THE CHALLENGE OF OBESITY AND ITS ASSOCIATED CHRONIC DISEASES

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The accompanying six articles on obesity pose a new challenge for the SCN and international policymakers because they present a completely new demand for coping with yet another problem. For some it will be an unnecessary distraction from the priorities of the Millennium Development Goals (MDGs) set out by the UN and G8 only a short time ago; for others, it highlights a problem that could surely be resolved through education enabling the public to comprehend the need for sensible eating and increased physical activity.

Why then should we address this problem? Do we run the risk of taking on too many nutrition issues when we are already failing to make sufficient progress with the MDGs, despite the declared commitments of governments?

For decades we have been concerned with the enormous impact of childhood malnutrition, communicable diseases and the scourge of natural disasters and wars on whole populations, especially the vulnerable groups within society. These problems have been the primary concern of a large number of UN agencies such as FAO, UNHCR, UNICEF, WFP and WHO who, often working with NGOs, have become renowned for their ability to cope with emergencies, as seen in the aftermath of the recent Asian Tsunami disaster.

Today, policies recognize the crucial importance of food, shelter and the nurturing of children; but it has always been recognized that poverty is a major constraint on progress. FAO, founded by Boyd-Orr who helped transform British food and agricultural policy before, but particularly during, World War II, led the drive to make the global agricultural community self-sufficient in food and capable of coping with the hungry and deprived. Over the last 60 years, governments in Western Europe, the ex-Soviet Union, the US and Japan have spent billions of dollars annually to ensure not only self-sufficiency in food but also improve production efficiency. This enabled even the poor to afford both meat and milk needed for child growth and cereals, butter and sugar for energy sources. After the War these commodities met the needs of millions of malnourished children and adults in Europe and the Middle East. These methods were then taken to the developing world to cope with a plethora of communicable diseases, poverty, contaminated water supplies, poor sanitation and childhood malnutrition whilst promoting economic development. Recently the benefits of using a free enterprise approach to development have become the principal focus of governments, which today has led us into an intense drive to enhance free trade and liberal economies.

Chronic diseases—a major problem for the developing world

Given the progress achieved in the past six decades, why should the problem of obesity assume such prominence? What is its relevance to development, aid and trade issues? The answer is that excess weight gain is now recognized to be of pivotal importance to the development of diabetes and high blood pressure, an increased risk of heart disease, stroke and several major cancers: in short, chronic diseases are already dominating the global burden of ill-health.

In the last five years, new WHO analysis highlighting the total burden of disability and premature death in all parts of the world has transformed our thinking. Figure 1 (next page) presents the surprising findings that, although communicable diseases are still dominant in the least developed countries, the numbers of deaths from chronic ailments such as cardiovascular diseases (ie, heart disease and strokes) and cancers are far greater in developing countries than in transitional and economically developed societies. Furthermore, projections over the next 30 years, based on current trends, show that the most common cause of death in the developing world will still be cardiovascular disease, with the epidemic of HIV/AIDS coming in third. The term "Western chronic diseases" or "diseases of affluence" is a misnomer since the greatest burden is borne by the poorer countries in Asia, Latin America and Africa, with these diseases being shown to affect particularly the poor, underprivileged sections of society. So chronic diseases, as well as obesity, affect the poor, especially those who have moved to live in the burgeoning slums of the big cities.
Ministers of Health from Asia, Africa and South America are worrying not only about traditional diseases and HIV/AIDS, but also meeting an escalating demand for imported, expensive insulin to treat the unprecedented increase in cases of diabetes. Recently, based on a wide variety of surveys, the International Diabetes Federation estimated the number of people with diabetes worldwide. Contrary to expectations, the top countries in the world for diabetes are India, China, the US, Pakistan and Japan (in that order), with 85 million of the global 193 million cases concentrated in these countries. There is a projected doubling in the incidence of Asian diabetes by 2025. In Asia, new evidence suggests that about 14% of all adults in the slums of India have diabetes, and a further 18% are expected to succumb to the disease in the next few years because their blood glucose levels are already poorly controlled.

Asia, however, is not alone in this situation because new surveys in the Middle East are suggesting that 20-30% of the population already has diabetes, and even higher rates can be found in the Caribbean and Pacific islands. In South Africa, heart disease rates are relatively low but diabetes is again a major health problem amongst the poor and unemployed in the townships and city slums.

**The nutritional basis for a global burden of ill-health: the WHO/FAO 916 report**

Three principal causes contribute to this new and escalating burden of chronic disease: tobacco use, inappropriate nutrition and physical inactivity. This is shown in the first comprehensive WHO analysis of the principal risk factors for the global health burden summarized in Figure 2 (next page). Tobacco use is clearly seen to be an appalling and unnecessary scourge. As a result, WHO, for the first time, initiated and promoted an international, legally-binding treaty to combat tobacco use adopted at the World Health Assembly in 2003.

Ministers of Health also realized the escalating burden of chronic diseases linked to the problem of inappropriate nutrition and physical inactivity. These issues were re-assessed by a joint WHO/FAO Expert Consultation which not only re-examined the original 1990 analysis but also updated it, using a new and transparent process of public consultation. For the first time, a draft of the report was placed on the WHO website for external comment before it was finalized under the directorship of Dr Gro Harlem Brundtland and her Assistant Director, Dr Derek Yach.

Controversy arose as growing evidence showed that excessive sugar intake contributed to the development of obesity. It was already known that the development of dental caries was dependent on sugar intake. Obesity became the biggest news story in the US media, and it was suggested that it might surpass tobacco as a major factor contributing to disease, disability and death in the US.

With a new binding international treaty controlling tobacco use, it is understandable that the interna-
tional sugar industry and several international food and soft drink companies promptly attempted to undermine the WHO/FAO 916 report’s credibility,4 claiming that it could not serve an appropriate basis for developing a strategy to combat chronic diseases. In January 2004, after further pressure from industry, the US Government initiated a series of interventions5 to question the validity of the report (in the context of discussions on the WHO Global Strategy on Diet, Physical Activity and Health, subsequently approved by the World Health Assembly in May 2004). Both FAO and WHO had launched the final report in Rome in March 2003, emphasizing the scientific rigour and the novel transparency of the process used in the report’s development. The Organizations also called for a new examination of nutrition policies. The report raised widespread interest because it focused for the first time on some of the underlying social and cultural factors influencing the development of disease and in particular, childhood obesity.

**Childhood obesity**

Childhood obesity has gained prominence due to its increasing prevalence in China, Japan, Malaysia, Thailand, South Africa, the Middle East, the Caribbean, and Latin America, as well as in the affluent West. This problem challenges the traditional medical and lay belief of adult obesity that ascribes it to individuals’ sloth or gluttony. Although some suggest blaming parents of obese children for their poor caring practices, most analysts recognize new and powerful environmental factors behind this epidemic. It is recognized that the reduction or even elimination of children’s ability to play safely outside the home, the increased use of motorized transportation, and the marked increase in the proportion of both parents working outside the home has greatly contributed to this increase in childhood obesity. Television and computer games help confine children and reduce their physical activity. It also became apparent that children were increasingly relying on a poor post weaning diet dominated by fast foods and drinks, rich in fat, sugar and salt with little fruit and vegetables. These trends have been overlooked by nutritionists despite their traditional concern for selective micronutrient deficiencies as well as undernutrition.

Further analysis revealed that the marketing practices of soft drink and food processing companies were targeting very young children in all parts of the world—at an age when children are highly susceptible to advertising—by-passing parental controls and establishing preferences for fast food and sugary drinks. As a result, the nutritional quality of children’s diets is distorted. Campaigns have been launched by NGOs calling for a ban on television commercials aimed at children, for new controls on marketing practices, for new nutritional standards for school food and for the removal of vending machines in schools.

Not only were the analysts and the media blaming the fast food and drink companies for the obesity epidemic, but also they were suddenly highlighting the financial vulnerability of particular food and soft drink companies. This new development had an immediate impact in the boardrooms of these companies. However, after the expected initial denials that they were in any way responsible for rising
childhood obesity, companies began changing their approach with surprising rapidity and sought to become “part of the solution” rather than “part of the problem”.

**A new global nutrition strategy is needed**

This intense international debate formed the background for the development of the 2004 WHO *Global Strategy on Diet, Physical Activity and Health* aimed at preventing chronic diseases. The Strategy sought to engage other UN agencies, governments and many other actors whilst recognizing that nutrition and physical inactivity required a different approach from that used for tobacco. Nevertheless, the World Sugar Research Association engaged a UK agricultural economist to produce a carefully constructed partial analysis of sugar producing economies. It identified those countries who would theoretically suffer if the 916 report became the reference document for calculating global food needs. Surprisingly the analysis ignored the population of China in calculating global needs and assumed no further growth in the world’s population. It also ignored the World Bank’s estimates that if the $6.4 billion annual subsidies by Western governments to their farmers were eliminated the developing world would benefit from a 40% increase in the world price and the employment of another 1 million farmers.

Despite the spurious nature of the objections to the agricultural implications of the 916 report and a well-defined and carefully constructed FAO paper on this issue, the G-77 group of developing countries attempted to undermine the proposal when it was discussed at the FAO’s Committee on Agriculture in Rome in February 2004. There the World Bank went further than before by suggesting huge agricultural benefits from implementing the fruit and vegetable goals of the 916 report. This requires, however, that the EU, US and Japan reform their vast agricultural and export subsidies which handicap the production of many different crops in the developing world.

This remarkable industrial and political involvement provides the background to these six papers on overweight and obesity. We know there are many dietary factors contributing to chronic diseases but the novelty of finding obese children in poor as well as rich families is beginning to dominate the political agenda.

These six papers emphasize the importance of monitoring children’s growth and developing new criteria for recognizing the currently underestimated problem of childhood obesity. They also supply estimates of the possible prevalence of adult obesity, its rate of increase, and a focus on the value of breastfeeding. The FAO paper highlights the remarkable changes in agriculture and the drivers of change in feeding patterns in association with the emergence of chronic diseases. The paper from IFPRI sets out the extraordinary speed of change in the delivery and accessibility of Western-style foods in the developing world and finally we have an early perspective on how we might cope with what is increasingly recognized as an “obesogenic toxic environment”.

We now need a new perspective on nutrition policy and an examination of why food and nutrition actors may have inadvertently contributed to setting the scene for this new phenomenon.

A more daunting challenge is how to best mesh all the nutritional gains that have been made over the last few decades with a nutrition policy for dealing with chronic diseases; how to integrate all other nutrition policies dealing with nutritional issues affecting the life cycle; and how to integrate the fundamental needs and rights of children, young women, mothers and adults to ensure they are protected and supported in an optimum nutritional way without splintering into competing interests. This is the new nutrition emergency and it has huge global implications.

**References**

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