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Feedback on WHO/FAO global report on diet, nutrition and non-communicable diseases

Comments from Douglas Taren, University of Arizona

The FAO/WHO report provides an ambitious policy to curb the rising rates of chronic diseases in less industrialised countries. The focus of the report is to provide guidance to individual countries on developing dietary and physical activity guidelines for their populations. The report parallels recommendations from several industrialised countries in that it recommends the increased consumption of fruits and vegetables, and places limits on the consumption of total fat, saturated fat, and simple carbohydrates (sugar). The recommended policy strategies are framed within traditional issues of human behaviour for changes in dietary patterns and physical activity along with the implications for monitoring and enhancing the production of fruits and vegetables. These recommendations are consistent with existing practices in America and other industrialised countries.

In my opinion, the recommendations do not place enough emphasis on two areas. Firstly, the differences in approaches that may need to be used in less industrialised countries compared with industrialised countries due to reduced resources and the existence of other prominent diseases such as higher rates of infectious diseases, HIV and malnutrition. Thus, there is a great need to conduct more research on what interventions can be successful in resource-poor environments compared with the successful examples provided by Japan and Finland. Secondly, the recommendations fall short by not clearly stating that countries need to shift resources away from unproductive expenses, such as large military budgets or central curative health care services, to more preventive oriented services. There needs to be a push for development to occur in the transition countries that does not discourage traditional diets and physical activity. An example is the increased purchases of automobiles that is occurring in less industrialised countries that accelerates pollution and decreases physical activity. There needs to be ways to improve rapid transportation, but at the same time allow people to not completely evade the need to walk. Driving door-to-door from home to work should not be encouraged and alternatives need to be provided. There is also a need to have countries limit unhealthy fast foods that are imported from industrialised countries. These policy statements should be explicit and highlighted.

Comments from Martin Wiseman, World Cancer Research Fund International

Even before it was published, some recommendations in the new WHO/FAO report had unleashed a furore of criticism from organisations with a commercial interest in the issues raised. Principally, the parts of the food manufacturing industry who use and sell sugar in drinks and confectionery raised a number of questions over the scientific foundation and rational basis for the recommendation that on average sugar should provide no more than 10% of dietary energy.

The tricky area of translation of science into policy offers opportunities to confuse the apparent objectivity of science with the subjective development of policy goals. The former may show – and in biology often does – continuous graded relationships between exposure and outcome, while policy demands clear targets and goals which can be quantified and towards which progress can be monitored and evaluated. However, the selection of a quantified goal in the absence of a biological threshold must involve other considerations, just as treatment thresholds for high blood pressure (or indeed the definition of hypertension) depend on factors other than the continuous relationship between blood pressure and cardiovascular outcome.

This issue is at the heart of public health nutrition. The analogy with clinical medicine is clear – presenting complaint, history, examination, and diagnosis and treatment based on application of knowledge using both science and judgement. The body of knowledge is identical: surveys represent the clinical history and examination; it is the prescription that is more difficult.

As an example of the public health nutrition cycle, the current WHO/FAO process has much to commend it. Having identified health risks and problems through methodical data collection and analysis, wide involvement of stakeholders has underpinned the development of the proposals for action. It is at this 'action' stage that conflicts often seem to arise, but without it the rest of the process becomes simply an academic exercise.

Though the world still provides us with abundant examples, economically developed societies seem to have forgotten that the default option – the natural state – is for disease, famine, plague and pestilence. Where we are fortunate enough to live in societies with good living standards and public hygiene, it is easy to forget how these were gained through the persistence of campaigners over the last century and a half. Public health is the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society. Someone has to do the organising and we as health professionals have a responsibility to lead in this area. The WHO/FAO process is a fine example of such leadership.

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