and finance policies; transportation policies; environmental/sustainability planning as well as local authorities and those responsible for urban development.
- Governments may need to simultaneously address issues of *unbalanced nutrition, over-nutrition* as well as *under-nutrition* and micro-nutrient deficiency, overweight and obesity. This will lead to a more coherent nutrition, agricultural and food policy.
- *Governments cannot act alone.* The combined energy, resources and expertise of the private industry (including, but not limited to, the food, beverage, sports goods, sport organizations, retail, advertising, insurance and media sectors), health professional bodies and consumer groups, academics and the research community are all essential to sustained progress.
- *The food industry has a critical role to play in providing healthy and affordable food.* Their initiatives to reduce the amount of salt, sugar and fats added to processed foods and to review many current marketing practices could accelerate health gains world-wide. **The food industry has an indispensable role. In fact, it not only has a “critical role to play in providing healthy and affordable food,” it is the sole role of the food industry – and its role is unique. No other entity has the responsibility for providing healthy and affordable foods. That said, food industry “initiatives to reduce the amount of salt...” have already produced a rich variety of consumer choices of low-sodium products. Whether they confer a health benefit or not, consumers already have those choices because of the public-spirited cooperation of the food industry. With the disintegrating scientific basis for general application of low-sodium diets, perhaps the strategy should be geared to encouraging production of medical foods for those placed by their medical provider on such dietary therapy.**
- *A life-course perspective* to chronic disease prevention and control is critical. This starts with maternal and child/adolescent health services, includes school and workplace structure and activities as well as home-based care for the elderly and disabled.
- *Globalization of diets and patterns of physical activity demands global responses.* There are limits to what individual Member States can do alone to promote optimal diets and healthy living. Several aspects of the strategy may be strengthened by using existing international norms and standards, such as Codex Alimentarius, and by addressing, for example, transnational aspects of harmful and beneficial marketing of foods to children and increasing access to fruit and vegetables. Global surveillance of major risk factors and consumption trends as well as international research into the causes, and course of, nutrition transition and physical inactivity would also benefit all countries.
- The strategy should be designed so that it will explicitly have an impact in the *poorest communities* in countries. Many strategies exist that benefit mainly the more affluent populations. Strategies that impact beneficially on the lives of the poorest in a country will generally require stronger government intervention and oversight. The strategy should also be *age-sensitive*.
- Further, since decisions about food and nutrition in the household are often mainly made by women, and patterns of physical activity differ by gender and age, the strategy should be *gender-sensitive*.

Discussion Points:

Do the existing institutional mechanisms in your country, both within and between government agencies, address diet and physical activity in a coherent and integrated way? What role does the Health Ministry have in these mechanisms? Do governments interact with private entities, NGOs or academic groups? Is interaction done in an effective way, and does it address both diet and physical activity *together* ?

6. From science to action

Action should be based on systematic needs assessments and solid evidence. **The Salt industry could not agree more. WHO should reconsider the quality of the evidence utilized by its “experts” and rely, instead, on such evidence-based reviews as those published by the Cochrane Collaboration.** Changes in diet and physical activity will require the combined efforts of many players over several decades. For many areas, a combination of sound and feasible strategies is needed with close monitoring and evaluation of impact; thus, with the exception of community-based pilot projects, short-term interventions and evaluations are discouraged. Governments are encouraged to build on existing structures that already address many aspects of diet and nutrition. For many countries, national diet and nutrition action plans have been developed that could be used as the basis for addressing chronic disease control.

The following list includes policies and actions that are being used in many Member States. The selection of what is best for an individual country will vary:

- ❑ *Advocacy and social mobilization*: the power of political leaders and societal role models using public fora to promote the major evidence based recommendations in the areas of diet and physical activity above should be fully used throughout the year and especially on World Health, Move for Health, World Heart, World Diabetes and other related Days.
- ❑ *Government policy* on diet and physical activity: development of a policy involves the participation of many groups in society. Government policy spreads the message and triggers actions at community level. Elements of a government policy may include the following general measures :
 - *Information and education*: aimed at allowing consumers to make fully informed decisions and protecting children from messages and products that could harm their health, it could bring together laws, regulations and activities related to food labelling and health claims, all aspects of food and beverage marketing (including advertising and sponsorship), public education campaigns and school education programmes aimed at increasing levels of physical activity and at promoting optimal diets.
 - *Food and agricultural policy*: providing incentives and support for production and marketing of healthier food, this could involve technological support for: production of fruit, vegetables and legumes and other healthy produce in agriculture; technological innovations to produce healthier foods; distribution chain and export of these products. Ways to stimulate this process include government support for school lunch programmes and other public catering and food aid programmes, as well as by developing contracts with local food growers so that they are ensured a local market.
 - *Pricing policy and subsidies*: several countries use complex subsidy systems to promote the production of various foods; others use taxes to increase or decrease consumption of foods; and some use public funds and subsidies to promote access among poor communities to recreational and sporting facilities. Each country may consider a review

of whether in totality, these financial measures lead to improved diets among their populations. Involvement of the Ministry of Finance in such reviews, and the development of economic analyses of the impact of chronic diseases on national finances may prove to be decisive in getting long-term supportive fiscal policies

- *Physical activity promoting policies include many sectors' responsibilities:* urban planners can develop policies to make walking, cycling and other forms of exercising easy and safe; schools can ensure that children receive daily physical activity; workplace policies can support physical activity breaks; and sport and recreation facilities should be involved in improving access to 'Sport for All' concepts and principles. The combined impact could be a major increase in activity levels across the life-course.
- *Better use of health services for prevention:* contacts with health service staff should be more effectively used to provide practical advice to patients and families on the benefits of optimal diets and increased levels of physical activity. Governments could consider incentives to make this a reality and encourage surveys to measure the extent of opportunities for prevention within services are being used. Governments should also consider an improved financing structure to encourage and enable health professionals to dedicate more time to advising on prevention of chronic diseases.
- *Incentives to make markets work for chronic disease prevention and control:* working with industry, governments could review how best to stimulate industry and retailers to increase their investment in the development of "healthy messages" supportive of the strategy, and in new product development to address the nutrient needs within the context of a balanced diet. Co-operative rather than adversarial relationships with industry have already led to many favourable outcomes related to diet and physical activity.
- *Greater involvement with health professional bodies and consumer groups* could amplify the effectiveness and reach of government policies by enlisting strong community support in a cost-effective way.
- *Investment in surveillance systems* to monitor major risk factors and their responsiveness to changes in policies and strategies is critical. These could build on systems already in place to some degree in some countries. Emphasis should be given initially to tobacco use, levels of physical activity, selected dietary components, as well as levels of blood pressure, serum cholesterol and blood glucose.
- *Investment in applied research, especially in community-based demonstration projects* combined with increased involvement of scientists in research related to diet and physical activity will lead to better-informed policies and policymakers and ensure that a cadre of expertise is created at national and local levels.

Discussion Points:

Do your country's health and surveillance systems adequately advise on prevention, and report on chronic disease risk factors at the various levels, i.e., hospitals, clinics, primary health care, private and public health sectors?

Bottom line: Get the science right before you rush into action. It's not right now!

NMH/WHO/HQ
10 Jan. 2003