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Global Health & Environment MONITOR

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Can a New Diet-Exercise Paradigm Combat The Chronic-Disease Pandemic?

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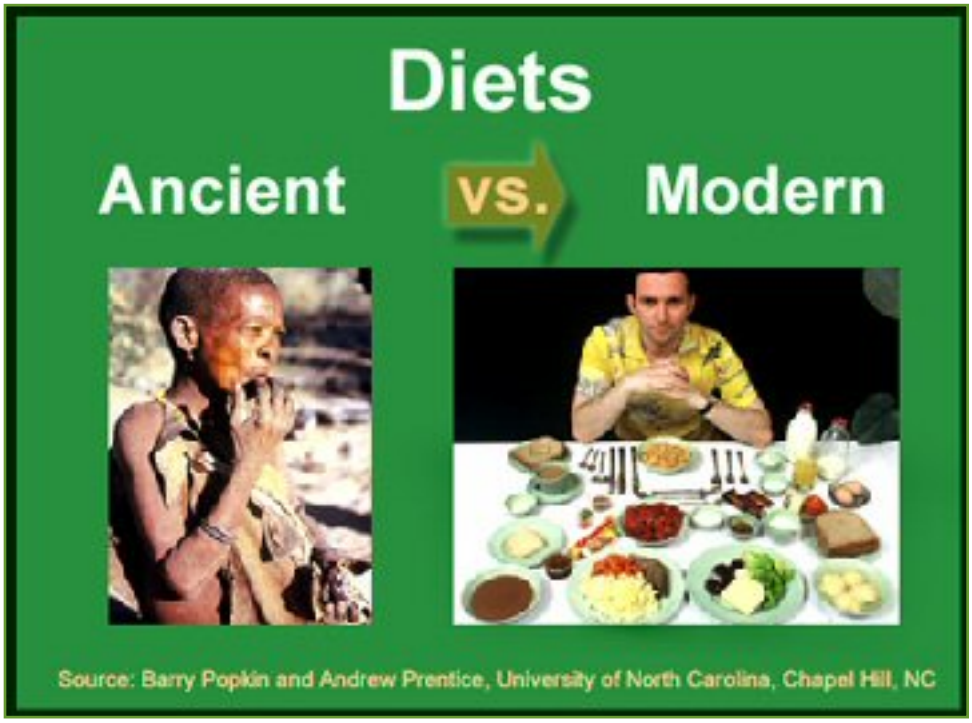
WHO/FAO Tackle Diet-Disease Epidemic

by Dr. Derek Yach, Executive Director, Noncommunicable Diseases and Mental Health, and Dr. Pekka Puska, Director, Noncommunicable Disease Prevention & Health Promotion, World Health Organization, Geneva



Calorie- and fat-laden diets, as well as sedentarism, are major culprits in modern-day chronic-disease pandemic.

"Less saturated fats, sugar and salt, [and] more fruit, vegetables and physical exercise [are] needed to counter cardiovascular diseases, cancer, diabetes and obesity," concludes a joint expert consultation of the World Health Organization/Food and Agriculture Organization (WHO/FAO) in a report on diet, nutrition and the prevention of chronic diseases. Released March 3, 2003, these updated recommendations are based on analysis of the best available evidence and the collective judgment of 30 experts. They are aimed at alleviating the increasing global burden of chronic diseases that the experts attribute to rapid changes in diet and lifestyle accompanying urbanization, economic development and market globalization in recent decades, particularly in developing countries and countries in transition.

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Developing Nations Lead Chronic Disease Epidemic

In 2001, chronic diseases contributed 46 percent of the global disease burden. This proportion is expected to rise to 57 percent by 2020. Contrary to widely held beliefs, however, chronic diseases are already the leading killer in most of the developing world, according to the expert report. In fact, by 2020, developing countries are projected to account for almost three-quarters of all deaths from chronic diseases, and 71 percent of deaths from ischaemic heart disease, 75 percent of deaths from stroke and 70 percent of deaths from diabetes. Indeed, cardiovascular disease (CVD) prevalence in India and China already exceeds the prevalence of CVD in all economically developed countries combined, the experts reported. Similarly, the global epidemic of obesity is not limited to industrialized nations. In parts of Asia, Latin America and Africa, the prevalence of obesity has doubled or tripled over the past decade.

A few, largely preventable risk factors -- high cholesterol, high blood pressure, obesity, tobacco use and low physical activity levels -- account for most of the world's rising chronic-disease burden, according to the WHO/FAO expert consultation. Throughout the world, but more recently and swiftly in developing countries and countries in transition, traditional, largely plant-based diets have been replaced by high-fat, energy-dense diets; simultaneously, there has been a decline in energy expenditure associated with less active lifestyles. In São Paulo, Brazil, for example, between 70 and 80 percent of the population now leads a sedentary life.

Experts Recommend Nutrient and Physical Activity Goals

To reduce the risk of chronic diseases, the experts recommend population nutrient goals, pointing out that, for best results, national and international strategies and policies should recognize the critical role of both diet and physical activity in determining optimal health. Thus, in addition to dietary intake objectives, the experts espouse moderate-intensity physical activity for at least an hour a day.

They also stress that the balance of energy consumption and physical activity, as well as food quality, are key determinants of nutrition-related chronic diseases. Overall, they emphasize that not all fats or carbohydrates are the same and that people should consume less high-calorie foods, especially foods teaming with saturated fats and sugar. In addition to being physically active, they encourage individuals to use less salt; enjoy fruits, vegetables and legumes; and select foods of plant and marine origin.

Specifically, the experts recommend that total fat contribute 15 to 30 percent of daily energy intake, with saturated fats comprising less than 10 percent, n-6 polyunsaturated fatty acids (PUFAs) 5 to 8 percent, n-3 PUFAs 1 to 2 percent, trans fatty acids less than 1 percent and monounsaturated fatty acids making up the rest of the fat-derived energy. The experts further recommend that total carbohydrates make up 55 to 75 percent of total energy, with free sugars (i. e., added sugars) contributing less than 10 percent. In addition, they advise protein comprise 10 to 15 percent of energy intake; salt intake be restricted to less than 5 grams/day; and at least 400 grams of fruit and vegetables be consumed daily. They emphasize consumption of more than 25 grams/day of total dietary fiber, primarily from whole grains, fruits and vegetables.

"The Epidemic Can Be Halted"

According to the experts, countries that have actively intervened in the diets and behaviours of their populations via integrated approaches linking communities, governments, food producers and processing industries have seen dramatic decreases in risk factors and disease rates. In North Karelia, Finland, for example, age-adjusted CVD mortality rates dropped dramatically between the early 1970s and 1995, mostly due to dietary changes assisted by community action and consumer demand. The Republic of Korea, which despite industrialization has largely maintained its traditional high-vegetable, low-fat diet, reports lower rates of chronic diseases and obesity than other industrialized countries with similar economic development. These examples confirm

that "This epidemic can be halted [and] …appreciable changes can occur rapidly," according to the convened experts.

WHO has stated that the expert report will serve as a critical science-based foundation for member states to prepare national health strategies and simple, food-based guidelines suited to local socio-economic conditions, both for individuals and populations. Meanwhile, it is a major step towards formulating WHO's "Global Strategy on Diet, Physical Activity and Health" for the World Health Assembly in 2004. [back to front....]

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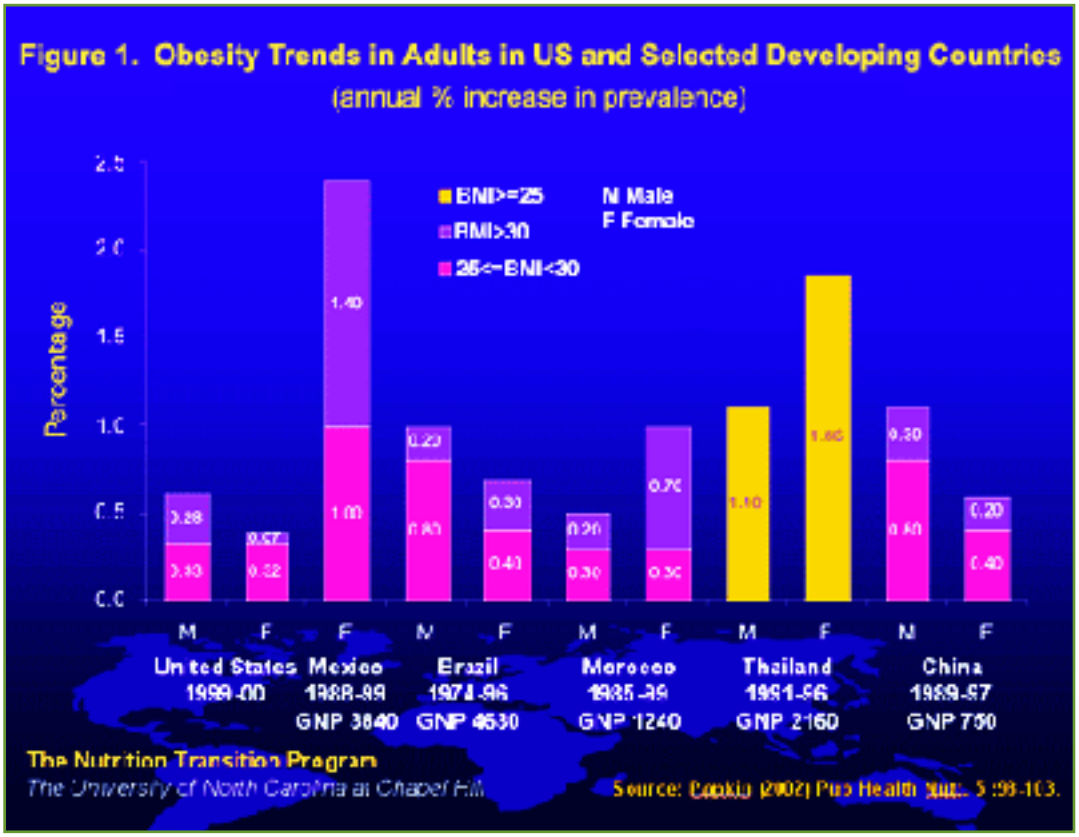
Worldwide Obesity Epidemic Tied To Urbanization, Technological Change

by Barry M. Popkin, Professor of Nutrition, Department of Nutrition, School of Public Health and School of Medicine, University of North Carolina, Chapel Hill

Both developing and industrialized countries are battling obesity.



The incidence of obesity and noncommunicable diseases is up worldwide, and increasing urbanization and technological change are the main catalysts for this remarkably rapid, and decidedly dangerous, rise. In countries as diverse as the United States, Mexico, Egypt and South Africa, levels of obesity and related co-morbidities, such as diabetes and cardiovascular diseases, currently affect 25 to 50 percent of the population. A "nutrition transition," or shift in diet, physical activity, health and nutrition, is the culprit, and can be traced to higher incomes, the influence of mass media and food marketing, and changes in the nature of work and leisure.

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The Nutrition Transition

Urban dwellers have vastly different lifestyles than rural residents. And their alternate patterns of food demand and time allocation have an enormous effect on diet, physical activity and overall health.

- **The urban diet**. Urban residents obtain a much higher proportion of energy from fats and sweeteners, and eat greater amounts of animal products than do rural residents, even in the poorest areas of low-income countries. In China, for example, 38.2 percent of the energy intake of urban adults is derived from fat, compared to 18.7 percent for rural adults. Urbanites consume a more diversified diet, and more micronutrients and animal proteins than rural residents, but they also have a considerably higher intake of refined carbohydrates, processed food, and saturated and total fat, as well as a lower intake of fiber.
- **Physical activity patterns**. New technologies impacting work and leisure, together with shifting diets, have enhanced obesity in urban areas. Body composition has changed in tandem with the transformation of a pre-industrial agrarian economy into an industrial, urban one. Urban occupations now require shorter workdays, and less physical exertion and activity. More than 54 percent of urban, but only 25.5 percent of rural Chinese women aged 20 to 45, for example, have occupations that require light-energy expenditure. Leisure activities have not only become more abundant, but also more sedentary, particularly with the penetration of mass media into the developing world. Almost all Chinese households, for instance, owned at least one working television set by 1997.
- **The obesity epidemic**. Changes in diet and physical activity have accelerated obesity rates in the developing world. In many cases, historically agrarian lower- and middle-income countries such as Egypt, South Africa and Mexico report overweight levels matching those of the United States -- and exceeding those of most European countries. Obesity levels are much higher in urban areas. In Indonesia and China, obesity among adults is twice as prevalent in urban as in rural areas; in the Congo, it is almost six times more prevalent. In general, the Middle East, Western Pacific and Latin America have far higher levels of obesity than other developing regions. In Figure 1, we show the annual rate of change in overweight levels and obesity among men and/or women in selected countries, including the United States, Mexico, China, Brazil, Thailand and Morocco. The rate of change is extremely high in many regions of the world.

The Health Consequences

Diabetes is one critical scourge associated with the obesity epidemic and its corresponding dietary and physical activity patterns. In the United States, Mexico, many Latin American nations, the Middle East and the former Soviet Union, 6 to 10 percent of the adult population has diabetes. Several studies also show that many cardiovascular diseases related to obesity and non-insulin-dependent diabetes mellitus, such as hypertension and atherosclerosis, are increasing rapidly. More recently, cancer rates have begun to escalate worldwide. In China, cancer- and cardiovascular disease-related deaths are increasing fast enough to offset the reductions in infectious disease deaths, as well as to account for increases in total mortality rates.

The Future

Prevention is the only feasible approach to obesity, because the cost of treatment and management imposes an intolerable economic burden on developing countries. There is, therefore, an urgent need for governments, in partnership with health professionals, nongovernment organizations and the food industry, among others, to integrate strategies to promote healthful diets and regular physical activity into policies and programs, including those designed to combat undernutrition. An effective course of action must include community

empowerment and support to overcome the environmental, social and economic constraints to improve dietary quality and reduce sedentarism. Finland and Norway, for example, succeeded in reversing extremely high levels of nutrition-related chronic diseases over a relatively short period through comprehensive food policy and community involvement. With effective public-private partnerships, less developed countries can begin to do the same. [back to front....]

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Welcome to the first fully online issue of CECHE's "Global Health and Environment MONITOR." The focus of this issue is the March 2003 joint World Health Organization/Food and Agriculture Organization report, which sets a new paradigm for reducing the risk of diet-related noncommunicable diseases (NCDs), today's leading killers in both industrialized and developing countries.

NCD gurus Derek Yach and Pekka Puska present highlights of the WHO/FAO report, stressing the rapidly increasing global NCD burden, and its causes and prevention. They focus on developing countries, nations that are neither well-prepared to address the consequences of the diseases nor economically able to implement improved nutrition and increased physical activity -- proposed strategies for NCD prevention. In a companion article, Barry Popkin reports on the global obesity epidemic as an NCD risk factor, and looks at its causes, consequences and proven strategies for prevention.

In the Insider's View, Michael Jacobson and Bruce Silverglade point to the still unfinished business of making healthy diets the "norm" for successfully preventing NCDs, and emphasize the need for bold actions, not just policies, that target the food and agricultural industries.

The Features section (formerly the Centerfold) spotlights two strategies for NCD prevention. The first, from the United States, is the Produce for Better Health Foundation's "5 A Day" program to promote the consumption of at least five daily servings of vegetables and fruit. The second, from Finland, comprises Ilkka Vuori's rationale and recipe for increased physical activity to reduce NCD risk, a strategy that has already produced results in Finland and several other European countries.

Policy Beat reveals the implementation and implications of the WHO/FAO report in the United States and around the globe, as addressed by public health policy veterans J. Michael McGinnis, J. A. Grisso and Kaare Norum.

Finally, through the eyes of CECHE Vice Chairman Mark Palmer and Syracuse University-CECHE scholar Kalyani Subbiah, CECHE News presents the latest on our organization's Global Democracy for Global Health project and application of the Health Belief Model in South India.

CECHE will continue to deliver pertinent information on current issues and events, and believes the online MONITOR will expand our ability to do so. To ensure our success, we invite comments on site content, structure and navigation, and welcome suggestions for upcoming issue topics.

Sushma Palmer

Sushma Palmer, D.Sc.
Chairman, CECHE

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"5 A Day The Color Way" Campaign Encourages Americans to Eat Their Colors Every Day

by Elizabeth Pivonka, Ph.D., President, and Frances Taccone, Ph.D., R.D., Development Director, Produce for Better Health Foundation, Wilmington, Delaware

While most Americans are aware that eating vegetables and fruit is important to a healthy diet, current trends are alarming: Vegetable and fruit consumption is declining; obesity is on the rise; and many consumers are replacing vegetables and fruit with high-calorie foods. In fact, just one in five Americans meets the USDA recommendation for consuming at least five servings of fruits and vegetables each day, according to the Produce for Better Health Foundation (PBH), a non-profit organization that promotes fruit and vegetable consumption. Furthermore, just 13 percent of American families with children and 44 percent of Americans over age 65 consume five daily servings of vegetables and fruit. Overall, vegetable and fruit consumption has declined nearly 14 percent over the past decade, from 874 annual servings per capita in 1992 to 754 in 2002.

Meanwhile, the science behind the health benefits of eating vegetables and fruit has grown stronger. A range of epidemiological studies over the last several decades from around the world demonstrate that frequent consumption of vegetables and fruit is associated not only with a reduction in cancer risk, but also with a lower risk of developing hypertension, myocardial infarction, coronary artery disease, cataracts, and asthma and other lung diseases. In addition, regular intake of vegetables and fruit may help maintain memory and promote healthy aging, urinary tract health, strong bones and teeth, and healthy body weight and blood sugar levels. (Download "The Health Benefits of Fruits & Vegetables" from www.5aday.com\.) While the mechanisms by which vegetables and fruit might improve human health are not fully known, there is ample scientific basis on which to recommend eating five to10 servings of vegetables and fruit each day.

The *5 A Day for Better Health* program was specifically designed to do just that: recommend -- and increase -- vegetable and fruit consumption among Americans. Started as a pilot project in 1988 at the California Department of Health with a grant from the National Cancer Institute (NCI), the program rapidly gained support and went national in 1991. PBH was founded to work with NCI on this national program. Over the next decade, the foundation delivered the "5 A Day" message via hundreds of supermarket produce departments, the media, and vegetable and fruit growers licensed to use the "5 A Day" logo on certain produce.

In addition, NCI funded nine "5 A Day" research projects, conducted public relations outreach, and managed "5 A Day" coordinators in every U.S. state and the military. In 2001, NCI expanded the program to include the Centers for Disease Control and Prevention, and several parts of the U.S. Department of Agriculture. Together with the American Cancer Society and other industry and public health groups, the institute also formed a *National 5 A Day Partnership*, governed by a steering committee of 10 members and chaired by PBH.

PBH unveiled its "Color Way" campaign in October 2002, urging consumers to eat a colorful array of vegetables and fruit, including at least one daily serving from each of five color groups -- blue/purple, green, white, yellow/

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orange and red. The campaign features: consumer relations materials; a store retail program; a TV public service announcement; national public relations; a redesigned Web site (www.5aday.com); school cafeteria posters; and a nutrition education program reaching 1 million school children in partnership with the makers of Crayola crayons. The "Color Way" campaign and "5 A Day" intervention may have played a role in the slight increase in vegetable and fruit intake recorded between 1991-1997 by the USDA's "Continuing Survey of Food Intake By Individuals." And without this intervention, the decline in consumption witnessed in the last decade would have been much greater, PBH estimates.

More recently, PBH has been working with the World Health Organization (WHO) to bring together nations around the globe to share "5 A Day" implementation strategies. The 3rd International "5 A Day" Symposium, convened in Berlin in January 2003, was the culmination of this joint effort. Next steps -- in the works with WHO -- include a *Global 5 A Day Partnership* scheduled for Rio de Janeiro in November 2003.

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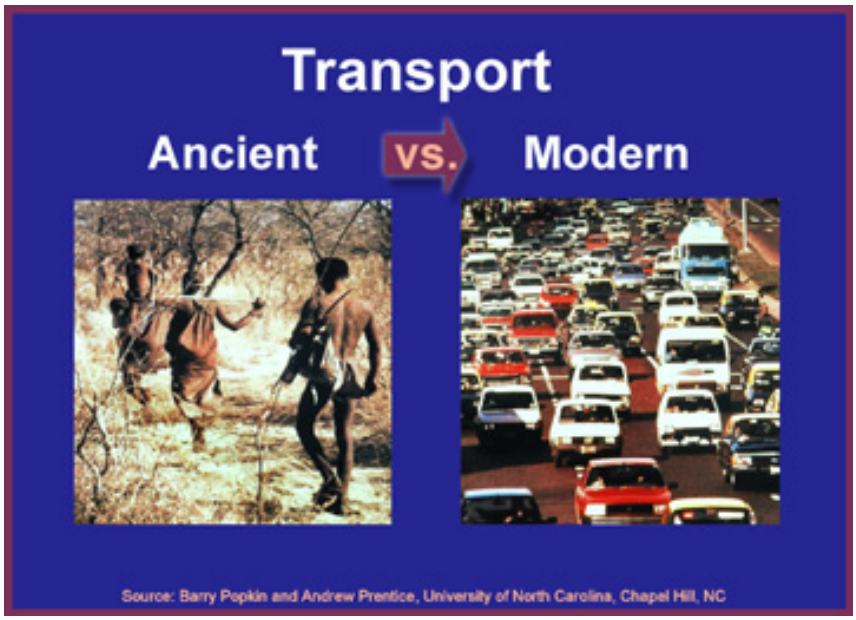
Sedentarism Rises, Becomes Global Health Hazard

by Ilkka Vuori, M.D., Ph.D., Temporary Physical Activity Expert, World Health Organization (Geneva), Tampere, Finland

Traditionally, prevention of chronic noncommunicable diseases (NCDs) focused on tobacco control and improved diet. In its new NCD prevention strategy outlined in a 2003 report on diet, nutrition and the prevention of chronic diseases, the World Health Organization (WHO) underscores increased physical activity as a key component. This new emphasis, first introduced by WHO in 2002, is based on several facts. Firstly, convincing scientific evidence reveals that a lack of physical activity, or sedentarism, substantially increases (as much or even more than most other common risk factors) the probability of several of the most common NCDs, including cardiovascular disease (CVD), diabetes, certain cancers and obesity, a major NCD risk factor. Secondly, sedentarism is common -- more prevalent that most other NCD risk factors, and it is rapidly increasing in most countries worldwide. Thirdly, the health consequences of sedentarism can be abolished or diminished substantially by moderate, feasible physical activity. And finally, increasing physical activity to sufficient levels to benefit health at individual and population levels is possible and economical, and may confer social and environmental advantages.



The Facts

Sedentarism causes 1.9 million deaths annually around the globe; and it accounts for an estimated 8 to 10 percent of all deaths in Eastern Europe alone, where physical inactivity is particularly common. In the elderly, sedentarism increases the risk of serious bone fractures by as much as 50 percent and may accelerate loss of independence by several years. Physical inactivity also doubles the risk of becoming obese and is undoubtedly a major factor in the global obesity epidemic. Conversely, enhanced physical activity substantially attenuates the risks associated with obesity, even without significant effect on body weight.

Although it is widely accepted that 30 minutes of moderate-intensity activity a day is sufficient to maintain good cardiovascular and metabolic health, WHO recommends 60 minutes a day of moderate-intensity exercise, such as brisk walking, to maintain healthy body weight, attain greater health benefits and avoid obesity. Sixty minutes of physical activity is particularly important for people with sedentary occupations.

Currently, at least 60 percent of the world's population does not meet even the 30-minute minimum. Meanwhile sedentarism is estimated to cause about 22 percent of all ischaemic heart disease and 10 to 16 percent of all ischaemic stroke, diabetes, colon cancer and breast cancer around the globe. Sedentarism also ranks seventh among WHO's risk factors for disease burden in developed countries, accounting for 3.3 percent of disability-adjusted life years. Added to elevated blood pressure, high cholesterol, overweight levels and obesity, the disease burden attributed to sedentarism increases substantially.

The financial costs of sedentarism are also high: In Canada, it accounts for about 6 percent of total health care costs. In the United States, physical inactivity together with obesity comprised 9.4 percent of the national health expenditure (US$94 billion) in 1995.

Obstacles, Potential for Risk-Reduction and Strategies for Success

Physical inactivity continues to rise with the use of machines and automation at work, in transportation and for domestic chores. Meanwhile, few populations worldwide, including people in affluent societies, practice compensatory physical activity in leisure pursuits. In developing-country metropolises and among socially

disadvantaged groups, traditions and lack of awareness are serious obstacles. In China, for example, bicycling, as a means of transportation, is rapidly decreasing -- without a compensatory increase in leisure-time physical activities because of a lack of tradition and opportunities.

This is disheartening news, especially since the risk-reduction from increased physical activity for several NCDs has been demonstrated in women and men, elderly subjects and high-risk groups. Two randomised controlled trials, one in the United States in 2002 and the other in Finland in 2001 revealed that modest changes in diet and physical activity decreased the development of new cases of type 2 diabetes by 58 percent within three years among high-risk middle-aged women and men.

Successive national physical activity programs in Finland since 1991 indicate that it is possible to maintain, and even expand, participation in leisure-time physical activities among various population groups. Several examples from major European cities demonstrate that walking and cycling as modes of transportation can be substantially increased. Bicycling grew by 7 to 16 percent in Basel, Switzerland, Graz, Austria and Hannover, Germany, and rose 29 to 43 percent in Delft, The Netherlands and Munster, Germany within a 10- to 20-year period as a result of cycling networks and traffic calming, for example. Maximum benefits, however, can be achieved only by comprehensive, long-term measures that combine individual, population and environmental approaches; meet the needs and expectations of the targeted subjects; use a variety of settings; emphasize local initiatives and actions; and support sustained collaboration among multiple partners in both governmental and nongovernmental sectors.

The first step is to win sufficient political support and commitment. This requires raising public awareness of the health benefits of physical activity. The experiences of the United States, Canada, several European countries and major international organizations such as WHO demonstrate that it is possible to apply such strategies and mobilize resources to increase health-promoting physical activity.

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Reversing the Nutrition Transition: Advocacy and Action, Not Reports, Are Key

by Michael F. Jacobson, Ph.D., Executive Director, and Bruce Silverglade, Legal Director, Center for Science in the Public Interest, Washington, D.C.

The March 2003 World Health Organization/Food and Agriculture Organization Joint Expert Consultation's report is a wake-up call to citizens and governments around the globe, reminding them that over-nutrition is a major cause of lost quality of life, illness and premature death. (Indeed, for non-smokers, diet is the leading cause of death in many countries.)

The report does not break new ground. Yet it is especially significant, because never before has an authoritative global agency weighed in so clearly on diet as a cause of chronic disease.

The report focuses on the main dietary culprits that cause hypertension, stroke, heart disease, certain cancers and diabetes -- in brief, the consumption of too few fruits, vegetables and whole grains, and too many salty foods, fatty meats, dairy products, soft drinks and other foods made with refined sugars. And it comes to essentially the same conclusions that other influential reports published by the U.S. Congress, U.S. National Academy of Sciences, U. S. surgeon general, World Cancer Research Fund and the World Health Organization (WHO) itself reached during the two decades spanning 1977 to 1997. Regardless of objections from the food industry and some nutrition professionals, the consistency in message in these reports reflects the near unanimity among scientists on the dietary contributors to chronic diseases.

"A ton of soft drinks -- an anathema to obesity, diabetes, heart disease..."

Scientific consensus on the causes of chronic disease should set the stage for policy action to reduce rates of these diseases. However, the WHO report does not include recommendations for policies that governments could adopt to help their citizens consume healthier diets. That absence is no oversight. A draft of the report recommended nutrition labeling on packaged foods, taxing less healthful foods and restricting their advertising to children, and subsidizing the costs of healthful foods. But more than 20 American food trade associations urged U.S. Secretary of Health and Human Services Tommy Thompson to tell WHO not to include such recommendations in its report. On July 2, 2002, Thompson acquiesced, saying, "... it is premature to use available data to develop national food and nutrition policy without further evidence." The food industry in the United States and possibly elsewhere also pressured WHO directly.

WHO plans on putting policy advice in a future report, but nongovernmental organizations and health experts need not wait to advocate sensible measures to help turn the tide of diet-related chronic diseases.

A Nutrition Transition Gone Wrong

The seemingly inexorable drift toward unhealthy eating habits is happening everywhere, from wealthy countries in North America and Europe to developing nations in Asia and Latin America. Populations that once ate diets low in salt and saturated fats, and high in whole grains and legumes have undergone a "nutrition transition"; today they

consume diets high in salt, saturated fats, and refined sugars and flours, and low in fruits, vegetables and legumes. In the wake of this transition comes, in the words of *The Wall Street Journal*, "an explosion in preventable diseases once found mainly in developed nations."

The nutrition transition has many causes, from the seductive taste of fatty, sugary and salty foods to inflated industry marketing budgets. Preventing and reversing the transition, and protecting the health of people in developing nations, will take more than learned reports and earnest, wishful thinking. It will take citizen outrage and government action.

The Road to Redemption Is Clear

In the United States, the nonprofit Center for Science in the Public Interest sponsored media campaigns in several communities that led to major increases in the proportion of low-fat milk consumed (see http://www.cspinet.org/reports/obesity.pdf). And even with paltry funding, programs like "5 A Day" have contributed to increased fruit and vegetable consumption.

But the impact of campaigns in a few small communities is negligible compared to the need. Major funding and creative laws are necessary if healthy diets are to become the norm rather than the exception. To this end, health advocates should consider:

- Price subsidies or consumer rebates to encourage fruit and vegetable consumption, as well as providing schools with free fruits and vegetables to promote better dietary patterns in children
- Paid-media campaigns to promote the consumption of more fruits and vegetables, and less meat, whole milk, cheese, butter, soft drinks, candy and processed foods
- Restrictions or taxes to discourage the use of hydrogenated shortening, coconut oil and other highly atherogenic, or artery-clogging, fats
- Duties on foods high in saturated fats or added sugars to generate revenues to sponsor dietary-change campaigns or to subsidize the costs of healthful foods
- Nutrition information, as well as alerts, on products high in saturated fats, added sugars and salt
- Requirements for chain restaurants to post the calorie content next to every item on menu boards and menus.

Such actions could help reverse the nutrition transition -- and its impact on chronic-disease rates -- before it's too late.

The authors invite nutrition advocates around the world to contact them for further information or assistance on policy advocacy via e-mail at mjacobson@cspinet.org.

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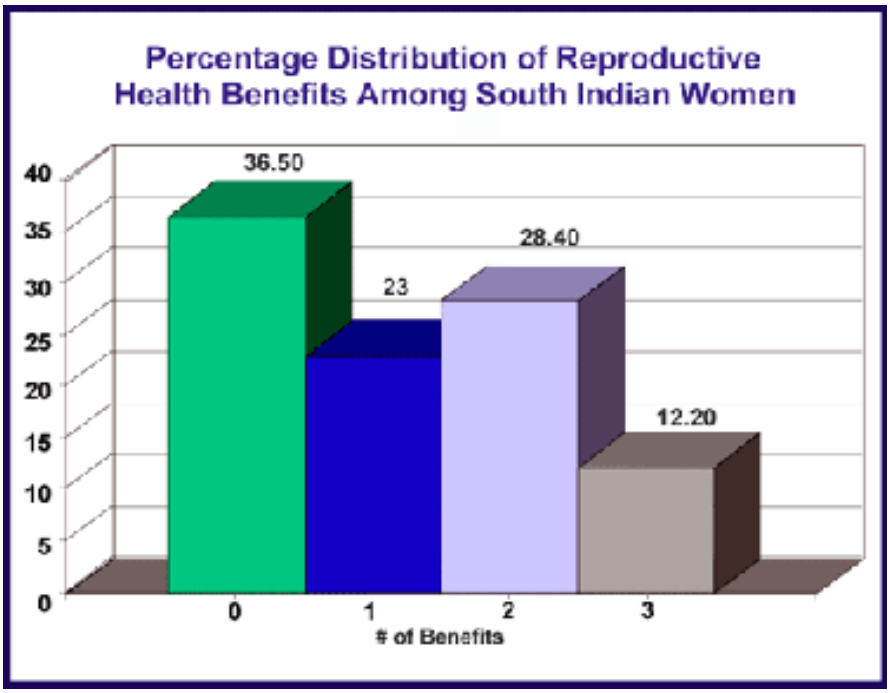
CECHE-Sponsored Study Among Women in South India Reveals Cultural Roots of Reproductive Health Behavior

While knowledge of family planning is almost universal in India, only 36 percent of married women aged 13 to 49 currently use modern contraception there. To examine the impact of health beliefs on family planning in the country, CECHE-sponsored Syracuse University graduate student Kalyani Subbiah interviewed 74 economically and educationally disadvantaged women in Chennai, South India in September 2000. The survey assessed both the women's health beliefs toward family planning, and the cultural and social factors impacting these beliefs. National health professionals were also interviewed for additional qualitative insights on reproductive health, beliefs and behavior focused on contraceptive usage, childbearing and sources for reproductive health information.



Regression analysis revealed that perceived benefits were the strongest predictor of good reproductive health behavior, defined as using contraception, having access to health care and citing doctors as a source of contraception.

A detailed analysis of the perceived benefits related by study participants revealed that nearly two-thirds (63.6%) of the women reported at least one, and as many as three, benefits for using contraception. (See chart.) Among the reported benefits were: a better lifestyle for children; affordability; freedom from fear of an unwanted pregnancy; recommendation by physicians for improving health; time to regain lost strength between pregnancies; spacing between children; and permanent contraception as an alternative to abortion. Two in five of the women (40.6%) enjoyed two or three benefits.

The most commonly cited reasons for using contraception were affordability and a better lifestyle for children. To the women, affordability seemed to imply economic constraints that could not support repeated pregnancies or many children. This point was illustrated by the following participant response: "My husband lost his job, and he asked me to undergo sterilization. We could not afford another child or even another abortion."

A better lifestyle for children meant that the women could lavish more resources and attention on their existing children. As one woman reported, "I underwent sterilization after two children. I wanted to give them the best life possible, and the only way I could afford to was if I stopped having more children." Another participant emphasized, "I have only one desire -- that my children should have a life that is not like mine. For that, I will do anything -- sacrifice my health, needs, happiness…and maybe even my life."

These responses, among many others, demonstrate that the surveyed women are not motivated by self when it comes to reproductive health behavior, but by the needs of their relatives and children -- by the larger unit, the family. Such culturally rooted reproductive health behavior among women has vast implications for future health education.

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Democracy, Good Health Remain Inextricably Linked

In April 2003, CECHE's vice chairman, Ambassador Mark Palmer, traveled to Qatar to meet with more than 100 Arab media, government and academic leaders, and to address a session on the role of the media and democracy in fulfilling the health and other needs of the Middle East. Echoing the United Nations Development Programme's 2002 *Arab Human Development Report*, a number of the leaders and session participants pointed to the gap in freedom, gender and knowledge as impeding the region's progress in health and other fields. Women from several Arab countries spoke out strongly about the need for reform. Meanwhile, the emir of Qatar introduced a new constitution that enables women to play a full role in his country, including voting in national elections.

Major change is in the air, and CECHE is active in the region, encouraging democracy through its Global Good Health Through Global Democracy by 2025 program. This project recognizes that key among the issues linking health and human rights are the universal and equal entitlements to good health and access to good health care -- rights that are often denied to citizens in certain nations.

The circumstances surrounding the outbreak of severe acute respiratory syndrome (SARS), which spread outwards from China across the world in late 2002 and early 2003, is a stark reminder of the inextricable link between honest and clear communications, better health and a clean environment -- CECHE's founding objectives -- and the growth of democracy and human rights. It took four months for communist political leaders to permit public health officials in China to share information about the SARS outbreak in Guangdong province with the World Health Organization (WHO), and another month of heavy international publicity and pressure to allow visits and access to data. But even in mid-April 2003, the head of WHO's Beijing office noted that the international community did not trust China's statistics.

According to veteran *New York Times* China correspondent John Pomfret (himself married into a Chinese family), "From the start, China's reaction to the disease was textbook Chinese communism."

"The SARS epidemic is not just a 'misstep' by the leadership in Beijing, but an endemic problem of the regime… placing an obsessive view of power above the interests, and the very lives, of its people," agreed the oppressed traditional Chinese health and spiritual group Falun Gong. Conversely, one retired senior Chinese official said the government response to SARS "will create new expectations among the masses. The old equation, 'We rule and you have no rights,' is finished now." (*Washington Post*, April 22, 2003)

The interplay between health and the need for democracy is clear. A more transparent, democratic government which had to answer to a free press would have informed its own people and the world much earlier, thereby saving many lives in China and beyond. This phenomenon -- reluctance by nondemocratic countries to divulge accurate and timely information about health crises -- is not new. Tragically, we have witnessed it before in China in the case of AIDS when leading activist Wan Yanhai was jailed for "revealing state secrets" upon publicizing a government report that proved Henan province officials privately knew about the extent of HIV infections. (*Washington Post*, April 27, 2003)

Initiated in 1999, CECHE's first democracy and health venture involved conceiving, organizing and participating in history's first meetings of the world's democratic governments and democratic nongovernmental organizations. The move caught the attention of *The Wall Street Journal*, which heralded Ambassador Palmer as "one of the architects of the first global conference to promote worldwide democracy." That conference was held in Warsaw, Poland in June 2000. Recent democratic breakthroughs in Mexico, Yugoslavia and Kenya, and serious first-time discussions and movement towards democracy in the Middle East, encourage us to persevere.

The second meeting of the world's democracies and democrats took place in Seoul, South Korea in November 2002 and endorsed an action agenda emphasizing regional cooperation in Asia, Africa and the Middle East -- where the major challenges to democracy are located. The next meetings are scheduled for Chile, Mali and Portugal.

CECHE is at work on, and in, a number of key countries and regions. For example, we support the Falun Gong,

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which continues to be repressed by the Chinese leadership. Meanwhile, one of our first objectives -- formation of a democracy caucus at the United Nations -- is already a reality.

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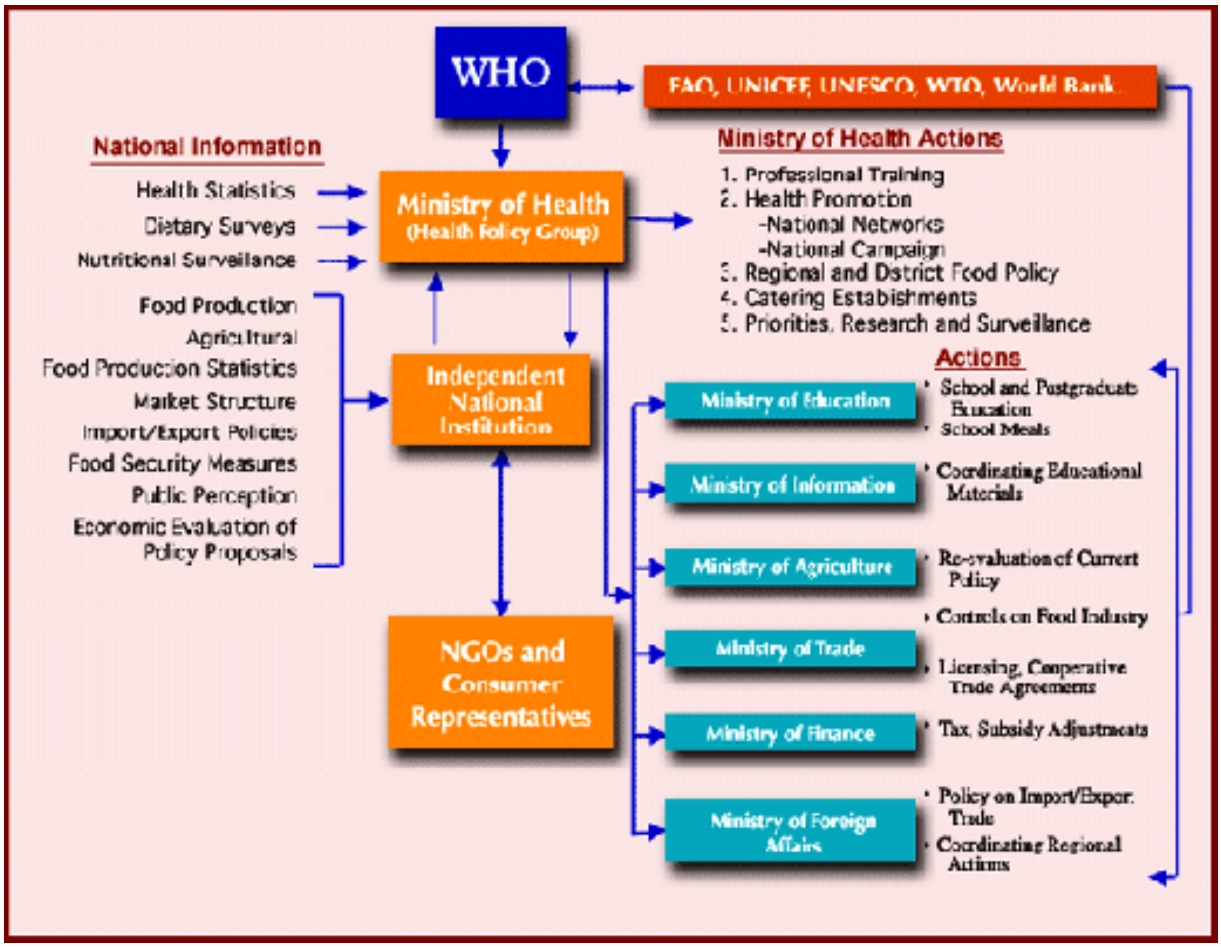
Effective NCD Prevention Calls for Central WHO Involvement

by Professor Kaare Norum, Institute for Nutrition Research, University of Oslo, Norway

Noncommunicable diseases (NCDs) are increasing worldwide. The challenge is to get countries, particularly developing ones, to focus on NCD prevention now to curtail this rapid and devastating spread.

The World Health Organization/Food and Agriculture Organization (WHO/FAO) report "Diet, Nutrition and the Prevention of Chronic Diseases" is central to WHO's strategy for diet, physical activity and health, as it provides a solid scientific basis for policy decisions and action items. The report's proposed strategy to prevent NCDs -- prevention is far more cost-effective than treatment -- must consider the impact of issues such as urbanization, and the unhealthy diets and sedentary lifestyle it tends to promote. Interestingly, this prevention could follow much the same policy in both developed and developing countries: healthier diets and enhanced daily physical activity.

The practical steps and measures to prevent NCDs would be different, however. To this end, WHO has consulted with member states in the six regions of the world (Africa, America, the Middle East, Southeast Asia, Europe and the Pacific) to identify problems, and discuss policies and measures best suited to developed and developing nations. For instance, both Norway and Thailand, one developed and one in-transition country, have implemented effective nutrition policies, which could serve as models for other nations.



Norway's policy encompasses increased self-sufficiency on a healthy food supply, regional distribution of health-promoting foods such as vegetables and fruits, and a sustained campaign to reduce saturated and total fat intake, as well as the monitoring of coronary heart disease, high blood pressure and blood lipid concentrations. In Thailand, social, educational, health and agricultural issues have been coordinated at every level of government and coupled with a grassroots campaign. The impact of these policies has been remarkable: In Norway, deaths attributable to

coronary heart disease were halved over a 20-year period, and in Thailand the prevalence of underweight preschoolers fell from 50 percent to 10 percent over 10 years.

In addition to pursuing national prevention strategies, WHO is consulting with U.N. agencies, nongovernmental organizations (NGOs) and international food companies to compile a global strategy for diet, physical activity and health. Both global and national strategies must be comprehensive, addressing multiple risk factors, maintaining a long-term perspective and involving all sectors of society with a multidisciplinary and participatory approach. Such strategies must also be part of a larger political effort for better nutrition and public health.

The importance of combining international and governmental policy and public/private partnership to create an environment conducive to appropriate dietary and physical activity patterns cannot be understated. Action should be based on needs assessments and solid evidence; however, baseline data are not easily obtained in many countries. Thus WHO must help, providing the leadership and technical support necessary to achieve this and other goals critical to strategy development and implementation.

The accompanying chart suggests the role WHO should play and the collaboration necessary between WHO, its member states and other U.N. agencies. The chart positions WHO as the leader and the lynchpin, uniting global resources for a common health cause. The Ministry of Health also plays a central role, yet it must collaborate with independent institutions and NGOs to get pertinent data, while partnering with other ministries, all of which are responsible for different tasks and actions. Furthermore, to ensure tangible results, WHO and its member states must encourage food companies to curb their intense marketing of unhealthy fast food, sweet drinks and snacks (especially to children).

The key is collaboration -- and cooperation -- and policies that support these values. No one organization, person or entity can curb a global problem. It is up to teams, partners in program, to wield the scepter of NCD prevention and facilitate world health.

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Convergence in Guidelines for Prevention of Chronic Diseases Dictates Lifestyle Change for Americans

by J.A. Grisso, M.D., M.Sc., Senior Program Officer, and J. Michael McGinnis, M.D., Senior Vice President and Director, Health Group, The Robert Wood Johnson Foundation, Princeton, NJ

The comprehensive and far-reaching World Health Organization/Food and Agriculture Organization (WHO/FAO) report "Diet, Nutrition, and the Prevention of Chronic Diseases" is particularly timely for a U.S. population facing an unprecedented obesity epidemic. It offers the prospect of collaborative WHO-FAO policies and programs to foster global initiatives that promote changes in agricultural production, food production and marketing, and economic development to elicit dietary behavior important to better health.

The urgency for change is compelling. Sixty-one percent of U.S. adults are overweight, and the prevalence of obesity in the country (31 percent) nearly doubled from 1980 to 1999. In children, overweight levels have tripled among adolescents and more than doubled among younger children since the 1970s, placing U.S. youths at increased risk in later years for heart disease, hypertension, diabetes mellitus and various cancers. The shift to micronutrient-sparse/energy-dense diets high in fat and simple carbohydrates, coupled with increasingly sedentary lifestyles at work and home, are key contributors to the problems and issues addressed in the report.

Dietary Guidance and Policy in the United States

Three organizations are central to the development and administration of dietary guidance and policy in the United States: the U.S. Department of Agriculture (USDA), the U.S. Department of Health and Human Services (DHHS) and the nongovernmental Food and Nutrition Board (FNB) of the National Academy of Science's Institute of Medicine. The "Dietary Guidelines for Americans" are the official U.S. dietary guidance developed jointly by USDA and DHHS by law. These guidelines, which include a graphic representation called the "Food Guide Pyramid," are updated every five years, and are based in part on "Dietary Reference Intakes" (DRIs) developed periodically by the FNB.

Comparison of WHO/FAO and U.S. Recommendations

The WHO/FAO recommendations and the Dietary Guidelines (as well as the DRIs) are generally similar with respect to fats, cholesterol, protein, carbohydrates (including grains, fruits, vegetables, free sugars and fiber), sodium chloride and daily physical activity. (See chart.) While the WHO/FAO report tends to present recommendations as percentages of energy intake and the U.S. guidelines as daily servings of fruits, vegetables and whole grains, their conclusions, both regarding carbohydrates and other nutrients, are comparable.

The WHO/FAO report also includes separate recommendations for preventing obesity, diabetes, cardiovascular diseases, cancer, dental diseases and osteoporosis. While the Dietary Guidelines do not present an extensive scientific review, such reviews are produced or commissioned as part of the process of developing the guidelines.

COMPARISON OF WHO/FAO AND U.S. RECOMMENDATIONS FOR DAILY DIETARY INTAKE AND PHYSICAL ACTIVITY

	WHO/FAO Recommendations	*Dietary Guidelines for Americans*	FNB *Dietary Reference Intakes*
Total fats	15-30% [a]	<or= 30%[b]	25-35%
Saturated fatty acids (SFAs)	< 10%	< 10%	As low as possible
Polyunsaturated fatty acids (PUFAs)[c]	6-10%		

n-6 PUFAs	5-8%	5-10%	
Trans fatty acids	< 1%		As low as possible
Cholesterol	<or= 300 mg	<or= 300 mg	
Protein	10-15%	4 servings (~ 10-15%)[b]	10-35%
Carbohydrates	55-75% (% total energy minus protein & fat)	6-11 servings Bread, Cereal, etc., group[b]	45-65%
Total dietary fiber	> 25g from foods[d]	> 25g	38g & 25g for men & women<= 50 yrs
Free sugars	< 10%[e]	12 tsps[f] or < 10%	< 25%
Sodium chloride	5 to 6g (iodized)	5 to 6g	
Fruits and vegetables	At least 400g	5-9 servings (~120g each)	
Physical activity of moderate intensity	At least 30, pref. 60, min.[g]	At least 30 min.	At least 60 minutes

[a] Percentages mean total daily energy consumed. [b] Also note recommendation: 2-3 servings each from Meat, Poultry, Fish, Dry Beans, Eggs and Nuts Group, and from Milk, Yogurt and Cheese Group. [c] n-3 PUFAs1-2%; Monounsaturated fatty acids Total fat minus (SFAs + PUFAs + trans fats). [d] Preferably from whole-grain cereals, fruits and vegetables. [e] All added monosaccharides and disaccharides, plus sugars naturally present in honey, syrups and fruit juices. [f] For a 2200 calorie diet only; less for fewer calorie diets. [g] Recommended duration varies with focus: cardiovascular risk reduction or weight reduction.

The Challenge to U.S. Policy-Makers, Food Marketers and Consumers

Both the WHO/FAO report and the Dietary Guidelines emphasize lifestyles that are active, as well as diets that feature fruits, vegetables and whole grains; are lower in free or added sugars, salt and fats (especially saturated fats); and maintain body weights within desirable ranges. For Americans, however, neither the WHO/FAO recommendations nor the Dietary Guidelines adequately address portion sizes and increased consumption of nutrient-empty, calorie-dense foods.

Over the last 20 years, more Americans are eating away from home, consuming more energy per meal and more snacks, and increasing total energy intake. Not surprisingly, these trends have led to an alarming rise in overweight levels and obesity. Despite policies for labeling of food products and prepared meals, improvement in American dietary patterns is hindered by the absence of effective incentives to motivate consumers to eat smaller portions and to substantially reduce their reliance on "nutrient-lite/calorie-dense" foods.

Similarly, the emphasis on fruits, vegetables and carbohydrates needs to be clarified for U.S. consumers to ensure that these recommendations are not misinterpreted and taken as a suggestion to consume more sweetened, refined food products. This, coupled with evolving insights into dietary fat components and uncertainties about appropriate protein targets, suggests that the Food Guide Pyramid needs to be redesigned to bring the graphic representation more in line with the recommendations.

Finally, improving the specificity and utility of food guidance and nutrition programs in the United States requires better baseline and trend data on nutrient intakes and food consumption from efforts in nutrition monitoring and nutrition research. Until we can discern more accurately what people are eating, where and why, our capacity to develop guidance and incentives that yield better dietary patterns will be limited.

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