

**TECHNICAL CONSULTATION ON A MULTI-STAKEHOLDER FORUM FOR
PREVENTION AND CONTROL OF CHRONIC DISEASES IN THE AMERICAS:
MARCH 23-24, 2009, WASHINGTON, DC**

Appendix:

**Environmental Scan of Partnerships, Initiatives and Research Focused
on Chronic Disease Prevention and Control**

Funding for this publication/project was provided by the Public Health Agency of Canada

The opinions expressed in this publication are those of the authors/researchers and do not necessarily reflect the official views of the Public Health Agency of Canada

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Summary

Purpose

The purpose of conducting this environmental scan was to learn more about the types of partnership arrangements, alliances and initiatives that currently exist, particularly those focused on chronic disease prevention and control. The findings of the scan will be used to inform the establishment of the multi-stakeholder alliance.

Methodology

This preliminary scan reviews 9 partnership arrangements, 9 initiatives and 2 research studies. The partnerships were identified through discussions with key informants at the Public Health Agency of Canada (PHAC) and the Pan-American Health Organization (PAHO), particularly the Chronic Disease Unit. In addition, past issues of *Chronic Disease Prevention & Control in the Americas*, the monthly newsletter of the PAHO/WHO Chronic Disease Program, were reviewed and other information was obtained through an extensive web search. This document will be updated on a regular basis as new information is identified.

Findings

In Section 1, types of partnership arrangements were identified including:

- Partnering organizations that act as brokers to persuade various interested parties to participate in dialogue, arrange collaborations and plan initiatives. It was noted that the broker organization may not necessarily be neutral but is recognized as fair and honest.
- Some of the organizations were established as federations to serve the interests of one primary stakeholder (e.g., consumers).
- Multi-stakeholder partnership arrangements were used to complement the more traditional tools of public policy, such as regulation.
- Partnerships were established across disciplines, sectors and countries, many featuring work from leaders in fields who had never before focused on health-related issues.

An analysis of the partnerships indicates that prerequisites for success include:

- Bringing together dedicated stakeholders from all parts of society to achieve real change. Multi-stakeholder alliances offer the opportunity to build capacity, share knowledge and build support for the goals of the initiative(s).
- Using partnerships/alliances is integral to leveraging limited resources and making the most impact with limited resources.
- The need to share common values, although they may be expressed differently. Successful partnerships are based on people working well together which requires flexibility, mutual trust and understanding.

- Clarity about the different roles in the partnership (e.g., public sector, private sector and civil society). All partners need to make it clear up front what is not acceptable and focus the process on trying to find mutual ground.
- Transparency and clearly defined accountability for the outcomes. Mitigate the risk of failure by clearly delineating projects/programs, establishing well-defined criteria containing benchmarks, and defining timeframes, activities and deliverables.
- Initiatives need to be well-resourced (financial and human resources) and those resources need to be well-managed.
- Strategic direction and guidance should be provided by a steering group of experts.
- Establishing a monitoring framework to ensure that achievements can be measured, learned from and used for future guidance. Aspects of monitoring that need to be addressed include: setting specific objectives and reporting on actions; focusing on relevant information when monitoring; devising appropriate methods of measuring results; communicating information clearly; and dedicating sufficient resources to allow effective monitoring.

In Section 2, a number of initiatives established by PAHO, WHO, regions, sub-regions, countries, and international governments are described. These initiatives provide examples of frameworks/forums (CARMEN, Ciclovía, DOTA, PANA/RAFA, EGO) and agreements upon which future alliances may be built (e.g., Physical Activity, Dietary Salt Reduction, Diabetes, Obesity, Trans Fat, Nutrition):

- *CARMEN Network (Conjunto de Acciones para la Reducción y Manejo de Enfermedades No Transmisibles)*, established in 1997, provides a forum for sharing, learning and collaborating among countries/territories of the Americas and partner organizations in order to reduce the burden of chronic non-communicable diseases, their risk factors and underlying determinants by supporting the development, implementation and evaluation of comprehensive, integrated prevention and control interventions. CARMEN was initially focused mostly on prevention and establishing demonstration projects, and on training via the “CARMEN School” of selected courses. Since the adoption of the PAHO “Regional Strategy on an Integrated Approach to the Prevention and Control of Chronic Diseases, including Diet and Physical Activity”, the Network was broadened to a wider prevention and control remit, and new TORs adopted at the 2007 biannual meeting in the Bahamas.
- *Physical Activity Network of the Americas - PANA/RAFA* was inspired by a combination of local and international factors. On the International front, WHO expanded its health promotion efforts into physical activity starting with a planning meeting in Geneva in 1997. During two consecutive scientific meetings in São Paulo in 1998 and 1999 (CELAFISCS International Symposium of Sports Sciences), representatives from several countries of the Americas discussed and developed the first official document to promote physical activity in the Americas entitled “Manifesto of São Paulo.” It has served as the basis for physical activity promotion throughout the Americas.
- *Agita Mundo - Move for Health Network*, officially launched in 2003 with the support of over 180 international and national institutions, advocates for physical activity. The Agita Mundo Network agreed to give first priority in supporting the WHO

Global Strategy on Diet, Physical Activity and Health announced at the World Health Assembly, May 2004.

- The Ministry of Health (MINSAL) in Chile launched a *Global Strategy against Obesity (Estrategia Global contra la Obesidad)* – EGO campaign, which aims to reduce obesity from 10 percent to 7 percent by 2010. EGO and a *Plan for Health Promotion* are currently being applied in 338 communities, roughly equivalent to 98% of the country.
- PAHO, the Public Health Agency of Canada (PHAC), and country participants at an Expert & Country Consultation in Florida, January, 2009, made a commitment to work on creating greater visibility of **dietary salt reduction**, since salt is not only a problem for people with hypertensive disease but also a problem of the entire population. Even a modest reduction in population salt intake results in a major improvement in public health.
- PAHO, together with the International Diabetes Federation (IDF) and the pharmaceutical industry, in 1996 issued the *Declaration of the Americas on Diabetes (DOTA)*, an action plan that in the last few years successfully coordinated several activities in the Region.
- PAHO established an initiative to eliminate industrially produced trans fatty acids from foods in the Americas. A special "*Trans Fat Free Americas*" expert task force convened by PAHO/WHO endorsed the goal in May 2007, indicating that a reduction of trans fat consumption by just 2 percent to 4 percent of total calories could prevent up to 225,000 heart attacks in Latin America and the Caribbean. The Task Force suggested that the goal can be met by major food producers in a matter of months or at most a couple of years; it is being done by several food companies already. In Rio de Janeiro, June 2008, PAHO convened a group of public health authorities, representatives of the food industry and cooking oil companies who signed a *Trans Fat Free Americas Declaration*.
- UK and the Netherlands convened a bilateral meeting in 2005 to bring together experts to discuss some of the important issues related to working with the private food sector to improve *nutrition* and exchange experiences and discuss best practices. There were mixed reviews where some participants fully supported tough legislation and regulation and others believed that self-regulation is effective.

In Section 3, two research studies are provided:

- *Epidemiological Profile of Risk Factors for Non-communicable Diseases among Brazilian Industry Workers Brasilia. CNI-SESI Study: 2007* was a successful collaboration between PAHO, the Brazilian Ministry of Health, the Brazilian Society of Cardiology, and SESI (Brazil's industry organization). Based on the results, SESI established a major NCD education and screening program.
- *The Food Industry, Diet, Physical Activity and Health: A Review of Reported Commitments and Practice of 25 of the World's Largest Food Companies* analyzed company reports, accounts and websites up to autumn 2005. The purpose was to find out what the largest food companies in three key sectors – manufacturing, retail and foodservice – report they are or are not doing in relation to health. Company self-reported activity was reviewed against a 'template' of issues derived from the WHO

Global Strategy on Diet, Physical Activity and Health. The study findings on stakeholder engagement indicated:

- ✓ 11 out of 25 companies engaged with industry associations.
- ✓ Only nine out of 25 reported engagement with Government or political parties.
- ✓ 12 out of 25 engaged with civil society.
- ✓ 10 out of 25 engaged with consumers.
- ✓ Cadbury Schweppes, Kraft, Unilever and McDonald's were the only companies to report engagement on all four fronts.

SECTION 1: PARTNERSHIPS

1.0 Alliance for a Healthier Generation

In 2005, the American Heart Association and the William J. Clinton Foundation formed the Alliance for a Healthier Generation and, in 2007 Governor Arnold Schwarzenegger of California joined the Alliance to serve as a co-lead along with President Bill Clinton and President of the American Heart Association. The goal of the Alliance is to stop the nationwide increase in childhood obesity by 2010 and to take “bold, innovative steps” to help all children live longer and healthier lives. The Alliance focuses on the places that can make a difference to a child’s health: homes, schools, restaurants, doctors’ offices, and communities.

The Alliance combines the American Heart Association’s extensive reach into communities across the country, its science expertise, presence in schools, and nationwide network of volunteers and supporters with the entrepreneurial approach, influence, and innovation of the William J. Clinton Foundation. The Alliance focuses on four key initiatives (each described in more detail below): The Healthy Schools Program, Industry Initiative, Healthcare Initiative, and Kids’ Movement.

Lessons Learned:

- The partners in the Alliance share similar values and focus on specific programs with defined goals, timeframes, activities and deliverables.
- The initiatives are well resourced (financial and human resources) and managed.
- There is clear accountability for the outcomes of the Alliance.

1.1 The Healthy Schools Program

With lead funding from the Robert Wood Johnson Foundation, ¹ the Alliance launched the Healthy Schools Program in February of 2006. The program sets criteria containing benchmarks for best practices for healthy schools in the areas of physical activity, nutrition and staff wellness, and recognizes schools that meet these criteria. Schools must meet the criteria in all of the domains in order to achieve the recognition status.

The Alliance established science-based nutritional guidelines for beverages and snack foods sold in schools. These guidelines can help ensure that the snacks students consume are nutrient dense and the portion sizes of snacks and beverages are age-appropriate. These guidelines were also adopted as the standards for Senate Bill 08-129: Healthy Beverage Policy. The rules will apply to beverages sold during the regular and extended school day, effective July 1, 2009.

In addition to recognition, the Healthy Schools Program provides onsite and online support to schools to: improve the nutritional value of food served in and out of cafeterias, including reimbursable meals and competitive foods; increase physical activity opportunities during the school day and after school; implement quality health and

¹ See further discussion of the Robert Wood Foundation – Childhood Obesity Program on page 20 of this document.

physical education programs; and offer programs for staff wellness. By combining technical assistance, grassroots- and nationally driven motivation, and visible recognition, the program's strategy is to create long-term systems changes in schools that will have important benefits for students.

The Healthy Schools Program provides its member schools with the following:

- National recognition for their small victories and big successes
- Customized support for creating a healthier school environment through a liaison available by phone and e-mail
- Implementation support and tools to help schools work towards creating a healthier school environment and achieving recognition.
- Networking opportunities with schools across the country on the quest to make their environments healthier.
- A database that includes resources and grant opportunities to help schools implement healthy changes and promote physical activity and healthy eating.

1.2 Industry Initiative

The Alliance for a Healthier Generation seeks to improve healthy options available for children through work with the food, beverage, fitness and health industries. In May of 2005, the Alliance announced an agreement with Cadbury Schweppes, Coca-Cola, PepsiCo and the American Beverage Association to establish guidelines for limiting portion size, increasing nutrient content and reducing calories in beverages available at school. Under the terms of the agreement, the beverage industry was tasked with spreading these standards to 75 percent of the nation's schools prior to the beginning of the 2008–09 school year and fully implementing them prior to the beginning of the 2009–10 school year.

In October of 2006, the Alliance announced another agreement with five of the nation's leading food manufacturers to help combat childhood obesity in America. Campbell Soup Company, Dannon, Kraft Foods, Mars and PepsiCo have joined with the Alliance to establish first-ever voluntary guidelines for snacks and side items sold in schools that will provide healthier food choices for the nation's children. These five food industry leaders agreed to invest in product reformulation and new product development, while encouraging broader support of the guidelines. The new guidelines, which were developed in conjunction with nutrition experts at the American Heart Association, will apply to foods offered for sale in schools outside of the National School Lunch Program to students before, during and after the school day. The guidelines cover foods and snacks, desserts, side items and treats sold throughout schools, including school vending machines, ala carte lines, school stores, snack carts and fundraisers.

1.3 Healthcare Initiative

The Alliance Healthcare Initiative is a collaborative effort with national medical associations, leading insurers and employers to offer comprehensive health benefits to children and families for the prevention, assessment and treatment of childhood obesity.

The program reimburses doctors for bringing children back for follow-up visits and for working with them on the adoption of healthy behaviors. Registered dietitians are also reimbursed for providing in-depth nutrition counseling over multiple visits to those children referred by their doctors. By working together, doctors and registered dietitians help children and their families adopt healthier eating habits to improve their health and weight. Participating companies have access to materials and resources developed by the Alliance to inform parents about childhood obesity prevention and treatment.

1.4 Kids' Movement

The Alliance has established the “empowerME” movement that is “by kids for kids” to inspire children to make healthy behavior changes and become advocates and leaders for healthy eating and physical activity. Other programs have been added to: *engage kids* “with cool, healthy messages” (Alliance in collaboration with media, celebrity and grassroots champions); encourage children to use their own voices and speak to each other; *get educated* (using tools such as on-line games about healthy eating and active living); and *get activated* (using a platform for youth activism).

For more information, visit www.HealthierGeneration.org.

2.0 Consumers International

Consumers International (CI), a not-for-profit company, was founded in 1960 as a world federation of consumer groups to serve as an independent and authoritative global voice for consumers. With over 220 member organizations in 115 countries, CI's international movement was established to help protect and empower consumers everywhere. The goal of CI is “to secure a fair safe and sustainable future for consumers in a global marketplace increasingly dominated by international corporations”. The organization works on the premise that the strength of the collective power can be used for the good of consumers throughout the world.

As a global watchdog, CI campaigns against any behavior that is perceived to threaten, ignore or abuse the principles of consumer protection. CI accomplishes this by:

- Working with national member organizations to influence governments, highlight marketplace abuses and raise grass roots support.
- Pressing consumer concerns through official representation on global bodies such as the UN, WHO, ISO and FAO.
- Raising awareness about purchasing choices through clear, engaging and accessible communication.

CI's basic set of consumer rights include: the right to satisfaction of basic needs; the right to safety; the right to be informed; the right to choose - select from a range of products and services; the right to be heard; the right to redress; the right to consumer education; and the right to a healthy environment -to live and work in an environment that is non-threatening to the well being of present and future generations.

CI is governed by a Council/Board elected by full members at CI World Congress held every three years. It is a founding signatory of the International NGO Accountability

Charter and is fully committed to its principles of legitimacy, transparency and accountability. Over one third of CI's income comes from membership fees and the remainder is made up of grants from governments, multilateral agencies, non-governmental organizations and trusts and foundations.

Consumers International has official representation on many global bodies, including: United Nations Economic and Social Council (ECOSOC) and related United Nations agencies and commissions; WHO; Codex Alimentarius Commission; ISO; UNESCO; UNICEF; International Electrotechnical Commission (IEC); and, UNCTAD. CI is also active at the World Trade Organization (WTO), although this does not have formal accreditation arrangements. At the regional and sub-regional levels, CI represents consumers at, among others the: United Nations regional Economic Commissions; Economic Community for West African States (ECOWAS); OECD; Latin American Parliament (PARLATINO); PAHO; and Association of Southeast Asian Nations (ASEAN). Representation at the European Commission is handled by the Bureau Européen des Union de Consommateurs (BEUC), an affiliated member of CI.

Lessons Learned:

- The member organizations of CI share the same values.
- CI has global coverage and strength in numbers.
- The organization is fully committed to the principles of legitimacy, transparency and accountability.

3.0 EU Platform on Diet, Physical Activity and Health

The EU Platform on Diet, Physical Activity and Health was created in 2005 to provide a forum for all interested actors at the European level where:

- They can explain their plans to contribute concretely to the pursuit of healthy nutrition, physical activity and the fight against obesity, and where those plans can be discussed; and
- Outcomes and experience from actors' performance can be reported and reviewed, so that over time better evidence is assembled of what works and Best Practice more clearly defined.

The aim was to explore best practice and encourage voluntary action on consumer information and labeling, advertising and marketing, and product development. The Platform brings together food manufacturers, retailers, the catering industry, advertisers, consumer and health NGOs, health professionals and public authorities, to conduct an open and informal discussion to examine ways of achieving binding commitments aimed at tackling the obesity epidemic.

The multi-stakeholder, voluntary approach represented by the Platform was an experiment by the Commission in partnering with business and civil society to produce results in a more rapid and flexible way as a complement to the traditional tools of public policy, such as regulation. The expectation was that eventually the impact of many actors

taking action together would build enough momentum to halt or even reverse the growth of overweight and obesity in Europe.

Lessons Learned:

- The achievement of results requires actions to be taken across the board and on all levels of decision-making, from local to community level. The *White Paper on a Strategy for Europe on Nutrition, Overweight and Obesity related Health Issues* adopted by the EC on 30 May 2007 cites the European Platform for Action on Diet, Physical Activity and Health as a key policy tool in the fight against obesity.
- The Platform has raised the profile of nutrition across the European policy environment and it has been the catalyst for actions to improve diet and nutrition at European, national, regional and local levels. The unique approach allows each stakeholder to make commitments that are coherent with their capacity and remit for action.
- From the outset it was recognized that the members of the Platform would need to monitor their achievements if they were to demonstrate their impact to others and to learn from their own practices. Since this is a challenging task and not all Platform members were equally skilled in this area, a Platform Monitoring Working Group, chaired by the European Commission and comprised members of the Platform, was established in March 2005. Considerable investment was made in building sustainable mechanisms to allow Platform Members to commit to actions, monitor and report on their results. An overview of the progress report and specific multi-country initiatives and achievements follow.

3.1 Overview of a Report on the Progress of the EU Platform

In March 2006, the Chairman of the Platform indicated the key objective of the Platform would be “to show that the Platform is going forwards in terms of implementation and monitoring of the commitments”. The *Second Monitoring Progress Report* was prepared by RAND Europe to present the achievements and to examine how successfully the Platform’s members were monitoring the Platform’s progress. The report identified a need for overall improvement and six aspects of monitoring that need to be addressed:

- Be specific when setting objectives and reporting on actions;
- Focus on relevant information when monitoring;
- Devise appropriate methods of measuring results;
- Communicate information clearly;
- State the Platform’s contribution to a commitment; and
- Dedicate sufficient resources to allow effective monitoring.

3.2 EU Platform Multi-Country Initiatives and Achievements (RAND Report)

- By May 2006, EuroCommerce increased the number from 8 to 13 of EU country’ national retail federations taking an integrated approach based on WHO’s obesity recommendations; however, this did not quite meet the 18 originally proposed.

- Carrefour, which has 8,800 stores in seven Member States (France, Belgium, Spain, Italy, Greece, Portugal and Poland), participated in public campaigns to promote the consumption of fruit and vegetables, and ran campaigns through in-store events and “Nutrition Weeks”. In 2006, 35 studies were conducted to assess these campaigns, and monitoring of consumption patterns showed annual increases of 10% in the consumption of organic fresh produce since 2004.
- Many member organizations of the European Consumers’ Organization (BEUC) publish consumer magazines to inform their members and the general public about issues of concern to consumers. BEUC member organizations committed to publishing regular articles on nutrition and, in 2006, BEUC exceeded its targets – at least 19 articles were published by members in nine different countries. Three BEUC members also conducted their own nutrition campaigns nationally.
- European Food Information Council (EUFIC) provides science-based information on food safety and quality, and, health and nutrition in a way that promotes consumer understanding to the media, health and nutrition professionals, educators, and opinion leaders. In 2006, EUFIC redesigned its website to offer clear, sound, science-based information on food and nutrition in five languages (English, French, German, Italian and Spanish) and dedicated a section of the new website to EU initiatives. Between the 28 June 2006 launch date and 31 October 2006, more than 1.6 million visitors visited the new website, compared with 1.1 million in the same period in 2005.
- EUFIC also committed to translating its educational materials on healthy diets and lifestyles into the Greek, Portuguese, Polish, Hungarian, Czech and Slovak languages by 2008. These translated materials were to be adapted and promoted in collaboration with partners in Member States, including local dieticians’ networks and renowned centres of research excellence, using their trusted “grass-roots” communications tools. It was anticipated that a further 85.1 million European citizens could potentially benefit from EUFIC’s information thanks to these translations.
- Platform members raised awareness of nutrition issues by organizing conferences and exhibitions. For example, the European Vending Association (EVA) organized a conference in April 2006 on the challenges and opportunities of the new diet and nutrition environment. The conference was attended by 100 people and covered by the main magazines in the vending press. The EVA published an interview with the Director-General of DG SANCO in its newsletter, which had 1,200 direct readers (and approximately 2,000 readers in total) in 11 languages.
- Other activities included: (1) Exhibition stand organized by the European Breakfast Cereal Association in the European Parliament to communicate the importance of eating breakfast and present the nutritional benefits of breakfast cereals. Nearly 300 people participated in daily activities and quizzes; (2) The European Snack Association organized a “Forum on Nutrition and Health” in June 2006, attended by more than 100 delegates from industry, non-governmental organizations (NGOs), EU institutions and advertisers; (3) In the context of promotional events, the Confederation of the Food and Drink Industries of the European Union (CIAA) committed to produce a framework for the development of national food weeks to promote healthy lifestyles by the end of the first quarter of 2007; (4) The International Baby Food Action Network (IBFAN) committed to inform parents, health

professionals and policy-makers about how breastfeeding can support reductions in obesity by distributing booklets, leaflets, and specialized publications, and by using other media channels, such as internet information sharing. IBFAN's UK website regularly produced 90,000 page impressions a month; articles were published in parent magazines as well as professional journals (such as the *Central European Journal on Public Health*). At a national level, information materials, such as posters and newsletters, on aspects of breastfeeding and its links to obesity prevention were produced and distributed in national languages. IBFAN Europe also contributed to the 2006 World Breastfeeding Week by developing action oriented materials and organizing events in many countries. (For more information, visit: http://ec.europa.eu/http://www.rand.org/pubs/technical_reports/2007/RAND_TR474.pdf).

4.0 Global Forum for Health Research

The Global Forum, established in 1998, is an independent non-profit foundation operating under Swiss law. It draws its operating income from international organizations, philanthropic foundations and government agencies. A Foundation Council, the highest policy- and decision-making body, is responsible for the definition of organizational objectives and priority areas as well as long-term vision. The Foundation Council is assisted by a Strategic and Technical Advisory Committee (STRATEC), composed of six members selected from Council members plus the chair.

The Global Forum's mission is to play a leadership role in catalyzing global research applied to the health problems of the poor through:

- engaging current and future high-level decision makers from high-, middle- and low-income countries;
- brokering coherence and partnerships between global players in research/innovation;
- promoting relevant research on health and health equity;
- advocating increased resources for relevant research and innovation by all sectors;
- encouraging the use of evidence in policy- and decision-making;
- stimulating dissemination of research findings to enable their utilization.

In 2008, the Global Forum celebrated 10 years of achievements, having effectively advocated around the "10/90" gap (i.e., only ten per cent of worldwide expenditure on health research and development is devoted to the problems that primarily affect the poorest 90 per cent of the world's population) and having driven the case for better targeted and prioritized research to address the health needs of poor populations.

The Global Forum closely collaborates with a range of organizations from all sectors including:

- *international organizations* (e.g., UNDP/UNFPA/WHO/World Bank Special Program of Research, Development and Research Training in Human Reproduction; WHO, World Bank);
- *non-governmental organizations and public-private partnerships* (Council on Health Research for Development; European Foundation Centre; Medicines for Malaria Venture);

- *research institutes and universities* (e.g., Ifakara Health Research and Development Centre and Swiss Tropical Institute; Indian Council of Medical Research; Johns Hopkins University);
- *governments* (e.g., Ministry of Health, Mexico; Government of Egypt; Ministry of Health, People's Republic of China; Government of Mali; Ministry of Health, Spain; Ministry of Health, Department of Science and Technology, Brazil; Ministry of Foreign Affairs/DANIDA); and *publishers* (e.g., ProBrook Publishing Limited; RealHealthNews; *The Lancet*).

Lessons Learned:

- To increase the global commitment to research for health, the Global Forum engages with key stakeholders through a variety of channels and media. The fundamental approach is to seek leverage through:
 - ✓ *Advocacy*: Assemble clear arguments based on careful analysis and synthesis, and deploy these arguments to persuade governments, donor and development agencies, research institutes and research councils, the private sector, the media and others.
 - ✓ *Brokerage*: Bring groups together, facilitating dialogue, arranging collaboration, initiatives and networks, as a committed agent that is not necessarily neutral but is recognized as a fair and honest broker.
 - ✓ *Catalysis*: Use limited size and resources to leverage significant change; engage with a wide variety of key actors worldwide; and ensure a high frequency of productive interactions with target groups.

5.0 Grand Challenges in Global Health

On 26 January 2003, at the World Economic Forum in Davos, Switzerland, Bill Gates announced a \$200-million medical research initiative—the Grand Challenges in Global Health—based on a century-old model, the grand challenges formulated by the mathematician David Hilbert. The partners for the initial Grand Challenges in Global Health initiative were the Bill and Melinda Gates Foundation (BMGF), the Canadian Institutes of Health Research (CIHR), the Foundation for the National Institutes of Health (NIH)², and the Wellcome Trust³.

The Global Health initiative was proposed by BMGF on the assumption that, with greater encouragement and funding, contemporary science and technology could remove some of the obstacles to more rapid progress against diseases that disproportionately affect the developing world. By 2005, 43 grants totaling US\$436 million had been awarded for research projects involving scientists in 33 countries.

² The Foundation for the National Institutes of Health was established by the US Congress and began operations in 1996 to serve as a non-profit catalyst for public-private partnering in support of research of the NIH. The foundation identifies and develops opportunities for innovative public-private partnerships involving industry, academia, and the philanthropic community.

³ The Wellcome Trust is a diverse biomedical research charity that spends over £600 million every year both in the UK and internationally to support and promote research to improve the health of humans and animals.

Grand Challenges in Global Health supports research to address a variety of diseases and conditions that affect the developing world including: HIV / AIDS; Other Infectious Diseases; Poor Nutrition; Vaccine-Preventable Diseases; Malaria; Pneumonia; and Tuberculosis. An example of research in progress under the vaccine-preventable diseases category is *Novel Therapeutic Vaccines for Acute and Persistent Papillomavirus Infections*. The project includes plans to identify and develop the optimal vaccine candidate, produce the vaccine for use in humans, and conduct the first trial of the vaccine to evaluate its safety in young women. Collaborators include: Georgetown University School of Medicine - US; Deutsches Krebsforschungszentrum - DE; BioSidus – BR; and Ludwig Cancer Institute – BR.

BMGF also launched Grand Challenges Explorations which focuses on rapidly evaluating a large number of innovative ideas that may lead to new vaccines, diagnostics, drugs, and other technologies, targeting diseases that claim millions of lives every year. Anyone with a bold idea that shows great promise may fill-out a two-page application to submit online. Winning grants are chosen approximately 4 months from the submission deadline. Explorations grants are solicited and awarded multiple times per year on a rolling basis, with each funding round addressing a few specific topics or themes. Explorations grants (approximately \$100,000 each) may be eligible for follow-on grants of \$US1 million or more, and could eventually evolve into Grand Challenges projects.

Lessons Learned:

- Grand Challenges in Global Health family of grants programs have one unifying purpose: “To overcome persistent bottlenecks in creating new tools that can radically improve health in the developing world”.
- Effective health research needs the collective effort of many people and organizations. Grand Challenges projects are managed by teams working in partnership across disciplines, sectors and countries, many featuring work from leaders in fields such as chemistry, engineering, statistics, and business, who have never before focused on global health.
- These partnerships offer the opportunity to build capacity, share knowledge and build support for health research.

For more information, visit: www.gcgh.org

6.0 National Fruit & Vegetable Program (U.S.A.)⁴

The National Fruit & Vegetable Program is an example of an extremely successful public/private nutrition partnership. This National Program, which replaces the 5 A Day for Better Health Program, seeks to promote good health and potentially reduce the risk of stroke, high blood pressure, diabetes, and some cancers by encouraging Americans to increase their consumption of fruits and vegetables. Along with the creation of the new

⁴ Other similar nutrition partnerships have been launched around the world including: Canada’s 5 to 10 a Day for Better Health Program; United Kingdom 5 a Day; Denmark’s 6 a Day Program; Australia’s GO for 2 & 5 Campaign; and New Zealand’s 5+ A Day Programme.

National Program in March 2007, a new public health initiative was launched – Fruit & Veggies–More Matters – to reflect new dietary guidelines.

The U.S. National Program is a public/private partnership, originally formed between the National Cancer Institute and the Produce for Better Health Foundation. In 2005, the Centers for Disease Control and Prevention (CDC) became the lead federal agency and national health authority.

The National Fruit & Vegetable Program network consists of Fruit & Vegetable Coordinators in all 50 states, U.S. territories and armed forces. Nutrition Coordinators work closely with partnering organizations and are responsible for planning and conducting fruit and vegetable activities in their state.

The National Fruit & Vegetable Program has established a Steering Committee composed of leaders from some of the largest organizations concerned with nutrition: American Cancer Society, American Heart Association, American Diabetes Association, Centers for Disease Control, CDC's Division of Nutrition, Physical Activity, and Obesity, National Council of Fruit & Vegetable Nutrition Coordinators, National Alliance for Nutrition and Activity, National Cancer Institute, Produce for Better Health Foundation, Produce Marketing Association, United Fresh Fruit and Produce Association, United States Department of Agriculture, Food, Nutrition and Consumer Services, Research, Education and Economics, Marketing and Regulatory Programs.

Lessons Learned:

- While the Program's strength comes from the combined efforts and resources of all the partners, the support and collaboration of the Steering Committee, made up of leaders of the partnering organizations, is critical.
- The National Program reflects the collaborative and synergistic relationship of governments (local, state, federal), not-for-profit groups and industry all working together to increase the consumption of fruits and vegetables for improved public health.

(For more information, visit: <http://www.fruitsandveggiesmatter.gov>)

7.0 Ovations Initiative

A global partnership was established in 2007 by Ovations, a UnitedHealth Group company,⁵ to address the growing epidemic of chronic disease. Ovations is partnering with the National Institutes of Health (NIH), the Oxford Health Alliance, and health care experts from around the world to develop specific strategies in concert with governments, non-governmental organizations and the private sector globally. Ovations and its

⁵ A subsidiary of UnitedHealth Group, Ovations is the largest company in the U.S. dedicated to meeting the health and well-being needs of people age 50 and older. It provides chronic disease management services, health insurance, Medicare-managed care and related services, access to prescription and non-prescription medications, and other healthy living products.

partners focus on applying what they know about managing, treating and preventing chronic disease at the local level around the world.

The focus of the initiative includes:

- Raising awareness of chronic disease and the potential global impact
- Developing, implementing and sharing best practices on preventing and managing chronic illnesses at the local level
- Building systems and infrastructure to address chronic disease that could also be used to manage other diseases more effectively and sustainably.

Ovations and its partners focus on creating an infrastructure for sharing the knowledge and skills necessary to prevent, manage and treat chronic illnesses in developed and developing countries. This includes improving the cost-effective deployment of human, technology and financial resources within the national health care systems.

As part of UnitedHealth Group's Corporate Social Responsibility program, Ovations is committing up to \$15 million in financial, managerial and in-kind resources over the next five years in support of the program, which is being developed in conjunction with the Clinton Global Initiative.

A Global Advisory Board of leading health care experts has been assembled to provide strategic direction and guidance for the program. The Advisory Board is chaired by Dr. Richard Smith, CEO, UnitedHealth Europe and former editor of the British Medical Journal and membership includes individuals from the Pan American Health Organization, The Gates Foundation, NIH, Grantmakers in Health, Chinese Academy of Medical Science, Evercare Health Care, University of Sydney, Physical Fitness Research Center of Sao Caetano do Sul – CELAFISCS, University of Cape Town, All India Institute of Medical Sciences, Isfahan Cardiovascular Research Center, and a member of the board of the Oxford Health Alliance.

Lessons Learned:

- Their combined experience demonstrates that Ovations' public-private partnership is the best way to identify, implement and share practical solutions for preventing and managing chronic disease globally.
- By working with governments, non-governmental organizations, non-profit groups, individuals and private companies, Ovations is able to expand and accelerate effective and practical programs to support the initiative's goals.
- By working with partners, Ovations can more effectively build capacity and share research knowledge

8.0 Oxford Health Alliance (OxHA)

OxHA was formed in 2003 as a partnership between Oxford University and Novo Nordisk A/S. OxHA enables experts and activists from different backgrounds to collaborate to raise awareness and change behaviors, policies and perspectives at every level of society. Alliance members are from around the world including leading

academics, activists and corporate executives, patients' rights advocates, doctors, nurses and others.

OxHA brings together as many companies, governments and organizations that can make a difference and establish alliances that can execute the WHO strategy against chronic diseases. The primary organizations in the Alliance are the **University of Oxford, Novo Nordisk A/S and World Health Organization**.⁶ The Alliance's first goal is to raise awareness among influencers and educate critical decision-makers to advance preventative measures and take action on combating chronic disease.

OxHA holds annual summits, the most recent in Sydney, Australia (25–27 February 2008) on the theme of 'Building a healthy future: chronic disease and our environment'. An outcome was "*The Sydney Resolution*" calling for action through broad alliances and partnerships of stakeholder groups to confront four preventable chronic diseases that account for 50% of the world's deaths: heart disease/stroke, diabetes, chronic lung disease and cancer; their underlying causes are tobacco use, physical inactivity and poor diet. The next summit is scheduled for 16 April 2009 at Trinity College, Oxford on the topic "Searching for Solutions".

Lessons Learned:

- To achieve real change, it is necessary to bring together dedicated stakeholders from all parts of society.
- Collaboration is needed among agencies, governments, corporations and businesses, donor agencies, professionals, consumers, non-government organizations and employee unions, civil society and individuals in taking urgent action to halt the devastating global impact of chronic diseases.
- OxHA members share a set of fundamental principles: How people live as societies, share opportunities, interact with the natural environment and design cities, transport systems, food systems, work places and housing will fundamentally determine future patterns of health and disease; Social and physical environments need to be fundamentally reshaped so that they are aligned with eradicating the epidemic of chronic disease; and, Health services need to be focused on prevention as well as cures.

⁶ Other organizations involved include: Bowker Media & Communications; Centre for Disease Control & Prevention, USA; Chinese Centre for Disease Control & Prevention; City University – London; Department of Health, UK; Earth Institute, Columbia University; European Association for the Study of Diabetes; European Centre on Health of Societies in Transition; Geneva University Hospitals; Health Canada; Healthy Eating & Active Living HE+AL Partnership; House of Commons; House of Mondaymorning; Institute for Alternative Futures; International Business Leaders Forum; International Council of Nurses; International Federation of Pharmaceutical Manufacturers Association; International Obesity TaskForce; Johnson & Johnson; JP Morgan; LIMIU Limited; Medical Research Council, South Africa; Memory Pharmaceuticals; Merck Sharp & Dohme; National Treasury, Republic of South Africa; Nestlé SA; New Health Group; OCDEM; OECD; PepsiCo; Pharma Futures; Stanford University School of Medicine; Strategy XXI Group Ltd; SustainAbility; The Abelson Company; The World Bank; UK Treasury; Umeå International School of Public Health; University of Brasilia; University of California at San Francisco; University of Geneva; University of New South Wales; University of Oxford/Radcliffe Infirmary; University of Queensland, School of Population Health; University of Sydney; University of Toronto; University Potchefstroom; Vanderbilt Diabetes Centre; and World Heart Federation

Based on lessons learned, other OxHA partnerships, collaboration and initiatives involving a broad range of stakeholders were launched:

- **Community Interventions for Health** (CIH - formerly Community Actions to Prevent Chronic Diseases, CAPCoD) (described in further detail below);
- **3FOUR50** an awareness-raising and action-based online social network, aimed at anyone wanting to take positive action to raise awareness of the chronic disease epidemic (described in further detail below);
- **Grand Challenges** project to draw up a list of Grand Challenges in Chronic Non-communicable Diseases to encourage research into chronic disease worldwide;
- **Evidence Collection** on chronic disease and the risk factors, the size and cost of the problem – and on practical, replicable solutions.
- **Oxford Dialogues** a series of topical meetings to engage a range of people in discussion on key topics including 'Patients' rights in Europe' and 'Information to and with patients: the role of health professionals'.

Visit www.oxha.org for more information.

8.1 Community Interventions for Health

The Oxford Health Alliance expanded the partnership approach by establishing Community Interventions for Health (CIH – formerly CAPCoD) – a chronic disease prevention research initiative – to develop and showcase sustainable interventions to address poor diet, tobacco use and lack of physical activity, demonstrating their effectiveness in a way that is both practical and scientifically rigorous, and adaptable to different cultures and communities. There is an Advisory Board and an Expert Panel.

The interventions are tracked across multiple countries and multiple settings: schools, health-care centers, workplaces and local communities. CIH provides evidence and practical advice on what does or does not work in chronic disease prevention. Data from all the phases of the project are shared and disseminated, in particular through the use of innovative online technology (e.g., 3FOUR50).

CIH focuses on five key areas: developing and in-transition communities; children and families; assessment of the interventions through a rigorously designed research study; the roles played by poverty and access in chronic disease death and disability; and comparative analysis between the different sites, using a shared set of measures, with a view to building the roadmap of best practice in chronic disease prevention.

CIH has identified three components integral to the design of the interventions:

- *Community coalition-building* – key stakeholders work together to encourage healthy lifestyle change throughout the community, for example advocating for bicycle paths and smoke-free environments or creating farmers' markets
- *Health education* – disseminating health messages is vital for success, for example through training of health professionals, using media, social marketing or peer educators.

- *Structural change* – structural interventions include advocating for and implementing policy change, environmental change (for example, improving the opportunities for physical activity in schools and workplaces) and economic change (such as reducing taxes on healthy foods). These combine to create communities in which the healthy choices are the easy choices. (Visit www.oxha.org/initiatives/cih/community-interventions-for-health for more information)

8.2 3FOUR50

3FOUR50 is a network to facilitate partnerships, collaboration and action among experts, leaders, innovators from a variety of sectors and with anyone genuinely concerned about chronic disease prevention. The name “3FOUR50” represents OxHA’s key message: 3 risk factors – tobacco use, poor diet and lack of physical activity – contribute to FOUR chronic diseases – heart disease, type 2 diabetes, lung disease and some cancers – which, in turn, contribute to more than 50 per cent of deaths in the world.

3FOUR50 unites individuals and organizations with a story to tell, provides a platform for members to showcase their work and work together on new projects, and highlights best practice in the area of prevention. The goal of 3FOUR50 is to become an awareness-raising and action-based online social network. (Visit www.3four50.com for more information)

9.0 Robert Wood Foundation – Childhood Obesity Program

The Robert Wood Foundation, an independent philanthropy devoted to improving health policy and practice, works with a diverse group of people and organizations to address problems at their roots and to help make a difference on the widest scale—particularly for the most vulnerable. The Foundation’s focus is health care delivery, how it’s paid for and how well it does for patients and their families.

A fundamental guiding premise of the Foundation is the stewardship of funds should be used to create leverage for change that is in the public’s interest. The Foundation creates leverage by building evidence and producing, synthesizing and distributing knowledge, new ideas and expertise. Their approach is to build partnerships by bringing together key players, collaborating with colleagues, and securing the sustained commitment of other funders and advocates improvement in the health and health care of Americans.

The Foundation has developed a framework to organize their grant making practices and areas of focus. This framework groups most of its grant making into four portfolio clusters: Human Capital, Vulnerable Populations, Pioneer and Targeted. Within the Targeted portfolio, the Foundation identified a group of critical issues to address: Childhood Obesity, Coverage, Public Health and Quality/Equality.

The Childhood Obesity Program was established to help all children and families eat well and get more exercise. It is focused on the children in those communities who are at highest risk for obesity. The Foundation’s goal is to reverse the childhood obesity

epidemic by 2015 by improving access to affordable, healthy foods and increasing opportunities for physical activity in schools and communities across the nation.

Lessons Learned:

- The Foundation is better able to leverage its resources by targeting efforts on specific areas of activity.
- Achievement of results can be monitored more successfully by setting specific time-limited objectives and establishing benchmarks, a plan of action, and a budget to accomplish the objectives in each of the critical issues.

SECTION 2: DESCRIPTION OF INITIATIVES

1.0 CARMEN⁷

PAHO developed the CARMEN initiative in late 1995, as a practical tool to assist member countries to meet the challenge of achieving “*Health for All*”. Since its inception in 1996-97, the membership of the CARMEN network has grown from a few countries to 30 members. CARMEN will be holding a biannual meeting in Peru in October 2009.

The mission of CARMEN is “to provide a forum for sharing, learning and collaborating among countries/territories of the Americas and partner organizations in order to reduce the burden of chronic noncommunicable diseases, their risk factors and underlying determinants by supporting the development, implementation and evaluation of comprehensive, integrated prevention and control interventions”. CARMEN aims to promote and establish comprehensive, integrated NCD prevention and policies and programs at the national and sub-regional levels in the Americas, in support of the achievement of the Regional Strategy on Chronic Disease Prevention and Control.

CARMEN was adapted from the CINDI⁸ program and addresses risk factors associated with non-communicable diseases and non-intentional injuries, potentially including:

- Biological conditions: blood pressure and cholesterol, obesity, and diabetes.
- Unhealthy consumption behaviors: smoking, dietary habits, and excessive alcohol drinking.
- Absence of health promotive or protective behaviors, i.e., sedentary lifestyles and lack of seatbelt use.
- Lack of use of preventive or screening devices such as PAP smears.
- Psychosocial factors: stress, social support, and work environment.

CARMEN initiative objectives at the regional and subregional levels include:

⁷ CARMEN is the Spanish acronym for “*Conjunto de Acciones para la Reducción Multifactorial de Enfermedades No transmisibles*”. At CARMEN’s November 2007 Biennial Meeting, a sub-group agreed upon the following English acronym: *Collaborative Action for Risk Factor Reduction and Effective Management of NCDs*.

⁸ CINDI is the Countrywide Integrated Non-Communicable Diseases Intervention Programme sponsored by the European Regional Office for the World Health Organization. 20 countries in Europe and Canada belong to this network of integrated community national projects to prevent and control NCDs.

- support the implementation of the *Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases*;
- serve as the principal agent to collect, analyze and disseminate information and share knowledge about the chronic disease problem and successful strategies for the formulation, execution, and evaluation of NCD policies and programs;
- promote best practices in health promotion and integrated prevention and control of chronic non communicable diseases;
- promote and support community participation in chronic disease prevention and control;
- stimulate and facilitate collaboration and networking among PAHO Member States, organizations, and institutions;
- coordinate actions with related WHO and PAHO initiatives and networks such as Healthy Municipalities, Healthy Schools, WHO Global Forum and similar initiatives in other regions (e.g. IMAN, MOANA, CINDI, SEANET); and
- integrate the initiative with related resolutions from the PAHO Directing Council and the WHO World Health Assembly.

At the country level, the CARMEN initiative aims to:

- raise political support and demonstrate commitment for the prevention of NCDs, their risk factors and determinants as a national public health priority;
- foster inter-institutional and intersectoral actions and create multidisciplinary teams to carry out the strategies for health promotion and integrated prevention and control of chronic non communicable diseases;
- conduct a situation analysis of NCDs and their risk factors and periodic monitoring, according to the abilities of each country;
- establish demonstration sites for interventions for the prevention and control of chronic diseases;
- implement the recommendations for Member States contained in the Regional Strategy and Plan of Action on an Integrated Approach to the Prevention and Control of Chronic Diseases;
- support the establishment of various networks (such as nutrition, physical activity, diabetes, etc) for sharing experiences and collaboration within countries.

2.0 Physical Activity Network of the Americas – PANA/RAFA

The **Physical Activity Network of the Americas - PANA/RAFA** was inspired by a combination of local and international factors. The Agita São Paulo Program and other community-based programs in the Americas demonstrated that PA promotion was timely and feasible. On the International front, WHO expanded its health promotion efforts into PA starting with a planning meeting Geneva in 1997. During two consecutive scientific meetings in São Paulo in 1998 and 1999 (CELAFISCS International Symposium of Sports Sciences), representatives from several countries of the Americas discussed and developed the first official document to promote PA in the Americas entitled "Manifesto of São Paulo," and it has served as the basis for PA promotion through the Americas. In 2000, these various efforts led to the establishment of the Physical Activity Network of

the Americas (Red de Actividad Física para las Americas), with strong support from the CDC, ACSM, CELAFISCS and PAHO.

The *Vision* of PANA is to promote PA for better health among all people in the Americas; and the *Mission* is to strengthen efforts to promote a healthy lifestyle through participation in regular PA by facilitating the integration and dissemination of policies, programs, strategies and experiences of local and national networks and institutions. The Guiding Principles of PANA/RAFA are: (a) to be an inclusive network integrating members of public, private organizations both nationally and internationally; (b) to focus on population-based public health research and programs; (c) to encourage the exchange of experience and knowledge; and (d) to provide an environment that enhances professional development.

The main programs that are part of the Network in different latin America countries include: Argentina (*A Moverse Argentina, Argentina en Movimiento, Salí a Moverte, Sacudete*); Bolivia (*Muévete Bolivia*), Colombia (launched in 2002 the Colombian PA Network, which includes the largest group of PA programs (12) in Latin América: *Muévase Pues, Muévete Bogotá, Risaralda Activa, Buga en Movimiento, Guajira Activa, Madrúgale a la Salud, Palpita/Vibra Quindío, Cauca Activa, Cundinamarca Activa y Positiva, Boyacá Activa, Colombia Activa y Saludable, Cali en Movimiento*); Costa Rica (*Movámonos Costa Rica*), Ecuador (*A Moverse Ecuador*), Guatemala, México (*Programa Nacional de Activación Física*), Panamá (*Muévete Panamá*), Paraguay, Perú (*Muévete Perú*), Uruguay, and Venezuela (*Venezuela en Movimiento, Red Venezolana de Vida Activa*). In addition, in Europe, Portugal set up the *Mexa-se Mais in Oeiras* and *Mexa-se pela sua saúde* from Ilha da Madeira programs.

3.0 Agita Mundo Network

WHO chose PA as the theme to celebrate World Health Day 2002 when nearly 2,000 events were held in 148 countries in 63 languages. In October 2002 a Network organization named for the "Agita Mundo - Move for Health" had its preliminary meeting in São Paulo. In April 2003 the organization was officially launched, with the support of over 180 international and national institutions. Its main purpose was to encourage physical activity (PA) around the world as an instrument to promote people's biological, psychological, and social health. To help achieve that objective, a mega-event, Agita Mundo - Move for Health Day, was planned for April 6th of every year. In 2003, over 2,100 events on five continents commemorated that event.

The purpose of the Agita Mundo - Move for Health Network is to advocate PA as a healthy behavior for people of all ages, nations, and characteristics. The Agita Mundo - Move For Health Network stimulates research, encourages the dissemination of information on the health benefits of PA and effective strategies to increase PA, advocates for PA and health, and supports the development of national and local programs and networks for PA promotion.

The specific objectives of the Agita Mundo - Move for Health Network are to:

- Advocate for PA and health through an annual Move for Health Day and other community-based and community-wide events, and inform policy makers of the importance of PA in public policy.
- Widely disseminate a clear, simple, consistently delivered message about the health and social benefits of at least 30 minutes of moderate physical activity every day.
- Stimulate the creation of regional and international networks for physical activity promotion and provide linkages between these networks.
- Promote and disseminate innovative approaches to develop alliances around the world to promote PA and good health.
- Share good practices and effective strategies and programs through websites, meetings, workshops, and publications.

Agita Mundo Network agreed to give priority to the WHO Global Strategy on Diet, Physical Activity and Health, announced at the World Healthy Assembly, May, 2004.

4.0 EGO Campaign – Global Strategy against Obesity in Chile

In Chile, an estimated 200 people die every day from causes associated with poor diet and lack of physical activity. More than half of Chileans are overweight, and 10 percent are obese. A national survey in 2003 found that 34 percent of Chileans over 17 have hypertension, 35 percent have high cholesterol, 16 percent are glucose intolerant, and 55 percent are at high or very high risk of a heart attack.

To address these problems in Chile, the Ministry of Health (MINSAL) launched a *Global Strategy against Obesity (Estrategia Global contra la Obesidad) – EGO* campaign, which aims to reduce obesity from 10 percent to 7 percent by 2010. Central elements of the strategy include: communication campaigns; school-based educational and food programs; regulation of marketing, advertising, and labeling of food; training of health teams; extension services; and research. The *EGO* and a *Plan for Health Promotion* are currently being applied in 338 communities, roughly equivalent to 98% of the country.

5.0 Dietary Salt Reduction Policies and Strategies in the Americas

An Expert & Country Consultation was held in Miami, Florida, 13–14 January 2009 to:

- Document the policies and initiatives in the Americas Region aimed at reducing dietary salt to prevent and control chronic non-communicable diseases (CNCDs);
- Feature relevant experiences in CARMEN countries and in other countries and WHO Regions; and
- Reach consensus on the Regional-, sub-regional- and national-level initiatives that can advance dietary salt reduction in the Americas and identify next steps for each.

The objectives included:

- Participants gaining a common understanding of the sodium sources and intake levels in countries of the Americas as well as any salt reduction policies and strategies that are emerging or in effect.

- Participants learning about salt reduction initiatives in countries outside the Americas and in other WHO Regions, and what interventions are proving effective.
- Participants reaching a consensus on next steps, to include:
 - ✓ Options for country-specific, sub-regional or regional actions appropriate to the Caribbean, Central and South American countries that will engage governments, civil society and private industry.
 - ✓ Joint projects to advance the development of salt reduction policies and strategies within the CARMEN network.
 - ✓ Resources needed to support next steps and potential sources to approach.

The meeting concluded with PAHO, the Public Health Agency of Canada (PHAC), and the country participants making a commitment to work on creating greater visibility of the issue, since salt is not only a problem for people with hypertensive disease but also a problem of the entire population; moreover, even a modest reduction in population salt intake results in a major improvement in public health.

The participants agreed that dietary salt reduction is one of the most cost-effective public measures available, and one that is relatively feasible in collaboration with industry and governments. However, it is not well appreciated how huge a contribution salt makes to the burden of chronic non-communicable diseases (CNCDs). It is important to educate policy-makers and the public, as well as industry.

There was general agreement to put the topic on the regional and sub-regional agendas, to look for national and regional advocates and champions, and to work on standardizing information. Information was also provided on opportunities for promotion through organizations such as SLAN (the International Latin American Congress on Nutrition held in November 2009 in Chile) and such new actors as the Food and beverage Alliance formed by six largest food and beverage companies, which cover 80% of world market, and SALCA, the South American consumer association.

It was recommended that:

- Dietary salt is a very strategic issue for PAHO and its Member Countries. An active effort to reduce salt consumption should be made as part of the PAHO *Regional Strategy on Chronic Disease Prevention and Control*, and lessons should be learned from the *Trans Fat Free Americas* initiative.
- There should be follow-up with PAHO technical areas and PHAC on convening a Regional Task Force on Salt Reduction Policies, and on improving the assessment of the situation as part of developing a more detailed plan for 2009-2010, to include policy recommendations and targets.
- The country participants present and the CARMEN network should be considered as primary networks for distributing all materials related to salt, which should be translated into Spanish and Portuguese.
- Internal awareness should be raised on the importance of salt reduction policies, e.g. a technical discussion session within the PAHO Health Surveillance and Disease Management Area with online information-sharing via Elluminate.

- Specific issues and targets should be included within the objectives of the Partners' Forum.

6.0 DOTA – Declaration of the Americas on Diabetes

The Pan American Health Organization, together with the International Diabetes Federation (IDF) and the pharmaceutical industry, in 1996 issued the Declaration of the Americas on Diabetes (DOTA), an action plan that in the last few years successfully coordinated several activities in the Region. This action plan was intended to combine efforts in the struggle against diabetes, consolidating the experience gained in recent years through direct collaboration with the countries of the area and through the alliance with DOTA and with other organizations and institutions of the Americas.

Activities organized by PAHO included a workshop on Chronic Complications and National Strategies for Diabetes Control in Latin America and the Caribbean (Washington, D.C., December 1999), the First Workshop on Strategic Diabetes Planning (Santa Cruz de la Sierra, Bolivia, October 1999), and the First Workshop on Epidemiological Surveillance of Diabetes (San Salvador, El Salvador, March 2000).

The information gleaned through these activities contributed to the design and ongoing review and update of the Diabetes Initiative for the Americas (DIA) (an action plan to improve the capacity of the health systems and services in member countries in order to organize programs for the surveillance and control of diabetes in the Americas).

6.1 Diabetes Initiative for the Americas (DIA): Action Plan for Latin America & the Caribbean, 2001–2006

The DIA called for people with diabetes, organized interest groups, and multidisciplinary care teams from both the public and private sector to be involved in this plan. Such involvement would strengthen the work with health providers, ensuring the early detection and appropriate management of diabetes and its complications.

The purpose of DIA was to improve the capacity of the health services and systems to organize surveillance and control of diabetes in the countries of the Americas. DIA consisted of three principal lines of action which relate to the following three mandates:

- improve the availability and use of epidemiological information;
- promote the rational use of available services through the implementation or evaluation of programs for diabetes care; and
- promote the design and development of educational and self-management programs that take into account the sociocultural characteristics of each region or country.

6.2 Central America Diabetes Initiative (CAMDI)

This project was a seed initiative with the goal of developing a national diabetes program in each of the participating countries: Honduras, Guatemala, Nicaragua, El Salvador, Costa Rica.

The components of the CAMDI initiative included: **Phase I** – identification of target population of people with diabetes; assessment of the quality of diabetes care; and improving access to high-quality diabetes care. **Phase II** – implementation of an integrated one-year-intervention program to include improving the quality of diabetes care as well as an educational program for medical personnel and people with diabetes; and implementation of a diabetes education program aimed at the general population.

During the approximate time span of a year, managers, health professionals, and persons with chronic diseases met in Learning Sessions (a total of three) for the purpose of obtaining training and of planning and evaluating activities. During these Learning Sessions, participants from health facilities/services worked on evaluating their services, evaluated an intervention plan based on the proposed change package, and proposed activities to be implemented during the time period of the activity. The commitment of each team was important for the proposed plans in terms of turning them into concrete actions.

The project demonstrated the need for non-communicable disease (NCD) prevention and control programs at the national and sub-regional level. The information collected could potentially serve as a basis for national health education campaigns and allocation of funds for the treatment of these chronic diseases at each country level.

6.3 Veracruz Initiative for Diabetes Awareness (VIDA Project)

The monitoring system for quality of care in Mexico indicated that in 2000, only 34% of all persons with diabetes receiving care were reported to have adequate metabolic control. As a result, the Ministry of Health in Mexico included diabetes as one of the health priorities in a national campaign for service improvement called *The Crusade for Quality Improvement*. In this context, an intervention project is being carried out in five primary-care centers in Veracruz, Mexico.

The intervention was a joint program of the Ministry of Health and the Diabetes Declaration of the Americas (DOTA) through the Pan American Health Organization / World Health Organization (PAHO/WHO). An assessment of the status of diabetes care was carried out in participating health centers as a baseline for the intervention. The study was an audit of medical records using the QUALIDIAB questionnaire promoted by DOTA.

The one-year intervention consisted of in-service training of primary-care personnel on diabetes management, including foot care, as well as the implementation of a structured diabetes education program and a variety of initiatives created by the primary health teams. Some of the innovations that were put in practice by primary-care centers in the VIDA project were the organization of diabetes clinics, a collective medical visit for the *Grupos de Ayuda Mutua* (Diabetic clubs), and the use of *promotores* (health promoters) to carry out diabetes education, as well as participation by people with diabetes in the project's learning sessions.

6.4 Institutional Response to Diabetes and Its Complications (IRDC): DOTA Caribbean Diabetes Initiative

The project *Institutional Response to Diabetes and its Complications* (IRDC) was supported by the Declaration of the Americas on Diabetes (DOTA), with the aim of improving the quality of diabetes care in the Caribbean:

Phase I consisted of an audit of medical records in outpatient clinics in The Bahamas and Jamaica, as well as in two hospitals in St. Lucia. The aim of the first phase was to assess the quality of care for people with diabetes. Overall, 563 patient charts were reviewed. Results indicated that the quality of diabetes care in participating countries needs to be improved and that country-specific patterns of care shown in the baseline study must be used in planning interventions that focus on quality of diabetes care improvement.

Phase II: Some of the activities to be considered for the next phase of the DOTA Caribbean Initiative are the review, implementation, and evaluation of current diabetes guidelines; in-service training for health professionals; and diabetes education.

6.5 DOTA Workshop on Quality of Diabetes Care

Diabcare, a system for measuring quality of care in diabetes, was created by the Saint Vincent Declaration. Inspired by the Diabcare project of Europe, DOTA supported the implementation of Qualidiab in six Latin American countries starting in 1999. The latest analysis of Qualidiab included data from 13,513 patients from centers in Argentina, Brazil, Colombia, Chile, Paraguay and Venezuela. The aims of the study were to define characteristics of people with diabetes attending participating clinics and to establish a preliminary diagnosis of the provided care. Main results indicated that poor metabolic control and insufficient insulin administration are common in Latin America. Results of Qualidiab show that quality of care for people with diabetes needs to be improved.

The first DOTA Workshop on Quality of Diabetes Care was held on 11–12 March 2002 in Ocho Rios, Jamaica, with the participation of Barbados, Bahamas, Trinidad and Tobago, Jamaica, and St. Lucia. Participants agreed to implement a diabetes-care survey in health centers, using the data-collection questionnaire discussed during the meeting.

7.0 Trans Fat Free Americas (TFA)

It was proposed that PAHO/WHO should lead hemispheric efforts toward a Trans Fat Free Americas by giving it high priority on the regional health agenda and by helping member countries develop policies, regulations, and legislation needed to implement the initiative and measure its progress.

7.1 TFA Task Force – 2007

PAHO established an initiative to eliminate industrially produced trans fatty acids from foods in the Americas. A special "*Trans Fat Free Americas*" expert task force convened

by PAHO/WHO endorsed the goal in May 2007, indicating that a reduction of trans fat consumption by just 2 percent to 4 percent of total calories could prevent up to 225,000 heart attacks in Latin America and the Caribbean. The Task Force suggested that the goal can be met by major food producers in a matter of months or at most a couple of years; it is being done by several food companies already.

PAHO convened a meeting with major food industry representatives in September 2007 to present the task force's findings and to discuss cooperative efforts to implement its recommendations. Participating companies included Burger King Corporation, Cargill Inc., ConMéxico (Consejo Mexicano de la Industria de Productos de Consumo, A.C.), Grupo ARCOR, Kraft Foods, Kellogg Company, McDonald's Corporation, Nestlé, PepsiCo, SADIA SA, Watt's SA, and Yum! Brands, Inc.

The Trans Fat Free Americas Task Force cited scientific evidence that consuming trans fats increases the risk of heart disease and possibly the risk of sudden cardiac death and diabetes. Consuming trans fats raises levels of "bad (LDL) cholesterol" while lowering levels of "good (HDL) cholesterol" and damaging the cells in the linings of blood vessels, which contributes to inflammation and blockage and leads to heart attacks. Although trans fats occur naturally in small amounts in unprocessed foods, they are primarily found in baked and processed foods containing partially hydrogenated vegetable oils. Partial hydrogenation is favored by food processors because it gives oils better texture and longer shelf life.

Concerns about the negative health effects of trans fats have already led to actions by both industry and governments to reduce their presence in foods. In 2006, Denmark passed legislation limiting trans fats to 2 percent of total fat in all foods sold in the country. Canada and the United States now both require labeling of trans fat in processed foods and recommend that consumers reduce trans fat consumption to as little as possible. Argentina, Brazil, Chile, Costa Rica, Paraguay, and Uruguay are all currently considering proposals to reduce trans fat consumption by their populations.

In the food industry, companies including Mc Donald's, Unilever, and Kraft Foods have voluntarily reduced trans fats in their products and eliminated them altogether in certain countries. In Argentina and Brazil, a number of local food companies have begun to switch from partially hydrogenated oils to non-hydrogenated unsaturated oils. In Costa Rica and Uruguay, local vegetable oil producers have voluntarily begun producing and marketing healthier oils.

To speed progress, the PAHO/WHO task force made the following recommendations:

- Industrially produced trans fat should be eliminated from food supplies in the Americas, with unsaturated fats promoted as an alternative. This will require government regulatory action in addition to voluntary action by industry.
- Trans fat should be limited through regulatory action to less than 2 percent of total fat in vegetable oils and soft margarines and to less than 5 percent in other foods.
- Governments should consider mandatory labeling of trans fat content in foods, the establishment of standards for product health claims, and mandatory disclosure of

types of fats in foods served in restaurants, food aid programs, schools, and other food service providers.

- Public health advocates should work with the food industry to set a timetable for phasing out industrial trans fatty acids and to promote healthier oils and fats in foods.
- Governments should support small food industries and services in their efforts to eliminate trans fats and adopt healthier alternatives.

7.2 Declaration of Rio de Janeiro – 2008

In Rio de Janeiro, June 2008, PAHO convened a group of public health authorities, representatives of the food industry and cooking oil companies who signed a *Trans Fat Free Americas Declaration*:

“Taking into account:

- That during the last decade conclusive scientific evidence has linked the consumption of industrially produced trans fatty acids (TFAs), with alterations of the metabolism of blood lipids, vascular inflammation and the development of cardio-vascular diseases;
- That the TFAs are, mainly present, in cooking oils, margarines and shortenings which are regularly used in the preparation of pastries, bread and "snacks" among others;

and

Considering the recommendations of international agencies, such as the World Health Organization (WHO) and the Pan American Health Organization (PAHO); in addition to the global trend to replace industrially produced TFAs;

1. Industrially produced Trans fatty-acids (TFAs) should be replaced in manufactured food and we suggest that its presence should not be greater than 2% of total fat in oils and margarines; and not greater than 5% of total fat in processed food. How to achieve this should be defined in accordance with the situation of the food industry and in dialogue with national public health authorities;
2. The nutritional label of processed foods should be obligatory, including the declaration of the content of TFAs and we suggest its harmonization in the Americas;
3. The alternative preferred to TFAs should be the unsaturated fats cis, including the polyunsaturated fatty acids of the family ω -3. The saturated fats (particularly myristic and palmitic acids) should only be used as substitutes of the TFAs, in the absence of a viable alternative for specific applications;
4. It is desirable that restaurants and food service companies advance toward the suggested changes and report on content of TFAs in their preparations. Public funded food programs should be an important part of this effort through food aid programs, hospitals, school feeding programs, etc.;
5. It is suggested that governments establish tax incentives for substitutes of TFAs, including crop production and processed foods. In addition, governments should also ensure funds for research on such substitutes; ease the transfer of new technology, and the creation of preferential credit schemes, among others;

6. It is desirable that public health authorities in coordination with the private sector, develop programs for educating the population on the different types of fat, the correct way to read labels and their application in everyday life;
7. The participating sectors recognize the need for discussing within their national working groups aspects related to the publicity of food that contains TFAs, in particular advertising that targets children and adolescents;
8. Studies and monitoring of the content of fatty acids should be conducted in the food supply, as well as food intake and biological markers of TFAs in the population. This will permit to identify what is the current situation and also evaluate changes after the adoption of the proposed measures;
9. We wish to maintain this regional and national dialogue, under the auspices of PAHO, with the aim of materializing the objective of Trans Fat Free Americas, in the shortest possible time.
10. We recommend that in order to materialize the present declaration and to adapt it to the reality of every country, that national working teams should be formed with the participation of industry, scientists, and public health authorities. Moreover, PAHO should convene periodically such working teams in order to evaluate progress, difficulties and challenges in their work;
11. Use the WHO Global Strategy on Diet, Physical Activity and Health as a framework for the national working teams.”

The Declaration provides a basis for future action through the proposed Partners’ Forum.

8.0 Ciclovías

Ciclovía is a resource-efficient and easily adaptable program that provides the public with an equal opportunity to engage in physical activity. The program is accomplished through the temporary closure of streets to motorized traffic, creating a safe and open space for pedestrians, runners, cyclists, and others. In addition to physical activity, Ciclovía programs have been shown to create jobs through temporary businesses, provide opportunities for community service, and reduce traffic-related air pollution. The concept of Ciclovía began in Bogotá, Colombia over 20 years ago and now nearly a million people fill the roads every Sunday morning to participate in the activities.

People participating in Ciclovía for three hours a week (150 minutes) are meeting their minimum weekly requirements for moderate-intensity physical activity as defined by the U.S. Department of Health and Human Services (HHS). Studies have shown that this amount of exercise can improve health outcomes and reduce the risk of coronary heart disease, stroke, some cancers, type 2 diabetes, osteoporosis, and depression (HHS). In fact, researchers investigating Ciclovía have produced models showing that some programs, such as those in Bogotá, Cali, Soacha (Colombia) and Guadalajara (Mexico), may already be providing their populations with 20% of their recommended weekly physical activity.

Ciclovía programs provide communities with many benefits beyond increased physical activity and improved health outcomes. A survey of existing Ciclovía programs in the

Americas showed that 55% provide economic opportunities through temporary businesses. In Bogota, 96% of these vendors were from the three lowest socioeconomic strata and for one third Ciclovía was their only source of employment. 63% of programs surveyed also reported engaging the community through volunteerism, providing students completing national service or retired citizens the opportunity to give back to the community.

Ciclovía may also have some environmental benefits. One pilot study in Bogota showed that particulate matter related to vehicular traffic was 13 times lower during Ciclovía than during a normal week day. This decrease could be the result of the replacement of 4,865 vehicles on the regular week day by 3,797 people during the Ciclovía in addition to the effect of a lower volume of vehicular traffic on Sundays.

Ciclovía programs have broad public appeal and provide a vehicle for partnerships among different sectors such as public health, transportation, urban planning, sports and recreation, environment and architecture.

9.0 UK and the Netherlands: Bilateral Meeting

In 2005, a bilateral meeting was organized by the Dutch Food and Consumer Product Safety Authority (VWA), jointly funded by the Dutch Ministry of Health, Welfare and Sport (VWS) and the UK Food Standards Agency (FSA). It was as part of a program of collaboration between the Dutch and the UK on nutrition, including a one-year secondment from the FSA to the VWA. The meeting brought together senior policy advisors and decision makers from the food industry, government, NGOs and scientific organizations from the UK, the Netherlands and European organizations, to discuss ways of working with the private food sector to improve nutrition. The objectives of the meeting were to:

- Assemble experts to discuss some of the important issues related to working with the private food sector to improve nutrition; and
- Exchange experiences and discuss best practices in relation to how the private food sector can be effectively involved in improving diet and nutrition including:
 - What should be the roles of different organizations and agencies?
 - What are the pros and cons of voluntary government guidelines versus industry-led self-regulatory processes?
 - How can we ensure that progress is effectively monitored?
 - Is there potential for greater co-operation between different countries on these issues?

The following are overviews of relevant presentations:

9.1 Task Force to Change the Fatty Acid Composition of Foods - Netherlands

A self-regulatory process was instigated by the Dutch Product Board for Fats, Margarine and Oils (MVO) to work with stakeholders including The Netherlands Nutrition Centre and the Dutch Food and Consumer Product Safety Authority to improve the fatty acid

composition of foods. The Task Force was a joint operation of the vegetable edible fats and oils industry and the restaurants industry. In addition to achieving reductions in trans fats less than 1 gram per 100 gram, some small reductions in the saturated fatty acids of foods were also achieved.

Industry initiatives were developed in partnership with government and public health organizations. The government was an important partner as an endorser of the activities and a generator of societal pressure. The Dutch Food and Consumer Product Authority incorporated the campaign message on liquid frying fat in its own monitoring activities. The Netherlands Nutrition Centre raised awareness of consumers' understanding of "good" and "bad" fats.

Lessons Learned:

- Self-regulation has shown to be effective in improving fatty acid composition. Furthermore it supports Corporate Social Responsibility and results in more permanent support. Self-regulation enabled industry to take into account practical feasibility factors like price and availability of raw material, to focus on the optimal reduction of both TFA and SAFA in a product.
- Continuous support and cooperation with government and public health organizations is indispensable to keep the process going.
- Signposting systems and campaigns, which increase consumer demand, accelerate improvements in the fatty acids composition of foods.

9.2 Tackling Trans Fats in Denmark

In 2001, a 'high trans menu' in Denmark contained about 30g of trans fatty acid per day; on January 1, 2004 food products on the Danish market containing fat with a trans fatty acid content above 2% were prohibited. The food industry was involved in the preparatory phase of the legislation and has been quick to adapt to the measure. Once the decision was made by the government, the food industry was very co-operative. A survey carried out after the entry into force of the rules shows that industrially processed trans fatty acids have been replaced in various ways in the food sector and that the level of trans fatty acids has decreased without any negative implications on prices or quality.

Lessons Learned:

- Timing – at the right time, in the right political environment – combined with increased public awareness including through the media – the scientific environment can influence the political agenda and ensure action
- Legislation is the most effective means of achieving change quickly. While people were already beginning to reduce trans-fats, legislation was the key to rapid change
- Most importantly, taking action through legislation means that you have something that can be enforced, including through sanctions for non-compliance.

9.3 Sustain: An Alliance for Better Food and Farming in the UK

Presenting a consumer perspective, Sustain indicated that it took at least thirty years to raise nutrition issues onto the government's agenda in the UK. The Alliance proposed working through large and diverse coalitions as a more effective approach to getting issues like nutrition on the government's agenda.

Lessons Learned:

- Be clear about the different roles of government, business and citizen's organizations. All partners need to make it clear up front what is not acceptable and focus the process on trying to find mutual ground.
- Government should set the standards for tough legislation and enforcement, business should abide by the letter and spirit of the law, and citizens need to keep a check on both sectors.
- Improving people's health through better food is going to continue to be a long and difficult process – if it were easy it would have been done already!

SECTION 3: RESEARCH STUDIES

1.0 Epidemiological Profile of Risk Factors for Non-communicable Diseases among Brazilian Industry Workers Brasilia. CNI-SESI Study: 2007

PAHO, the Ministry of Health, the Brazilian Society of Cardiology, and SESI, Brazil's industry association, successfully cooperated on a pioneer epidemiological study concerning non-communicable diseases afflicting Brazilian industry workers. The aim of the study was to establish cost-effective preventative actions that could be used to reduce the morbidity-mortality rates due to these diseases and consequently enhance the life expectancy and standards of these workers. Based on the results, SESI has established a major NCD education and screening program.

Through each phase of development, the project was presented, discussed and approved by the members of the partner institutions. The high participation rate of companies and workers confirmed that the operational objectives of the fieldwork were reached. It was noted that studies of this scope are not frequent in the world; the best known were carried out in industries and companies in the U.S. (Chicago) over 30 years ago.

2.0 The Food Industry, Diet, Physical Activity and Health: A Review of Reported Commitments and Practice of 25 of the World's Largest Food Companies (Lang, Rayner & Kaelin)

In April 2006, a study was conducted by a team at the Centre for Food Policy, City University London. The purpose was to review the health-related reporting of some of the world's largest food and drink companies in the light of concerns raised by the World Health Organization's 2004 Global Strategy on Diet, Physical Activity and Health (DPAS). The DPAS called for the reversal of these trends through a program of action by member states and international agencies alongside the private sector, civil society and non-governmental organizations.

The study analyzed company reports, accounts and websites up to autumn 2005. The purpose was to find out what the largest food companies in three key sectors – manufacturing, retail and foodservice – report they are or are not doing in relation to health. Company self-reported activity was reviewed against a ‘template’ of issues derived from the WHO Global Strategy on Diet, Physical Activity and Health

The study reported on the top 10 food manufacturers, top 10 food retailers and top five foodservice companies of the world, by sales:

- Headquarters of these companies are in the USA (11), UK (4), Germany (4), France (3), the Netherlands (2), Switzerland (1) and Japan (1).
- The food manufacturers (with the parent HQ country) are: Cadbury Schweppes (UK), Coca-Cola (USA), ConAgra (USA), Danone (F), Kraft (USA), Masterfoods/Mars (USA), Nestlé (CH), PepsiCo (USA), Tyson (USA), Unilever (NL/UK) • The food retailers are: Ahold (NL), Aldi (G), Carrefour (F), Ito-Yokado (J), Kroger (USA), Metro (G), Rewe (G), Schwarz (G), Tesco (UK), Wal-Mart (USA)
- The Foodservice companies are: Burger King (USA), Compass (UK), McDonald’s (USA), Sodexho (F), Yum! (USA)
- The range of turnover in the companies studied is from \$11 billion in the case of Burger King to \$256 billion in the case of Wal-Mart.
- The smallest turnover reported on is five times larger than the entire biennial budget of the World Health Organization.
- Companies spread of sales goes from being in just one country (Kroger in the USA) to nearly every country in the world (Coca-Cola and PepsiCo report being in over 200).
- Food manufacturers and foodservice tend to be highly spread-out internationally, with retailers more geographically spread but fast globalizing.

The study findings on stakeholder engagement included the following:

- 11 out of 25 companies reported that they engaged with industry associations. The seven manufacturers were Cadbury Schweppes, Coca-Cola, ConAgra, Kraft, PepsiCo, Tyson and Unilever. The two retailers were Carrefour and Metro. The two foodservice companies were McDonald’s and Sodexho.
- Only nine out of 25 report engagement with Government or political parties. The six manufacturers were: Cadbury Schweppes, Coca-Cola, Danone, Kraft, Nestlé and Unilever. The two retailers were Ahold and Metro. The one foodservice company reported engagement with government was McDonald’s.
- 12 out of 25 report engagement with civil society. The seven manufacturers were Cadbury Schweppes, Coca-Cola, ConAgra, Danone, Kraft, Nestlé and Unilever. The four retailers were Ahold, Metro, Rewe and Tesco. The sole foodservice company was McDonald’s.
- 10 out of 25 report that they engage with consumers. Of these, the five manufacturers were Cadbury Schweppes, Danone, Kraft, Nestlé and Unilever. The three retailers were Ahold, Ito-Yokado and Tesco. The two food service companies were McDonald’s and Sodexho.
- Cadbury Schweppes, Kraft, Unilever and McDonald’s were the only companies to report engagement on all four fronts.

The study findings on company promotion to its own staff and community on healthy lifestyles and physical activity included the following:

- 10 out of 25 companies reported that they have staff health programs. The five manufacturers were Cadbury Schweppes, Coca-Cola, ConAgra, Kraft and Nestlé. The two retailers were Metro and Rewe. The three foodservice companies were Compass and McDonald's and Sodexo.
- 19 out of 25 reported community programs. The companies not reporting activity were: Masterfoods, Ahold, Aldi, Ito-Yokado, Schwarz and Burger King.
- Of the 19 companies reporting contributions to or support for community program work, 11 were active in hunger programs which are often about giving surplus foods to particular social groups. In the USA, this action is tax-deductible. Companies include: ConAgra, Kraft, Nestlé, Tyson, Carrefour, Kroger, Metro, Rewe, Compass, Sodexo and Yum!
- 16 companies reported activity in nutrition education. The ones who did not were: Cadbury Schweppes, Masterfoods, Aldi, Ito-Yokado, Metro, Schwarz, Wal-Mart, Burger King and Yum!
- Five companies report no action at all in the areas measured here: Masterfoods, Aldi, Ito-Yokado, Schwarz and Burger King. • Companies rated as active in all three areas include: Coca-Cola, ConAgra, Kraft, Nestlé, Rewe, Compass, McDonald's and Sodexo.