features, approaches and contents of the report of the Consultation can be viewed in an article in Public Health Nutrition2.

In the light of the updated population nutrient intake goals recommended by the joint WHO/FAO expert consultation, national FBDG should be reviewed, or formulated as necessary by adapting recommended population nutrient intake goals to local situations. The goals and recommendations of the joint WHO/FAO expert consultation provide an important scientific basis for developing and implementing global, regional and national strategies for improving the health and nutritional well-being of the world population.

3.5 Overview of the Global Strategy on Diet, Physical Activity and Health and its regional implications

Dr Denise Costa Coelho, WHO Headquarters

In May 2004, the 57th World Health Assembly endorsed the WHO Global Strategy on Diet, Physical Activity and Health (DPAS) in resolution WHA57.17. The DPAS was developed through an inclusive and extensive process of consultations with all concerned stakeholders, in response to a request from WHO Member States at the 2002 World Health Assembly (WHA55.23). A total of 81 countries attended six regional consultations, and 11 United Nations agencies, 25 international nongovernmental organizations and 25 international industry associations were consulted. The WHO Director-General chaired roundtable discussions with senior executives of 13 international companies, and with 13 nongovernmental organizations. An international reference group advised the process. A consultation with countries of the Eastern Mediterranean Region was held in Cairo, 30 April-2 May 2003.

In the resolution, the Health Assembly acknowledged that “... malnutrition, including under-nutrition and nutritional deficiencies, is still a major cause of death and disease in many parts of the world, especially in developing countries, and that this strategy complements the important work of WHO and its Member States in the overall area of nutrition” (WHA 57.17). Members States have expressed their concern that WHO should continue to consider the whole spectrum of nutrition diseases in its work. There are common solutions, common policy options to jointly address these conditions. Keeping the best balance is the challenge and the opportunity to move the nutrition agenda further.

DPAS sets as key principles for action that: strategies and policies should be multisectoral, address all major chronic noncommunicable disease risk factors and have a long-term perspective; its implementation needs to address all age, sex and socioeconomic groups; advocacy must be

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sustainable and continuing; entry point at country level should be political; tools for countries should be based on needs; macro and micro levels should be addressed in combination. It recommends that policies aiming at environmental change, and those aiming at change, which are the individual’s responsibility, should be balanced and appropriate to national and regional circumstances.

FBDG are a core component of DPAS implementation. Member States are encouraged to “… draw up national (food-based) dietary guidelines, taking account of evidence from national and international sources. Such guidelines advise national nutrition policy, nutrition education, other public health interventions and intersectoral collaboration. They may be updated periodically in the light of changes in dietary and disease patterns and evolving scientific knowledge.” WHO, in cooperation with other international organizations, is recommended to facilitate the drafting and implementation of national food-based dietary and physical activity guidelines, in collaboration with national agencies.

The private sector should also be a significant player in promoting healthy diets as the healthy choices should be the easy ones. The food industry is recommended to limit levels of saturated fats, trans-fatty acids, free sugars and salt in existing products and to develop and provide affordable, healthy and nutritious choices to consumers. The industry can play an important role in providing consumers with adequate and understandable product and nutrition information and in practicing responsible marketing that supports the strategy, especially to children. But, above all, it can and should strive for healthy workplaces that promote a healthy diet and physical activity among its workforces.

The DPAS created a new and exciting momentum for work in the area of nutrition for WHO. Nutrition-related diseases are interconnected in the life cycle. Populations, families and even individuals are being burdened by several of these conditions. Public policies can change this scenario and decrease the dual burden of nutritional diseases. A science-based, comprehensive, integrated and action/policy oriented “nutrition agenda” should be set at global, regional and country levels, addressing the whole spectrum of the nutrition problems, interconnecting current policies, technical guidelines and strategies. Building and implementing the nutrition agenda should be a collective responsibility and a multi-stakeholder effort.

WHO’s continued work in nutrition contributes to DPAS implementation while addressing the whole spectrum of nutrition diseases, and should be reinforced. It includes the development/updating of national intersectoral food and nutrition plans and policies, the updating and implementation of national FBDG, the development and implementation of strategies to address obesity, particularly childhood obesity, the
promotion of fruit and vegetable consumption, and the setting-up of comprehensive school-based nutritional interventions through the “Nutrition Friendly Schools Initiative”.

To reinforce its work in these and other areas, WHO aims at building a strong network in nutrition with regions, countries and other global organizations; and at providing Member States and the international community with technical guidance and collaboration. WHO also acts globally and internationally to raise awareness and commitment, to build alliances, networks and partnerships, to address issues that are international in nature, and to develop and implement a communication strategy for “Nutrition: Where do we collectively want to be in 2015?”

In the plenary discussion which followed, the question was raised whether the BMI cut-off point for obesity in the Region should be 25 or 23 as is currently being considered in Asia. At present, there is no agreement among the experts, so the BMI cut-off point of 25 is still valid.

### Points raised in the discussion

- In Asia, the BMI cut-off point for obesity is now under consideration. Similar research is needed to determine appropriate cut-off points for obesity in the Eastern Mediterranean/Near East Region.

- Recommendations for physical activity, that are appropriate for the Region, should be considered.

- Sugar intake is a major and hard to address concern in this Region because the sugar industry is very powerful.

- Development of FBDG should be a multisectoral effort in which the food and agriculture sector is a key player.

### 3.6 Process and steps in developing food-based dietary guidelines

*Dr Antonia Trichopoulou, University of Athens Medical School*

The realization that diet is an important determinant of human health is not new. What is new; however, is; first, the documentation of our knowledge about what is healthy in diet and what is not; second, the semi-quantification of our understanding; and third, the realization that changes can be successfully implemented at either the individual or the population level.
These facts impose on us, nutrition scientists and public health officials, an obligation to act. As a first step towards meeting this obligation, national FBDG have been developed, and conscientious citizens have been asked to adopt them toward better nutrition for a better life.

The ability to monitor and compare the dietary habits of different populations is important in the formulation of dietary guidelines and in planning and implementing national food, nutrition and agricultural policies. In the field of public health, emphasis should be placed on the importance of recording standardized and comparable dietary data and the promotion of nutrition surveillance systems.

The first step in developing FBDG is the compilation of a national report, which reflects available information on energy, food and nutrient intake, as well as health indicators (prevalence of overweight and obesity, blood lipids, mortality, morbidity, physical activity and smoking). The report should identify the major nutrition and health problems. It should also point out the inadequacies of data collected, which would limit the comparability of the collected data.

The national report should not only compile data but should be a stimulus for future projects in the area of nutrition and health. The report should also serve as a basis for improvements and for the planning of such future projects, and show what still has to be done in order to obtain comparable and representative data. In order to obtain comparable data between countries, according to the European 2004 Health and Nutrition report the assessment should take place during a whole year in order to avoid seasonal fluctuations. Uniform age groups should be used; the sampling method should be standardized between all countries; a standardized database for the calculation of nutrient intake should be used among all countries; and the data should be representative for the target population.

Standardized assessment methods are also needed for physical activity and smoking, and for overweight and obesity (self-reported or measured), and uniform cut-off points should be applied. Many studies have evaluated the association between single foods, food groups, or nutrients and chronic diseases. During the last 10 years the focus has been on the identification of a dietary pattern that maximizes longevity.

FBDG are easier for the public to follow than recommendations about nutrient intake alone. Patterns of food intake may be more relevant to health and disease than intakes of specific foods or particular nutrients. FBDG can incorporate aspects of the socio-cultural environment that affect food availability and choices, and can overcome behavioural obstacles that hinder their implementation. To develop FBDG, consensus is needed among the ministries of health, agriculture, and commerce, the scientific community, and nongovernmental organizations. Dietary guidelines should also be as simple as possible and provide common-sense advice.
Dr Trichopoulou also presented the Mediterranean diet and the corresponding food guide in a pyramid shape (see Annex 5). She briefly mentioned the importance of preserving the knowledge and use of traditional foods, noting that the Department of Hygiene and Epidemiology in the University of Athens Medical School has started studying the traditional foods of Greece.

### Points raised in the discussion

- In more than one country, one or more national organizations/institutes work on developing FBDG or food composition tables. It is more effective if they unite their efforts.
- A major challenge is to develop clear and sensible nutrition messages that can be readily adopted by the public.

### 3.7 Food and dietary data needed for the preparation of food-based dietary guidelines

*Dr Antonia Trichopoulou, University of Athens Medical School*

The presentation refers to the report Monitoring public health nutrition in Europe (European Union Report, 2003). Definition of indicators of health should be consistent across member states. Indicators should be defined for food and nutrient intake, including breast feeding; nutritional status, anthropometry and physical activity.

To define the food and nutrient intake, the European Union uses the following indicators:

- consumption/availability of vegetables (excluding potatoes and vegetable juice)
- consumption/availability of fruit (excluding fruit juice)
- consumption/availability of meat and meat products
- consumption/availability of fish
- saturated fatty acid content of the typical diet
- polyunsaturated fatty acid content of the typical diet
- mono-unsaturated fatty acid content of the typical diet
- non-starch polysaccharides content of the typical diet