Workshop on the Implementation of the Global Strategy on Diet, Physical Activity and Health in the Pacific

3-6 April 2006
Suva, Fiji
A workshop on the Implementation of the Global Strategy on Diet, Physical Activity and Health in the Pacific was held in Suva, Fiji from 3 to 6 April 2006. This workshop was organized by the World Health Organization, in partnership with the Secretariat of the Pacific Community (SPC) and the Food and Agriculture Organization (FAO) of the United Nations. This workshop followed on from an earlier workshop on Obesity Prevention and Control Strategies in the Pacific, held in Apia, Samoa in 2000. At this conference, a call for action on obesity was announced and a strategic approach agreed upon to curb the obesity epidemic in the region.

The objectives of the Suva workshop were to:

1. Review progress and share experiences in the prevention and control of obesity, diabetes and related chronic diseases in the Pacific; and

2. Identify priority actions on which countries and territories should focus to achieve maximum impact in the implementation of the Global Strategy on Diet, Physical Activity and Health (DPAS).

An invitation to participate in the forum was extended to two participants from each of 21 Pacific island countries: a senior health officer responsible for the prevention and control of obesity and noncommunicable disease and a senior policy-maker in agriculture/fisheries, food trade, sports and recreation, urban planning, education, economic development, or finance. Representatives from 19 Pacific island countries and partner agencies attended the workshop. Others at the meeting included resource persons, temporary advisers, observers and the WHO and SPC secretariat.

Prior to the workshop a questionnaire was sent to the representatives in each of the participating countries. The questionnaire asked representatives to identify initiatives currently being utilized and those which they felt would be useful in their countries for the prevention and control of obesity, diabetes and related chronic diseases. In consultation with relevant officials in their country, representatives were also asked to develop a specific strategy for obesity prevention that could be further developed during the workshop. This strategy could be a new initiative, or build on an existing strategy in the country. Participants were asked to prepare a two-page summary of their proposed strategy.

The workshop objectives were achieved through individual presentations and group discussion. The workshop started with an overview of the DPAS followed by an update on current regional and national initiatives in relation to the Pacific Diet and Physical Activity Strategy. These presenters indicated that there have been many strategies developed in the past few years around the implementation of the global strategy at the global, regional and subregional level. Many of these are applicable to Pacific countries and Pacific island countries should use these to strengthen their current strategies.

The remaining workshop presentations were divided into a number of sessions that included: macro-level (national), micro-level (local), and health promotion strategies. International and regional examples of strategies were provided where appropriate.
At the macro-level, most of the discussion centred on creation of regional standards and guidelines which countries could then adopt and adapt for their own use. Food-based dietary guidelines that were developed by SPC have been adopted and adapted for local use in most Pacific island countries. Country representatives requested similar guidelines for physical activity. Micro-level strategies included mainly settings approaches such as healthy schools, workplaces, churches and communities. There was broad agreement among countries currently involved in curriculum-based health promotion in schools for a need to shift to a “whole school” approach that reinforces curriculum learning, with a supportive school environment that involves management, parents and the community. For example, lessons on healthy eating in the classroom should be accompanied by selling healthy foods in school tuck shops.

A Health Promoting Workplace is a common strategy undertaken in the Pacific and works well when combined with role modelling by health workers and other leaders. The Non-Communicable Disease (NCD) Mini-Steps initiative developed in Fiji is recommended as an excellent entry point to promoting a healthy workplace. Examples of Health Promoting Churches in Fiji and Tonga and a Health Promoting Village in Samoa were provided. The participants agreed that the implementation of Health Promoting Communities in Pacific countries has great potential as a tool to promote healthy eating and physical activity.

Health promotion topics centred on social marketing, advocacy, and Health Promotion Foundations. The experiences of Fiji, French Polynesia, Tonga and Vanuatu were helpful in the discussion of these topics. The need for social marketing strategies in the Pacific was highlighted during the Samoa workshop in 2000. Unfortunately, social marketing is currently being underutilized in the region. There is a need for training in social marketing and WHO and SPC have been asked to give workshops at the sub-regional or in-country level. Adequate funding for health promotion activities remains a problem in many Pacific island countries. The establishment of Health Promotion Foundations in Pacific island countries, funded through taxes on unhealthy foods, tobacco, and alcohol, may be one mechanism to provide sustainable funding.

Other discussions focused on the need to increase the production of local fruits and vegetables for consumption in Pacific island countries, a regional approach to food labelling, and the need for increased training of health workers especially around physical activity.

Country representatives presented their proposals at the end of the meeting. In the evaluation of the workshop, most of the respondents indicate that they were confident they could implement their proposal but would have to discuss it with management at home before progressing further.

Recommendations

1. School-based interventions need to change from being solely curriculum-based to whole school initiatives.

2. Pacific Islands Forum Secretariat be approached by WHO to suggest that Health Promoting Schools in the Pacific be included as an agenda item for the Education Ministers’ Meeting to be convened in Nadi, Fiji in October 2006.

3. Forum member countries are encouraged to apply for Pacific Regional Initiatives for the delivery of basic Education Project (PRIDE) for funding support of their health promoting curriculum activities.
(4) Regional Food-based Dietary Guidelines developed by SPC should be adopted by Member States after being adapted for local needs. Training be provided for health care workers, including ways to communicate the guidelines to the public.

(5) WHO-SPC Regional Guidelines on Physical Activity be developed and these guidelines be adopted by Member States after being adapted for local needs.

(6) Clinical Practice Guidelines for the Management of Overweight and Obesity should be used for education of doctors, nurses, nutritionists and other allied health workers, where appropriate and relevant.

(7) Regional training be carried out in these key areas.
   a. Physical Activity: SPC has run three workshops and should evaluate them for impact and use this information to assist in designing future training workshops.
   b. Communication strategy and behaviour change communication should be linked with training on physical activity and nutrition and should be country specific with multi-year plan instead of just one-off training, which is not cost-effective, as competencies attained are not sustained.
   c. Specific training on monitoring and evaluation of programmes is required. This training needs to be country specific and to include training on statistical software usage (e.g. Epi-Info).

(8) Countries considering Healthy Workplace initiatives are encouraged to use the NCD Mini-STEPS initiative as an entry point to their engagement of management and workers. It also provides an excellent surveillance and evaluation tool.

(9) Community settings continue to be an opportune setting and Pacific island countries are encouraged to explore and utilize this platform to implement their diet and physical activity strategies.

(10) Relevant issues in the context of DPAS should be brought to the attention of the next Pacific Agricultural Ministers Meeting. One of the issues noted by the meeting was the need to augment the production of fruit and vegetables for local consumption and support this by promoting integrated nutrition education in a gardening/horticulture programme.

(11) The group supports the need for the Codex Alimentarius Commission to consider the major food issues underlying the burden of illness in the Pacific caused by NCDs.

(12) The group agreed upon the importance of food labelling as a mechanism to assist consumers in making choices to reduce dietary risk factors as identified by DPAS. Any labelling for the Pacific should be carefully adapted to local needs and be supported by an appropriate education campaign.

(13) Research Intervention: recognizes the strong evidence that Type 2 diabetes can be prevented with lifestyle intervention through diet and physical activity with maximum risk reduction in older age groups. There is a lack of evidence from Pacific island countries as to the benefit of lifestyle interventions. NCD STEPS and other surveys indicate that populations in Pacific island countries would benefit from
lifestyle interventions. The group, therefore, supports initiation of a regional research intervention on the prevention of diabetes in high-risk individuals through lifestyle intervention and encourages appropriate countries to participate. Regional and international organizations may be willing to provide assistance.

(14) Consideration should be given to a regional approach to food labelling in the Pacific. It was noted that this is an important issue for the regional Codex Coordinating Committee as well as the Standards and Conformance work by the Forum Secretariat.

(15) Health Promotion Foundation establishment be advocated as an effective mechanism for sustainable funding of health promotion activities. The meeting congratulates French Polynesia, Fiji, Kiribati, Tonga and Vanuatu for the important work they are doing in this regard and encourages other countries to do so, advocating for the establishment of taxes on unhealthy foods, tobacco and alcohol as a mechanism for raising funds for health promotion programmes and for ensuring their sustainability.

(16) NCD STEPS continues to be a key factor in NCD strategic planning and advocacy and WHO, Fiji School of Medicine and other relevant agencies should continue to work together with countries to expedite the process.

(17) A network of information sharing for physical activity should be established for the Pacific region. It could be similar to the current Pacific Nutrition network (PACNUT). This could be started with the Asia-Pacific Physical Activity Network (APPAN), which seeks to stimulate, inform and support implementation, evaluation of studies and surveillance of physical activity in as many Pacific island countries as possible.

(18) Country Proposals developed during the workshop represents prioritized activities identified by the participants for the implementation of the DPAS in their respective countries. Follow up is to be done by WHO and SPC to ensure significant progress and impact, and coordination with other expertise for assistance in implementation. Countries are at different stages of implementation of NCD strategies or National Plan of Action on Nutrition, which is also reflected, to some extent, in their respective proposals.
1. INTRODUCTION

The burden of chronic NCDs has rapidly increased, accounting for almost 60% of the 56 million annual deaths worldwide and 47% of the global burden of disease in 2002. The most important risk factors for NCD include tobacco use, overweight or obesity, inadequate intake of fruit and vegetables, physical inactivity, high blood pressure, high blood sugars and high concentrations of cholesterol in the blood. It is necessary to concentrate on these risk factors to substantially reduce the impact of chronic diseases on human populations. Most countries in the midst of health transition, including many Pacific island countries, are facing a double burden of disease, where chronic disease or NCD prevalence is increasing rapidly alongside a continuing high prevalence of infectious diseases and undernutrition, posing a significant economic burden on already strained health systems, individuals and society. Some of the highest rates of obesity in the world are found in the Pacific islands. Prevalence rates of 80.2% in Nauru\(^1\) and 93.5% in American Samoa\(^2\) have been reported.

The workshop on Obesity Prevention and Control Strategies in the Pacific held in Samoa in 2000 adopted a Call to Action on Obesity and agreed on a strategic approach to curb the obesity epidemic. At this meeting it was agreed that three fundamental elements should form the framework of the regional response to obesity: the creation of supportive environments, promotion of positive behaviours and the mounting of a clinical response (See Text Box 1). WHO and the Secretariat of the Pacific Community have produced strategic documents and declarations in support of national plans for chronic disease prevention and control. The Tonga Commitment by the Pacific Ministers of Health (2003) and the Samoa Commitment to Achieving Healthy Islands (2005) have provided new impetus for Pacific island countries to develop and/or enhance actions. The DPAS endorsed the principle that cross-sectoral policies that generate sustainable access to healthy diets, opportunities for physical activity and promotion of healthy choices must be in place to address the challenges of chronic diseases. A Pacific response will involve local, national and intercountry action across a wide range of sectors.

**Box 1 Regional response to obesity**

The creation of supportive environments: environmental determinants of obesity to be addressed through healthy public policies that promote the availability and accessibility of a variety of low fat, high fibre foods and that safe places and opportunities for physical activity be provided.

The promotion of positive behaviours: behavioural determinants of obesity to be addressed through the promotion of personal awareness, attitudes, beliefs and skills that motivate and enable people to modify recently introduced unhealthy eating patterns, and to increase physical activity which has declined with modernization.

The mounting of a clinical response: the existing burden of obesity and associated conditions need control through clinical programmes and staff training to ensure effective support for the maintenance or loss of weight among those already affected.

**Text Box 1 Framework for approach to obesity in Pacific Island Countries**

\(^1\) Nauru NCD Risk factors STEPS Report, 2007

\(^2\) American Samoa NCD Risk Factor STEPS Report, 2007
A workshop was held in Suva from 3 to 6 April 2006, to identify priority actions on which countries and areas should focus to achieve maximum impact on the prevention and control of obesity, diabetes and related chronic diseases in the Pacific.

1.1 Meeting objectives

(1) Review progress and share experiences in the prevention and control of obesity, diabetes and related chronic diseases in the Pacific.

(2) Identify priority actions on which countries and territories should focus to achieve maximum impact in the implementation of the DPAS.

1.2 Participants and resource persons

Representatives from 19 countries and territories in the region attended the workshop. An invitation to participate in the forum was extended to two participants from each of 21 Pacific island countries, a senior health officer responsible for the prevention and control of obesity and noncommunicable disease and a senior policy-maker in agriculture/fisheries, food trade, sports and recreation, urban planning, education, economic development, or finance. In addition, partner agencies from within the region were represented and also consultants, temporary advisers and a number of observers. Annex 1 gives a full list of participants.

On the first morning of the workshop, Dr Tekie Iosefa, the Health Adviser from Tokelau and Mrs Ana Kavaefiafi, Principal Queen Salote School of Nursing in Tonga were elected Chair and Vice-Chair respectively, and Ms Wila Saweri, Technical Advisor Nutrition, Papua New Guinea and Ms Karen Tairea Community Nutritionist, Cook Islands, were elected as Rapporteurs.

1.3 Organization

The workshop was designed to achieve the workshop objectives and built around individual presentations and group discussions. The presentations were provided by representatives of participating countries, partner agencies, and consultants and temporary advisers. The format of the presentations included background papers, clinical guidelines for the management and control of obesity, country presentations, and case studies of obesity control programmes from both the region and internationally.

There were six major workgroup sessions.

(1) Setting the scene

(2) Macro-level strategies

(3) Micro-level strategies (local settings)

(4) Health promotion specifics

(5) Monitoring and evaluation

(6) Country proposals

Annex 2 provides the workshop agenda. An evaluation questionnaire was administered on the last day of the workshop.
1.4 Opening ceremony

The opening began with devotion from Rev. Dr Martin Finau and then the Fiji Minister of Health, the Honourable Mr Solomone Naivalu, welcomed participants with some remarks as the hosting country. There were then remarks from each of the main partners in SPC, FAO, International Obesity Task Force (IOTF) and with the WHO Representative South Pacific delivering the final opening remarks on behalf of the Regional Director of the WHO Regional Office for the Western Pacific.

2. PROCEEDINGS

Prior to the workshop, a questionnaire was sent to the representatives in each of the participating countries. The questionnaire asked representatives to identify initiatives currently being utilized and those which they felt would be useful in their countries for the prevention and control of obesity, diabetes and related chronic diseases. The questionnaire used as a basis the three fundamental elements that formed the framework of the regional response to obesity discussed at the meeting in Samoa (See Text Box 1). In consultation with relevant officials in their country, representatives were also asked to develop a specific strategy for obesity prevention that could be further developed during the workshop. This strategy could be a new initiative or built on an existing strategy in the country. Participants were asked to prepare a two-page summary of their proposed strategy prior to the workshop.

The structure of the workshop was reviewed in an introductory session, explaining how the objectives were to be achieved, by Dr L.T. Cavalli-Sforza, Regional Adviser, Nutrition, WHO Regional Office for the Western Pacific and responsible officer for this meeting. The workshop started with an overview of DPAS followed by an update on current regional and national initiatives in relation to Diet and Physical Activity strategy for the pacific. Participants were reminded of the action plans developed at the ‘Workshop on Obesity Prevention and Control Strategies in the Pacific’ in Samoa in 2000 and the ‘Workshop on Fruit and vegetable promotion in the Pacific Islands’ in Christchurch in 2004. These presenters also indicated that there have been many initiatives in the past few years around the implementation of the global strategy at the global, regional and subregional level. Many of these initiatives were developed by WHO and SPC and are applicable to Pacific island countries. Participants were told of the WHO-SPC collaboration on national surveys and planning in NCD and nutrition, food-based dietary guidelines, and physical activity training. These resources are all part of the implementation of DPAS in the Pacific. It was suggested that countries should use these resources to strengthen their current programmes.

The remaining workshop presentations were divided into a number of sessions that included: macro-level (national), micro-level (local), and health promotion strategies. International and regional examples of strategies were provided where appropriate.

At the macro-level, most of the discussion centred on creation of regional standards and guidelines which countries could then adopt and adapt for their own use. Food-based dietary guidelines that were developed by SPC have been adopted and adapted for local use in most Pacific island countries. Country representatives requested similar guidelines for physical activity which was drafted during the workshop by a working group and to be progressed further with consultation with PICs. Regional and national food standards were discussed in relation to codex processes.

Micro-level strategies included mainly settings approaches such as healthy schools, workplaces, churches, and communities. There was broad agreement among countries currently
involved in curriculum-based health promotion in schools for a need to shift to “whole school” approaches incorporating the environmental issues in addition to just curriculum. For example, lessons on healthy eating in the classroom should be accompanied by selling healthy foods in school tuck shops. Other initiatives like nutrition friendly school and child friendly schools were also introduced and how they serve as approaches or strategies to implement diet and physical activity interventions at local level.

A Health Promoting Workplace is defined as a place where everyone works together to achieve an agreed vision for the health and well being of workers and surrounding community. It provides all members of the workforce with physical, psychological, social and organizational conditions that promote and protect health and safety. This is a common strategy undertaken in the Pacific to promote healthy diet and physical activity and works well when combined with role modelling by health workers and other leaders. Fiji had undertaken an initiative of developing a tool for monitoring of NCD risk factors in workplace program called ‘Noncommunicable Disease (NCD) Mini-Steps’ and it is based on the WHO STEPwise approach to chronic disease risk factor surveillance (STEPS) tool and methodology. It has also become a good entry point for initiating health promoting workplace which the PICs were encouraged to use.

Health Promoting Communities is the other setting presented with examples of Health Promoting Churches in Fiji and Tonga and a Health Promoting Village in Samoa. Participants agree that such settings approach has great potential as a tool to promote healthy eating and physical activity in PICs.

Other health promotion topics included social marketing, advocacy and health promotion foundation models. The experiences of Fiji, French Polynesia, Tonga and Vanuatu in regards to their attempts and progress to use hypothecated tax for financing of health promotion were discussed. The need to move from simple information, education and communication (IEC) approach to health communication to more behaviourally focussed marketing campaigns were highlighted in the meeting. This had been also highlighted during the ‘Workshop on Obesity Prevention and Control Strategies in the Pacific’ in Samoa in 2000 but unfortunately it is currently being underutilised in the region. There is a need for training in social marketing and WHO and SPC have been requested to conduct either subregional or in-country training.

Adequate funding for health promotion activities remains a problem in many Pacific island countries. The establishment of Health Promotion Foundations in Pacific island countries, funded through taxes on unhealthy foods, tobacco and alcohol, is one mechanism to provide sustainable funding.

Other discussions focused on the need to increase the production of local fruits and vegetables for consumption in Pacific island countries, a regional approach to food labelling, and the need for increased training of health workers, especially with regard to physical activity. Country representatives presented their proposals at the end of the meeting.

The following summaries from the presenters give an overview of the key points emphasized during the presentations:

2.1 Presentations

(a) Preventing chronic disease: a vital investment (Dr T. Cavalli-Sforza)

The causes of the main chronic disease epidemics are well established and well known. The most important modifiable risk factors are: unhealthy diet and excessive energy intake; physical inactivity and tobacco use expressed through the intermediate risk factors of raised blood pressure,
raised glucose levels, abnormal blood lipids and overweight and obesity. In 2005 the estimated loss in national income from the impact of heart disease, stroke and diabetes are as much as $18 billion in China, $11 billion in the Russian Federation, $9 billion in Brazil and $2.7 billion in India. US$ 556 billion the estimated amount China will lose in national income over the next 10 years as a result of premature deaths caused by heart disease, stroke, and diabetes.

There are ten misunderstanding of chronic disease that the report tries to unravel:

10. NCD affect mostly high income countries but the reality is that four out of five chronic disease deaths are in low and middle income countries.

9: Low and middle income countries should control infectious diseases before they tackle NCD but reality is that low and middle income countries are at the centre of double burden of disease

8: NCD mainly affect rich people but the reality is that in all but the least developed countries of the world, the poor are much more likely to develop chronic diseases and die as a result

7 NCD are often viewed as primarily affecting old people but the reality is that almost half of chronic diseases occur prematurely, in people under 70 years of age

6 Certain NCD, especially heart disease, are often viewed as affecting primarily men but the reality is that it affects women and men almost equally.

5 Chronic diseases is a result of unhealthy "lifestyles", they have only themselves to blame but individual responsibility can have its full effect only where individuals have equitable access to a healthy life, and are supported to make healthy choices.

4 Nothing that can be done anyway but the major causes of NCD are known, and if risk factors were eliminated, at least 80% of cardiovascular disease and type 2 diabetes would be prevented; over 40% of cancer would be prevented.

3 Solutions for NCD prevention and control are too expensive to be feasible for low and middle income countries but a full range of chronic disease interventions are very cost-effective

2 “My grandfather smoked and was overweight – and he lived to 96” Outliers inevitably exist, but are extremely rare. Most NCDs can be traced back to the risk factors, and can be prevented.

1 "Everyone has to die of something": Certainly, but death does not need to be slow, painful, or premature. Death is inevitable, but a life of protracted ill-health is not.

(b) Regional obesity prevention efforts, NPAN and NCD strategies (Dr T. Cavalli-Sforza)

Obesity and related NCD are imposing a very heavy burden on the health care systems and the economies of Pacific countries, as well as on the quality of life of their people. A recent analysis by the World Bank shows that the cost of managing NCD accounts for about half of all health expenditure in some Pacific Island Countries (PIC). To respond to the obesity epidemic in the Pacific, in 2000, WHO, FAO, SPC and the International Obesity Task Force, organized a Workshop on Obesity Prevention and Control Strategies in the Pacific where a strategic approach based on three fundamental elements to tackle the obesity epidemic was formed: Raising awareness of the obesity problem, Creating supportive environments through public policies and programmes, and Strengthening clinical services.

These approaches were further discussed at the Meeting of Ministers of Health of Pacific Countries in Tonga, in 2003, and a Commitment to Promote Healthy Lifestyles and Supportive Environments was adopted with a STEPwise Framework for national NCD strategies and plans development was adopted.
Future action by WHO to help implement the Global Strategy in the Region will include continued support for national strategic leadership in plan development & implementation (NPANs & NCDs), developing the capacity to advocate for improved diets & lifestyles, helping to generate funds for nutrition and NCD prevention programmes through health promotion foundations and by shifting resources within national budgets. WHO will also support the review of national dietary guidelines and their communication and implementation and finalization of the regional guideline on physical activity. In working with Ministries of Education and MOH in countries, improve school curricula as well as knowledge, skills and school environments to promote healthy diets and lifestyles. Promoting increased availability of fruits, vegetables and traditional local foods and increased collaboration and networking among sectors and agencies. Consideration for regulatory approaches, such as Price controls, Restrictions on supply and Mandatory labelling requirement should be also made.

(c) Questionnaire result and proposal framework (Dr T Waqanivalu)

Since the ‘Workshop on Obesity Prevention and Control Strategies in the Pacific’ in Samoa in 2000 there have been subsequent meetings that have highlighted the need to address diet and physical activities. The latest NCD STEPS result gives an indication of how severe obesity is in each country as communicated through the questionnaire. Some countries have moved on to developing either NCD strategies or a National Plan of Action on Nutrition which contains diet and physical activity strategies. The STEPS framework for planning is commonly used with strategies divided into macro- and micro-levels for population approaches, and clinical for an individual approach, with prioritization of Core, Expanded and Optimum strategies. Within the framework in their own country, participants are encouraged to identify strategies that will have greatest impact in their community. Those without a NCD or nutrition strategy were encouraged to formulate one so that diet and physical activity are always included within the context of NCD prevention and control.

(d) Principles and practicalities of health promoting workplace (Dr T Waqanivalu)

The workplace is another opportune setting for promotion of healthy diet and physical activity. In most Pacific island countries the urban working population is at greater risk of NCD than the rural population. While there are guidelines, there has to be innovative ideas and great flexibility in establishing Healthy Workplace Settings. The mini-STEPS tool used by Fiji has become a good entry point into workplaces and in specifically addressing diet and physical activity. Some innovation in moving the national NCD meetings from venue to venue, with the incentive of NCD screening, using the mini-STEPS survey tool and hosting staff members, also proved a worthwhile initiative. In all of these and other diet and physical activity strategies, there is a great need for a champion to drive these initiatives.

(e) Clinical practice guidelines for the management of overweight and obesity (Ms S. Pearson)

The development of clinical practice guidelines for the management of overweight and obesity are recommended for the Pacific Islands region. Guidelines help to focus government and health professionals on the obesity epidemic and provide an evidence-base for public health initiatives. Clinical guidelines empower clinicians with standard knowledge for working with overweight and obese individuals and highlight important health conditions associated with obesity, including diabetes, heart disease and some cancers.

Development of clinical practice guidelines for the Pacific island countries can be adapted from the Australian clinical guidelines. Development of the guidelines must be complimented by clearly defined strategies for distribution and clinical training. Extensive training programmes are available to support the Australian guidelines and could also be adapted for the Pacific Island region.
(f) The Australian Heart Foundation Tick programme (Ms M. Dunlop)

The Tick programme was established in 1989 by the Australian heart Foundation, a nongovernmental organization, as a way to help consumers make healthier choices between products in a particular food category. The programme is voluntary and companies choose whether to participate.

Companies apply to the Heart Foundation to have their product approved to carry the Tick trademark. The approval process involves independent chemical testing and analysis. Companies pay an annual royalty fee to display the Tick on their approved product. These fees are used to support nutrition research, education programmes for consumers, administration and random testing of approved products to ensure continued compliance with approval requirements.

(g) Trade and legislation issues (Mr D. Clarke)

Mr Clarke presented their conclusions on the most promising legislative interventions to prevent and decrease obesity in Pacific island countries.

Their work involved a scan of international initiatives in the area, and a stocktaking of existing Pacific interventions to identify how new legislation could be used to improve obesity control strategies. In the process, we considered the contextual issues that Pacific countries must consider if they wish to legislate assistance for their obesity prevention measures. As well as local conditions, the relevant context includes consideration of WTO Agreements and domestic trade policies as factors that must influence Pacific law on the issue.

A number of interventions were recommended, some for implementation at the country level, and some for action at a regional level. The most promising intervention considered was the tax mechanisms, in particular, the combination of taxes on unhealthy products, with revenue obtained applied to health-promoting activities.

(h) Health promotion foundations (Mr D. Clarke)

A presentation was given on the benefits of a health promotion foundation as a mechanism to build sustainable structures and programmes for health-promoting activity. We provided an outline of the benefits of establishing a foundation and discussed in detail the lessons that can be learnt from Tonga’s experiences by other countries in the region.

(i) Physical activity programmes in Australia (Ms M. Dunlop)

Programmes are in place at both the national, state and local levels of government in Australia. Programmes fit within an overarching policy framework and plans, such as Healthy Weight 2008 and Be Active Australia. The initiatives are implemented based on national physical activity guidelines and obesity clinical guidelines. Integration and coordination of activities across sectors such as education, transport and environment are important to ensure consistent messages, maximization of resources and efforts and to create supportive and enabling environments.

Walk to Work Day (and the companion event, Walk Safely to School Day) are examples of how initiatives interact across sectors and can build on and help promote existing programmes. Such initiatives provide an opportunity to build local alliances and partnerships, and local infrastructure and community action. These initiatives are subject to ongoing monitoring, review and evaluation and early data is showing very promising results from these interventions.
(j) Developing physical activity guidelines in the Pacific (Dr P. Phongsavan)

The promotion of physical activity in the Pacific region is extremely important in reducing premature deaths and disabilities associated with diabetes, cardiovascular disease, colon and breast cancers. It is recommended that individuals maintain adequate levels of activity in everyday living throughout their lives. At least 30 minutes of moderate-intensity on most days reduces the risk of NCDs. For preventing weight gain, more activity is required. The translation of these recommendations into a standard set of guidelines is essential to support national policies and plans/strategies for achieving a population-wide increase in physical activity levels in the Pacific. This presentation outlines the key elements of physical activity, and how these elements have been communicated through physical activity guidelines. The presentation also highlights the importance of different guidelines for different outcomes, linkage with national physical activity plans and policies, and other health/non-health issues, and the concept of “active living”. A framework for conceptualizing, developing and communicating the guidelines to the target populations and health professionals are outlined.

(k) Review of physical activity best practices in developing countries (Dr P. Phongsavan)

This presentation summarized findings from the review of physical activity interventions in developing countries, carried out by the Centre for Physical Activity and Health (CPAH), with support from WHO Geneva. The aims of the review were to support the DPAS implementation, to document the evidence base on the design and implementation of the physical activity interventions and to share the findings on current best practice in interventions to promote physical activity among developing countries. Of 34 case studies identified, 15 were classified as best practice case studies from 14 countries. The review identified the following essential prerequisites for implementing physical activity interventions: high level political commitment; guiding policy; funding and stakeholders support; leadership and a coordinating team; clear objectives; clear programme identity; implementation within national physical activity guidelines; integration of physical activity with other interventions; multiple strategies at multiple levels; targeting the whole population and specific population groups; and implementation within local reality. The review also highlights the need to strengthen process and impact/outcome evaluation for current and future programmes. Only then, will it be possible to adequately assess the quality of the interventions, and in turn, increase the evidence base on the design and implementation of interventions in developing countries.

(l) Principles of social marketing and behaviour change communication (Dr W. Parks)

This presentation was split into two parts—Part A: Social marketing and mobilization over time; and Part B: Principles. Part A described how the technical field of health communication, of which social marketing and mobilization are two sub-fields, has evolved and continues to change, from the patient education approach (1950s) through the basic needs approach and increasing community engagement (1970s), on to adoption of marketing design principles, including the 4 “Ps” (product, price, placement and promotion) (1980s), to strategic communication for behaviour and social change (1990s), the latter representing a combination of lessons learnt from previous decades. The presenter also considered some of the major challenges in changing behaviours, including: knowledge is not enough; competition to healthy behaviour must be recognized; behaviour changes in gradual stages; and an enabling environment is required.

Part B highlighted some of the basic principles of social marketing and mobilization and their application to the promotion of health. Four principles (out of many) were highlighted: (1) repeatedly use research; (2) develop a few clear behavioural objectives; (3) Use the “Ps” in design; and (4) plan for multi-year, integrated communication, combining a carefully researched and executed mix of administrative mobilization, advocacy, public relations, community mobilization, interpersonal communication, mass media advertising and point-of-service promotion.
(m) Principles of advocacy and profiles (Dr. W. Parks)

This presentation was also divided into two Parts—Part A: Defining advocacy; and Part B: Examples of advocacy tools. Part A began by recognizing that health promotion is a multi-layered approach aiming to sustain behavioural and environmental adaptations conducive to health. Health promotion includes: health promotion policy development; creation of supportive environments; strengthening of community action; development of personal skills; and reorientation of health services.

Advocacy to raise and sustain political and financial commitment for the promotion of health is a vital strategy across all layers. Advocacy for NCD denotes activities designed to place NCD interventions high on the political and development agenda, foster political will, increase financial and other resources on a sustainable basis and hold authorities accountable to ensure that pledges are fulfilled and results are achieved. There are several types of advocacy, such as: (a) policy advocacy that includes the creative communication of evidence and information to senior politicians and administrators about the impact of an issue at national level, and the need for action; (b) programme advocacy, used at local, community levels to convince opinion leaders about the need for local action; and (c) media advocacy, used to generate support from governments and donors, validate the relevance of a subject, and put issues onto the public agenda through the media.

Part B considered various tools that have been developed to support advocacy approaches, including: PROFILES (developed by the Academy for Educational Development); the AIDS Impact Model (AIM), from the POLICY project of the Futures Group; and Johns Hopkins University’s A-Frame for Advocacy. The main discussion was on PROFILES, a computer program originally designed to demonstrate the contribution that improved nutrition can make to human and economic development. Work is now underway to develop new PROFILES software including NCD interventions. The PROFILES package (computer programs, training, and template presentations) is a means to engage national leaders in policy dialogue about public health issues. PROFILES translates technical information into terms that make sense to non-experts and has been shown to build consensus, leverage new resources, better target existing resources, and positively influence the way policy-makers think about public health programmes. PROFILES represents a tool that could be used for advocacy purposes to foster political and financial support for improved diet and physical activity interventions. The presenter also looked at some recent work on monitoring and evaluating advocacy and provided a list of relevant websites.

(n) General principles of monitoring and evaluation (Dr. W. Parks)

This presentation began by highlighting several questions that make us frown. How do we know if health promotion is actually making a difference? What should we measure? Who decides what to measure? How do we measure what needs to be measured? Who should make these measurements? Where? How often? At what level? And how can we make best use of the information? Is health promotion contributing to overall country programme results for prevention and control of NCDs? Are we doing the right things? Are we doing them right? Are we making a difference?

But the presenter encouraged us to stop frowning (or at least to not frown as much!). Basic and proven principles, processes and methods to address these questions are available, but we must apply sufficient resources, including monitoring and evaluation, planning time, creativity and analytical discipline. The presentation defined various terms associated with programme planning, including situation analyses, monitoring, evaluation and indicators.
Examples of indicators from WHO’s DPAS were then examined in relation to a health promotion outcome model (developed by Professor Don Nutbeam). Combining this model with DPAS indicators could allow NCD programme planners to track information across several vital levels. Level 1: health promotion actions such as communication, social marketing, social mobilization, advocacy (using several DPAS process indicators). Level 2: health promotion outcomes such as health literacy, social action and influence, healthy public policy and organizational practice (again using DPAS indicators). Level 3: intermediate health outcomes such as behavioural impact on risk factors, effective health services and healthy environments (as measured by another set of DPAS indicators). Level 4: population health outcomes using several DPAS biomedical indicators (e.g. cause-specific mortality).

The presentation also highlighted various monitoring and evaluation resources for NCD programme managers currently under development including: WHO STEPwise approach to chronic disease risk factor surveillance (STEPS); Global School-based Student Health Survey (GSHS); Health Behaviour in School-aged Children (HBSC); WHO Global InfoBase; and the European Community Health Indicators (ECHI). The presentation concluded by recognizing that while monitoring and evaluation are difficult, there are many important reasons to engage in this enthusiastically: to test programme effectiveness; make a case to change programme practices; to justify continued financial or political support; to answer stakeholder questions; and to provide continuous feedback at all levels. The presenter reminded us that nothing succeeds like success. If successes in NCD prevention and control are not measured and recorded, the opportunity to generate further success is lost.

(o) Promotion of Production and Consumption of Fruit and Vegetables in the Pacific: A challenge and opportunity for agriculture (Mr D. Schulz)

Mr Schulz introduced the participants to FAO’s comprehensive food chain approach, highlighting ongoing activities, starting with fruit and vegetable production and protection, post-harvest food safety and quality assurance, food processing, storage and marketing, to the end-consumer, supported through food composition research and nutrition education. He pointed out that aims of horticultural programmes include the achievement of greater availability for local consumption, improved nutrition, higher grower incomes and export potential, depending on the commodities. He also informed the meeting about the Global Inventory, Reference Materials and Food Safety Training Programme to Improve the Safety and Quality of Fresh Fruits and Vegetables and explained the application of measures such Good Agricultural Practices (GAP), Good Hygienic Practices (GHP) and Good Manufacturing Practices (GMP) to prevent hazards at appropriate points in the fresh fruits and vegetables chain. Mr Schulz closed the presentation by drawing to members attention several points for consideration: (i) the need to strengthen recognition of fruit and vegetable production also for local consumption; (ii) the need to enhance integrated nutrition education in gardening/horticulture programmes at the farm level; (iii) the importance of incorporating nutrition considerations into agricultural development policies and programmes at policy level; and (iv) the need to ensure safety and quality throughout the food chain.

(p) Codex and its application in the Pacific region: how codex can contribute to improving diet and health in the Pacific (Mr D. Schulz)

Mr Dirk Schulz, FAO Food and Nutrition Officer for the Pacific, also provided a presentation on Codex and its application in the Pacific region, with a view of how Codex can contribute to improving diet and health in the Pacific.

In the introduction, he explained that the codex is usually associated with two closely related matters, the Codex Alimentarius Commission (CAC), which is the international body mandated to develop Codex texts, and the Codex Alimentarius, that is the collection of standards, codes of practice, guidelines and related texts developed and approved by the CAC. Key objectives of the CAC
are the protection of consumer health, ensuring fair practices in the food trade and the coordination of all food standards work by international organizations. Mr Schulz also provided insight into the organizational structure encompassing General Subject Committees, Commodity Committees, Task Forces, and Regional Coordinating Committees and pointed out that the Coordinating Committee for North America and the South West Pacific (CCNASWP) is currently chaired and hosted by Samoa. He went on to elaborate the structures in place at national level, such as the codex contact point and national codex committees. Furthermore he explained the benefits of using internationally accepted ready-to-use food standards and guidelines, which could form the basis for development of such standards in Pacific island countries, thus avoiding duplication of efforts and promoting harmonization at international level.

Mr Schulz then elucidated the linkage between codex and DPAS, referring, inter alia, to the 2003 World Health Assembly Resolution WHA/56.23, requesting the CAC to give full consideration to evidence-based action to improve health standards of foods consistent with DPAS. To this end, FAO and WHO have established an electronic forum so Member States can provide their comments to assist drafting an action document highlighting action that could be taken by Codex, in the framework of its mandate, to facilitate the implementation of DPAS. Within the Pacific context, this was seen as an important issue, given that NCDs in the region are related to the increased importation and consequent consumption of unhealthy food items. As part of a broader approach, it was noted that codex could contribute to an environment that supports actions to reduce common nutritional risk factors and the incidence of chronic diseases through, for example, its food composition and processing standards, as well as guidelines on food labelling. It was clear however, that food labelling provisions need adaptation by each country and must be complemented with awareness and education measures to ensure that consumers can actually use them for informed purchase decisions.

Guidelines on diet and lifestyle (Dr V. Puloka)

The main Pacific teaching tool is a three food group system, shown on the SPC poster: energy food, body-building food, and protective food. These represent simple advice on healthy eating. After 2000, other guidelines were in use from various countries, such as Australia, France and the United States of America. Some countries developed their own guidelines, which were mostly adaptation from other countries, while some received help from nutritionists around the region, but there were few nutritionists available.

At a regional level it was felt that there is a need for a standard guide to show a healthy diet in terms of the relative amounts of different food groups that should be eaten. Taking the lead, the SPC reviewed and updated the three food group posters and developed a regionally acceptable food guide poster, along with a key healthy lifestyle activities poster. The process included extensive consultation, research on what proportion of each food group should be eaten, and piloting in four countries, with several drafts before completion of the final version.

Next in the process is the development of national versions, with support from the SPC for national modification of the regional food guide posters. Each country may substitute pictures with locally appropriate food items and translate text into their local language or dialect. There are also French Bislama version available.

To date, the following have completed their national versions: American Samoa, Federated State of Micronesia (Chuuk), Fiji, Niue, Marshall Islands, Samoa and the Commonwealth of the Northern Mariana Islands. Kiribati, Federated State of Micronesia (Kosrae), the Solomon Islands and Palau are now ready to work on theirs, while Cook Islands, Guam, Nauru, Tuvalu, Papua New Guinea, Federated State of Micronesia (Pohnpei and Yap) are using the unmodified regional version. French Polynesia, New Caledonia, Wallis and Futuna are yet to utilize this resource.
The challenge for each country is to have one guideline in use nationally. There is a need for guidelines to be developed for young children and resources should be reviewed and updated regularly.

How national plans and policies are addressing global strategies (Dr V. Puloka)

This presentation examined the current status of existing NCD national policies or plans that support DPAS. There are two main policies in the region, the National Plan of Action for Nutrition (NPAN) and the more recent National Strategy to prevent and control noncommunicable diseases.

Following International Conference on Nutrition (ICN) many countries were very active in developing their own NPAN with support from both WHO and SPC and funding from various partners including Australian Agency for International Development (AusAID) and Japan International Cooperation Agency (JICA). Unfortunately few of them were fully used or implemented. They were either incomplete, un-endorsed or there were insufficient multisectoral involvement. A full evaluation of NPAN activities will be very helpful in guiding us forward in this matter. However, over the last few years there has been a resurgence of interest in NPAN and action to develop, update and implement these plans. Almost all NPAN are based on ICN themes, which are very comprehensive. Actions are based on perceived needs, data, studies, available resources and a perception of what works.

More recently some consideration given to other documents e.g. DPAS, Global Strategy for Infant & Young Child Feeding (GSIYCF), Millennium Development Goals (MDG) and NPAN should overlap with those global strategies. The global strategies highlight actions which can be effective in promoting health and nutrition and existing NPAN can therefore be reviewed to include and modify actions if they are realistic in that country. This may mean no changes, an addition or a modification, and may not need to be rewritten.

Following the meeting of Ministers of Health – (Tonga commitment 2003) recommendations to develop NCD strategies were agreed upon in recognition of the importance of NCD in the region. Many countries have progressed and developed NCD plans. Most are in the early stages, recently completed or still being finalized. In some cases, these are produced separately from NPAN, but they should always be complementary and in agreement.

Again few countries have actively used the global strategy as a source of information for their NCD plan. Countries could review what they have and see if it can be improved with ideas from the global strategy. Those countries with STEPS data are in a good position to use this to build in a mechanism to evaluate and review NPAN or NCD plans.

Most documents are written to cover a five-year period, but these should be reviewed regularly, with a focus on the most realistic, easiest and effective actions, and the use of ideas from other countries in the region, the global strategy and other key documents.

Promotion of fruit and vegetable consumption in the Pacific (Dr V. Puloka)

This presentation focused on the promotion of fruit and vegetable consumption in the Pacific. Traditionally, the Pacific diet consisted of fruits, vegetables and fish. Today, eating patterns have changed dramatically with the majority of people lacking healthy daily amounts of fruits and vegetables.

There has been much promotional work to increase traditional fruit and vegetable consumption in the region, but mostly on generic local foods. This has been important work but it is difficult to
make headway in competition with spam and corned beef producers, who have big promotions with prizes of winning a car or a holiday to sell their products.

Promoting local food, including fruits and vegetables is one of the most common promotional activities in the region. It includes recipe promotions, advertising in stores and markets, support to farmers and home gardeners, local food days (on World Food Day), and television, radio and media advertisements. Many of these promotion activities are good work but lack good evaluation of effectiveness. It appears that there needs to be specific promotion of fruits and vegetables, both local and imported, as consumption of fruits and vegetables are low among local populations across the region.

The ‘Workshop on fruit and vegetable promotion in the Pacific Islands’ in New Zealand in 2004 was convened for this purpose and it included nine participants from eight Pacific Island countries.

The classification of certain foods and whether they are fruit or vegetable was discussed. The main traditional foods include breadfruit, bananas, plantains, tubers (yams, sweet potato, taro, and cassava), potato, corn, peas, carrots, beans and lentils, and seaweed. The following recommendations were made:

- the body-building group includes legumes, such as beans and lentils as well as nuts and seeds
- the fruit and vegetable (protective) group includes, for example, pumpkin, peas, carrots, seaweed, eating banana (ripe bananas)
- the starchy (energy) group includes taro, breadfruit, sweet potato, cassava, yam, cooking or green banana.

Defining a serving or portion was also discussed. The WHO recommendation of 400g of fruit and vegetable a day needs to be translated in a language that people understand. It was decided to use the common servings approach, where each serve is about 80gm of fruit or vegetable and to use common objects readily available in homes to give people a sense of a serving size. Supporting materials were needed and SPC developed a poster for this.

(1) Obesity Prevention in the Community (OPIC), Fiji (Ms J. Schultz)

The presentation focused on what the Obesity Prevention in the Community (OPIC) project is about, who is involved, the target group, how the goals and action plan for intervention were created and mainly focussing on the Fiji component.

Healthy Youth Healthy Community is the Fiji component of an Obesity Prevention in Community Project being implemented in four countries: Australia (Geelong, Victoria) New Zealand (Mangere, Auckland), Tonga (three districts in Tongatapu) and Fiji (seven secondary schools in the Nasinu area). It targets secondary students age 13–18. The project addresses the increasing rates of obesity in young people in all four sites.

The main objectives of the project are to establish reliable baseline information on obesity in adolescents age 13–18; find the most cost effective ways of preventing obesity in young people; identify sociocultural factors that promote obesity and the most effective ways to influence them; evaluate the effects of food-related policies that influence obesity; estimate the economic and health burden of obesity; and determine how resources can best be allocated to prevent the problem.
It uses analytical studies—economics, sociocultural and policy studies, to inform interventions. The strengths of the project are approaches which include engaging youths and the community at all stages of the intervention decisions, using multiple strategies, such as education policies and environmental and social marketing programmes. The action plan which guides the intervention programme was developed through a workshop using the ‘analysis grid for environments linked to obesity’ (ANGELO) framework. Participants representing the intervention communities (school students, teachers, community leaders, youth group leaders) actively took part in this workshop and in the development of the action plan.

The action plan objectives include increasing the capacity of the community to promote healthy eating and regular physical activity and to reduce the development of overweight and obesity in youths in the Nasinu community; reducing the proportion of youth who skip breakfast and lunch on school days; improving the healthiness of school food and after-school snacks; increasing fruit intake; increasing the proportion of students who live close to school that walk to and from school; increasing the amount of active play after school and on weekends; and decreasing the amount of time spent watching television.

Strategies to achieve the objective of improving healthiness of school food include development and implementation of school food policy; development and dissemination of information to parents, teachers, student and school management. Strong partnerships have been developed with ministries of education and health, schools, churches/religious organizations and local businesses in the Nasinu area. To sustain the project, Healthy Youth Healthy Community has developed structures within the community and schools to help implement the plan of action.

Baseline information on food and eating, physical activity and quality of life has been collected from both intervention schools and comparative schools. Evaluation is planned as a three-year follow-up survey after baseline. In addition, all intervention programmes include an evaluation component.

Health Promoting Schools in the Pacific: (Ms J. Schultz)

Ms Schultz provided an overview of the SPC ‘Strengthening of the school-based NCD Prevention Project’ with NZAID support. The project is SPC’s response to the increasing rates of overweight and obesity in children. It was piloted in three Pacific countries: Cook Islands, Fiji, and Palau. Selection was based on four criteria: on request from the country; where overweight and obesity in children appeared to be an issue; no obesity prevention programme being in place in schools; and at least one country representing Polynesia, Melanesia and Micronesia.

The school setting was selected because it has well defined existing structures (a readymade platform for a more intersectoral approach) that can promote integrated action using health promotion approaches: the healthy settings; the main focus is on adolescent health and positive body image; healthy lifestyle with physical activity and diet; and partnerships. The physical education curriculum in secondary schools was identified as the component of the comprehensive health promoting school programme to focus on because the primary school curriculum generally has a very strong health component that is absent in secondary school, physical education has never been used in the Pacific as a strategy to prevent obesity and both boys and girls take physical education.

The overall aim was to strengthen the physical education part of the secondary school curriculum to emphasize physical activity, nutrition, and emotional health in addition to physical fitness for sports performance. The project had four phases. Only phase one (planning and development) was piloted in three countries: Cook Islands, Fiji and Palau. Phase one outputs included a formal agreement between the Ministry of Education and Ministry of Health, a physical education curriculum review or a new one developed.
Cook Islands were able to have a formal agreement signed between the Ministry of Education and Ministry of Health, as well as develop a physical education and health curriculum. Fiji was able to have input to include nutrition into the physical education curriculum. Support was obtained from both ministries through advocacy.

The challenges faced include practicalities of partnership between health and education, the timeline for project was unrealistic for countries (they needed a longer period to pilot project, two years at least) and more advocacy was needed to clarify roles and responsibilities for long-term prevention of NCD in the Pacific. The project had not been formally evaluated due to staff turnover but this should be done to determine whether the concept can be applied across the Pacific.

2.2 Country Proposals

This is a summary of strategies developed by participants during the workshop which they were to develop further and have endorsed by appropriate authorities in their country and submitted to WHO and SPC for technical and possible financial support.

<table>
<thead>
<tr>
<th>Country</th>
<th>Prioritized Project/Programme Proposal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Samoa</td>
<td>Development of National NCD Strategic Plan</td>
<td>New strategy</td>
</tr>
<tr>
<td>Commonwealth of the Northern Mariana (CNMI)</td>
<td>Re-establish Food and Nutrition Council</td>
<td>Ongoing activity</td>
</tr>
<tr>
<td>Cook Islands</td>
<td>Promotion of physical activity and fruit and vegetable consumption</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Fiji</td>
<td>Green prescription &amp; prevention to delay onset of diabetes in patients with impaired glucose tolerance</td>
<td>Part of NCD Plan</td>
</tr>
<tr>
<td>FRP</td>
<td>Sports in School</td>
<td>Ongoing – no funding support needed</td>
</tr>
<tr>
<td>Marshall</td>
<td>Formulation of National NCD Plan</td>
<td>Part of regular WHO budget for 2006</td>
</tr>
<tr>
<td>Micronesia</td>
<td>Community-based NCD Prevention</td>
<td>Pilot in one island</td>
</tr>
<tr>
<td>New Caledonia</td>
<td>Need to finalize</td>
<td></td>
</tr>
<tr>
<td>Niue</td>
<td>Partnership building &amp; NCD Mini-STEPS</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Palau</td>
<td>Palau in Motion</td>
<td>Ongoing</td>
</tr>
<tr>
<td>PNG</td>
<td>Strategy for NCD prevention &amp; Control beginning at workplace (Healthy workplace intervention)</td>
<td>Need advocacy</td>
</tr>
<tr>
<td>Western Samoa</td>
<td>Community Based NCD Strategy with communication strategy</td>
<td>Part of NCD Plan</td>
</tr>
<tr>
<td>Solomons</td>
<td>Move for Health Strategy</td>
<td>Need to ensure addressing of both burdens of under – and over - nutrition</td>
</tr>
<tr>
<td>Tokelau</td>
<td>Development of NCD Strategic Plan</td>
<td>NCD STEPS completed</td>
</tr>
<tr>
<td>Tonga</td>
<td>Social Marketing on Diet &amp; Physical Activity</td>
<td>Part of reviewed NCD Plan</td>
</tr>
<tr>
<td>Tuvalu</td>
<td>School Based &amp; Community Based Strategy</td>
<td>Need to finalise</td>
</tr>
<tr>
<td>Vanuatu</td>
<td>Health Promoting Workplace</td>
<td>Ongoing</td>
</tr>
<tr>
<td>Kiribati</td>
<td>Reduction of NCDs in the Workplace</td>
<td>Part of NCD Plan</td>
</tr>
<tr>
<td>Nauru</td>
<td>Integration of Nutrition Education and Home Gardening</td>
<td>Ongoing activity under Ministry of Agriculture</td>
</tr>
</tbody>
</table>
2.3 Evaluation

The results of the evaluation questionnaire are reported in Annex 3. In summary:

a) Participants generally felt that objectives of the workshop were either partly or fully met and that the workshop covered most of the important strategies and approaches for implementation of the DPAS.

b) Some participants felt that there was adequate coverage of diet but not physical activity.

c) There was some consensus that the format of the workshop could have been improved by using small group discussion and a greater variety of teaching methods. Presentations could have been more interactive and the duration of the workshop was too short for the wide range of topics covered. It was suggested that workshop be extended to five days instead of four.

d) Many participants felt that the workshop provided a useful opportunity for information sharing and networking with colleagues from other countries.

e) There was some dissatisfaction with the administration of the workshop. Travel and per diem arrangements need to be improved. More support staff is required for logistics; and some participants would like to change of the meeting venue for subsequent workshops.

f) Most of the participants felt confident they could implement their proposal, pending endorsement of their respective ministry.
3. RECOMMENDATIONS

(1) School-based interventions need to change from being solely curriculum-based to whole school initiatives.

(2) Pacific Islands Forum Secretariat be approached by WHO to suggest that “Health Promoting Schools” in the Pacific be included as an agenda item for the Education Ministers’ Meeting to be convened in Nadi, Fiji in October 2006.

(3) Forum member countries are encouraged to apply for Pacific Regional Initiatives for the delivery of basic Education (PRIDE) Project for funding support of their health-promoting curriculum activities.

(4) Regional Food-based Dietary Guidelines developed by SPC should be adopted by Member States after being adapted for local needs. Training be provided for health care workers, including ways to communicate the guidelines to the public.

(5) WHO-SPC Regional Guidelines on Physical Activity be developed and these guidelines be adopted by Member States after being adapted for local needs.

(6) Clinical Practice Guidelines for the Management of Overweight and Obesity should be used for education of doctors, nurses, nutritionists, and other allied health workers where appropriate and relevant.

(7) Regional Training be carried out in these key areas:

   a) Physical Activity: SPC has run three workshops and should evaluate them for impact and use this information to assist in designing future training workshops.

   b) Communication strategy and behaviour change communication should be linked with training on physical activity and nutrition and should be country specific with a multi-year plan instead of just “one-off” training, which is not cost-effective, as competencies attained are not sustained.

   c) Specific training on monitoring and evaluation of programmes is required. This training needs to be country specific and include training on statistical software usage, e.g. Epi-Info.

(8) Countries considering Health Promoting Workplace initiatives should use the NCD Mini- STEPS initiative as a framework. It also provides an excellent surveillance and evaluation tool.

(9) Community settings continue to be an opportune setting and Pacific island countries are encouraged to explore and utilize this platform to implement their diet and physical activity strategies.

(10) Relevant issues in the context of DPAS will be brought to the attention of the next Pacific Agricultural Ministers Meeting. One of the issues noted by the meeting was the need to augment the production of fruit and vegetables for local consumption and support
this by promoting integrated nutrition education in a gardening and horticulture programme.

(11) The group supports the need for the Codex Alimentarius Commission to consider the major food issues underlying the burden of illness in the Pacific caused by NCDs.

(12) The group agreed upon the importance of food labelling as a mechanism to assist consumers in making choices to reduce dietary risk factors, as identified by DPAS. Any labelling for the Pacific should be carefully adapted to local needs and be supported by an appropriate education campaign.

(13) Research Intervention: recognizes the strong evidence that Type 2 diabetes can be prevented with lifestyle intervention with diet and physical activity with maximum risk reduction in older age groups. There is a lack of evidence from the Pacific island countries as to the benefit of lifestyle interventions. NCD STEPS and other surveys indicate that populations in Pacific island countries would benefit from lifestyle interventions. The group, therefore, supports initiation of a regional research intervention on the prevention of diabetes in high-risk individuals through lifestyle intervention, and encourages appropriate countries to participate. Regional and international organizations may be willing to provide assistance.

(14) Consideration should be given to a regional approach to food labelling in the Pacific. It was noted that this is an important issue for the regional Codex Coordinating Committee as well as the Standards and Conformance work by the Forum Secretariat.

(15) A Health Promotion Foundation establishment is advocated for countries as a good mechanism for sustainable funding of health promotion activities. The meeting congratulates Fiji, French Polynesia, Kiribati, Tonga and Vanuatu for the important work they are doing and encourages others to do the same, advocating for the establishment of taxes on unhealthy foods, tobacco and alcohol as a mechanism for raising funds for health promotion programmes, and ensuring their sustainability.

(16) NCD STEPS continues to be a key factor in NCD strategic planning and advocacy and WHO and Fiji School of Medicine and other relevant agencies should continue to work together with countries to expedite the process.

(17) A network of information sharing for physical activity should be established for the Pacific region. It could be similar to the current network for nutrition (PACNUT). This could be started with the Asia-Pacific Physical Activity Network (APPAN), which seeks to stimulate, inform, and support implementation, evaluation of studies, and surveillance of physical activity, in as many Pacific island countries as possible.

(18) Country proposals developed during the workshop represent prioritized activities identified by the participants for the implementation of DPAS in their respective countries and follow up is to be done by WHO and SPC to ensure its significant progress and impact and to coordinate with other expertise for assistance in implementation. Countries are at different stages of implementation of NCD Strategies or National Plan of Action on Nutrition, which is also reflected, to some extent, in their respective proposals.
ANNEX 1

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ANNEX 2

WORKSHOP PROGRAMME

DAY 1 - Monday 3rd April

0800  Registration and posting of posters on Dietary and Physical Activity / lifestyles guidelines, display of IEC materials to communicate and promote use of guidelines, NCD or Nutrition plans including the 2-page proposal summary already prepared by participants

0830  Opening (Welcome, Introductions, Photo, outline of approach for workshop and selecting of chairperson & rapporteurs)

Setting the Scene

0930  WHO ‘Global Strategy on Diet, Physical Activity & Health and Global Report ‘Preventing Chronic Disease: A vital investment’ including Stepwise approach to Implementation of Integrated, Comprehensive Chronic Diseases Prevention and Control [Tommaso]

0950  WHO Kobe Expert Meeting and recommendations for preventing Childhood obesity [Chizuru]

1005  Refreshment break (and complete matrix of NPAN & NCD Strategies)

1030  Regional Obesity Prevention Efforts, NPAN & NCD Strategies (Samoa 2000, Fiji 02, Tonga 03, Samoa 05) [Tommaso]

1040  How are national plans and policies already addressing the DPAS strategy and other international commitments? [Viliami]

1100  Proposal Framework highlighting the questionnaire findings, the main areas of focus and output of the workshop [Temo]

1130  Discussion

1200  Lunch

Macro-Level Strategies

Dietary Guidelines and Fruit & Vegetable Promotion

1400  Global Dietary Guideline (WHO & FAO) and its promotion [Chizuru]

1415  ‘Healthy Eating Healthy Action’ - NZ [Tim]

1425  Guidelines on diet and lifestyle in SPC region [Viliami]

1440  Promotion of fruit & vegetable in the Pacific (SPC) – Christchurch meeting [Viliami]

1450  Promoting increase production and consumption of Fruit & Vegetables [Dirk]

1505  Country Presentations on dietary guideline and Fruit & Vegetable promotion (5-10 min)

   Samoa (Dietary guideline, Fruit Tree Promotion & Growing Easy)
CNMI (Using guideline appropriately for different population)
Tokelau (Home gardening project)

1530 Discussion on way forward for guidelines and promotion of production & consumption of fruit & vegetables

1545 Refreshment

*Integrating Diet & Physical Activity intervention in health system*

1600 Country Presentation on management of obesity and diabetes with lifestyle (10' each)
  - Australian National Guideline on Weight Control [Suzanne]
  - Tuvalu (PIP program)
  - Tonga [Viliami]
  - Pacific Diabetes Strategy – NZ [Tim]

1645 Delaying progress from Impaired Glucose Tolerance (IGT) to Diabetes through diet & physical activity [Viliami]

1700 Proposed multi-country project and discussion

1800 Cocktail

**DAY 2 - Tuesday 4th April**

6:00 Walk for Health

*Trade policies and food regulatory approaches to improve diets*

0800 Review of the application of trade policies and food regulatory approaches to improve diets in the Region and global developments in this area [Dave Clarke]

0830 Discussion

0845 Country Presentations on interesting experiences to share (10' each)
  - American Samoa (bottled drinks tax)
  - Northern Mariana Islands (taxes on sugary foods and drinks + fatty foods)
  - Micronesia (tax on alcohol and tobacco could be followed by future tax on fat and sugar + turkey tail ban tried without success in Yap)

Discussion on next steps and need of support and setting targets
Labelling and information on food as a guide to healthy choices

0930  Overview on Codex guidelines [Dirk Schultz]

0945  Australian Healthy Food tick system [Marion Dunlop]

1000  Country presentation (10' each)

   New Caledonia [The need to have all food labelled in French]

1010  Discussion on how to establish and implement legislation to ensure that all imported food is labelled based on agreed standards - steps needed to achieve this.

1030  Refreshment

Physical Activity Guideline and Best Practice

1100  Regional Physical Activity Guideline [PH]

1120  SPC’s Physical Activity Manual [Viliami]

1130  Best Practice: “Evidence based Physical Activity program review in developing countries “[PH]

1145  Country presentation on Physical Activity promotion (10' each)

   Nauru

   Australia

1205  General discussion on the way forward for Physical Activity guideline and promotion

1230  Lunch

Local Government Interventions to improve environments

1330  Country Presentation (10' each)

   Fiji (Nasese “Move for Health Walkway”)

   Marshall Islands

1350  Global examples - Spain Experience [Colin]

1405  Discussion on way forward for supportive environment

1425  Discuss and continue prepare proposals

1500  Refreshment break

1530  Discuss and continue prepare proposals

1715  ‘Walk for Health’ along Nasese Walkway
DAY 3 - Wednesday 5th April

06:00   Walk for Health

Micro-Level Strategies (Local Settings)

School interventions to promote healthy diets and physical activity

0800   Health Promoting Schools in the Pacific: overview on current activities and WHO, FAO and NZAID support [Jimaima, Tommaso]

0840   Obesity prevention in schools: assessment issues, indicators and cut-offs [Chizuru reports on the June consultation]

0900   Country presentations - reports from countries with active school health programmes (10’ each)
          Cook Islands (school curriculum and school food policy)
          Niue (SHEP)
          Kiribati

0930   The OPIC project: how it works and how it can contribute to obesity prevention programmes in schools and communities in other Pacific countries [Jimaima]

0945   General discussion on way forward for health promoting schools interventions

1000   Tea break

Workplace-based interventions for obesity prevention

1030   Principles and practicality of Healthy Island / Healthy workplace [Temo]

1045   Country presentation - Examples of programmes from countries (10’ each)
          Tonga
          Solomon Islands

1105   General discussion on way forward for interventions through health promoting workplace

Community-based interventions

1130   The role of Churches in obesity prevention in the Pacific
          Health promoting Village - Samoa
          Healthy Church Initiatives – Fiji ‘Apostles Gospel Outreach Fellowship International
          Healthy Church Initiatives – ‘Free Church of Tonga’

1200   Discussion – role of other community groups – Women’s Organisation etc

1230   Lunch
Health Promotion Specifics

Communication Strategies – Social Marketing & Behavior Change Communication in addition to Health Education

1330 Principles of Social Marketing & Behavior Change Communication [Will Parks]

1345 Country presentations (10’ each) - Examples from Fiji

NZ

1410 Next steps for the development and effective use of Communication Strategies for obesity prevention in the Pacific and support needed

Discussion of proposals

1500 Tea break

1515 Finalization of proposals by countries – discussion with facilitators

DAY 4- Thursday 6th April

0600 Walk for Health

Advocacy tools and initiatives

0800 Principles of Advocacy and profile [Will Parks]

0830 Advocacy examples [UNICEF]

0845 Country presentation: Examples of active advocacy for obesity prevention in Pacific countries [10’ each]

Palau

Vanuatu

0905 Discussion - Next steps for the development and use of advocacy tools and strategies for obesity prevention in the Pacific and support needed

Health Promotion Foundation and other financing mechanisms

0930 WHO/SPC promotion of Health Promotion Foundation and Pro-lead [Viliami/Dave]

Situation in Pacific countries [10’ each]

French Polynesia

Fiji
0955 Discussion - Next steps for the development and use of Health Promotion Foundation and other financing mechanisms for obesity prevention in the Pacific and support needed

1030 Refreshment

**Monitoring & Evaluation**

Monitoring and evaluation of programme process and impact

1045 General Monitoring and Evaluation Principles [Will Parks]

1100 OPIC project example [Jan Pryor]

1130 WHO STEPS survey and other options [Temo]

1145 General Discussion on Evaluation

**Pulling It Together**

1200 Presentation of Proposals – 5 min per country

1300 Lunch

1400 Presentation of Proposals –continued (5 min per country)

1500 Summary & General Discussion – Next Steps

1530 Closing & Refreshments
Workshop on ‘Implementation of Global Strategy on Diet, Physical Activity & Health in the Pacific’, Suva, 3-6 April 2006

Evaluation Questionnaire Results

1. The objectives of the workshop were as follows:
   a) To review progress and share experiences in the prevention and control of obesity, diabetes and related chronic diseases in the Pacific; and
   b) Identify priority actions on which countries and areas should focus to achieve maximum impact in the implementation of the DPAS.

Do you feel that these objectives were:

<table>
<thead>
<tr>
<th>Completely met</th>
<th>Partly met</th>
<th>Not met</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>15</td>
<td>1 (Objective B)</td>
</tr>
</tbody>
</table>

2. Did the workshop cover most of the important strategies / approaches for implementation of the DPAS?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>Missing</th>
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<tbody>
<tr>
<td>29</td>
<td>3</td>
<td>1</td>
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</table>

If not, what was missing?

Not enough Physical Activity and too much in a short time

Traditional & Cultural approaches

3. What do you think about the guidance provided for improving diets?

<table>
<thead>
<tr>
<th>very good</th>
<th>good</th>
<th>not very good</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>16</td>
<td></td>
</tr>
</tbody>
</table>

If not very good, what else would have been helpful?

4. What do you think about the guidance provided for improving physical activity?

<table>
<thead>
<tr>
<th>very good</th>
<th>good</th>
<th>not very good</th>
<th>missing</th>
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</thead>
<tbody>
<tr>
<td>18</td>
<td>11</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

If not very good, what else would have been helpful?

Not enough of Physical Activity

5. What do you think about the format of the workshop?

<table>
<thead>
<tr>
<th>Useful</th>
<th>Could be improved</th>
</tr>
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<tbody>
<tr>
<td>13</td>
<td>20</td>
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</table>

Explain how?

- Too much in short time, too intense - should make for 5 days
- Small group discussion would have been better
6. What do you think about the presentations in general?

<table>
<thead>
<tr>
<th></th>
<th>very good</th>
<th>good</th>
<th>not very good</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15</td>
<td>18</td>
<td></td>
</tr>
</tbody>
</table>

If not very good, what else would have been helpful?

Could change chairperson and repertoire day by day

7. What do you think about the discussion sessions in general?

<table>
<thead>
<tr>
<th></th>
<th>very good</th>
<th>good</th>
<th>not very good</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9</td>
<td>19</td>
<td>5</td>
</tr>
</tbody>
</table>

If not very good, what else would have been helpful?

Discussion in smaller groups to ensure participation of all

Somethings not clearly presented

Not enough time

8. Do you think that the workshop provided a useful opportunity for Information Sharing and networking with colleagues in other countries?

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Other (please explain)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30</td>
<td>2</td>
<td>2 - not enough time to share with others &amp; the morning walk was good in that sense but still need more time</td>
</tr>
</tbody>
</table>

9. What is your assessment of the general administration of the workshop?

<table>
<thead>
<tr>
<th></th>
<th>very good</th>
<th>Good</th>
<th>poor</th>
<th>very poor</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>5</td>
<td>20</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
- A lot of mix up and delays in Travel arrangements and confirmations to and from workshop
- Delay in per diem arrangements - should be properly organized
- Availability of secretariat support when needed
- Country Liaison Officers to assist in arrangement

10. How do you think we could improve such meetings in the future?

- Information on presentation sent early to countries
- More time for monitoring and evaluation
- Time management to be improved
- 5 days instead of 4
- Travel & Per diem better organized
- Balance of Physical Activity time
- More support staff for logistics - one is not enough
- Too many topics in too short a time - preferred less topics but more depths
- Hold the meeting in town instead of away from town
- Ensure right country representatives attend
- Working group sessions
- More time for proposal preparation and presentation

11. What is your personal feeling of the proposal you have prepared?

<table>
<thead>
<tr>
<th>Not sure and need to discuss further</th>
<th>Feel confident but need to discuss further at home and technical expertise</th>
<th>Feel very confident and would like support to progress it further to fruition</th>
<th>Other (please specify)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>22</td>
<td>5</td>
<td>1 - don’t speak English, 1 - feel confident to progress without much help</td>
</tr>
</tbody>
</table>

12. What kind of follow-up action or information would help maximize the impact of the workshop?

- Another workshop
- Another workshop on Advocacy
- STEP Survey to be carried out
- Training on Physical Activity
- Follow up of countries to check for implementation of program
- Share information between countries
- Exchange documents regularly as a newsgroup
- WHO to identify priorities in countries
- Group countries together with similar projects and conduct tele-meetings/ Follow up constantly by e-mails
- Post information on website
- Distribute the workshop report
- Regular contacts
- Mentoring of country groups by SPC / WHO
○ Presentation of more scientific studies presented
○ Keep in contact with NCD Office in WHO SP

13. Any other comments
○ Thanks for accepting me, I have learnt a lot from the workshop but more time and clarification on proposals
○ Thanks for the great work and a productive week - hope to implement some activities
○ Provide more information to participants before coming to the workshop
○ Thank you for the worthwhile opportunity - will implement
○ Need to improve time management
○ Thank you but evaluate organizing committee especially Travel & Perdiem
○ Behavior change communication built in to every NCD workshop
○ Advocacy tools and professional development
○ Thank you for the opportunity
○ Healthy Food at tea break & cocktail
○ Hotel gymnasium for rainy days
○ Half-day break in middle of workshop
○ Venue was good
○ Fruitful and enjoyable time
SUMMARY

1. INTRODUCTION
   1.1 Meeting objectives
   1.2 Participants and resource persons
   1.3 Organization
   1.4 Opening ceremony

2. PROCEEDINGS
   2.1 Presentations
   2.2 Country Proposals
   2.3 Evaluation

3 RECOMMENDATIONS

ANNEXES:

ANNEX 1 - FINAL LIST OF PARTICIPANTS

ANNEX 2 - WORKSHOP PROGRAMME

ANNEX 3 - WORKSHOP EVALUATION QUESTIONNAIRE AND RESULTS

Keywords:

Obesity – prevention and control/ Pacific Islands/ Samoa
Diabetes mellitus – prevention and control
Chronic disease – prevention and control
Health promotion
Physical Activity
Diet
Nutrition