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Global Strategy on Healthy Eating
Physical Activity and Health (DPAS)
IMPLEMENTATION PLAN FOR
LATIN AMERICA AND THE CARIBBEAN
2006-2007

FINAL VERSION



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1. INTRODUCTION

The WHO Diet and Physical Activity Strategy (DPAS) was endorsed by the 57th World Health Assembly on May 2004¹ after considering the growing burden of non-communicable diseases (NCD) and compelling scientific evidence on the effectiveness of interventions that can avert up to 80% of diabetes and cardio-vascular disease cases and 30% of some cancers, as well.²

This document outlines a three phase stepwise approach for the implementation of the WHO Diet and Physical Activity Strategy (DPAS) for Latin America and the Caribbean (DPAS-LAC) during 2006-2007. The three phases are:

1. Pilot phase - in which national guidelines for action will be developed and implemented in a select number of countries during; implementation strategies are set forth in this document.
2. Normative phase - in which a WHO/PAHO Resolution will be discussed and adopted by Member States during the 2006 Directing Council Meeting.
3. DPAS implementation phase – in which previously mentioned Resolution and the evaluation of the pilot phase.

The stepwise approach will make possible a consensual implementation; with the participation of key stakeholders in the public/private sector, the scientific community, non-governmental organizations (NGOs) and others. Such consensus is not only vital for the pilot phase, but will also provide the basis for achieving the other two phases. This implementation plan takes into account other WHO and PAHO resolutions that are in synergy with the DPAS. These include past (e.g. WHO Resolution on NCD Prevention and Control in 2000; the 130th session of Executive Committee: Public Health response to non communicable diseases in Latin America in 2002) and future resolutions (e.g. NCD, Health Promotion and the Nutrition Strategy, 2006 that will be presented during PAHO's Directing Council later this year.)

¹ WHO, Global Strategy on Diet, Physical Activity and Health, 2004. The Acronym DPAS stands for "Diet and Physical Activity Strategy"

² WHO, Report of a Joint WHO/FAO Expert Consultation, Diet Nutrition and the Prevention of Chronic Diseases, WHO TRS 916.

2. THE PROBLEM OF NON-COMMUNICABLE DISEASES AND ASSOCIATED RISK FACTORS

2.1 Trends in NCD and associated behavioral risk factors

Non-communicable diseases (NCDs) and non-intentional injuries represent nearly 70% of all causes of death in the Region of the Americas, mostly affecting those 18-70 years old. The Disability-Adjusted Life Years (DALYs)³ lost because of NCDs such as obesity, stroke, diabetes, and heart disease in the Americas amount to 12.5 million DALYs adding to the 4.6 million DALYs lost to childhood and maternal under nutrition⁴. Most NCDs are nutrition-related, hence the importance of the WHO Global Strategy on Diet and Physical Activity. One important example of such a relationship is the rapid rise of obesity rates among adults and youth, that increases two to three-fold the risk of developing NCDs. Several national surveys in Latin America and the Caribbean show that about 50 to 60% of adults are overweight and obese. Seven to twelve percent of children under 5 years old are obese; this is six times the current percentage of under-nutrition for the same age-group. Moreover, in Mexico and Chile, recent national surveys show that about 15% of adolescents are obese.

The progression of nutrition-related NCDs is influenced by well documented risk factors. Among the most important ones are poverty, the inter-generational effect of poor intrauterine growth, under nutrition in the first 3 years of life, and inadequate diets and physical inactivity during youth and adulthood. The ill-health and mortality associated with NCDs are extraordinary and pose an enormous burden to health care systems, social services, and personal economic and social stability. Once thought as “*diseases of affluence*”, NCDs are far-reaching and indiscriminate, affecting the Region’s poor far more than the wealthy.

Most countries in LAC are experiencing a significant shift in their *dietary patterns* characterized by a decreased consumption of fruits, vegetables, whole grains, cereals and legumes and a parallel increased consumption in foods rich in saturated fat, sugars and salt; among them, milk, meats, refined cereals and processed foods.⁵ These changes have been found to contribute to the emergence of the epidemics of obesity, diabetes and CVD. However, it should be noted that these same dietary trends have made possible the diversification (and “westernization”) of the diet of millions of rural migrants who left behind a monotonous and nutrient deficient plant-based diet. This phenomenon is indeed a double edge sword for it has also been linked to the reduction in child under nutrition and stunted growth observed during the last 20 years.

³ One DALY equals the loss of one healthy year of life. This figure excludes the U.S. and Canada.

⁴ Jacoby E. PAHO Regional Consultation of the Americas on Diet, Physical Activity and Health: A CALL TO ACTION. Food and Nutr Bulletin UNU, vol 25, No2, 2004:172-174

⁵ Monteiro CA, Preliminary Analysis, 2004

The dietary pattern changes noted above have occurred concurrently with a worrisome decrease in population levels of *physical activity*, well documented in several countries. Between 30-60% of the regions' population does not achieve the minimum recommended levels of physical activity.⁶ Physical inactivity is greater in urban places, increasing with age and most prevalent among women. Recent evidence indicates that recreational activities, like the practice of sports or structured exercise, during leisure time, are the most common form of physical activity among the higher income and education brackets. Conversely, utilitarian physical activity, like walking for transportation, is highly prevalent among the vast majority of the population in the region and its incorporation in the health promotion repertoire is now increasingly advocated in Europe and the Americas.

It should be noted that physical inactivity not only contributes to the development of NCDs but can also lead to mental illness, accumulation of stress, lower school achievement and even negatively affect social interaction.

2.2 Social, economic and cultural factors influencing food choice and physical activity

The previously described behavioral changes on diet and physical activity are to a large extent the result of historical, economic and social changes that interact and mold human behaviors. In fact, the increasing prevalence of inactivity in the last half century is most likely the result of increased urbanization and motorized transportation, urban zoning policies that promote car-dependent suburbs, lack of attention to pedestrians and cyclists in urban planning, the ubiquitous presence of labor-saving devices in domestic life, and the growing use of computers at work and for entertainment. As has been noted elsewhere, population-wide declines in knowledge, self-efficacy, or social support related to physical activity are much less plausible explanations for the decline in the prevalence of physical activity⁷.

Similarly, the observed decreased consumption of fruits, vegetables, whole grains, cereals, and legumes, and increased consumption of energy dense foods, are influenced by several factors. A connection has been observed between obesity and poverty. Most likely as a result of the readily available, highly palatable and low-cost processed foods that are high in sugar and laden with fat. That coupled with intense and highly specialized marketing and advertising efforts, has contributed to the mass-culture of pre-packaged foods, soft drinks and eating out, common in most cities today. In fact, the changing food preferences of the public is part of a larger phenomenon –labeled as *diet transition*-- which is fueled by

⁶ That recommendation consists of 30 minutes of moderate p.a. at least 5 days a week. The World Health Organization. Sedentary lifestyle: A Global Public Health Problem. Geneva: World Health Organization, 2002.

⁷ Sallis J Cervero R et.al. An Ecological Approach to Creating Active Living Communities (2006). Ann Rev Pub Health Advance publication online Sep 30, 2005

growing salaries in cities, time constraints, change in relative prices and the continuous innovations in food technology and their distribution systems.⁸

Parallel to the aforementioned changes, and in part influenced by them, the production, availability and price of fruits, legumes, vegetables and cereals, have been negatively impacted by this *diet transition*. This is a problem in Europe (EU) as well as in Latin American. Today, more than 20 EU countries are unable to offer at their market shelves the recommended 146 Kg of fruits and vegetables per person annually.⁹ On the other hand, in Latin America during the last 30 years, in spite of some increases in the availability of fruits and vegetables, the share of energy available from both, as a proportion of the total energy per capita available, has remained in the range $\pm 1\%$ for vegetables, and decreased to -9% for fruits.

Information, education and advertising can also be considered environmental factors because in one way or another they shape public demand. Unfortunately, public health information on diet and nutrition (including food labeling) is still limited in LAC, reaching only small groups; whereas, information in the form of commercial advertising is the main “educational” mechanism, leading to negative consequences on diet and health. This is the case of children to whom large food marketing efforts are being directed.¹⁰

The increased recognition of above mentioned environmental factors as powerful influences on individual behaviors have led to an ecological approach to behavioral change. This perspective, as later explained, is embraced by the DPAS and constitutes an important pillar of this implementation plan.

2.3 Direct and Hidden Costs of Non communicable diseases

The direct medical costs associated with NCDs are staggering. According to a recent WHO Report on Chronic Diseases¹¹ the cost of treating heart disease in the US totals US\$352,000 million, about 20% of its total health expenditures. Medical costs, however, are only part of total costs related to NCDs. In the UK, for example, the medical care costs of treating heart disease in 1999 was \$3,000 million; while, hidden costs like *informal care* and *loss of productivity*, combined, represented \$7,500 million. Similarly, during 2005 in Brazil, heart diseases will represent an income loss of about \$3,000 million, and in 2015, it is estimated to reach \$9,300 million, with an accumulated 10 year period loss of \$50,000 million. Lost productivity is compounded by the fact that most NCDs are catastrophic to middle and low-income families, particularly in countries where social security and health insurance cover only a small group of the population.

⁸ Uauy R, Monteiro CA. Food and Nutrition Bulletin 2004;25(2):175-82.

⁹ Robertson A. , Brunner E and Sheehan A. Food is a political issue. In: Marmot M and Wilkinson R (eds) Social determinants of health

¹⁰ IOM, Food Marketing to Children and Youth: Threat or Opportunity? December 2005

¹¹ WHO, Preventing Chronic Diseases: A Vital Investment, Geneva 2005

Most middle and low-income countries in Latin America and the Caribbean are also severely affected by the high cost of treating NCDs. Estimated total direct medical costs of treating Diabetes Mellitus (DM) totaled US\$10,720 million in 2000, while indirect costs – productivity losses – totaled US\$54,495 million.¹² Preliminary estimates of the cost of obesity and related co-morbidities in Andean countries like Bolivia, Colombia and Perú, showed that if these countries were to treat obesity and three of its main clinical complications i.e., diabetes, hypertension and hypercholesterolemia, they would require financial resources of up to 25% of their current public health budgets.¹³

NCDs represent a serious challenge to economic growth because they reduce a sizeable amount of an individual's earning potential as well as those family members required to provide care. These losses represent up to five-times the direct medical costs in LAC. Moreover, the cost of treating NCDs is clearly above the means of most nations, including developed ones. This realization along with evidence from epidemiological and clinical studies, have been instrumental in shifting the public health focus from treatment to preventive strategies. Preventing NCDs is the most important challenge to public health in the Americas.

3. THE PUBLIC HEALTH EVIDENCE FOR PREVENTING NON-COMMUNICABLE DISEASES

3.1 The Scientific Evidence

An extended body of research encompassing observational studies and clinical trials, and decades of population follow-up studies, provide evidence that besides our genes, certain diet patterns, including foods and preparations; leading an active life; and refraining from smoking, pays in terms of biological potential, immunity, longevity and quality of life. The most important recommendations on diet and physical activity, for which scientific consensus exists are presented in this section. In addition, information is provided on environmental and policy interventions that will aid in the implementation of these recommendations.

3.2 Food and Dietary Recommendations

A comprehensive review of the available scientific information can be found in the WHO Technical Report, Diet Nutrition and the Prevention of Chronic Diseases.¹⁴ The Report highlights the fact that chronic disease is preventable and that risks begin in the uterus and continue into old age, hence the importance for diet and nutrition recommendations to take a life-cycle approach.

¹² Barceló A, Aedo C. et.al. The cost of diabetes in Latin America and the Caribbean, Bulletin of the World Health Organization 2003, 81 (1) 19-27

¹³ Suarez R. et al. A PAHO Report: Costs of Obesity in LAC (Oral Communication).

¹⁴ WHO TRS 916, 2003

a) *Dietary recommendations:* These recommendations are primarily intended for all family members, particularly individuals above 5 years of age.

- Moderate total energy consumption striving towards a healthy weight;
- Limit the consumption of saturated fats and favor poly- and mono-unsaturated ones. Make efforts to eliminate trans-fats from individual's diet and ideally from the country's food-supply;
- Increase consumption of a variety of plant sources, including: fruits, vegetables, whole grains, legumes and a variety of nuts;
- Limit the intake of processed foods high in sugar, fat and salt;
- Consume alcohol in moderation.

b) *Life-cycle recommendations:* Include recommendations that have the potential to favor the optimal development of the cardiovascular, hormonal and immune systems, the kidneys and liver; thus exerting important role in chronic diseases prevention. The recommendations listed below are consistent with those that promote optimal infant and child growth & development. DPAS should coordinate with programs and health professionals working in infant & child health as well as the elderly in order to synergize efforts at least on the following themes:

- Exclusive breastfeeding for the first 6 months of life;
- Promote better women's health and nutrition throughout life;
- Improve the quality of infant and small child feeding through the use of nutrient dense and/or pre-packaged complementary foods when the former is difficult to achieve;
- Promote sensible approaches to improve the diet of the elderly considering the particular physiological and social circumstances in which they live.

c) *Environmental interventions:* These include several options that will help individuals follow and meet the healthy eating recommendations stated above. Moreover, the proposed interventions will require intersectoral participation and strong leadership from the Ministries of Health (MOH) and close collaboration with MOA (Agriculture) and trade experts.^{15,16}

Supply-side interventions:

- Promote agricultural policies that take health and nutrition into account. For example promote financial incentives that favor the production of fruits & vegetables, reduce fat in livestock and eliminate trans-fats in processed foods;

¹⁵ WHO, Global Strategy on Diet, Physical Activity and Health, 2004

¹⁶ Haddad L. What Can Food Policy Do to Redirect The Diet Transition? IFPRI Discussion Paper 165, 2003

- Promote urban agriculture and gardening programs that can help to introduce high quality vegetables in the family diet;
- Improve the quality of the diets/foods served or distributed by the public sector or food-aid programs, including school feeding programs and reformulate them to prevent the emerging problems of obesity and non-communicable diseases. Chile and Brazil have reported initiatives in this area;
- Promote standards of diet quality and fat content in restaurants and school cafeterias. This is already been done in countries like Jamaica, Brazil, Ecuador and Chile;
- Incorporate a health concept in the international food trade in order to improve the quality of food imports. Currently, mostly sanitary and phytosanitary criteria rather than dietary quality are specified in relevant CODEX Alimentarius Standards. This is an important area that may have significant population reach;
- Create incentives for the development of healthier products by the food industry;
- Promote life-cycle interventions that incorporate existing ones promoted by the public and private sectors.

Demand side interventions:

- Promote accurate and objective information and education to the public and to specific audiences. Promotional and dissemination activities will require the public health sector's leadership, financial resources and technical capacity in order to be sustainable over time. An example of this type of initiative is the collaboration between PAHO and the International Life Sciences Institute (ILSI) in a three country project, the *Healthy Lifestyles, Healthy People* project.
- Develop or update the national food and dietary guidelines with the participation of different sectors, including the private sector. For example, Food Based Dietary Guidelines and National Nutrition Plans should be synchronized with the DPAS implementation. Several countries in the region have existing initiatives in this area;
- Improve product labeling to make it easier for the public to understand nutritional information and improve their dietary habits. The simplification of current "Nutrition Facts" is the subject of several initiatives such as "*Salud te Recomienda*" in Puerto Rico;
- Increase the relative price of unhealthy food choices through taxes or other disincentives. The "price" strategy has been used by trade sector and public health sectors in the past and represents a viable alternative. There are few experiences in the region;

- Develop guidelines/regulations for food marketing and advertising to children. There is compelling evidence that marketing to children influences their preferences and that the majority of products being advertised are high energy and high fat content. There are initiatives in Rio (Brazil), Chile and Ecuador;

3.3 Physical Activity (PA) Recommendations

Approximately thirty years ago scientific evidence on the positive health impact of exercising started to appear in the literature. The experts proposed that the ideal amount of *exercise* (aerobic exercise or sports) was between 20-30 minutes at least three times a week. During the 90s a new appraisal of the data collected gave way to a new paradigm that recommended *moderate intensity daily physical activity* for at least *30 minutes* (such as walking, dancing, cleaning the house etc) that could reap similar health benefits as those from the exercise model. Since, most studies were based on subjects practicing recreational exercise recommendations favored leisure time physical activity.

Recently, and because of the work of urban planners that for decades have promoted the human dimension of cities, making them friendly to walking and biking, public health professionals are looking at urban space as a critical environment for the promotion of physical activity; not only with respect to recreation but with respect to incorporating daily physical activity as part of our lives. This has given rise to a new and more comprehensive concept: *Active Living*.

The realization that in poor and middle-income countries people walk a lot more, either for recreation or transportation, than industrialized ones has led to increased attention to walking and how to improve the quality of that activity. This has prompted intersectoral collaborations to flourish among urban planners, public health professionals, city governments, transportation experts, road safety officials and exercise and entertainment advocates. These collaborations are crucial to attain population impact in physical activity promotion.

- a) *Individual PA recommendations*: Epidemiologic and clinical studies indicate that substantial health benefits can be achieved with at least 30 minutes of daily moderate intensity physical activity, such as brisk walking, cycling and dancing.¹⁷ WHO and CDC have endorsed such recommendation and DPAS also supports it. Additional benefits can also be obtained if individuals participate in higher intensity or engage in longer periods of physical activity. On the other hand, for individuals who wish to maintain a healthy weight, it appears that 60-90 minutes per day of moderate intensity physical activity may be required.

¹⁷ Pate R.R., Pratt M., Blair S.N., Haskell W.L. et al. Physical Activity and the Public's Health: A Recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. JAMA 1995;273:402-407.

b) *Environmental interventions for PA*: Interventions and policies at this level support the development of more favorable circumstances for individuals to adopt an active lifestyle or active living. Many of the proposed interventions or policies have been described elsewhere.^{14, 18}

Promotional initiatives and national guidelines development:

- Facilitate efforts to reach consensus among different actors within the health sector and obtain intersectoral agreements for collaboration are critical initial steps for the increased participation of different partners and likelihood of success. There are important initiatives in this regard: The Physical Activity Guidelines of Chile; the WHO/PAHO Healthy Municipalities and various efforts by CDC and PAHO to bring together city planners, transportation experts and public health professionals;
- Discuss and share lessons learned from promotional work of the Physical Activity Network of the Americas (PANA) and its national member networks, including Agita Sao Paulo and the Colombian network of P.A. *Vida Chile* has also developed diverse national initiatives that are important to take into account;

Institutional approaches:

- Promoting physical activity efforts in the workplace are important because they engage employers, employees to create an institutional culture for health promotion. For example, posting point-of-decision prompts in the workplace that encourages people to use stairs.
- Increased attention and outreach to schools' physical education (PE) programs in the Region. In some countries, parents and the popular media are receptive to the health risks implied by the elimination of PE from schools' curricula. Several public health researchers are turning to the school as an important setting for health promotion initiatives. An example includes PAHO and ILSI initiative "*Healthy Lifestyles, Healthy People*" in Brazil, Mexico and Chile.

Urban approaches:

- Expand on innovative and effective initiatives that promote walking and biking that include at least the following three programs/policies: (i) Rapid Mass Transportation systems favor active transportation and establish limits to excess reliance on the use of private-cars; (ii) Road Safety contributes to active living by protecting pedestrians and bikers; and (iii) Alternative Transportation, a popular policy that emphasizes the use of bikes and other modes of non-motorized transportation in the cities. In some cases, these three alternatives are presented or

¹⁸ Pratt M et. al. Promoting physical activity in the Americas. *Food and Nutr Bull*, vol 25. no.2:183-193, UNU, 2004

promoted in one package by institutions that advocate their adoption, like the World Bank. Existing comprehensive interventions can be found in the cities of Curitiba, Porto Alegre and Rio in Brazil, and Bogotá in Colombia.

- Support existing government efforts in the area of recreation. City Councils have enacted several initiatives among them, comprehensive plans for recreation, such as the Instituto de Recreación y Deportes de Bogotá (IDRD) that features a wide array of activities and infrastructure efforts. The Ciclovías initiative is one of the most notorious activities that utilizes major city streets for massive recreation, like jogging, walking and biking. Essentially, closing roads to motorized traffic for about 6 hours on holidays and Sundays. Presently, there are at least 15 cities in Latin America have Ciclovías.
- Support CDC and PAHO intersectoral collaboration in several programs throughout the region, e.g. a study of the impact of the *Built Environment* on physical activity and health in Bogotá; The Active Cities, Healthy Cities Award; the Inter-sectoral Workshop for Physical Activity Promotion (México, Brazil and Perú), etc;
- Identify additional city initiatives, large or small, that can provide for the seamless implementation of active living models. These can be a starting point for the DPAS implementation. Some of the cities that can be considered are: Bogotá, Rio, Chacao (Ven), Quito (Ecuador), Guadalajara (Mex). Similarly, the Healthy Municipalities network is another important option with its local networks in different countries.

4. GUIDING PRINCIPLES FOR ACTION

This section addresses key criteria that will guide the implementation process of the DPAS that will begin with the planning stage at the regional as well as the country level. Fostering changes and/or improving the existing environment are central activities in public health. The challenge of changing diet behavior, food choice and shifting the entire population into active living is a major endeavor that requires short to long term planning and objectives. Some, if not most of the changes require action in areas outside the public health sector and that cannot be easily influenced by health professionals. Therefore, the ability to articulate the importance of health and the need for change in other sectors is central to successful public health leadership. The campaign to defend the breastfeeding practice from aggressive marketing of infant formula, and the battle against tobacco use are valuable examples to bear in mind. Similarly, DPAS will focus much of its attention outside the health sector in the areas of public policy, agriculture, city planning, and road safety, among others.

4.1 A new approach to “scientific evidence” for interventions

A basic tenet of public health research maintains that in order to advance the benefits of any given treatment to the society at large it is necessary to follow the pathway:

Efficacy Trials → Effectiveness Trials → Implementation

Any of the above two “Trials” should be Randomized Control Trials (RCT) in order to provide “incontrovertible” scientific evidence of causality. In other words, that intervention A makes outcome B possible. However, when it comes to behavioral change, a lineal rationale is insufficient. Very little information obtained in efficacy trials linking diet and physical activity to health outcomes, has been translated into programs. Several authors wonder whether this inability to translate evidence into practice may be responsible for the limited achievements of the Healthy People 2000 in the areas of diet and physical activity.

The difficulties in translating basic research into population level practice have prompted several investigators to examine closely the context in which interventions are being planned and implemented, and not only focus on issues of “efficacy”. It has been suggested that new approaches should pay more attention to the following two concepts, in addition to the more traditional concept of “Efficacy and Effectiveness” (the traditional ones).

The *first concept* relates to translating theory into real-world-conditions and considers several issues. This includes the “Reach” of the intervention (characteristics and size of the target population), “Adoption” (To what extent the intervention can be applied in different settings and by different interventionists?), “Implementation” (How an effective intervention can be delivered in a standard fashion and create an impact?) and “Maintenance” (How an intervention can stay in place in the long-run)¹⁹

The *second concept* redefines “scientific evidence”. Conventional thinking posits that the RCT is the basic building block for creating new knowledge in public health. However, numerous investigators, are revisiting the subject proposing the inclusion of an array of several other techniques and methods^{20,21} Among them, observational studies, time-series studies, quasi-experimental studies, qualitative studies, econometric estimations, etc. and if used concurrently can provide better insight for future interventions.

In fact, the above two concepts have become paramount in identifying preventive strategies or programs in Latin America and the Caribbean. The emergence of

¹⁹ Glasgow RE et. Al Why don't we see more translation of Health Promotion Research to Practice? Rethinking the Efficacy-to-Effectiveness Transition. AJPB Augut 2003 Vol 93. No 8: 1261-67

²⁰ A systematic and extensive review of this matter can be also found in Victora CG, Habicht, JP et.al. Evidence-Based Public Health: Moving Beyond Randomized Trials, Am J Pub H, March 2004, vol.94, No. 3: 400-405

²¹ CDC A Report on Recommendations of the Task Force on Community Preventive services: Increasing Physical Activity. MMWR Oct 26, 2001, Vol 50, No. RR-18

numerous health promotion interventions in the last 15 years, coupled with a new thinking on what constitutes “scientific evidence” are making possible a re-appraisal of those interventions and the emergence of “best practices” or “interdisciplinary approaches” in health promotion. Such approach is the basis for the summary of interventions identified at the Regional Consultation of the DPAS in Costa Rica as well as those listed in the previous section.

4.2 Enabling environments: Its importance for a sustained behavioral change

Behavioral change is not only a matter of personal responsibility because of its overwhelming link to environmental factors. Economic, market and cultural dynamics, and urban designs are powerful forces that shape eating and physical activity patterns and must be addressed to ensure that the easy choices are healthy choices.

Successful public health interventions recognize that eating and physical activity are human behaviors that are responsive to a variety of factors, not only good information. In fact, individuals generally consider health issues as just one of many factors in deciding what to eat, whether to exercise, or to quit smoking. For instance, in choosing whether to eat more fruits because will that will bring health, many competing factors are at stake. Competing factors are notably short-term ones such as convenience, time availability and price, to cite just a few²². Some enabling environments include: the institutional set-up in the work place and schools, regulations, social norms, prices, taxation, several types of incentives etc. Therefore, public health strategists need to take into account all factors that influence key human behaviors that will make the healthy choice the easy choice.

It must be recognized that not all desirable changes will happen (or actually occur) in a top-down fashion. Informed and educated consumers and citizens can improve not only their own personal choices but also help initiate changes in the supply side of the equation. This is why the role of information/education remains central to DPAS implementation.

An enabling environment is all the more important given the fact that the impoverished populations in the Americas are the ones bearing the greatest burden of NCDs and the ones with the lowest rates of good dietary and physical activity practices. This is true among less developed²³ as well as developed nations in the region.²⁴

4.3 Step-wise implementation and based on existing initiatives and interventions

The DPAS-LAC will draw on existing successful interventions, programs and policies. Furthermore, the DPAS will coalesce in a coherent common framework

²² Hill JO, Wyatt HR, Reed GW, Peters JC. Obesity and the environment: Where do we go from here? *Science* 2003; 299:853-56.

²³ WHO World Health Report 2002. See also footnotes 2 and 4 on page 1.

²⁴ Eyre H, Robertson RM, Kahn R Preventing Cancer, Cardiovascular Disease, and Diabetes. *Diabetes Care*, vol.7: 1812-24, July 2004

the various initiatives and programs. Furthermore, it will provide a platform for the start of a cost-effective strategy. A number of important initiatives are now underway in the Region and the Costa Rica Consultation in 2003 identified some of them.^{25,26} The task of identifying specific interventions will take place at both the regional and in-country levels. A preliminary attempt to systematize existing interventions is presented in section 3 of this document.

Regional and country levels will be encouraged to follow the stepwise approach for DPAS implementation. This is important to bear in mind because moving from independent to collaborative work, from one sector's vision to intersectoral approaches and from small localized interventions to more generalized actions, will require not only a vision but time and resources.

4.4 Public Health Leadership and Consensus Building

The mandate of the 57 World Health Assembly, urges State Members to implement the DPAS. The public sector represented by WHO/PAHO, at the Regional level, and the MOH at the country level will be the convening institutions that will assist in the DPAS implementation among member states. The public health sector will invite other partners and stakeholders, including the private sector, to partake in implementation of DPAS. Entities whose contributions should be coordinated include health ministries and governmental institutions responsible for policies related to food, agriculture, youth, recreation, sports, education, commerce and industry, finance, transportation, media and communication, social affairs and environmental and urban planning. Furthermore, health ministries have an essential responsibility for coordinating and facilitating the contributions of other ministries and government agencies.

At both the regional and country level the first action will be to convene a representative group of institutions and individuals to discuss the DPAS, explore interventions and future participation. The convening institution will distribute a draft paper of the DPAS with some preliminary ideas for its implementation.

The diverse composition of the initial group as well as the multifaceted approaches and interventions require avoiding complex and strict rules for operation. Overall, there needs to be a positive attitude towards building consensus.

5. GOALS AND OBJECTIVES OF DPAS IN LAC

Targeting and promoting healthy diet, physical activity, and smoking cessation are likely to yield good health results as those three risk factors are associated with a number of diseases, including, obesity, diabetes, hypertension,

²⁵ Pratt M et.al. Promoting physical activity in the Americas (2004), Food and Nutr Bull, vol 25:183-193, No.2 UNU

²⁶ Uauy R and Monteiro CA, The challenge of improving food and nutrition in Latin America, Food and Nutr Bull, vol 25:175-182, No.2 UNU

cardio-vascular disease and several cancers. Most patterns of unhealthy behaviors rapidly spread and cluster among the poor, a fact that has been repeatedly shown in the Americas²⁷. Economic, market and cultural dynamics are powerful forces that shape the process and must be addressed in order to achieve the desired behavioral changes. Furthermore, the role of government is crucial in achieving lasting change in public health. Governments have a primary steering and stewardship role in initiating and developing the strategy, ensuring that it is implemented and monitoring its impact in the long term.

The global strategy should foster the formulation and promotion of national policies, strategies and action plans to improve diet and encourage physical activity. National circumstances will determine priorities in the development of such instruments. Because of great variations in and between different countries, regional bodies should collaborate in formulating regional strategies, which can provide considerable support to countries in implementing their national plans. Because of the above, the DPAS in Latin America and the Caribbean rests on one central motif: *“Make healthy choices the easiest choices”*

5.1 Goal

Improve the health of Latin America and Caribbean populations through better diet and the adoption of active lifestyles.

5.2 General Objectives

- Raise awareness and understanding about the importance of a healthy diet and an active lifestyles for all, with emphasis on the poor;
- Develop and implement national plans, including interventions and policies that enable environmental and behavioral changes, and are sustainable over time;
- Promote intersectoral participation, including civil society institutions and private sector;
- Evaluate changes resulting from regional and national implementation plans, including identification of worthwhile interventions/policies and changes in population diet and physical activity levels;
- Assure active technical support to countries' Implementation Plans from WHO/PAHO and other partners.

5.3 Objectives for 2006-2007

- Increased awareness and visibility of the problems and actions promoted by the DPAS-LAC among the general public, health

²⁷ PAHO, Health in the Americas 2002, Non-communicable diseases and injuries, STP No. 587: 276-278

professional and political leaders of Latin American and Caribbean countries;

- Consolidate an intersectoral partnership and team work at the regional level;
- Develop guidelines for DPAS implementation, including regional and country level activities;
- Development a pilot implementation of DPAS in three to four countries.

6. MOVING INTO ACTION

6.1 Regional Activities

A regional meeting, convened by WHO/PAHO, will initiate the implementation plan. This meeting is expected to take place the 25-28 of *April 2006*. Participants will include several WHO-HQ, WHO RO, MOH country representatives in which DPAS implementation has started, partner organizations, public health institutions and other UN institutions like FAO. (Section 7 includes a list of partner institutions.) The objectives of this meeting are to discuss the DPAS implementation and form a Steering Committee (SC) that will lead its implementation in LAC (see Figure 1 for suggested organizational structure of the DPAS implementation plan.) In addition, identify initiatives/interventions/policies on diet and PA promotion that are relevant to the DPAS objectives

Suggested activities for the SC are the following:

- i. Plan and oversee the DPAS implementation pilot phase;
- ii. Select three to four countries for pilot implementation of DPAS;²⁸
- iii. Elaborate guidelines for country implementation plans with input from national partners;
- iv. Provide input to a Regional Mass Media campaign;²⁹
- v. Provide input to the PAHO Resolution on the DPAS implementation.

²⁸ Criteria for selecting countries for participation includes: The burden of NCD has been identified, associated risk factors are subject of monitoring and study, there are public, private or civil society initiatives to prevent NCD or promote healthy eating and physical activity, there is political commitment to support DPAS, there are diverse local human and material resources for implementation.

²⁹ DPAS implementation coincides with the planning of a regional media campaign to promote healthy eating and physical activity. Such campaign has been developed by PAHO (Public Information and DPC/NC) in association with Mr Mario Kreutzberger, a TV host (Univision) known as “Don Francisco.”

6.2 Country Level Activities

The following are suggested activities for the country's implementation plan:

- i. Making the case for action at the country level;
- ii. Selecting key relevant interventions and policies to be promoted in a step-wise fashion;
- iii. Identification of resources;
- iv. Dissemination and communication of activities;
- v. Evaluation.

6.3 Organizational Structure

The organizational set-up requires simplicity and clear leadership. It is suggested that the SC conforms two working groups, each in charge of PA and diet and nutrition respectively given the specialization and unique characteristics of the two subjects. Each of these WG can further incorporate other members from countries or partner institutions if deemed necessary. The Unit of NCD at PAHO will be the secretariat of the entire process and activities. See organizational chart in Figure 1 at the end of this document.

6.4 Stakeholders and Partners DPAS

The successful implementation of DPAS depends on the capacity to convene several partners and stakeholders. In as much as so many activities relevant to DPAS are already underway will require a broad inclusive approach. Below is a list of potential stakeholders and partners in various sectors.

Public Health Sector: This sector is represented by WHO, PAHO country offices, Centers and networks (i.e. CARMEN, Healthy Municipalities and Healthy Schools) and MOH in the Americas Region. Includes in particular Departments or Division that deal with Health Promotion and NCD prevention and control;

Other Public Sector: Includes sectors others than health. Among them: FAO at the UN system level. At the national level MOA, MOE and Local Governments and Municipalities;

Multilateral Agencies: The World Bank and the Inter American Development Bank.

Academic and Scientific Institutions: Caribbean Health Research Council; INTA, Chile; INSP Cuernavaca, México; Propia, U. La Plata, Argentina; IIN, Lima, Perú; Universidad de Sao Paulo, Brazil; CELAFISCS, Sao Paulo, Brazil; American College of Sports Medicine (ACSM); IDR D Bogotá, Fundación FES, Universidad del Valle (Colombia); School of Community Health at Portland State University; Latin American, Caribbean and Iberian Studies Program (LACIS) at the University of Wisconsin-Madison.

Professional Associations: Asociación Latinoamericana de Diabetes, IOTF (Latin America and Caribbean)

NGOs, Private Institutions and Networks: IFAVA: International F&V Association; Five-A-Day groups in: Argentina, Chile, Perú, Brazil, México, Colombia etc; International Life Sciences Institute (ILSI); Inter American Heart Foundation; Agita Sao Paulo; Muévete Bogotá, Red de Actividad Física de Colombia; Fundación Ciudad Humana, Bogotá Colombia; Physical Activity Network of the Americas (PANA/RAFA); The Global Forum, Santiago, Chile; Centro Internacional de Gestión Urbana, Quito, Ecuador.

WHO Collaborating Centers: CDC Collaborating Center on Physical Activity and Health Promotion, Atlanta, US;

Private Sector: Produce for Better Health; Sporting Goods Industry; Produce Marketing Association, Newark, Delaware, US;

Communications: Mr Mario Kreutzberger (Don Francisco), TV Host, and radio networks collaborating with PAHO;

6.5 The role of the Private Sector

The private sector (including the food industry, retailers, catering companies, sporting-goods manufacturers, advertising and recreational businesses, insurance and banking groups, pharmaceutical companies and the media) has an important role to play as responsible employers and as advocates for healthy lifestyles that promote healthy diets and physical activity. All public sector industries are potential partners with governments and nongovernmental organizations in implementing measures aimed at sending positive and consistent messages that facilitate and enable integrated efforts to encourage healthy eating and physical activity. Because many companies operate globally, international collaboration is crucial. Cooperative relationships with industry have already led to many favorable outcomes related to diet and physical activity. Initiatives by the food industry to reduce the fat, sugar and salt content of processed foods and portion sizes, to increase introduction of innovative, healthy, and nutritious choices; and review of current marketing practices, could accelerate health gains worldwide. Suggested lines of action to the food industry, sporting-goods manufacturers among other private corporations include the following:

- Promote healthy diets and physical activity in accordance with national guidelines and international standards and the overall aims of the global strategy;
- Limit the levels of saturated fats, trans-fatty acids, free sugars and salt in existing products;
- Continue to develop and provide affordable, healthy and nutritious choices to consumers;
- Provide consumers with accurate and understandable product and nutrition information;

- Practice responsible marketing particularly with regard to the marketing of foods with high content of saturated fats, trans-fatty acids, free sugars, or salt, especially to children;
- Assist in developing and implementing physical activity programs;
- Support the creation and enhancement of public areas for recreation;
- Support the development and implementation of massive public transportation systems;
- Assist in the communication efforts of the DPAS through access to mass media.

6.6 Roles and Responsibilities of the Public Health Sector

The public health sector represented by PAHO and countries' MOH has a critical responsibility in the DPAS-LAC implementation; therefore their specific roles are detailed herein:

WHO: Provide technical and financial support to the DPAS implementation and actively participate in the initial stages of the implementation and remain a member of the Steering Committee

PAHO:

- Convene a Regional meeting to discuss DPAS and organize a Steering Committee;
- Seek the political, logistical and financial support from PAHO's regional governing bodies and MOH to the DPAS-LAC;
- Provide the Secretariat role in the DPAS-LAC implementation plan;
- Prepare the draft document for the Directing Council meeting 2006;
- Help in the creation of a website, allowing an easy flow of information among different organizational levels and the public as well;
- Carry out fundraising activities and provide resources to regional activities of the DPAS-LAC;

Ministry of Health:

- Convene national stakeholders –including intersectoral participation-- and develop an implementation plan;
- Provide logistic support and funds to the implementation of the national DPAS implementation plan and its evaluation;
- Conduct fundraising activities;

7. TIME TABLE

Date	Activity
February 27, 2006	Draft of the PAHO Directing Council resolution
April 25-28 2006	Regional meeting for DPAS implementation
May 17, 2006	First Teleconference for DPAS Coordinating Committee
September, 2006	Pilot implementation activities start in at least 3 countries
October, 2006	PAHO Directing Council to discuss Resolution on DPAS
May 2007	DPAS Coordinating Committee Discuss implementation plan based Resolution and country experience.

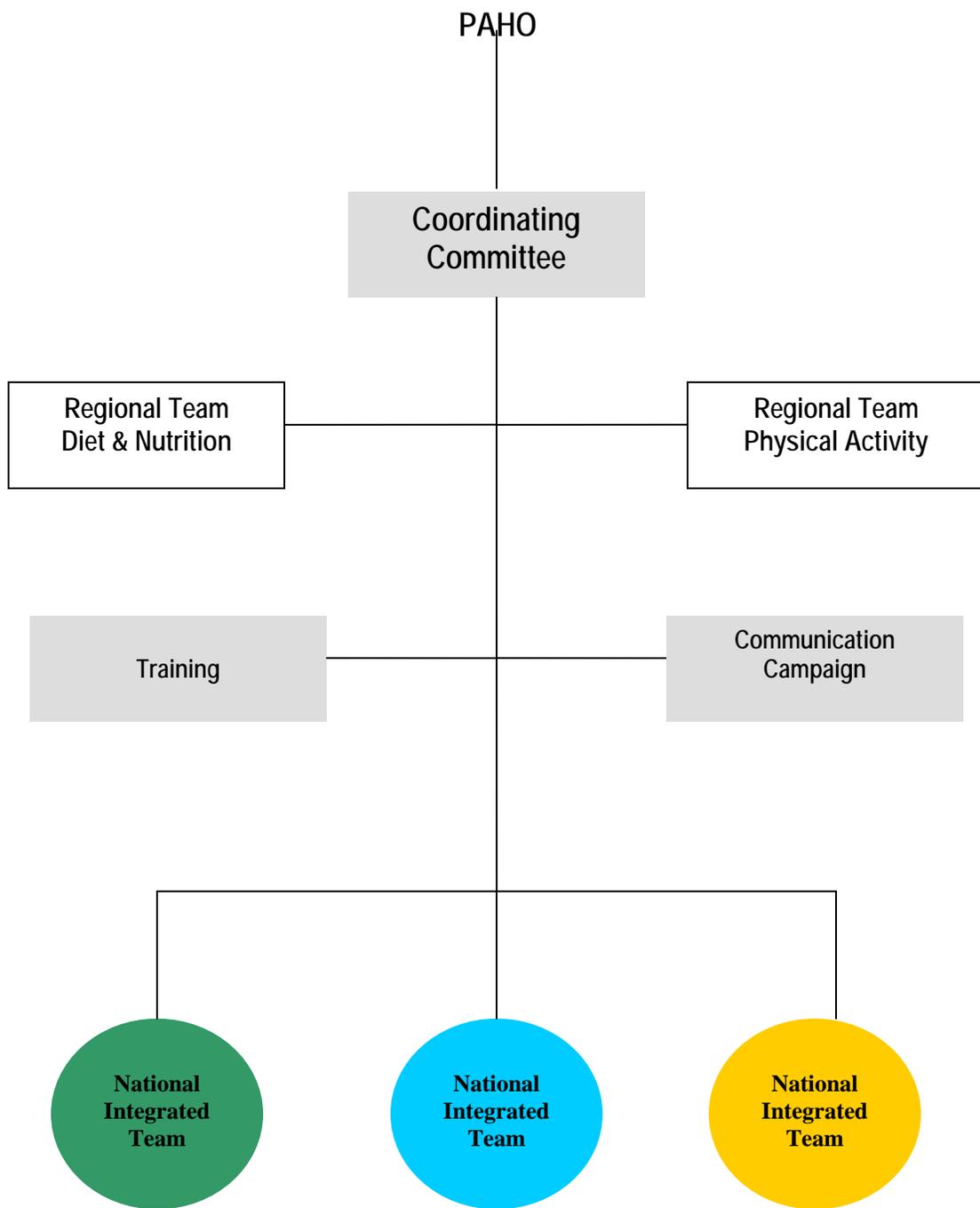


Figure 1: Organizational layout of the DPAS Implementation Plan in Latin America and the Caribbean