

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

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

Background

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

Development of the global strategy

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

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Preface

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

As a result of the consultation in the African Region, the following key issues were identified and recommendations to address them formulated: the double burden of communicable diseases (especially HIV/AIDS, malaria and tuberculosis) and NCDs at a time of serious financial constraints for governments and individuals; the coexistence of various forms of malnutrition – undernutrition, micronutrient deficiencies and overweight and obesity – and related problems of food supply and quality; cultural constraints, including current perceptions of overweight and obesity. Also of concern is provision of regular physical activity, especially for girls and women; and of suitable open spaces and sports facilities for physical activity. Capacity-building at national level will be important to support NCD prevention and management activities; as will the availability of culturally sensitive information, education and communication materials aimed at promoting appropriate behavioural change. This report summarizes the discussions at the consultation and outlines the recommendations made.

1. Introduction

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

Four factors in the epidemiology of these diseases – poor diet, physical inactivity, tobacco and alcohol use – are of overwhelming importance to public health. Diet and physical activity have recently been the subject of intensified high-level attention by a Joint WHO/FAO Expert Consultation on Diet, Nutrition and the Prevention of Chronic Diseases.² The report of the Expert Consultation makes recommendations, inter alia, for optimum nutrition and for worldwide action to stimulate physical activity within a health context. WHO is currently developing a global strategy on diet, physical activity and health to give effect to these and other recommendations.

The African regional consultation on the development of the global strategy was held in Harare, Zimbabwe from 18 to 20 March, 2003, and was attended by participants from 14 Member States, regional representatives of FAO and UNICEF, scientific experts, and WHO regional and headquarters staff (Annex). Dr Francis Ofei (Ghana) and Dr Izaak Odongo (Kenya) were elected as Co-Chairmen, and Mr Ibahim Napuli (Ghana) and Dr Kagnassy Dado Sy (Mali) as Rapporteurs.

Dr Mohammed Belhocine (Director, Division of Noncommunicable Diseases, WHO Regional Office for Africa), welcoming the participants on behalf of the Regional Director, Dr Ebrahim M Samba, said that current developments in global health – the emergence and re-emergence of communicable diseases, the increasing burden of morbidity and mortality due to NCDs and the rise in risk factors for those diseases – called for a clear strategic vision, and concrete and concerted action by Member States, WHO and other health partners. An important example of such action was the development of the Framework Convention on Tobacco Control, to which the African group of countries had made a major and unified contribution, placing public health concerns above all other interests. The development of a global strategy on diet, physical activity and health would complement that and other WHO activities related to the prevention and control of NCDs. The African regional consultation was an important step in the process, and he urged participants to share their experiences and, on their return home, to advocate for the adoption and successful implementation of the global strategy.

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

After a series of presentations by WHO staff, scientific experts and country representatives (summarized in sections 2 and 3), the participants examined the situation in countries in the African Region, priorities for action and key players in three areas: diet and nutrition; physical activity; and information, education, social mobilization and advocacy (section 4). A set of conclusions and recommendations was adopted (section 5).

2. The global perspective

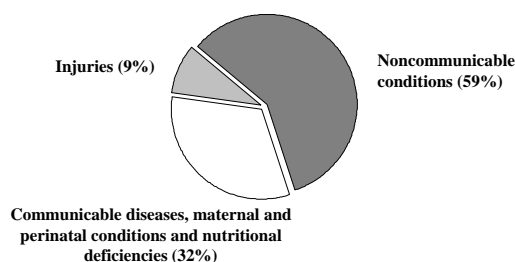
2.1 Health in transition

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

² *Diet, nutrition and the prevention of chronic diseases. Report of a Joint FAO/WHO Expert Consultation.* Geneva, World Health Organization, 2003 (WHO Technical Report Series, No. 916).

Figure 1
Death, by broad cause group 2000

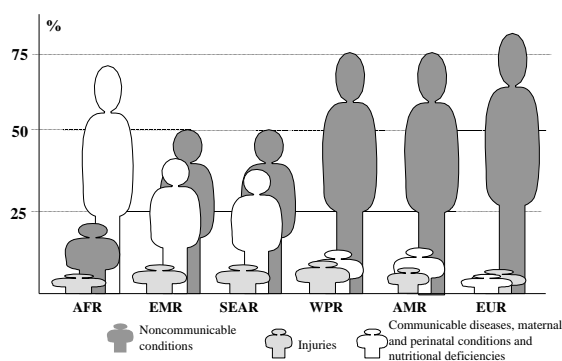
Total deaths: 55,694,000



Source: WHO, World Health Report 2001

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

Figure 2
Deaths, by broad cause group and WHO Region, 2000



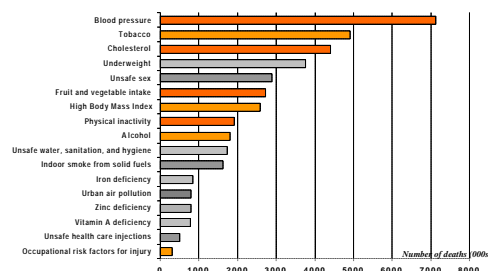
Source: WHO, World Health Report 2001

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

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

³ *The world health report 2002. Reducing risks, promoting healthy life.* World Health Organization, Geneva, Switzerland, 2002.

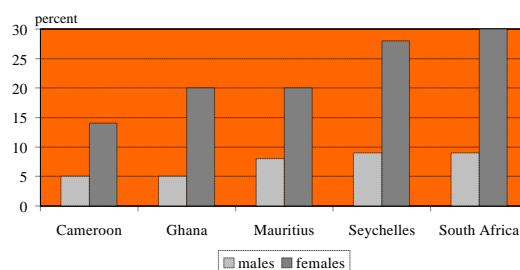
Figure 3
Global deaths in 2000 attributable to selected leading risk factors



Source: WHO, World Health Report, 2002

The figures also make clear the important role played by undernutrition. This must not be forgotten in the concern to address overnutrition. In many countries, both forms of malnutrition co-exist. Balanced diet can play an essential role in improving population health. However, surprisingly high prevalences of overweight are found in African countries, especially among women (Figure 4). Childhood obesity too is a growing problem across the world, with physical inactivity a major factor.

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



Cameroon: urban sample, 2000; Ghana: rural and urban Accra, 1997; Mauritius: national, 1998; Seychelles: national, 1994; South Africa: national, 1998
Source: WHO, Surveillance of Risk Factors related to noncommunicable diseases: Current status of global data, Geneva, 2003

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

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

Diet is a powerful instrument in this regard. In Finland, the North Karelia project, through community-based activity encouraging a healthier diet, annual CHD mortality was reduced by 73% over 25 years. In Japan, reduction of salt intake resulted in lower blood pressure levels and greatly reduced stroke mortality; in Mauritius, changing cooking oil from palm to soy bean oil resulted in a 15% decrease in serum cholesterol in the population; and in Poland, a change in dietary fats resulted in a 20% decline in heart disease mortality.

There are many obstacles to implementing prevention activities, but they can be overcome. They include: outdated concepts such as seeing NCDs as “diseases of affluence”; a lack of understanding about the speed with which prevention activities can make an impact on

morbidity; low public visibility for success stories in comparison with the needs of sick patients; powerful commercial interests that block policies and generate conflicting messages; traditional training of health personnel that emphasizes curative care; and inertia among institutions, financing bodies, and services.

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

2.2 Diet and cardiovascular disease

There is a substantial body of observational and experimental epidemiological evidence linking diet and (ischaemic) CVDs. The role of saturated fats in increasing coronary heart disease is particularly well established. In contrast, polyunsaturated fats exert a preventive effect in respect of blood cholesterol and CVDs. However, a meta-analysis of the epidemiological data from trials in which saturated fats are reduced shows limited impact on total mortality, mainly because it is difficult for the general public to sustain substantial changes in their dietary behaviours.

Vitamin supplementation is a long-standing issue. While cohort studies have suggested that some vitamins have a substantial effect on CVD prevention, randomized controlled trials of dietary supplements such as carotene and vitamin E have shown no beneficial effects.

Fibre intake prevents CVDs, although the effect is not very large.

Observational studies indicate that high sugar intake may have detrimental effects, e.g., by raising total calorie intake, and sugar-dense foods may favour overweight and substitute for healthier foods.

There is ample evidence that a diet rich in fruits and vegetables benefits cardiac health and, in particular, can reduce blood pressure. The role of salt in increasing blood pressure is also well established.

Promisingly, observational and experimental data strongly suggest that omega-3 fatty acids (derived from fish and some vegetables oils) can prevent primary and secondary CVDs, and substantially reduce sudden death.

Excess calorie intake and weight increase (together with physical inactivity) increase the risk of hypertension, diabetes, blood lipid disorders, CVDs and overall mortality. The current epidemic of overweight, which is also seen in developing countries, is a most worrying public health problem. Measures to avoid sustained positive energy balance should therefore be a priority in all countries.

Diet affects the heart through two mechanisms: some foods (e.g., those high in saturated fats) support the development of atherosclerosis and ischaemic heart disease, while others (e.g., fruits and vegetables, fish) are health promoters and prevent disease.

While there is sufficient evidence on the relationship between diet and CVDs to guide policy, there are still shortcomings in the available data and several challenges remain. Most epidemiological data come from western countries and may not be fully relevant to developing countries where diets and other factors may differ substantially. Another major challenge is to identify effective behavioural interventions.

The paucity of data from developing countries should not prevent the initiation of timely preventive actions in these countries in view of the rapid emergence of CVDs and the rapid nutritional transition. The latter largely results from globalization, including liberalization of trade, extended markets and fast communications. Globalization can also have some favourable

effects on health for example by increasing the availability of fruits and vegetables in some instances.

Policies should aim at promoting healthy dietary habits in populations through proper health education and effective interventions that inter alia encourage existing favourable dietary habits (e.g., traditional diet based on complex carbohydrates) wherever appropriate.

2.3 Physical activity and health

As recently as the 1940s, physical activity was considered to be a cause of heart attacks, and heart attack patients were advised to stay in bed. Since then successive studies have changed this view. Initially, vigorous activity was advocated as the means of staying healthy. Since the 1970s, however, research has shown that moderate-intensity physical activity is also beneficial for health, and the accumulation of moderate activity for 30 minutes on most, or preferably all, days of the week is recommended as an effective CVD prevention measure.⁴ The confirmation that inactivity is a global risk factor for NCDs (*The world health report 2002, op .cit.*) and the institution of the initiative “Move for health” have reinforced this view.

Physical activity has measurable biological effects, affecting cholesterol levels, insulin sensitivity and vascular reactivity. Moreover, these effects are dose-dependant – the more exercise the greater the health benefits. However, considerable health benefits can be gained with only small increases in moderate physical activity, e.g., regular walking.

Low fitness represents a similar risk for heart disease as smoking, high cholesterol, high blood pressure, high body mass index and family history, but it has a higher prevalence. Intervention to reduce this risk factor could therefore have a significant impact on public health, with important economic implications for health services.

The world health report 2002 describes the opportunities for people to be physically active in terms of four domains of their day-to-day lives: at work; for transport; in domestic duties; or in leisure time. In some countries, physical activity at work and in the domestic domain remain dominant, and in areas of nutritional deficiency some workers may be experiencing levels of physical activity that are detrimental to health. In other countries, particularly in the developed world, physical activity at work and in the home has diminished as sedentary jobs have become more common, and physical activity as a recreation is playing an increasing role. These changes are being seen across the life course and inactivity is becoming increasingly common among young people, in particular as daily duration of television viewing increases. For countries in transition across the world, the pattern is changing, especially in urban areas, and increases in NCDs are observed as physical activity decreases.

The scarcity of adequate data, especially in developing countries, is a major challenge. Definitions of physical activity need to be standardized and baseline studies and surveillance should be undertaken to establish representative national data sets in the various domains of activity and to identify vulnerable groups. Validated and culturally sensitive instruments are needed to assess the current situation and to monitor and evaluate interventions. Research on the interaction between nutrition and physical activity is also needed.

People must be made aware of benefits to health of physical activity and encouraged to be more active on an everyday basis. Multisectoral approaches will be needed to counter barriers such as lack of time, motivation, confidence and support from family and friends, inadequate facilities, and fear of injury. Strategies should include raising awareness, developing of social support networks at the community level, and promoting behaviour change at the individual level. Even simple actions can make a difference. For example, in a shopping mall, notices encouraging people to take the stairs rather than escalators increased stair use by 30%.

⁴ *Diet, nutrition and the prevention of chronic diseases. Report of a Joint FAO/WHO Expert Consultation, op.cit.*

3. The regional perspective

3.1 The health transition in Africa

Although high prevalences of communicable diseases, food shortages and undernutrition are still being encountered in many countries in the Region, African countries, like the rest of the world, are being affected by epidemiological, nutritional and demographic transition. NCDs, especially CVDs, are increasing rapidly throughout the Region and were estimated to have caused 22% of all deaths in 2001. They now constitute the major health problem in some countries (e.g., Algeria, Mauritius and Seychelles) and are as important as communicable diseases in others (e.g., Côte d'Ivoire, Nigeria). In Harare, prevalence in women of the risk factor obesity (BMI ≥ 30 kg/m²) is now higher than that of HIV infection.

At the economic and social level, NCDs are exacerbating the poverty of individuals and households that depend on them, reducing the workforce, and affecting those age groups least affected by HIV/AIDS, such as grandmothers who care for HIV/AIDS orphans. Health services already overburdened with cases of communicable disease are unable to cope, and treatment of NCDs does not reduce their incidence and is extremely expensive.

Successful preventive measures could therefore have a significant impact, and it is important to act without delay to curb the growing NCD epidemic. Africa must learn from the experiences of other regions and from research, and must seek the necessary resources to act quickly. Advocacy, coherent policies, legislation, health education and empowerment of individuals to take responsibility for their own health, and an appropriate balance between public health and commercial interests will all play a role in achieving the changes needed.

3.2 Country experiences

In describing their national experiences, some country representatives drew on the information collected by them and provided on a questionnaire concerning activities related to diet, physical activity and health, which had been sent to Member States prior to the consultation.

Prior to independence in **Algeria**, most of the population lived in rural areas with few means of transport. Manual work was the norm and men, women and children alike were obliged to make constant physical efforts. Health problems were largely related to communicable diseases, aggravated by nutritional deficiencies, particularly in children. Following independence in 1962, people flocked to the towns in search of work and a better quality of life. The rise in standard of living that came with the oil boom of the 1970s allowed many to enjoy a wider variety of foods, and to afford cars and other consumer goods. These changes were accompanied by a rise in NCDs, which are currently the leading cause of death and disability in the country. NCDs are also a major economic problem owing to the direct costs of treatment and the indirect costs of absenteeism from work. Liberalization of the market and current agricultural policies have encouraged the increased availability of foods rich in fats and salt, while fruit, vegetables and fish have become expensive. A comprehensive strategy is needed to reduce NCD risk factors and the risk of serious complications in people with NCDs.

HIV/AIDS and other sexually transmitted diseases are the major public health concerns in **Cameroon**, although the Government is striving to take into account strategies to combat all diseases in the context of poverty reduction and national development. Efforts are being made to stress the importance of physical activity for health, and initiatives to promote sport at all levels of the population are being implemented.

The Ministry of Youth and Sports in the **Gambia** recognizes the potential benefits to health, functional capacity and well-being of physical activity, and is committed to the integration of sports in the national development programme, particularly in the health sector where preventive health-care programmes are in place. Physical activity programmes have been initiated with the aim of increasing physical activity, improving health and performance at school and work, and reducing health costs. Training opportunities for physical education teachers are being increased. Health sector objectives include ensuring that preventive health-care programmes draw

attention to the health benefits of sports, and promoting positive attitudes to sports in men and women. In recent years sports have been seriously neglected in schools and other educational institutions, and most of the existing facilities in schools and recreational centres are old and run down. Efforts are needed to counter these trends. Land is a limited and precious resource that has to be shared between different uses and users. The Government is adhering to the environmental prescription of Agenda 21 of the Earth Summit for Sustainable Environmental and Human Development. It will require an environmental impact assessment for the planning of sports events and the building of all sports facilities and will require all stakeholders in sports to promote environmental awareness programmes.

The major risk factors for NCDs appear to be gaining in importance in **Ghana**, with prevalence of high blood pressure estimated at 30–40%, although prevalence data from national surveys are generally inadequate. Awareness of the importance of healthy diet and physical activity is low, and unhealthy eating habits, a growing number of fast-food outlets which appeal to young people, a culture that does not encourage exercise, particularly for women, poor layout of roads that prevents pedestrian access, and lack of sports and recreational facilities are contributing to rises in NCDs. Communicable diseases, including HIV/AIDS are more visible as public health problems and health resources are scarce. NCDs are perceived as being diseases of the affluent, and obesity is considered to be a sign of success in life. Government has a moral dilemma in sanctioning investments in the country by companies whose products do not contribute to a healthy diet, and the lack of hard national data makes advocacy difficult. Ghana has an intersectoral committee on nutrition and diet and an intersectoral sports council. Legislation and regulation are limited, and focus on food safety. Exclusive breastfeeding is encouraged and promotion of breast-milk substitutes is not allowed. While there is a Codex Alimentarius committee, Codex provisions appear to have little influence. There is no national plan on diet and physical activity but the food and agricultural sector development policy, which is linked with the country's poverty reduction programme, ensures food security. Training of health workers currently includes information on healthy diet but little about physical activity. Partnerships with nongovernmental organizations and the private sector have been established in the area of prevention and control of diabetes. Initiatives are being planned to raise awareness, improve diet, promote sports in schools and establish pedestrian walkways on "ceremonial streets".

In **Kenya**, some 55% of the population live below the poverty line. Rainfall is unreliable, often resulting in poor harvests and low yields. Communicable diseases such as malaria are the leading causes of death, and surveillance focuses on these diseases. The Ministry of Health established an NCD department only in 2001, and tools for baseline NCD surveys are yet to be developed. A survey on national food composition was carried out in 1993 and a survey on anaemia and status of iron, vitamins and zinc in 1999. There are few data on physical activity, although there has been some intersectoral action to encourage physical activity for those with physical disabilities. Factors contributing to the high prevalence of undernutrition include poverty, unfavourable climatic conditions, cost and unavailability of agricultural inputs, cultural practices that cause some communities to shun specific foods, and inadequate knowledge about correct foods. Overactivity in poor-nutrition settings has a negative impact on health. Obesity is a growing problem, especially in urban communities where increasingly sedentary lifestyles, changes in eating habits and lack of knowledge are contributory factors. Foods containing unsaturated fats are more expensive.

While no nationwide data on NCDs are available in **Mali**, it is clear that prevalences of NCDs are rising, especially in urban areas. As elsewhere, there is migration from rural to urban areas, which has led to changes in diet and other lifestyle factors. Undernutrition, especially in children and women, and food safety remain the major nutritional problems, however. The health services do not currently give priority to NCDs, although there are some prevention and control activities at the community level. Constraints are institutional, cultural and environmental. There are no mechanisms to integrate policies on nutrition and physical activity, which are directed, respectively, by the Ministry of Health and the Ministry of Youth and Sports. Relevant legislation

is limited, although there is some regulation of specific food ingredients, such as salt. Mali has national policies and strategies regarding the marketing of breast-milk substitutes and food safety. In the area of physical activity, progress has been made since World Health Day 2002. Special “Move for health” days involving political leaders are now observed, and interventions to increase awareness of the benefits of physical activity are being implemented. It is hoped that evidence from the consultation will convince policy-makers of the need for improvements in facilities for physical activity and sports.

Surveys carried out in **Mauritius** in 1992 and 1998 showed high prevalences of NCD risk factors and low levels of physical activity, especially in women. Awareness of the influence of diet and physical activity on health is relatively high in children and adults. There is no national policy on NCD prevention and control, but there are provisions for low customs duties on staple foods and fruit, and on sports equipment. Following direct intervention by Government from 1987, palm oil has been entirely replaced by soy bean oil for cooking, and this has been accompanied by a drop in cholesterol levels in the population. A government health promotion campaign is currently under way and there is a mobile screening unit for early detection of NCDs and referral to hospital. A Government white paper with strong NCD and physical activity components is under preparation.

Of the population of 17 million in **Mozambique**, 80% live below the poverty line. Two studies of risk factors for cardiovascular diseases have been carried out. Data indicate that there is a high prevalence of high blood pressure and that fruit and vegetable intake is relatively low; some 22% of the population in Maputo are overweight. Obstacles to gaining increased political commitment include lack of recognition of NCDs as a priority and cultural and financial constraints. There is no integration of policies on diet, nutrition and physical activity but there is a food and nutrition committee, in which the Ministry of Health plays a leading role. The national food and nutrition policy focuses on guidelines for the provision of food to those who are undernourished. There is also a policy to promote physical activity. Education on healthy diet and physical activity is given in rural and urban schools at primary and secondary levels. Health professionals provide advice on diet and physical activity to patients and their families in hospitals and sometimes at other health service levels. Training in this area is included in the curricula for physicians, nurses and nutrition-related health professions. Promotion for special health days involves the private health sector and the media. Awareness of the importance for health of diet and physical activity is greater in urban than in rural areas.

As elsewhere in the Region, **Nigeria** has been experiencing the double burden of communicable and noncommunicable diseases, and an NCD prevention and control programme was established as early as 1989- 1990. A national expert committee on health formulated a policy for NCD management, identified risk factors for NCDs and undertook a national NCD survey. With WHO support, a new comprehensive NCD policy was formulated in 2002. It focuses on prevention, identification of risk factors and strengthening of four centres of medical excellence to cope with people with disabilities. An intersectoral committee on physical activity and health has also been established. Strategies include advocacy, health promotion, health education, community mobilization, intersectoral collaboration, training and capacity-building, and integration of NCD prevention and management into primary health care. A further NCD survey in six regions of the country is planned. A medium-term plan of action for the period 1990-2001 was implemented but lack of funds and political will in some areas were obstacles to further progress. Nigeria needs support to convince politicians and policy-makers of the benefits of NCD prevention activities and to raise awareness in the population.

The **United Republic of Tanzania** is experiencing a transition from a cereal-based diet using home-prepared foods to increasing consumption of processed, energy-dense foods high in fats and sugars, especially in urban areas, where fast foods are becoming readily available. NCD surveillance is under development. Data are currently limited, but the prevalence of risk factors for these diseases is reported to be high, the prevalences of diabetes, hypertension and CVDs are rising, and mortality from strokes is high. There is a lack of expertise and funds for managing NCDs, and use of health services by people with NCDs is poor. Undernutrition and

communicable diseases, including HIV/AIDS, continue to take priority. Cultural constraints and lack of awareness of the risk factors are also obstacles to progress. The Government has policies on food and nutrition, breastfeeding and regulation of the marketing of breast-milk substitutes, established in accordance with international guidelines. The multisectoral committee on diet, spearheaded by the Tanzanian Food and Nutrition Centre, provides advice on healthy eating and promotes healthy lifestyles, but does not currently give practical advice on physical activity. Legislation covers safety and labelling of food, and national standards are set by the Bureau of Statistics on the basis of the Codex Alimentarius. Advice on healthy diet and lifestyles is only provided through school health authorities, although curricula for health professionals do include some information on diet. Despite active media involvement, levels of awareness in the population remain very low.

Since independence in the 1980s, **Zimbabwe** has seen a transition in lifestyles, which has been accompanied by a rise in NCDs. A national health survey in 1999 showed sharp rises in diabetes mellitus, hypertension and asthma. The Government takes a multisectoral approach to nutrition and health at all levels, especially in the community. There is currently an acute shortage of dietitians in hospitals, however, and there is no training course for dietitians in the country, although training for nutritionists is available. Zimbabwe is currently experiencing serious food security problems. The nutrition council is nevertheless developing a national food and nutrition policy, which will also cover physical activity. A survey of diet and NCDs in hospitals is also planned. Nongovernmental organizations are providing support for programmes to supplement the feeding of children under five years of age, and pregnant and lactating women. Curricula for teachers and other professionals do not include information on the influence of diet and physical activity on health.

4. Priorities for action in African Member States

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

4.1 Food and nutrition

Undernutrition remains the dominant feature in Africa, and nutrition policies and planning in Africa overwhelmingly focus on this aspect of malnutrition. Overweight and obesity are common, however, even among poor people, and often coexist with undernutrition within the same families and communities. It is vital to draw attention to the true complexity of the situation and to highlight the need to develop comprehensive nutrition policies that encompass all forms of malnutrition in order to manage undernutrition efficiently, while simultaneously starting to address overnutrition. Policies should give particular attention to vulnerable groups such as children (especially orphans), pregnant and lactating women, those living with HIV/AIDS, refugees and older people, and should be well planned and executed. Data on nutritional status are currently inadequate, and surveys based on the STEPS surveillance model developed by WHO should be undertaken. The STEPS model could be linked to other surveillance models.

Nutrition policies should have a life-course perspective and should take account of the quantity and quality of food available, cultural norms in relation to diet, economic development, and legislation and regulations on food safety and trade. A multisectoral approach is needed, for example, through the formation of national nutrition councils with broad participation.

Food quantity and quality

Food distribution chains and storage facilities are frequently inadequate. Healthy foods, for example, fruit and vegetables, are often expensive. Furthermore, some traditional food crops are disappearing. As a result many people, especially those who are poor, cannot afford sufficient food or enough food of the right quality to provide a balanced diet. Land use and agricultural practices should be improved to increase yields of good quality local products, and food storage and distribution networks should be strengthened to ensure sustained accessibility.

The food industry should be encouraged to improve the nutritional quality of the products it supplies, for example, by reducing salt, sugar and saturated and total fat content. Where

appropriate, suitable food fortification programmes should be instituted to combat micronutrient deficiencies (e.g., iron, vitamin A, iodine, folate).

Natural and manmade disasters (cyclones, drought, wars, political strife) may lead to hunger and starvation. Emergency-preparedness programmes should be implemented to improve long-term planning and to ensure that food relief supplies are available, and that they comprise healthy foods, and also that donated foods are labelled in accordance with the national nutrition policies of donor countries and with international standards.

Cultural norms in relation to diet

When food is available, it is usually offered and accepted in abundance; the amounts seen as sufficient and the amounts consumed are frequently excessive, leading to overnutrition and obesity. Moreover, it is socially acceptable and considered desirable to be overweight, especially for women, in many countries in Africa. Weight loss is also increasingly associated with HIV/AIDS, making it undesirable. Information and education on portion size and food mix for optimal nutrition are needed, for example, food-based dietary guidelines, plate models, information on the nutritional value of local and traditional foods. Preparation methods should be investigated to determine ways of changing those that are detrimental to food quality (e.g., overcooking of vegetables), and encouraging reduction of salt, sugar and saturated and total fat content. Certain traditional practices may lead to nutritional problems (e.g., eggs may be withheld during pregnancy or from young children, menstruating women may not be allowed to eat iron-containing foods), while others are favourable (e.g., pastoral Masai dietary practices) and should be encouraged. Studies on knowledge, beliefs, attitudes and practices are needed to better understand traditional practices and to guide promotion of healthy food choices.

Development

Food and nutrition should be considered in the context of development. Poverty, unemployment, rural underdevelopment, lack of clean and safe water supplies and lack of political commitment to NCD prevention and management all affect the ability of people to make healthy dietary choices. Countries need to develop policies to tackle these issues. NCD prevention through diet and physical activity should be integrated into primary health care services and all health care professionals should receive adequate training in this area.

Legislation and regulation

Many countries in the Region do not have the necessary legislative and regulatory environment to ensure healthy nutrition, and will need technical support to develop appropriate laws and regulations on food processing standards (e.g., amount and type of fat, amount of salt and sugar, type of meat, etc.; food industry products should attain Codex Alimentarius standards). This also applies to food labelling, food marketing and advertising (including control of misleading health claims), food service management, healthy school feeding schemes, food hygiene, quality of food provided by street-vendors, and quality of imported food, especially staples (including control of dumping and smuggling of poor quality foods). Collaboration with the food industry will be needed for the development and implementation of such regulations. Countries will also need support in instituting effective monitoring systems to ensure the implementation of such regulations.

4.2 Physical activity

In most countries of the Region, there is a lack of awareness at all levels of the benefits to health of physical activity and a shortage of clear and consistent messages on the subject. The attention required for other vital needs, e.g., HIV/AIDS, other communicable diseases and the nutrition transition, contributes to the failure to give adequate priority to the promotion of physical exercise. It is important to bear in mind also, that in nutrition-poor settings, excessive physical work can be detrimental to health.

Physical education and sport in schools are under threat in many countries owing to competing academic priorities, lack of facilities, financial constraints and lack of parental support. There is also little emphasis on physical activity in the workplace and at the community level, again owing to economic pressures and lack of facilities. For individuals, long working hours, commuting, competing leisure time activities and cultural factors are further obstacles to regular physical exercise.

A national mechanism should be put in place for establishing a multisectoral advocacy committee to gather locally-relevant evidence, make the case for action, identify target audiences and develop clear, culturally-relevant, evidence-based messages concerning physical activity and health. National policies to promote physical activity for health should be developed and should include sustainable and realistic strategies for the different domains of physical activity. Small, inexpensive, population-based interventions (e.g., Move for health) should be initiated as a useful start. Financing mechanisms should be multisectoral and sustainable. The physical activity offered in schools should be diverse and attractive, should be integrated in the curriculum in a meaningful way, and should encourage students to develop the habit of physical exercise that will be continued throughout their lives.

Environments, especially in urban areas, are often not conducive to physical activity, and lack of pathways, and pollution and crime are major obstacles. Creating environments that encourage physical activity (e.g., through Healthy Cities initiatives) should be a component of urban planning policy.

There are real cultural and/or religious constraints within the Region to taking up physical activities, particularly for girls and women. Religious leaders and women's groups should be involved in seeking culturally-sensitive solutions so as to increase physical activity opportunities for women that are mutually acceptable to the community and individuals.

Effective, multisectoral partnerships at various levels will be needed to translate policy into action that covers the entire population, including people with mental and physical disabilities, housewives, children not in the school system, school leavers and unemployed people. Innovative interventions making effective use of the media should be designed to disseminate messages about the benefits to health of physical activity. Action should be linked to existing programmes and infrastructures and physical activity networks should be created to maximize impact.

Advocacy and education are needed to increase awareness in health professionals of the benefits of physical activity for secondary prevention of NCDs and to show that elaborate infrastructures for such activities are not needed.

Monitoring and evaluation are essential to ensure sustainability of priority actions. They should be built into programmes from the outset and adequately resourced. Evaluation should include outcomes and processes as well as ongoing surveillance.

4.3 Information, education, social mobilization and advocacy

Countries should collaborate with communication experts to ensure that the information provided on diet, physical activity and health is culturally sensitive, with appropriate use of language. Messages should be translated into all the local languages used in the population, and should include information on the transition in nutrition habits, the significance of risk factors for NCDs, the advantages and disadvantages of traditional practices in relation to diet and physical activity, cooking methods, knowledge about refined foods, perceptions of body size, and barriers to participation in physical activity.

Health promotion interventions are often conducted without baseline or situation analysis, monitoring and evaluation, and there is insufficient information on suitable entry points for intervention. Evidence-based information must be generated to convince policy-makers and the public of the need for changes and to enable pilot programmes to be planned on a sound scientific basis. Countries will require support to find the necessary resources, develop skills and identify affordable tools to gather data and plan and implement appropriate interventions. Information on current situations in the Region, best practices and existing qualitative data should

be reviewed and disseminated. Health promotion should be integrated with disease prevention activities and should be institutionalized within the health services.

Advocacy strategies are needed to raise political awareness of the significance of diet and physical activity for NCD preventions and to mobilize activists and advocates. Such strategies should include information on: the current health situation, future disease projections, the potential impact of prevention and the economic implications of NCDs and NCD prevention.

Training of health professionals in the Region is generally focused on prevention and control of communicable diseases. Initial and in-service training curricula should be modified to include prevention and management of NCDs and development of social marketing and advocacy skills.

Information, education and advocacy activities should move beyond the current focus on the individual and try to influence the environment, to ensure that it supports behavioural change, for example by increasing awareness of existing supportive laws and regulations and ensuring that they are enforced, identifying additional appropriate legislative and regulatory measures, and addressing globalization, sustainable development, trade policies and agreements and commercial pressures. Existing declarations, action plans and activities should be reviewed to ensure that comprehensive and integrated nutrition and physical activity policies are developed in the context of NCD prevention.

Literacy levels are still low in some countries. Efforts should be made to increase literacy and to ensure that information, advocacy and social mobilization programmes are appropriate for communities with low literacy levels and with literacy polarization. Governments need to be convinced that investments in education will lead to improvements in health, especially among poor people.

4.4 Key players

United Nations and other international organizations, intergovernmental organizations, donor countries and nongovernmental organizations have a major role to play in: increasing awareness of the situation in the Region; supporting Member States in developing appropriate policies, legislation and regulation, information, education and communication materials, and emergency-preparedness plans; supporting national capacity-building; promoting research on suitable and affordable surveillance and monitoring tools; and negotiating with the food industry at the international level.

Academics, health professionals, traditional leaders, nongovernmental organizations and civil society should be encouraged to become involved in national advocacy activities using the mass media and other channels of communication to increase awareness of the significance of diet and physical activity for health among politicians and other decision-makers, and in the general public.

Governments should strengthen multisectoral collaboration, drawing in the ministries responsible for health, agriculture, finance, sports, youth and women's affairs, environment, urban planning, transport and trade, to ensure the development and implementation of integrated policies related to diet, physical activity and health. Where appropriate, participation of nongovernmental organizations and civil society should be encouraged.

Health professionals (doctors, nurses, midwives, dieticians, nutritionists, health promotion experts), physical education and sports teachers, traditional, religious and community leaders, among others, should be aware of and promote the benefits of a healthy diet and physical activity.

The food industry (including enterprises involved in marketing, advertising, distribution and retailing of food products) has an important role to play in ensuring that healthy foods are available and affordable.

Individuals should be encouraged to take greater responsibility for ensuring that they and their families make healthy choices regarding diet and physical activity, throughout their lives.

5. Conclusions and recommendations

The African Regional Consultation on the development of the WHO global strategy on diet, physical activity and health adopted the following conclusions and recommendations.

5.1 Conclusions

1. The participants endorsed the preparation process for the WHO global strategy on diet, physical activity and health as presented in the consultation document, and welcomed the broad consultation that is under way.
2. The consultation endorsed the *Report of a Joint FAO/WHO Consultation on Diet, Nutrition and the Prevention of Chronic Diseases*, together with its recommendations.
3. There is sound scientific evidence regarding the common risk factors underlying NCDs, the benefits to health of improvements in diet and increased physical activity throughout life, and the cost-effectiveness of NCD prevention measures.
4. There is clear evidence that the current global transition in diets and lifestyles resulting mainly from urbanization, and, in some countries, ageing of populations, is leading to a rapid rise in NCDs (epidemiological transition).
5. Member States in the African Region face the double burden of communicable diseases (especially HIV/AIDS, malaria, tuberculosis) and noncommunicable diseases at a time of serious financial constraints. They also face the double burden of problems related to undernutrition and nutrition-related NCDs.
6. Relevant regional data are scarce owing, inter alia, to inadequate research and surveillance.
7. There are encouraging signs of increased awareness of the importance of NCDs among political leaders and policy-makers, but more needs to be done to ensure that these diseases and their risk factors are given strong and immediate attention while countries continue to address communicable diseases.
8. Relevant legislation, where existing, generally focuses on food safety.
9. Populations are not sufficiently aware of the benefits of a healthy diet and physical exercise and how to make the right lifestyle choices to help prevent NCDs; cultural perceptions influence such choices.
10. Facilities for general physical activity and sports are inadequate, and physical activity and physical education in schools are decreasing.
11. Governments have a duty to take action on diet, physical activity and health as part of their responsibility for protecting the health of their populations in the context of national development.
12. It is important to act now in order to curb the emerging NCD epidemic.

5.2 General recommendations

To WHO

1. Continue efforts to develop a global strategy on diet, physical activity and health that is comprehensive, reflects the realities faced by countries, recognizes regional, national and local differences, is sensitive to cultural aspects and includes clear guidance on implementation. Approaches must be multisectoral, involving a wide range of stakeholders, and must cover all levels: international, regional, national, community and individual.
 2. Continue technical leadership in the area of diet, physical activity and health.
 3. Develop relevant core messages for advocacy and for information, education and communication materials used at country and local level.
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4. Provide guidance on the formulation of legislation and regulations related to diet, physical activity and health.
5. Promote and support relevant research.
6. Provide support to Member States in formulating and implementing relevant policies.

To Member States

7. Promote awareness at the highest political level across all sectors of: the emerging epidemic of NCDs; their risk factors; the extremely high costs of treating NCDs which can drain the resources of developing countries; and cost-effective measures available for preventing NCDs.
8. Support the development and adoption of the global strategy and promote its implementation at the global, regional and national levels.
9. Integrate prevention and control of NCDs and their risk factors into policies concerning health, nutrition and development, and into health services, especially at primary health care level.
10. Ensure adequate and sustained financial allocations to national activities on diet, physical activity and health.
11. Strengthen human resource development and national capacity for surveillance, prevention and control of NCDs.
12. Support relevant research.
13. Establish mechanisms to ensure participation of nongovernmental organizations, civil society, communities, the private sector and the media in activities on diet, physical activity and health.

5.3 Regional recommendations

To WHO

14. Ensure that the global strategy on diet, physical activity and health takes due account of the double burden of communicable and noncommunicable diseases and the existence of high prevalences of undernutrition and micronutrient deficiencies, as well as rising overnutrition in many African countries. The global strategy should build on existing programmes and should give realistic guidance as to how African countries can translate policies into action in the face of current constraints.
15. Increase advocacy at the international level for support to African Member States to ensure that development policies are consistent with the promotion of healthy lifestyles.
16. Create a database of existing tools for rapid assessment, surveillance, monitoring and evaluation currently being used in the African Region; develop new, and refine existing tools, and support countries in developing the capacity to use them.
17. Collect and disseminate best practices in the Region in relation to diet, physical activity and health.

To Member States

18. Promote awareness at all levels of government of the need to institute prompt action to prevent further increases in noncommunicable diseases, while maintaining programmes to prevent and control communicable diseases.
19. Undertake surveys on nutritional status and levels of physical activity to expand the evidence base.
20. Develop comprehensive nutrition policies that cover all forms of malnutrition and give due attention to vulnerable groups such as orphans, pregnant and lactating women and older people (especially widows).

21. Establish a national nutrition council and a national committee to promote physical activity, both with multisectoral representatives.
 22. Review health infrastructures and services, currently focused mainly on prevention and control of communicable diseases, to identify ways in which they can be reoriented to take into account the increasing need for prevention and management of NCDs.
 23. Review agriculture policies with a view to increasing local production of healthy and affordable foods.
 24. Review education, sports, urban planning and transport policies to determine ways in which physical activity can be promoted and facilitated.
 25. Undertake knowledge, beliefs, attitudes and practices surveys on diet, physical activity and health (including perceptions of overweight and obesity, traditional food preparation and use, and benefits of physical exercise, especially in girls and women) with a view to promoting changes in behaviour that are favourable to health.
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Annex List of participants

Member States

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Gambia

Mr Duwa O Jatta, Deputy Permanent Secretary, Department of State for Youth and Sports, Banjul (*Presenter*)

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Ms Julia Tagwireyi, Coordinator, Food & Nutrition Council, Office of President & Cabinet, c/o Scientific Industrial and Research Development Centre, Harare (*Rapporteur, working group on information, education, social mobilization and advocacy*)

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Technical experts

Dr Pascal Bovet, Head, Unit for Prevention and Control of Cardiovascular Disease, Ministry of Health, Victoria, Seychelles (*Technical presentation: Diet and cardiovascular disease*)

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