

WHO global strategy on diet, physical activity
and health:
The Americas regional consultation meeting report

San José, Costa Rica, 23–24 April 2003



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Towards a WHO global strategy on diet, physical activity and health

Background

- 1979 The Global Strategy for Health for All by the year 2000 underlined the growing importance of chronic noncommunicable diseases (NCDs) for developed and developing countries alike.
- 1985 The Thirty-eighth World Health Assembly called for increased efforts to assess the importance of NCDs and to coordinate long-term NCD prevention and control programmes (resolution WHA38.30).
- 1989 The Forty-second World Health Assembly urged the promotion of intersectoral and integrated approaches for the prevention and control of NCDs, especially at the community level in developing countries (resolution WHA42.45).
- 1990 In its report *Diet, nutrition and prevention of noncommunicable diseases*, a WHO Study Group made recommendations to help prevent chronic diseases and reduce their impact (WHO Technical Report Series, No. 797).
- 1997 *The world health report 1997. Conquering suffering, enriching humanity* described the high rates of mortality, morbidity and disability from the major NCDs and proposed the development of a global strategy for NCD prevention and control.
- 1998 Recognizing the burden on public health services resulting from the growth in NCDs, the Fifty-first World Health Assembly requested the Director-General to formulate a global strategy for NCD prevention and control (resolution WHA51.18).
- 2000 The Fifty-third World Health Assembly endorsed the WHO global strategy for NCD prevention and control and urged Member States and WHO to increase efforts to combat NCDs (resolution WHA53.17).
- 2001 A WHO consultation called for urgent action to combat the growing epidemic of obesity, stressing the importance of prevention (*Obesity: preventing and managing the global epidemic. Report of a WHO consultation*. WHO Technical Report Series, No. 894).
- 2001 *Macroeconomics and health: investing in health for economic development*, the final report of the Commission on Macroeconomics and Health, noted that many NCDs can be effectively addressed by relatively low-cost interventions, especially prevention activities related to diet and lifestyle.
- 2002 Having considered a report on diet, physical activity and health, the Fifty-fifth World Health Assembly requested WHO to develop a global strategy on diet, physical activity and health (resolution WHA55.23).
- 2002 "Move for health" was the theme for World Health Day, 7 April 2002. "Move for health" has become a continuing initiative across the world.
- 2002 *The world health report 2002. Reducing risks, promoting healthy life* described how a few major risk factors account for a significant proportion of all deaths and diseases in most countries. For chronic NCDs, some of the most important include tobacco consumption, overweight and obesity, physical inactivity, low fruit and vegetable intake and alcohol consumption, as well as the risks posed by intermediate outcomes such as hypertension and raised serum cholesterol and glucose levels.
- 2002 A joint FAO/WHO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases examined the latest scientific evidence available and updated recommendations for action (see below, *Phase I*, for details of its report published in 2003)
- 2003 The Framework Convention on Tobacco Control was adopted by the Fifty-sixth World Health Assembly in May 2003 (resolution WHA56.1).

Development of the global strategy

- 2003 **Phase I**
Finalization and dissemination of *Diet, nutrition and the prevention of chronic diseases. Report of a joint FAO/WHO Expert Consultation* (WHO Technical Report Series, No. 916)
- Phase II**
Circulation of a consultation document to guide development of the strategy. Document made public through WHO web-site – January 2003
Six regional consultations to gather information that will form the basis of the strategy (March–June 2003).
Consultations with relevant United Nations and other international organizations, with civil society organizations and with the private sector (May–June 2003).
- Phase III**
Reference Group, a group of internationally recognized experts, to advise WHO on the preparation of a draft global strategy.
Completion of the draft strategy (September 2003).
- 2004 Submission of the draft strategy to the Executive Board at its 113th session (January 2004).
Discussion of the revised draft strategy at the Fifty-seventh World Health Assembly (May 2004).

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Preface

This report of the consultation in the Region of the Americas, on the global strategy on diet, physical activity and health, is the fourth in a series of six. Organized by the Regional Office for the Americas, the consultation gave the Member States' perspective on the issues encountered and made specific recommendations on direction, both for the countries of the Region, and for the development of the global strategy. As a whole, the series of reports provides a summarized global account of the status of knowledge about the links between diet, physical activity and health, and the work in countries to address the pandemic of chronic diseases. Added to this will be contributions from consultations with other United Nations organizations, civil society and the private sector. Together these will provide the foundation for the development and formulation of the Global Strategy on Diet, Physical Activity and Health and subsequently for action to make measurable changes in diet and physical activity at population level, with positive consequences for the prevention of noncommunicable diseases (NCDs).

As a result of the consultation in the Region of the Americas, the following key issues were identified and recommendations to address them formulated: the rising socioeconomic burden of NCDs across the Region; the high rates of overweight and obesity, even while some countries are also still experiencing undernutrition; increasingly sedentary lifestyles; the lack of political recognition and public awareness of the significance of the situation; and lack in many countries of capacity in the health services to lead multisectoral policies, including health promotion efforts. While there is recognition of the need to take a public health approach to the prevention and control of noncommunicable diseases, more evidence is needed to strengthen the case for action on diet, physical activity and health. Few countries have sustained national policies to promote physical activity, although many have initiated "Move for health" activities. This report summarizes the discussions at the consultation and outlines the recommendations made.

1. Introduction

Noncommunicable diseases, especially cardiovascular diseases (CVDs), cancers, obesity and type 2 diabetes mellitus, now kill more people every year than any other cause of death. The World Health Organization (WHO) has responded to the global rise in NCDs by giving increasing attention to their prevention and control in recent years (see Box).

Four factors in the epidemiology of these diseases – poor diet, physical inactivity, tobacco and alcohol use – are of overwhelming importance to public health. Diet and physical activity have recently been the subject of intensified high-level attention by a Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases.¹ The report of the Expert Consultation makes recommendations, inter alia, for optimum nutrition and for worldwide action to stimulate physical activity within a health context. WHO is currently developing a global strategy on diet, physical activity and health to give effect to these and other recommendations.

The regional consultation in the Americas on the development of the global strategy was held in San José, Costa Rica from 23 to 24 April 2003, and was attended by participants from 11 Member States, technical experts, representatives of the World Bank, the Caribbean Food and Nutrition Institute and the Institute of Nutrition of Central America and Panama, and staff from WHO Regional Office for the Americas/PAHO and WHO headquarters (Annex). Ms Florencia Cerruti (Uruguay) was elected as Chairman, Ms Mary Lou Valdéz (United States of America) as Vice-Chairman and Mr Godfrey Xuereb (Caribbean Food and Nutrition Institute, Jamaica) as Rapporteur.

Dr Delia Villalobos Alvarez Villalobos (Vice-Minister Health and Sports, Costa Rica) welcomed the participants on behalf of Dr Maria del Rocio Saenz Madrigal, the Minister of Health of Costa Rica, and outlined her country's actions on diet, physical activity and health. Costa Rica is politically committed to taking steps to ensure that its people live longer and healthier lives. Healthy nutrition, healthy lifestyle choices and physical activity are given priority in national health strategies and are important components of health promotion and NCD prevention activities, with emphasis on CVDs. A framework for intersectoral action in those three areas is being established. In addition, "Move for health" activities, including capacity-building, are being extended across the country with the active participation of communities, sports associations and schools.

Dr Pekka Puska, Director, Noncommunicable Disease Prevention and Health Promotion at WHO headquarters, describing the process of formulating the strategy, stressed the value of country and regional input and thanked the participants for convening to share their experience.

Dr Sandra Murillo (National Technical Coordinator for Costa Rica, Institute of Nutrition for Central America and Panama), speaking on behalf of the country office for the WHO Region of the Americas/PAHO, and Dr Wilma Freire (Chief, Nutrition Unit, Family and Community Health, PAHO) also extended a warm welcome, emphasizing the need to address the serious problems of the rising levels of NCDs. They urged participants to mobilize their health sectors, other sectors and institutions, civil society and the private sector so that NCD policies can be translated into effective action at the local level, recognizing at the same time that the risk factors for these diseases also require attention by individuals.

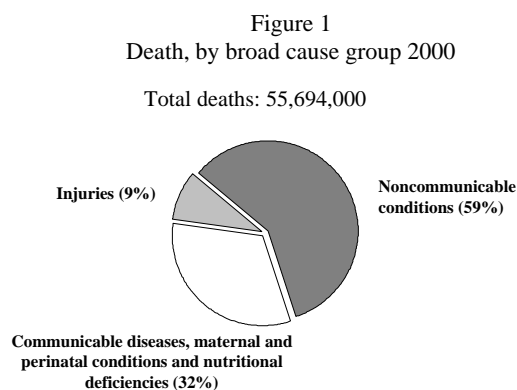
After a series of presentations by WHO staff and scientific experts (summarized in sections 2 and 3), the participants worked in groups to examine the key issues in relation to diet and nutrition, and to physical activity, and to identify the barriers and obstacles to progress, priority actions and key players in these two areas (section 4). On the basis of the discussions in these groups, the consultation adopted a series of recommendations (section 5).

¹ *Diet, nutrition and the prevention of chronic diseases. Report of a Joint FAO/WHO Expert Consultation.* Geneva, World Health Organization, 2003 (WHO Technical Report Series, No. 916).

2. The global perspective

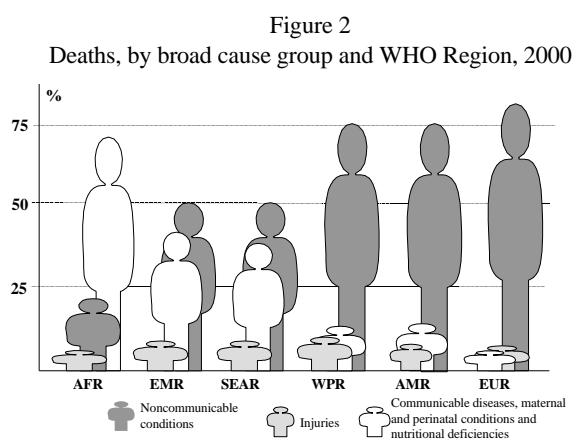
2.1 Health in transition

The world's health is undergoing an unprecedented transition on several fronts: epidemiological, nutritional and demographic. The result, felt keenly at country level and substantiated unequivocally by scientific evidence, is a broad shift in disease burden. The majority of deaths (59%) are from NCDs (Figure 1).



Source: WHO, World Health Report 2001

In the European, American and Western Pacific Regions, NCDs are in an overwhelming majority. The South-East Asia and Eastern Mediterranean Regions are in transition, with NCDs now a more significant public health problem than infectious diseases (Figure 2).



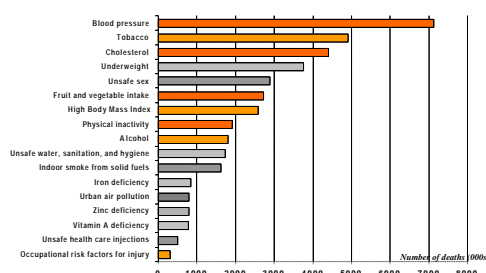
Source: WHO, World Health Report 2001

The African Region is also in transition and, while in many countries in the Region communicable diseases still predominate, the incidence of NCDs is rising rapidly.

A wealth of medical research shows the risk factors responsible for this growing pandemic and clearly points out the strategies needed to reduce their impact. The data gathered for *The world health report 2002* show high blood pressure to be the major contributing factor to all deaths in the world (Figure 3).² Of the ten leading risk factors, six relate to nutrition, diet and physical activity. Progress in these two areas, combined with reductions in tobacco and alcohol use, will have enormous importance for the prevention of NCDs and will lead to major health gains that are cost-effective. This could have an enormous public health impact in the Americas.

² *The world health report 2002. Reducing risks, promoting healthy life.* World Health Organization, Geneva, Switzerland, 2002.

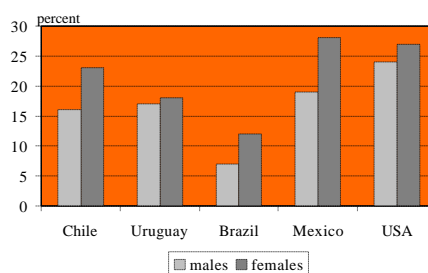
Figure 3
Global deaths in 2000 attributable to selected leading risk factors



Source: WHO, World Health Report, 2002

The figures also make clear the important role played by undernutrition. This must not be forgotten in the concern to address overnutrition. In many countries, both forms of malnutrition co-exist. Balanced diet can play an essential role in improving population health. Childhood obesity too is a growing problem across the world, with physical inactivity a major factor. In the Americas, rates of overweight and obesity are very high and are still rising. Moreover, the increases in many of the developing countries of the Region are greater than in the United States of America where they are nevertheless a major concern (Figure 4).

Figure 4
Prevalence of Obesity (BMI ≥ 30 kg/m²) among adults
in selected countries in the Americas



Sub-national samples for Chile, Uruguay, Brazil, national samples for Mexico, USA. Data from late 1990s or 2000
Source: WHO, Surveillance of Risk Factors related to noncommunicable diseases: Current status of global data, Geneva, 2003

Close to 80% of the NCD burden is now found in the developing world, moving to lower and lower socioeconomic groups and contributing strongly to inequities in health. The determinants of these changes are urbanization, changes in occupation and many global influences. The transition concerns adults and children alike.

NCDs are to a great extent preventable diseases. While genetic susceptibility to NCDs may be a factor, appropriate preventive action can alter environments, protect against risk factors and change life expectations. On a population scale, relatively modest behavioural changes affecting several of the risk factors simultaneously, can make swift, affordable and dramatic changes in population health.

Diet and physical activity are powerful instruments in this regard. In Finland, the North Karelia project, through community-based activity encouraging a healthier diet, annual coronary heart disease mortality was reduced by 73% over 25 years. In Japan, reduction of salt intake resulted in lower blood pressure levels and greatly reduced stroke mortality; in Mauritius, changing cooking oil from palm to soy bean oil resulted in a 15% decrease in serum cholesterol in the population; and in Poland, a change in dietary fats resulted in a 20% decline in heart disease mortality. Trials in China, Finland and the United States, in people at high risk for diabetes randomly allocated to a diet and physical activity or a control group showed that, over three years, those in the former had 60% less new cases of diabetes.

There are many obstacles to implementing prevention activities, but they can be overcome. They include: outdated concepts such as seeing NCDs as “diseases of affluence”; a lack of understanding about the speed with which prevention activities can make an impact on morbidity; low public visibility for success stories in comparison with the needs of sick patients; powerful commercial interests that block policies and generate conflicting messages; traditional training of health personnel that emphasizes curative care; and inertia among institutions, financing bodies, and services.

Food consumption and physical activity patterns are a key to tackling NCDs. However, these behaviours are embedded in the environment, the community, and in areas such as agriculture and food policies. It will be essential to work with all these sectors as partners, and to look carefully at what factors influence consumption patterns, in dialogue with those partners. The problems are complex, and cannot be solved by any one entity on its own. The consultation process for the global strategy will draw all those partners into debate, with the specific intention of working positively towards change. WHO is confident that, with this background and through broad consultation, the global strategy will be successfully developed and implemented, leading to major health gains in Member States and globally.

3. The regional perspective

3.1 A public health response to chronic diseases

The development of a WHO global strategy is just the start: a comprehensive framework for action will also be needed to reduce the socioeconomic burden of NCDs. Actions must be evidence-based to ensure their effectiveness, and financing is essential to secure implementation. A further vital element is the active participation of the population. The Member States of the Region have already approved a systematic public health approach to the prevention and control of NCDs, which takes into account the epidemiological perspective, social dynamics in respect of behavioural changes, and economic aspects.

There is no doubt of the importance of NCDs in the Region. Type 2 diabetes mellitus in particular is predicted to show the greatest increases owing to the high prevalence of risk factors for the disease and because of demographic factors. Prevalence currently varies from 7–9% in countries in South America to 14% in the United States, 15% in Mexico and more than 18% in Barbados. In turn, diabetes is a risk factor for CVDs and can lead to disabilities. It is directly associated with diet and physical activity.

The rates of NCDs are often higher among poor people because they are usually less well educated and informed about health, have less access to affordable health services and are less likely to adopt preventive behaviours. For example, a 1999 study in Bolivia showed that those with a lower level of education had higher rates of diabetes, while another in Jamaica showed that 59% of patients with cancer, diabetes and mental illness had financial problems.

NCDs can have serious economic consequences for countries, for patients and for their families. The direct and indirect costs of diabetes in terms of treatment, premature mortality, and temporary and permanent disability for Latin America and the Caribbean in 2000 have been estimated at more than US\$ 65 thousand million. Prevention programmes would cost a fraction of this amount and the evidence indicates that they would have an enormous impact. As indicated in section 2, randomized trials have demonstrated the efficacy of changes in diet and physical activity in preventing diabetes. However, these were controlled studies with intensive interaction between subjects and researchers. There is a need to translate such experiences into preventive programmes for entire populations and to evaluate their impact on the level of all NCDs.

The evidence clearly indicates that investment in prevention would be justified. Three elements are fundamental: public policies, health services and community action. These elements underpin the CARMEN project (*Conjunto de Acciones para la Reducción Multifactorial de las Enfermedades No Transmisibles*; actions for the multifactorial reduction of noncommunicable diseases). The threat from NCDs to public health justifies State intervention: (1) there are

inequalities in the distribution of diseases and opportunities for prevention and control in different population groups; (2) the acquisition of risk factors in the population has social components; and (3) the effectiveness of community action depends on the social environment and public policies. Moreover, health institutions have not changed with the epidemiological transition; there is political and institutional inertia and it is difficult to gain consensus to a public health approach. The State must accelerate responses – not just by the ministry of health but through intersectoral action in order to reduce the socioeconomic burden of NCDs in the countries of the Region.

3.2 Challenges in improving diet and nutrition in the Americas

The burden of NCDs in the Region in terms of health and cost is now considerable and Latin American countries do not have the resources to provide adequate treatment. Prevention is vital to reduce this burden and to protect today's children from premature death and disability in the future.

While in the majority of countries in the Region the epidemiological transition is at an advanced stage, others, including Bolivia, Ecuador, Haiti, Nicaragua, Guatemala and Peru continue to experience high infant mortality rates, and some are still dealing with malnutrition caused by nutritional deficits. A comparison of age-adjusted rates for NCDs in adults shows that diabetes is several times more prevalent in Mexico and Nicaragua than in Canada, and stroke associated with hypertension is more frequent in all the countries of Latin America than in Canada.

Prevention policies need to take a life-course approach to prevent an accumulation of risks for NCDs. This means implementing integrated policies to ensure that mothers are healthy prior to conception and during pregnancy so that they produce healthy babies; that infants and children achieve optimal growth and development, are protected from infections, and develop healthy dietary and physical activity patterns; and that adolescents maintain these patterns into a healthy adulthood, avoiding risky behaviours, including substance abuse (tobacco, alcohol, illicit drugs). It also means providing the socioeconomic and environmental conditions that support healthy lifestyle choices.

Dietary trends in the Region, as elsewhere, show an increase in consumption of energy-dense foods, and a decrease in consumption of grains, fruit and vegetables and other sources of fibre. There has been a rise in the proportion of calorie intake accounted for by fats in almost every country but Cuba (which has experienced particularly difficult socioeconomic conditions). Calories from protein are adequate for the most part, but consumption of beans has declined. Body mass index and obesity levels are increasing in most countries. For most countries, therefore, protein-energy malnutrition is no longer the main issue, and nutritionists must change their focus to energy balance and the quality and quantity of carbohydrate and fat intakes.

The Joint WHO/FAO Expert Consultation categorized the diet- and activity-related risks for NCDs. Overweight and obesity, physical inactivity, high intakes of saturated fats, *trans* fatty acids, myristic and palmitic acids, high sodium intake and high alcohol intake are convincing risk factors for CVDs, diabetes and certain cancers. The interactions between diet, physical activity and health are complex, but there is no doubt that the evidence all points to the need for changes in behaviour. While many countries have developed guidelines to encourage healthier dietary and lifestyle choices, much greater investment in preventive measures is needed to tackle the situation. In the United States in 1997, food industry advertising totalled some US\$ 11 000 million compared with the US\$ 333 million spent by the United States Department of Agriculture on nutrition education. Advertising, marketing and pricing policies have a significant impact on consumer habits and can change the balance between supply and demand. Demand and consumption are nowadays driven largely by the way in which food is produced, processed, distributed, traded, marketed and advertised, and these processes are operated mainly to maximize profits. For example, the price of fat calories has reduced dramatically as has the cost of animal fat – producing and consuming fats has become very inexpensive and demand for high-fat foods is very high. United States data show that increase in obesity is partly due to this

decrease in the price of fat. Supermarkets dominate retail food sales in many countries – with the top five multinational companies controlling 50- 80% of the market. These shops devote a large volume of display space to alcohol and sweet and salty energy-dense foods, with tempting offers of more food for less money. Restaurants too encourage the “buy one get one free” mentality.

The consumer is tempted on all sides and needs help to counter these environmental influences; help that must go beyond the provision of nutritional guidelines and food labelling. Much greater efforts are needed to strengthen the demand for healthier products and to ensure that they are affordable to all sections of the population. Interventions might include increasing the relative price of unhealthy foods and facilitating the selection and consumption of healthy foods at lower prices. For example, interventions could support subsidizing fruit and vegetables and lower-fat dairy products, forming food cooperatives to introduce economies of scale; and providing independent consumer information, in the form of attractive handouts giving simple messages, at the point of purchase. Efforts are also needed to modify the food supply. Production technology and marketing of fruit and vegetables need to be improved to raise consumption levels, especially among the poorer sections of populations. Subsidies and incentives for the production and marketing of products rich in saturated fats should be phased out, and production of foods low in animal fats should be facilitated. Regulations governing the international food trade should be reviewed from a nutritional and health perspective and dumping of foods high in dairy fats in developing countries should not be permitted. The food offered in public institutions, especially schools, should follow dietary guidelines.

The benefits of a free market should be balanced against the costs of the impact of unhealthy diets on health. The Region must not only succeed in eliminating hunger but should also promote eating and physical activity habits that will ensure the best possible quality of life and least loss of good health.

3.3 Food and agriculture policy: issues related to prevention of NCDs

National food supplies depend on annual domestic production, imports and exports, and any food stocks from previous years that may have accrued. The supply chain is complicated, with many links between the choices producers make as to the commodities they produce and those of consumers in deciding what to eat. Elements involved include decisions concerning the storage, transport, processing, marketing and retailing of foods.

Historically governments have been heavily involved in the agriculture sector, especially in developed countries. Policies, which are mostly commodity-specific, have generally been concerned with ensuring food security and affordability by improving production and reducing fluctuations, and also with stabilizing farmers’ incomes. They bring benefits in terms of rural development, increased productivity and foreign revenues. However, they apply mainly to large-scale farming, may create surpluses, often distort world markets and have little to do with the long-term health of populations.

The most common components of agriculture policies relate to farmers’ overheads (provision of taxes, subsidies and low-cost credit in relation to land, equipment, technical assistance, insurance); production (income and price supports, marketing boards, subsidized food distribution); infrastructure (land, irrigation, roads, transport, storage and processing facilities, research and development, surveillance of pests and diseases); and trade (tariffs, quotas, export subsidies, exchange rate differences).

Data from the United States show that technological improvements in the agriculture sector led to a substantial decline in relative food prices in the period 1976 to 1994. Furthermore, in 2000, supplies of fruit and vegetables would not have been sufficient to meet the daily intake recommended in national dietary guidelines for everyone in the population, while supplies of meat, added fats and added sugars were more than adequate.

There are limitations as to how far agriculture policies can be influenced with a view to reducing NCD risk. Such policies are broad and changes may not meet the needs of specific population groups. They also have to comply with international requirements in terms of the regulations of the World Trade Organization and intergovernmental organizations such as the

European Union, as well as structural adjustment programmes, etc. Policy decisions and food choices are often short-term and there may be multiple objectives when malnutrition is also present.

Efforts are therefore needed to make the case for moving towards healthier food supplies. Changes will require political leadership at the highest levels, intersectoral cooperation in policy development and implementation, capacity-building and the definition of clear and consistent objectives, which are in line with dietary guidelines but which take into account cultural, social, environmental and economic realities. Other activities should include the mobilization of interest groups and the introduction of innovative solutions, such as urban-based fruit and vegetable production.

3.4 Challenges in promoting physical activity in the Americas

Physical inactivity has become a major public health problem throughout the Region in recent years. It is an important risk factor for obesity, CVDs, diabetes, and colon and breast cancer and results in substantial health and economic costs. It is a major contributing factor to death and disability, causing an estimated 2 million deaths and loss of 19 million disability-adjusted life years (DALYs) globally each year. It also accounts for 2–6% of health care costs; in the United States the costs are estimated at US\$ 76 thousand million annually. A conservative estimate put the number of deaths in the Region of the Americas attributable to physical inactivity in 2000 at 300 000. Some 10–20% of the population are inactive and almost 50% are insufficiently active, with females somewhat less active than males. While there have been some successes in encouraging people to take up physical activity in their leisure time, this has not balanced the decline in physical activity due to other changes in lifestyle: increasingly sedentary jobs, increased availability of mechanized transport, and less physical activity in everyday tasks. The evidence clearly points to the benefits of physical exercise in reducing all-cause mortality and the risks of NCDs, and thereby contributing to improved mental health and healthy ageing.

Quite modest levels of physical activity are beneficial. The consistent recommendation from WHO and other bodies for general health is the accumulation of at least 30 minutes of moderate intensity physical activity on most days of the week.³ In a modern developed society, 60 minutes of daily physical activity may be needed to prevent weight gain.⁴ Most people fail to meet these recommended levels of physical activity.

There is now a large body of evidence concerning the determinants of physical activity at the individual and societal level, although more surveillance is needed to clarify trends in males and females in different cultures. Those determinants include genetic predisposition, higher income and education, those with confidence in activity skills, as well as family and cultural factors. An environment that encourages physical activity, for example, with safe streets, paths for cycling and walking, and sports facilities, is also crucial.

National policies should be geared to influencing these determinants and achieving behaviour change. The United States Preventive Services Task Force and CDC are carrying out a systematic review of the English language scientific literature on physical activity interventions as part of a guide to community preventive services. Of the 14 categories of strategy being examined, six are highly recommended as effective: high-quality physical education in schools; promotion of individualized behaviour change, with programmes tailored to each person; non-family social support (e.g., walking clubs, orienteering groups); creation or enhancement of access (e.g., trails, worksite facilities); community-wide education campaigns using the mass media and other techniques; and point-of decision prompts (e.g., notices by elevators suggesting that people take the stairs). Evaluation of relevant interventions in the areas of transportation and urban planning is also under way.

³ WHO and other bodies (Centers for Disease Control and Prevention (CDC), United States National Institutes of Health, American College of Sports Medicine)

⁴ Indications made in reports from WHO and the United States Institute of Medicine.

A joint WHO/PAHO/CDC workshop held in 2002 developed a model framework for a comprehensive national physical activity policy. The framework comprises a four-step process: making the case for physical activity as an important public health issue; undertaking a needs assessment, identifying effective strategies and interventions and the settings in which they may be implemented; and implementation of interventions. Elements of successful programmes include consultation at all levels, preparation of a written plan and objectives, a stable support base, clear programme identity and messages (emphasizing that physical activity provides fun and enjoyment), and integration with policies for diet, overall health promotion and other health-related sectors. A wide range of partners will need to be involved in implementation, including government sectors for health, education, sports, and transport, local government and relevant areas of the private sector. Evaluation should be incorporated into each step in order to establish what works and how to refine approaches.

A number of successful population-based strategies for promoting physical activity are being implemented in the Region (e.g., the PAHO Healthy Municipalities initiative, CDC Stair Wellness Project, Agita Sao Paulo (Brazil) (see section 3.5), Vida Chile) and information and experiences are shared through the Network for Physical Activity in the Americas. However, there is an urgent need for more action.

3.5 Building coalitions in physical activity promotion: Agita Sao Paulo

As indicated in section 3.4, there is clear evidence linking physical inactivity and NCDs. A survey of the prevalence of risk factors for NCDs in Sao Paulo, Brazil in 1990 showed that 69% of the population were leading sedentary lives, nearly 40% smoked, 22% were hypertensive and 18% were obese. National figures for 1997 indicated a clear socioeconomic gradient, with the richer sections of the population undertaking more leisure-time activity; males were also more likely to be physically active than females. In the 20 years to 2000, adiposity increased 18% in girls and 31% in boys.

The interrelationships between the individual and his or her social and physical environment are complex and it is clear that no one sector alone can tackle the problems that surround increasingly sedentary lifestyles. There must be political commitment at the highest level on the need for making changes, and activities must take a life-course approach to encouraging physical activity.

“Agita Sao Paulo”, the “Move for Health” programme in Sao Paulo, developed by CELAFISC (Centre of Studies of Physical Fitness Research Laboratory, São Caetano do Sul), has succeeded in establishing a coalition of partners to promote physical activity. The first stage was to build intellectual partnerships of national and international organizations and to establish a scientific board whose experts made the case for changes and developed a framework for action. This was followed by the development of institutional partnerships, involving a large number of governmental and nongovernmental organizations and the private sector, and the formation of an intersectoral executive board. The board meets monthly to assess the progress of projects and exchange information and experiences. The programme also has a newsletter, which publishes best practices. Government departments, nongovernmental organizations or institutions may lead programmes. This structure provides everyone with a sense of ownership of the programme on an equal basis.

Interventions are aimed at specific groups (e.g., students, employees, older people), with the common message that the accumulation of 30 minutes of moderate to vigorous physical activity on most days of the week is beneficial to health. Emphasis is given to respect for the individual and messages are positive, stressing the enjoyment and mutual gains from physical activity.

Activities cover a wide range of settings, including educational institutions, the workplace, the environment and the health sector. In schools, special classes on quality of life and active citizenship, distribution of handbooks, discussions and videos have resulted in a substantial increase in the number of children undertaking the recommended levels of physical activity. Interventions to enable people to be more physically active have included changes in transportation, opening schools at weekends to provide extra facilities and reducing violence in the environment. New housing developments are taking into account the need to provide fitness clubs and other facilities. Workplace interventions encourage employees to be more active. Classes to encourage physical activity are offered to patients with hypertension and diabetes, and family health programmes are being implemented in rural populations. These activities are also integrated with advice on nutrition, and guidelines such as food pyramids have been distributed. A medical committee coordinates activities among health professionals and medical students, and ensures that the results of the programme are published in scientific journals. Appropriate training programmes have also been instituted.

Agita Sao Paulo activities and materials are clearly identified by a logo, and every effort is made to identify innovative and cost-effective approaches. The movement has had a substantial impact in the four years it has been in operation. Some 56% of the population of Sao Paulo now recall the programme and 2% per year are starting to be more active. The programme has a surveillance system with focus groups and data collection. However, more evaluation is needed to determine the impact of various activities.

Agita Sao Paulo has been taken as a model for similar programmes across the country and the Region, through the Network for Physical Activity in the Americas, and “Move for health” has become a worldwide movement. The aim is to provide a comprehensive, coordinated and positive approach to a common cause that has a clear conceptual framework, is socially inclusive, builds on intersectoral partnerships and networks, empowers people, and brings mutual benefits/gains.

3.6 Country activities on diet, physical activity and NCD prevention

The Nutrition Programme of the WHO Region of the Americas/PAHO has undertaken a survey in the countries of the Region by means of a questionnaire to determine the prevalence of several risk factors for NCDs in men and women (obesity, high cholesterol, hypertension, diabetes and smoking); the activities being undertaken in relation to diet, physical activity and NCD prevention, including city initiatives to develop healthier transportation policies and public spaces for recreation; and the institutions involved in those activities. A preliminary analysis has been made of the responses received from 28 countries.

The results indicate that many risk factors are more prominent in the poorer countries of the Region. The prevalence of levels of cholesterol of ≥ 240 mg/ml measured in population studies ranges from around 8% in Colombia to nearly 50% in Chile and several countries show rates that are higher than those in the United States and Canada (17–19%). In several developing countries (e.g., Paraguay, Guatemala) the prevalence of diabetes is higher than in the United States and Canada (4–5%). Smoking rates are substantially higher in Latin American countries than in the United States and Canada, and rates are much higher in men than in women.

The study examined the type of activities undertaken by nutrition-related public and private institutions. Provision of information was the most frequent activity, especially by nongovernmental institutions, with emphasis on activities among children and women, and in relation to micronutrient deficiencies and obesity. There were fewer interventions on physical activity.

Of the 22 countries that have a public office with responsibility for physical activity only seven said that it was under the authority of or related to the ministry of health, elsewhere the office is part of an independent sports authority. Physical education in schools is obligatory in 19 of the 28 responding countries. The required duration per week ranges from less than one hour in one country to more than four hours in two countries. Published data on the diet of the adult

population is available for 12 countries at the national level and three at the local level; 11 countries have no information. Published data on physical activity contain information on adults in five countries, children and youth in two countries and both in 10 countries; for 11 countries there is no information.

A number of cities in countries across the Region have taken exemplary measures to influence transportation policies and provide recreation facilities in the interests of promoting physical activity.

The survey represents a useful step in compiling information from across the Region, but more work is needed to verify the data and to investigate further the type and quality of the activities being undertaken.

4. Priorities for action in Member States in the Americas

The following issues are drawn from the collective experience of the Member States.

Member States should develop comprehensive, multisectoral policies for surveillance, health promotion and health care management in the area of diet and physical activity.

4.1 Diet and nutrition

There is a need to convince governments and the general public alike of the social and economic importance of the epidemiological and nutritional transition, and to correct the popular misconception that poverty is always associated with malnutrition rather than obesity or NCDs. Countries therefore need support to improve their surveillance systems so as to provide evidence on the magnitude and implications of overweight, obesity and other nutrition-related diseases and to obtain information on dietary habits, nutrition and patterns of physical activity.

The prevailing orientation in society in general and within the health sector is towards curative services, and not enough is known about public health approaches. Health professionals, particularly physicians, are reluctant to change focus. Health systems should be reformed to give higher priority to diet and physical activity, and resource allocations for NCD prevention and health promotion should be increased. Research should be carried out to increase understanding of cultural factors and to find ways of providing social support for behavioural change. Governments should develop a comprehensive and integrated strategy of action for the promotion of healthy dietary and lifestyle choices.

In most countries in the Region, dietary intakes of various foods do not meet the recommended levels. Nutritious foods are often the most expensive and inaccessible. Consumption of fruits, vegetables and cereals is low and intakes of foods rich in fat, sugar and salt are high and rising. Moreover, meals are increasingly being eaten outside the home, and generally contain higher proportions of energy-dense foods. Multisectoral policies are needed to influence supply and demand in a healthier direction. Fiscal and legislative measures can be used to influence the food industry and the mass media can be mobilized to help educate people about healthy diets and nutritious national culinary traditions. Strategies include instituting healthy diet and lifestyle promotion in schools and higher educational establishments, encouraging catering services in schools, workplaces and community institutions to serve healthier meals, and establishing organic family and community gardens and orchards. Health professionals should increase their involvement in the design of information and education materials. Successful national experiences should be evaluated, documented and compiled at the international level for dissemination across the Region.

Food industry advertising is very powerful. Governments should introduce or strengthen regulations to control food labelling and advertising, and dialogue with the food industry should be initiated to stimulate cooperation in the production and marketing of healthier foods. There is also a need to counter advertising claims by improving the communication of information. Campaigns for the promotion of healthy lifestyles, which include integrated information on diet and physical activity, should be instituted. Use of social marketing techniques and mobilization

of the mass media to encourage dissemination of accurate information for consumers are recommended.

Greater emphasis should be given to promotional activities related to diet and health within the health services with a view to achieving behaviour changes across the life span. This will require the reorientation of services to give more attention to preventive approaches. Strengthening of institutional and human resources capacity in this area and support for the design and implementation of appropriate promotional and educational programmes will be needed. Countries should document and share successful strategies.

In many countries, the health sector is currently not in a position to lead the development of multisectoral, integrated strategies on diet, physical activity and health. Moreover, governments experience difficulties in ensuring compliance with existing norms and regulations in relation to food products. The role of ministries of health in policy development should be enhanced to ensure that the policies for all sectors take public health into account. International support will be needed to strengthen the capacity of the health sector and national regulatory agencies and to identify leadership models that can be promoted in the Region.

The current situation requires multisectoral national responses with commitment at the highest political level. In many cases, health ministries need to take the lead, but ministries of education, agriculture and trade, scientific and professional institutions, the private sector, nongovernmental organizations including consumer and community groups, and the mass media should also be involved. Health professional curricula need to be reformed to incorporate the new vision of a healthy diet and active living for the improvement of quality of life and prevention of NCDs. Support for national efforts will be needed from PAHO/WHO and other relevant international organizations.

4.2 Physical activity

Few countries in the Region have sustained, well-funded multisectoral national policies for promoting physical activity as part of a healthy lifestyle and as a means of NCD prevention. Ministries of health should advocate for such policies and for the incorporation of physical activity in the agendas of other sectors. Policies should have clear objectives, should link integrated evidence-based health promotion with activities to promote physical activity and a healthy diet, and should be elaborated in the context of human development. The development of local government plans should be encouraged. Approaches should focus on specific settings, such as education, the workplace and communities. All policies and programmes should include monitoring and evaluation components.

Multisectoral alliances at the local, state and national levels are needed to advocate for change and to coordinate activities and implement comprehensive and socially inclusive policies. It should be recognized that leadership may come from either governmental or nongovernmental sectors or institutions. However, efforts will be needed to overcome institutional inertia and unwillingness to change. Long-term sustainability can be secured by sharing responsibilities among different governmental and nongovernmental sectors (e.g., ministries of health, education, finance, justice, urban planning, transport, environment, and security, scientific societies, educational institutes, the private sector, employers' and workers' federations, NCD patient and advocacy groups, Lions and Rotary, churches). Research centres should be established within the Region to undertake research, for example to determine the direct and indirect costs of sedentary lifestyles, and the impact of policy, legislation, incentives and subsidies on population levels of physical activity. International networks for physical activity and health promotion, like the Network for Physical Activity in the Americas and networks for health-enhancing physical activity (HEPA) should be expanded.

The health sector should play a leading role in the promotion of physical activity. However, health systems are oriented to the provision of curative services and there are few plans and programmes related to physical activity. Moreover there is a lack of human resources with skills in this area and a shortage of simple diagnostic, intervention and evaluation instruments for physical activity. It may be necessary to generate incentives to stimulate structural and functional

changes to ensure that physical activity is included in health sector policies and to encourage research within the health sector on determinants, physiological mechanisms, consequences and cost-effective intervention strategies with respect to physical activity.

Education and training of health, physical education and sports professionals and teachers should emphasize the concepts of health promotion and the moderate accumulation of physical activity, and health professionals should be encouraged to include physical activity as a meaningful component of health management. Curricula of schools and higher education institutions, including teacher-training colleges, should be updated to emphasize the benefits of active citizenship and healthy lifestyles and to promote a culture of physical activity. Spaces, opportunities and incentives for physical activity should be created in the workplace. Manuals and guides on physical activity aimed at specific groups and settings should be developed and distributed to support interventions.

People need the right environment, with attractive accessible and secure pathways, parks and other public spaces and clean air, to encourage them to increase their levels of physical activity. Advocacy is needed to convince political leaders at all levels of the opportunities for making changes that will benefit public health, such as improvements in urban planning and transport policies and establishing targets for public spaces and pathways with a view to the creation of safe and pedestrian-friendly cities.

Greater efforts are needed to disseminate information on the benefits of physical activity and re-orient attitudes, perceptions and behaviours at all levels to promote physical activity as part of a healthy lifestyle. Surveillance systems should be strengthened so that behavioural risks and lifestyle changes can be monitored over time, to provide an evidence base for public policy and action. Research is needed to identify innovative approaches to health promotion for specific population groups and settings (e.g., using social marketing principles), and to strengthen the skills needed to implement them. The mass media should be encouraged to publicize key messages.

5. Conclusions and recommendations

5.1 Conclusions

The Member States of the WHO Region of the Americas/PAHO that participated in the consultation recognize the importance of the elaboration of a WHO global strategy on diet, physical activity and health and welcome the wide consultation process that is under way. WHO is encouraged to complete this process and to urge Member States to adopt the strategy and to develop national plans and country-specific integrated strategies for diet, physical activity and health. The participants also recognize physical activity as a right of every citizen, as well as a fundamental instrument for improving the physical and mental health of individuals and for fostering social integration.

5.2 Recommendations

The participants adopted a series of recommendations that can be summarized as follows.

To WHO/PAHO

1. Continue to collect and disseminate sound scientific evidence on the importance of diet and physical activity for health.
2. Convince governments of the magnitude and implications of the problems concerning unbalanced diets, physical inactivity and related NCDs, and of the need for political commitment to comprehensive multisectoral policies on diet, physical activity and health.
3. Collect and disseminate information on successful international, regional, national and community-based strategies on diet, physical activity and health.

4. Develop appropriate models for information, education and communication materials programmes that can be adapted for local use.
5. Stimulate health systems research to promote the inclusion of preventive population-based activities in health services.
6. Collect and disseminate information on successful leadership models.
7. Promote the formation of international multisectoral alliances and networks for the promotion of physical activity and healthy dietary choices.
8. Increase advocacy in other relevant international organizations for priority to be given to public health interests in relation to policies that affect diet and physical activity.
9. Support Member States in their efforts to:
 - develop activities to estimate the prevalence of NCDs and their risk factors, and to monitor trends in diet and physical activity;
 - determine the direct and indirect costs of unhealthy diets, physical inactivity and NCDs;
 - design and implement programmes that promote a healthy diet;
 - strengthen institutional and human resource capacity to undertake research and to develop and coordinate intersectoral policies on diet, physical activity and health, for example, through regional workshops and seminars;
 - develop and implement education and training programmes to develop relevant skills.
 - design, validate and implement information, education and communication programmes to increase awareness of the importance of diet and physical activity for health, to achieve changes in demand for safe and healthy foods and to promote active lifestyles.
 - encourage ministries of health to advocate for the incorporation of action to promote healthy diets and physical activity in the agendas of other sectors (agriculture, education, finance, justice, transport, urban planning).

To Member States

10. Strengthen surveillance and data collection systems to estimate the magnitude and costs of problems related to diet, physical activity and NCDs and to ensure evidence-based decision-making.
11. Undertake cost-benefit analyses to make the case for the development of healthy diet and physical activity promotion.
12. Ensure political commitment to the elaboration and implementation of comprehensive, multisectoral and socially inclusive policies linking diet, physical activity and health in the context of human development.
13. Encourage local government to develop local plans and programmes.
14. Ensure that policies, plans and programmes have clear objectives, take a life-course approach, and are properly financed in order to sustain implementation, monitoring and evaluation.
15. Establish and strengthen institutional structures responsible for programme implementation.
16. Take action to generate conditions that strengthen intersectoral cooperation at national, state and local levels and encourage community participation.
17. Strengthen the role of ministries of health to promote their leadership in intersectoral cooperation.
18. Reorient health services to give increased emphasis to health promotion and disease prevention and to include advice on physical activity and diet as part of health care management.
19. Revise curricula of health and other relevant professionals to include information on diet, nutrition and physical activity and their importance for health, and to increase capacity for intersectoral policy development.

20. Review legislation and regulations on food safety, labelling and advertising and the provision of consumer information, and strengthen relevant regulatory agencies.
 21. Promote dialogue with the private sector to stimulate the production, distribution and marketing of healthy foods and the development of affordable and accessible opportunities for physical activity.
 22. Revise educational curricula to increase in-class time devoted to physical activity and promote opportunities for increased free-time participation.
 23. Review urban planning and transport policies, setting targets for the creation of safe and attractive public spaces for physical activity.
 24. Institute information, education and communication campaigns to raise public awareness of the importance of diet and physical activity for health.
 25. Develop culturally acceptable manuals and guides for use in specific population groups and settings.
 26. Form alliances with the mass media to promote healthy lifestyles through the provision of accurate information.
 27. Undertake and stimulate relevant research and disseminate research findings.
 28. Document and share successful strategies and approaches.
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