

PAHO Regional Consultation of the Americas on Diet, Physical Activity and Health

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A call to action

In May 2002, 191 Member States of the World Health Organization (WHO) mandated that action be taken to develop a global strategy on diet, physical activity, and health (WHO/GS) to guide future efforts and resources in addressing the burgeoning problem of noncommunicable diseases worldwide. To that end, the Pan American Health Organization (PAHO) convened a regional meeting in Costa Rica on April 23–24, 2003. Delegates from 11 countries were in attendance, along with representatives of multisectoral institutions, nongovernmental organizations, and expert members of the scientific community.

In this brief introduction, I would like to address some issues before presenting the reader with a summary of the conclusions of the meeting. The issues are the magnitude of the epidemic of noncommunicable diseases, the key risk factors that need to be targeted and how best to deal with them, and the need for a common nutritional agenda attuned to the changing times.

The problem and the challenges

The impetus of the WHO/GS was a result of recent data demonstrating that noncommunicable diseases and nonintentional injuries represent nearly 70% of all causes of death in the Region of the Americas among those 70 years of age and younger. The disability-adjusted life years (DALYs)* lost to noncommunicable disease risk factors (high blood pressure and cholesterol levels, overweight, low intake of vegetables and fruits, and sedentary lifestyles) among the less developed countries in the region, excluding the United States and Canada, amounts to 12,458,000 DALYs added to the 4,677,000 DALYs lost to childhood and maternal undernutrition [1]. The repercussions of that situation on individuals and families are extraordinary, posing an even greater strain on already frail health-care systems, social services, and personal economic stability. Once thought to be “diseases of affluence,” noncommunica-

ble diseases are far-reaching and indiscriminate, and curing them is much more costly than curing common infectious diseases. All of these factors have contributed during the last decade to create a greater attention to preventive strategies. This is the new challenge to public health in the Americas [2].

Inadequate diets, physical inactivity, and tobacco use are the key health risk factors that account for most noncommunicable diseases and mortality. Thus, targeting those three behaviors is likely to yield better health results than emphasizing a disease-specific preventive approach. This concept was emphasized throughout the Consultation and is probably the most sensible strategy at hand. As was pointed out elsewhere [3], most patterns of unhealthy behaviors are set by the more affluent sectors of society, later to spread and cluster among the poorest. Economic, market, and cultural dynamics are powerful forces in shaping that process, and therefore they must be addressed to achieve the desired behavioral changes (see the report by Nugent [4] in this issue for an in-depth examination of the agricultural ramifications of the noncommunicable diseases issue). For health-conscious individuals, generally in the upper echelons of society, health literacy may suffice, provided material resources and time are plenty. For most that is not the case.

Successful public health interventions have to come to grips with the fact that eating and physical activity are human behaviors that respond to a variety of factors, not just to good information. In fact, individuals generally consider health as just one among many other factors when deciding what to eat and whether to exercise or quit smoking. For instance, in considering whether to make the choice of eating more fruits because that will bring health some 10 years down the road, many other competing factors are at stake. Serious competitors are notably short-term ones, such as convenience, immediate reward, time availability, and price, to cite just a few [5]. This is why public health strategists need to take into account all factors that influence key human behaviors, not only those associated with health motives.

* One DALY is equal to the loss of one healthy life year.

Child nutrition and maternal health are also vital to a long and healthy life. Thus, efforts to promote optimal women's diet and nutrition, healthy pregnancies, exclusive breastfeeding, and adequate complementary feeding not only are the foundation of optimal child growth and development, but also are key to promoting a long life free of noncommunicable diseases. This shows not only a clear convergence of objectives, but also that the underlying nutritional principle is similar: diet quality. In fact, for instance, undernutrition problems in the region focus on several micronutrient deficiencies leading to stunted growth, iron-deficiency anemia, low levels of vitamin A, and women's reproductive risk due to low folic acid levels. Likewise, dietary quality is crucial to preventing nutrition-related chronic diseases, such as cardiovascular disease, diabetes, and obesity.

If a life-cycle perspective is to be adopted, then optimal growth must be emphasized over gaining weight exclusively. By the same token, the age-old concept that a chubby child is a healthy child needs to be reconsidered as a gauge of health and a guide to child-feeding. Alarming escalating rates of obesity in children and adolescents require prompt action on this front. In children as well as in adults, it seems that merely quenching hunger will not necessarily carry health along.

Main conclusions of the working groups

The following is a summary of the regional consultation's two working group discussions and conclusions. Those interested in reviewing complete transcripts of the working group conclusions can obtain a copy upon request to the author.

Diet and nutrition working group

Inadequate diet of the population. In developed and developing countries of the Americas, the available data show an overall low and decreasing level of consumption of fruits, vegetables, whole grains, cereals, and legumes, while the consumption of foods rich in saturated fat and sugar, oils, and meats is on the rise. As Uauy and Monteiro note in this issue [6], those dietary changes are to a large extent supply-driven. The authors argue that the lower price of food as compared with most other commodities, such as education, health, clothing, and communications, coupled with new marketing strategies, has contributed to the aforementioned dietary changes. Priority actions to improve the quality of the population food supply are the development of policies aimed at increasing availability of and access to healthful unprocessed foods; reduction of salt, sugar, and saturated fat in processed foods; and substantial intersectoral collaboration at the national and international level, particularly among health, agricultural, educational, and regulatory organizations.

Inadequate understanding of the problem and lack of public health leadership. There is a preconception that most national public health systems and public health authorities remain unaware of the problem that elevated rates of noncommunicable diseases pose in the region, namely, the high burden of morbidity and mortality that is associated with them. The disproportionate toll of noncommunicable diseases on poorer populations has many negative social and economic consequences. In order to reverse this current situation, it was deemed a necessity to publicly call attention to the catastrophic impact of inaction; hence, the role of WHO and PAHO was perceived as crucial.

Health services should include diet- and health-promotion activities. Most health personnel are far from being active promoters of healthy dietary habits. Specialization and curative approaches are pervasive in most professional training and supported in health systems. Interaction with patients increasingly requires a more integrated approach to behavioral change than mere transmission of health information. The group called for a reorientation of health-care services to provide greater emphasis on disease prevention. Health-care providers should be trained to assess and counsel patients on disease-prevention behaviors, such as improved diet, regular physical activity, and smoking cessation, rather than on disease-specific prevention. Similarly, current nutritional programs aimed at children and women of childbearing age can improve their medium- and long-term health outcomes by focusing on children's growth and development, and by emphasizing quality over quantity in existing nutritional programs and national dietary guidelines.

Better information to the public. In a world saturated with food advertising that more often than not promotes unhealthy dietary habits or makes unfounded beneficial health claims, effective food labeling is recognized as an important resource to consumers. It was also considered necessary that public health systems more often and more consistently employ mass media approaches to develop health literacy. Finally, regulation of advertising was suggested as an option to protect consumers, particularly children.

Physical activity working group

A new paradigm in physical activity promotion. Today the key public health recommendation for preventing or delaying morbidity and mortality is to accumulate a minimum of 30 minutes of moderate physical activity throughout the day, on most days of the week. This recommendation has been well established in the scientific literature and goes well beyond the practice of vigorous sports and aerobics to include more moderate activities such as walking, climbing stairs, dancing, or bicycling, which can be easily incorporated into the daily routine. Health professionals should play an active role

in explaining and promoting the adoption of the new physical activity recommendations.

Public policies and environments for active lifestyles. A successful promotion of an active lifestyle requires more than the best possible public information program. There is a need to establish public policies and norms, in conjunction with environments that enable individuals to remain active for life. Some examples are effective physical education programs in the schools, community walking clubs, good public transportation systems that include rapid motor transportation, encouragement of bicycling and walking, and policies to control crime on the streets.

Multisectoral alliances. The diversity of actions needed to promote physical activity, such as those listed above, requires multidisciplinary as well as multisectoral interventions. Thus, public health efforts should incorporate vital partnerships and alliances with sectors such as transportation, education, local governments, and sports, as well as private industry and nongovernmental organizations. Sometimes the actions of different players converge in practice, although their motives or objectives are not necessarily identical. The

ability to walk peacefully from work to home without running the risk of being mugged is an aspect of quality of life to one person, crime control to others, and physical activity to many in this Consultation.

Role of the health and education sectors in the promotion of physical activity. Disease prevention is now accepted as the most cost-effective way to tackle the epidemic of noncommunicable diseases. Thus, health-promotion activities ought to be part of the health provider's counseling repertoire. Hence, the training of health professionals and the norms of clinical management must reflect the proposed changes in professional practice. Likewise, the education sector has an enormous potential to instill healthy habits of entire generations, provided they keep physical education programs and other health-promotion activities alive and in good shape.

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