PREVENTION OF HEALTH RISK FACTORS IN LATIN AMERICA AND THE CARIBBEAN: GOVERNANCE OF FIVE MULTISECTORAL EFFORTS
PREVENTION OF HEALTH RISK FACTORS IN LATIN AMERICA AND THE CARIBBEAN: GOVERNANCE OF FIVE MULTISECTORAL EFFORTS

Editor
María Eugenia Bonilla-Chacín
Health, Nutrition and Population
Latin America and the Caribbean region
World Bank
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<tr>
<td>ADL</td>
<td>activities of daily living</td>
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<tr>
<td>ALAD</td>
<td>Latin American Diabetes Association</td>
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<tr>
<td>ALIAR</td>
<td>Alianza Libre de Humo—Argentina (Smoke-free Partnership—Argentina)</td>
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<td>ANCT</td>
<td>Alianza Nacional para el Control del Tabaco (National Alliance for Tobacco Control), Uruguay</td>
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<tr>
<td>ANMAT</td>
<td>Administración Nacional de Medicamentos, Alimentos y Tecnología Médica (National Administration of Drugs, Food, and Medical Technology), Argentina</td>
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<td>ANSA</td>
<td>Acuerdo Nacional para la Salud Alimentaria (National Agreement on Food Health), Mexico</td>
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<tr>
<td>ASAGA</td>
<td>Asociación Argentina de Grasas y Aceites (Argentine Fats and Oils Association)</td>
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<tr>
<td>AsAT</td>
<td>Asociación Argentina de Tabacología (Argentine Tobacco Association)</td>
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<tr>
<td>BAC</td>
<td>blood alcohol concentration</td>
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<td>BAT</td>
<td>British American Tobacco</td>
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<td>BMI</td>
<td>body mass index</td>
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<tr>
<td>BRT</td>
<td>bus rapid transit</td>
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<tr>
<td>CAICHA</td>
<td>Argentinian Chamber of Sausages and Related Products Industry</td>
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<tr>
<td>CAMDI</td>
<td>Central American Diabetes Initiative</td>
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<tr>
<td>CANACINTRA</td>
<td>Cámara Nacional de la Industria de la Transformación (National Chamber for the Transformation Industry), Mexico</td>
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<td>CASEN</td>
<td>Encuesta de Caracterización Socioeconómica Nacional (National Socioeconomic Survey), Chile</td>
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<tr>
<td>CATCH</td>
<td>The Child and Adolescent Trial for Cardiovascular Health</td>
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<td>CATU</td>
<td>Comisión Antitabáquica del Uruguay (Uruguayan Anti-Tobacco Commission)</td>
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<tr>
<td>CCE</td>
<td>Consejo Coordinador Empresarial (Business Coordination Council), Mexico</td>
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<tr>
<td>CDC</td>
<td>Centers for Disease Control and Prevention, U.S.</td>
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<td>CHD</td>
<td>coronary heart disease</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>CHLCC</td>
<td>Comisión Honoraria de Lucha contra el Cáncer (Honorary Commission to Fight Cancer), Uruguay</td>
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<td>CIC</td>
<td>Comisión de Investigación Científica (Scientific Research Commission), Buenos Aires, Argentina</td>
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<td>CIET</td>
<td>Smoking Epidemic Research Center</td>
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<tr>
<td>CIPA</td>
<td>Chamber of Food Products Industrialists</td>
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<tr>
<td>CLACCTA</td>
<td>Comité Latinoamericano Coordinador para el Control del Tabaquismo (Latin American Coordinating Committee on Tobacco Control)</td>
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<tr>
<td>CNCD</td>
<td>Chronic noncommunicable diseases</td>
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<td>COFEMER</td>
<td>Comisión Federal de la Mejora Regulatoria (Federal Commission for Regulatory Improvement), Mexico</td>
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<td>CONACRO</td>
<td>Consejo Nacional para la Prevención y Control de las Enfermedades Crónicas no Transmisibles (National Council for the Prevention and Control of Chronic Noncommunicable Diseases), Mexico</td>
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<td>CONADE</td>
<td>Comisión Nacional de Cultura Física y Deporte (National Commission of Physical Culture and Sport), Mexico</td>
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<td>CONAGO</td>
<td>Conferencia Nacional de Gobernadores (National Conference of Governors), Mexico</td>
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<td>CONAGUA</td>
<td>Comisión Nacional del Agua (National Water Commission), Mexico</td>
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<td>CONAL</td>
<td>Comisión Nacional de Alimentos (National Food Commission), Argentina</td>
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<td>CONCAMIN</td>
<td>Confederación de Cámaras Industriales (Confederation of Chambers of Industry), Mexico</td>
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<td>CONEVAL</td>
<td>Consejo Nacional de Evaluación de la Política Social (National Evaluation Board of Social Policy), Mexico</td>
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<td>ConMEXICO</td>
<td>Consejo Mexicano de la Industria de Productos de Consumo (Mexican Council of Consumer Products Industries)</td>
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<td>CONPES</td>
<td>Consejo Nacional de Política Económica y Social (National Council for Economic and Social Policy), Colombia</td>
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<td>COPAL</td>
<td>Coordinadora de las Industrias de Productos Alimenticios (Coordinator of Food Product Industries), Argentina</td>
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<tr>
<td>COPD</td>
<td>chronic obstructive pulmonary disease</td>
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<td>CPI</td>
<td>Consumer Price Index</td>
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<td>CSO</td>
<td>civil society organization</td>
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<td>CVD</td>
<td>cardiovascular disease</td>
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<tr>
<td>DALYs</td>
<td>disability-adjusted life years</td>
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<td>DBP</td>
<td>diastolic blood pressure</td>
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<tr>
<td>DEIS</td>
<td>Health and Information Statistics Directorate</td>
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<tr>
<td>DHS</td>
<td>demographic and health survey</td>
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<tr>
<td>DIGESA</td>
<td>Dirección General de Salud (Directorate General of Health), Uruguay</td>
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<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>DOT</td>
<td>Department of Transportation</td>
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<td>DOTA</td>
<td>Declaration of the Americas on Diabetes</td>
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<tr>
<td>EAAB</td>
<td>Empresa de Acueducto y Acantarillado de Bogotá (Bogotá Water Supply and Sewage Company)</td>
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<tr>
<td>ECV</td>
<td>Encuesta de Condiciones de Vida (Quality of Life Survey), Colombia</td>
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<td>EHPM</td>
<td>Encuesta de Hogares de Propósitos Múltiples (Multiple Purpose Household Surveys), El Salvador</td>
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<td>EMNV</td>
<td>Encuesta de Hogares sobre Medición de Nivel de Vida (National Standard of Living Survey), Nicaragua</td>
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<td>ENCOVI</td>
<td>National Quality of Life Survey (Encuesta Nacional de Condiciones de Vida), Guatemala</td>
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<td>ENFR</td>
<td>National Risk Factors Survey</td>
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<td>ENHA</td>
<td>Expanded National Household Survey</td>
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<tr>
<td>ENSANUT</td>
<td>Encuesta Nacional de Nutrición y Salud (National Health and Nutrition Survey), Mexico</td>
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<tr>
<td>EPHF</td>
<td>Essential Public Health Functions</td>
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<tr>
<td>EPODE</td>
<td>Ensemble Prevenons l’Obesite Des Enfants (Together Let’s Prevent Childhood Obesity)</td>
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<tr>
<td>ETB</td>
<td>Empresa de Telecommunicaciones de Bogotá (Bogotá Telephone Company)</td>
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<tr>
<td>FAIPA</td>
<td>Federación Argentina de la Industria del Pan y Afines (Argentine Federation of Baked Products Industry)</td>
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<tr>
<td>FAO</td>
<td>Food and Agriculture Organization</td>
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<td>FBS</td>
<td>food balance sheet</td>
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<td>FCND</td>
<td>Food Consumption and Nutrition Division</td>
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<td>FCTC</td>
<td>Framework Convention on Tobacco Control</td>
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<td>FDA</td>
<td>Food and Drug Administration, United States</td>
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<tr>
<td>FENALCO</td>
<td>Federación Nacional de Comerciantes (National Federation of Businessmen)</td>
</tr>
<tr>
<td>FET</td>
<td>Fondo Especial del Tabaco (Special Tobacco Fund), Argentina</td>
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<tr>
<td>FIC</td>
<td>Inter-American Heart Foundation</td>
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<tr>
<td>GATS</td>
<td>Global Adult Tobacco Survey</td>
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<tr>
<td>GDP</td>
<td>gross domestic product</td>
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<td>GIVE</td>
<td>Statistics and Health Information Directorate</td>
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<td>GGCA</td>
<td>Globocan Global Cancer Atlas</td>
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<td>GNP</td>
<td>Gross National Product</td>
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<tr>
<td>GUIA</td>
<td>Guide for Useful Interventions for Physical Activity</td>
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<tr>
<td>Abbreviation</td>
<td>Full Name</td>
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<tr>
<td>GYTS</td>
<td>Global Youth Tobacco Survey</td>
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<td>HSS</td>
<td>Health and Human Services</td>
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<tr>
<td>IADB</td>
<td>Inter-American Development Bank</td>
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<tr>
<td>ICSID</td>
<td>International Centre for Settlement of Investment Disputes</td>
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<tr>
<td>IDF</td>
<td>International Diabetes Federation</td>
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<tr>
<td>IDRD</td>
<td>Instituto Distrital de Recreación y Deportes (District Recreation and Sports Institute), Colombia</td>
</tr>
<tr>
<td>IDS</td>
<td>individual survey</td>
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<tr>
<td>IDU</td>
<td>Instituto de Desarrollo Urbano (Urban Development Institute), Colombia</td>
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<tr>
<td>IFPRI</td>
<td>International Food Policy Research Institute</td>
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<tr>
<td>IMES</td>
<td>Specific Domestic Tax</td>
</tr>
<tr>
<td>IMESI</td>
<td>tobacco excise tax, Uruguay</td>
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<tr>
<td>IMSS</td>
<td>Mexican Social Security Institute (Instituto Mexicano del Seguro Social)</td>
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<tr>
<td>INAL</td>
<td>Instituto Nacional de Alimentos (National Food Institute), Argentina</td>
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<tr>
<td>INCA</td>
<td>National Institute of Cancer</td>
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<tr>
<td>INE</td>
<td>National Institute for Statistics</td>
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<tr>
<td>INEC</td>
<td>National Institute of Statistics and Census (Encuesta de Hogares de Propósitos Múltiples)</td>
</tr>
<tr>
<td>INNSZ</td>
<td>Salvador Zubirán National Institute of Medical Sciences and Nutrition</td>
</tr>
<tr>
<td>INSP</td>
<td>Instituto Nacional de Salud Pública (National Institute of Public Health), Mexico</td>
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<tr>
<td>INTA</td>
<td>National Institute of Livestock Technology</td>
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<tr>
<td>INTI</td>
<td>Instituto Nacional de Tecnología Industrial (National Institute of Industrial Technology), Argentina</td>
</tr>
<tr>
<td>IP-TFA</td>
<td>industrially produced partially hydrogenated fat</td>
</tr>
<tr>
<td>ISSSTE</td>
<td>Instituto de Seguridad y Servicios Sociales de los Trabajadores del Estado (Institute for Social Security and Social Services for State Workers), Mexico</td>
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<tr>
<td>L&amp;M</td>
<td>low- and middle-income</td>
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<tr>
<td>LAC</td>
<td>Latin America and the Caribbean</td>
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<tr>
<td>LMP</td>
<td>Land-use management plan</td>
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<tr>
<td>LUVEC</td>
<td>Liga Uruguaya de Voluntarios de Educación para la Prevención y Control del Cáncer (Uruguayan League of Education Volunteers for Cancer Prevention and Control)</td>
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<tr>
<td>MADD</td>
<td>Mothers Against Drunk Driving</td>
</tr>
<tr>
<td>MERCOSUR</td>
<td>Mercado Común del Sur (Common Market of the South)</td>
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<tr>
<td>MHAS</td>
<td>Mexican Health and Aging Study</td>
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<tr>
<td>Acronym</td>
<td>Full Form</td>
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<tr>
<td>MoALF</td>
<td>Ministry of Agriculture, Livestock, and Fisheries</td>
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<tr>
<td>MOH</td>
<td>Ministerio de Salud (Ministry of Health)</td>
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<tr>
<td>MSP</td>
<td>Ministerio de Salud Pública (Ministry of Public Health)</td>
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<tr>
<td>MxFLS</td>
<td>Mexican Family Life Survey</td>
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<tr>
<td>NCD</td>
<td>noncommunicable disease</td>
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<tr>
<td>NCD/D</td>
<td>noncommunicable disease and disability</td>
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<tr>
<td>NCHS</td>
<td>National Center for Health Statistics</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>PA</td>
<td>physical activity</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organization</td>
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<tr>
<td>PASL</td>
<td>Programa de Abasto Social de Leche de LICONSA (Social Milk Supply Program), Mexico</td>
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<tr>
<td>PEMEX</td>
<td>Mexican Petroleum</td>
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<td>PHA</td>
<td>Public Health Activities</td>
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<td>PI</td>
<td>Physical inactivity</td>
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<tr>
<td>PMC</td>
<td>Plan Maestro de CicloRutas (CicloRutas Master Plan), Bogotá, Colombia</td>
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<tr>
<td>PNCT</td>
<td>National Program for Tobacco Control</td>
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<tr>
<td>POT</td>
<td>Plan de Ordenamiento Territorial</td>
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<tr>
<td>PROFECO</td>
<td>Federal Consumer Protection Agency</td>
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<tr>
<td>PRONASA</td>
<td>Programa Nacional de Salud 2007-2012 (National Health Program 2007-2012), Mexico</td>
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<td>PROPIA</td>
<td>Programa de Prevención del Infarto en Argentina (Program to Prevent Heart Attacks in Argentina)</td>
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<td>PROSESA</td>
<td>Programa Sectorial de Salud 2007-2012 (Sectoral Health Program 2007-2012), Mexico</td>
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<td>PSA</td>
<td>public service announcement</td>
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<tr>
<td>QALYs</td>
<td>Quality Adjusted Life Years</td>
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<tr>
<td>R&amp;D</td>
<td>research and development</td>
</tr>
<tr>
<td>RENALOA</td>
<td>Red Nacional de Laboratorios Oficiales de Análisis de Alimentos (National Network of Official Laboratories for Food Protection), Argentina</td>
</tr>
<tr>
<td>RENAPRA</td>
<td>Red Nacional de Protección Alimentaria (National Food Protection Network), Argentina</td>
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<tr>
<td>SAGARPA</td>
<td>Secretaría de Agricultura, Ganadería, Desarrollo Rural, Pesca y Alimentación (Secretariat of Agriculture, Livestock, Rural Development, Fisheries, and Nutrition), Mexico</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
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<tr>
<td>SBP</td>
<td>Systolic blood pressure</td>
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<td>SE</td>
<td>Secretaría de Economía (Secretariat of Economy), Mexico</td>
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<tr>
<td>SEDENA</td>
<td>Secretaría de la Defensa Nacional (Secretariat of National Defense), Mexico</td>
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<tr>
<td>SEDESOL</td>
<td>Secretaría de Desarrollo Social (Secretariat of Social Development), Mexico</td>
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<tr>
<td>SEMAR</td>
<td>Secretaría de Marina (Secretariat of the Navy), Mexico</td>
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<tr>
<td>SEP</td>
<td>Secretaría de Educación Pública (Secretariat of Public Education), Mexico</td>
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<td>SET</td>
<td>Supplementary Emergency Tax</td>
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<tr>
<td>SFLAC</td>
<td>Spanish Fund for Latin America and the Caribbean</td>
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<tr>
<td>SHCP</td>
<td>Secretaría de Hacienda y Crédito Público (Secretariat of Finance and Public Credit), Mexico</td>
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<tr>
<td>SMU</td>
<td>Sindicato Médico del Uruguay (Uruguayan Medical Union)</td>
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<tr>
<td>SNDIF</td>
<td>Sistema Nacional para el Desarrollo Integral de la Familia (National System for Comprehensive Family Development), Mexico</td>
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<tr>
<td>SS</td>
<td>Secretariat of Health</td>
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<tr>
<td>STPS</td>
<td>Secretaría del Trabajo y Previsión Social (Secretariat of Labor and Social Welfare), Mexico</td>
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<tr>
<td>SUMEFA</td>
<td>Uruguayan Society of Family Physicians</td>
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<td>SUT</td>
<td>Uruguayan Tobaccology Society</td>
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<tr>
<td>TFC</td>
<td>Transnational food companies</td>
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<tr>
<td>TFR</td>
<td>Total fertility rate</td>
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<tr>
<td>TLS</td>
<td>Traffic light system</td>
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<tr>
<td>TM</td>
<td>TransMilenio, Bogotá, Colombia, bus rapid transit system</td>
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<tr>
<td>TTC</td>
<td>Transnational tobacco companies</td>
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<tr>
<td>UATA</td>
<td>Unión Antitabáquica Argentina (Argentine Anti-Smoking Union)</td>
</tr>
<tr>
<td>UNICA</td>
<td>Argentinian Beef Industry Union</td>
</tr>
<tr>
<td>UNLP</td>
<td>Universidad Nacional de la Plata (National University of La Plata), Argentina</td>
</tr>
<tr>
<td>VAT</td>
<td>Value added tax</td>
</tr>
<tr>
<td>VIGI+A</td>
<td>Health Surveillance and Disease Control</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<td>WHO</td>
<td>World Health Organization</td>
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NCDs represent an important and growing burden to the health and economies of the Latin America and the Caribbean (LAC) region. However, some of this burden can be prevented or control through targeted clinical services and multisectoral activities aimed at improving diet, promoting physical activity, and reducing tobacco use and alcohol abuse. This study focuses on these population-wide, multisectoral interventions to prevent risk factors for NCDs.

This report complements the regional study entitled “Promoting Healthy Living in Latin America and the Caribbean: Governance of Multisectoral Activities to Prevent Risk Factors for Noncommunicable Diseases,” which hopes to contribute to the design of multisectoral policies to effectively prevent NCDs in the region. This study seeks to answer the following questions: What is the health and economic burden of NCDs in the region? What are countries doing to promote healthy living and prevent risk factors for NCDs? What are the main governance challenges countries face in developing and implementing population-wide NCD prevention interventions and which are the success stories? What else can the region do to reduce health risk factors and prevent the onset of NCDs?

This second volume of the regional study documents governance challenges in the design and implementation of promising or successful population-wide interventions intended to prevent health risk factors in LAC. This second volume focuses on the process whereby public officials develop and implement primary-prevention policies and programs. Specifically, this volume is composed of five commissioned case studies on multisectoral interventions to promote healthy living in the region. These case studies examine which stakeholders participated directly or indirectly in the decision-making process; what positions they held; which incentives they faced; which strategies they pursued; how did existing institutional arrangements affect the decision-making process; what lessons can be drawn from these processes; and what were the successes and setbacks?

Health policies are shaped not just by public officials, but also by wider and contextual social and political processes (Roberts and others 2008). In population wide interventions, these processes tend to be complex. In contrast to secondary prevention and curative interventions that take place within the health system, population-based interventions involve a multitude of actors and opposing forces within and outside government.

This report provides a glimpse into the types of opposing interests and power games involved in proposing, passing, and implementing successful or promising population-based health interventions in LAC. The aim is to provide information on the struggles and challenges involved in the design and implementation of policies, presenting an array of possible instruments and models that could be useful and adaptable to specific scenarios.
To study how successful or promising policies and programs intended to prevent risk factors for NCDs were developed and implemented, this study uses the framework detailed in the work by Roberts and others (2008), which was used to explain the political economy of tobacco control in low- and middle-income countries in Bump and others (2009). This framework explains the politics of any health reform and, in doing so, shows how health policies are shaped by the interaction of four factors: players, each player’s relative power, the position taken by the players, and the public perception of the reform. The interplay between the different stakeholders, their power to shape policies, and the strategies they use inevitably affects the short- and long-term outcomes of any population-based reform (Roberts and others 2008). According to this framework, the abovementioned four factors are not fixed and can be influenced through political strategies that the players adopt.

The first four case studies examined are the following: Argentina’s policies to reduce the consumption of trans fats and sodium; Bogotá’s (Colombia) built environment that promotes physical activity; Mexico’s National Agreements on Food Health (the National Strategy to Fight Obesity); and Uruguay’s anti-tobacco policies. Because Argentina’s and Mexico’s policies are relatively new, information on their effectiveness is limited. They have been included here because they are some of the region’s most comprehensive policies in the fight against NCDs risk factors and because similar policies have proven to be highly cost-effective elsewhere. Uruguay’s and Bogotá’s policies are older, and their effectiveness has been better documented. A fifth case—Argentina’s tobacco control policies—was added to this analysis. Despite the fact that Argentina has not yet signed the Framework Convention on Tobacco Control, the country has advanced in tobacco control, and its experience could have important lessons for the region.

The selection of the case studies was based on an overview of major population-based interventions in the region. The first four were considered to be some of the most representative and promising examples of policies and programs that promote healthy lifestyles and reduce risk factors for NCDs. Each case study was included because it examined a program or policy targeting a distinct risk factor. In addition, to ensure as wide as possible a representation, the case studies were drawn from different countries. There was no case study commissioned on alcohol control. Although there are some good examples of alcohol control policies in LAC, they are limited in their geographical focus or on the array of interventions or sectors involved.

This complementary volume presents, after the introduction and before the documentation of the five case studies, an overview of the first volume of the regional study. Each case study starts with a description of the context in which the multisectoral policy under review was designed, including the epidemiological situation and the prevalence of relevant health risk factors. The context review is followed by a detailed description of the relevant policy and by an analysis of the policy design and implementation process, the key players in these processes, and the strategies used by each player to support or oppose the policy. Each case study concludes with an analysis of the factors that made possible the design and implementation of the policies reviewed and the lessons learned from the design and implementation processes.
References


Photography: María Eugenia Bonilla Chacín, The World Bank, Latin America and the Caribbean Region
The purpose of this report is to contribute to the design and implementation of policies that promote healthy living in Latin America and the Caribbean (LAC), thus effectively preventing premature mortality from noncommunicable diseases (NCDs) in the region. It examines the health and economic impact of NCDs in the region and the governance challenges in the design and implementation of multisectoral policies to prevent these conditions, including policies to improve diet, increase physical activity, and reduce tobacco use and alcohol abuse. The study focuses on how policy decisions involving multisectoral interventions to prevent health risk factors are taken, which stakeholders directly or indirectly participate in those decisions, which incentives they experience, and what strategies they use in these processes.

The document is based on desk reviews, an analysis of existing databases, and commissioned case studies. In analyzing the health and economic burden of NCDs and their risk factors, this study incorporates new detailed analysis of dietary patterns in selected countries in LAC. It also includes new analyses of household surveys that explore the potential impact of NCDs on labor markets and on households’ health expenditures in the region. Finally, for the analysis of the governance challenges involved in the design and implementation of selected multisectoral policies in LAC, country case studies were commissioned. These case studies were mainly based on interviews with key stakeholders that participated in these processes.

The Health and Economic Burden of NCDs in LAC

The Latin American and Caribbean region has been experiencing a rapid demographic and epidemiological transition. Not only is the region’s population aging fast, it is also experiencing major lifestyle changes, including dietary alterations and more sedentary ways of
life. These changes, in turn, have led to shifts in LAC’s disease and mortality profiles, which have translated into a greater proportion of NCDs within the overall burden of disease.

NCDs such as heart disease, stroke, cancer, and diabetes are the main causes of death and disability in the region. In addition, NCD death rates in LAC (adjusted by age) are higher than those prevalent in higher income countries; in fact, the region has some of the highest diabetes death rates in the world. And not only are death rates higher in LAC than in higher income countries, people in the region are also dying from these conditions at younger ages. NCDs affect everyone in the region, rich and poor, urban and rural residents, men and women.

NCDs also represent an increasing economic and development threat to households, health systems, and economies in the region. NCDs require continuous contact with the health system for long periods of time and, if not controlled, can result in costly hospitalization. Moreover, out-of-pocket payments for health services, particularly for drugs, can impoverish households that have members with these conditions. Data from Colombia, Jamaica, Nicaragua, and Peru show that out-of-pocket expenditures in households that include someone with a chronic condition are more than double those of households that do not; the greatest difference is in expenditures on drugs. In Colombia and Nicaragua, households with a chronic disease patient are also more likely to have catastrophic health expenditures. NCDs also generate a large negative impact on the labor market, particularly in countries where most workers are in the formal sector. Evidence from Brazil, Chile, Colombia, El Salvador, and Honduras suggests that NCDs have a greater negative impact (5 percent or higher) on labor market participation in more formal economies such as Chile’s or Brazil’s. The combination of NCDs’ effect on labor participation, hours worked, and productivity suggests that in these countries these diseases could have a negative impact of about 0.25 percent of gross domestic product (GDP), which could increase to 0.40 percent once the effect of related disability is included.

Much of this health and economic burden can be avoided, however, since an important share of NCDs is due to exposure to preventable risk factors, such as an unhealthy diet, a sedentary lifestyle, tobacco use, and alcohol abuse (WHO 2005). Indeed, there are cost-effective, population-based interventions designed to reduce exposure to these risk factors (WHO 2011a). Many of these interventions require the active participation of several sectors outside of the health sector, although the health sector’s involvement is key to ensure that these needed interventions actually occur.

Risk Factors for NCDs in LAC

An unhealthy diet represents an important health risk for the LAC population. Diets in several countries in the region are dense in energy and high in sodium, refined sugar, and fats. An analysis of household surveys from Bolivia, Costa Rica, Ecuador, Guatemala, Honduras, Nicaragua, and Panama shows that, on average, the consumption of added sugar and fat in these countries’ diets is higher than WHO’s recommended levels. Moreover, estimates from all these countries indicate that caloric intake in a large share of households is higher than necessary to maintain a healthy weight. Average sodium intake is also higher than recommended levels, while the intake of fruits and vegetables is lower. These dietary patterns are likely to increase the risk of developing NCDs. Energy-dense diets, and diets rich in salt, sug-
ars, and fats and poor in fruits and vegetables increase the risk for cardiovascular diseases, diabetes mellitus, certain cancers, dental caries, and osteoporosis (WHO 2003).

Energy-dense diets, combined with a sedentary lifestyle, are responsible for the large percentage of overweight and obese adults in the region, particularly among women. According to WHO data, half of adult men and two-thirds of adult women in the region are overweight or obese, greatly exceeding the average rate in the Organisation for Economic Co-operation and Development (OECD) countries. Indeed, due to the disability-adjusted life years (DALYs) lost attributed to high body mass index (BMI), the Burden of Disease Study 2010 ranked high BMI as the first health risk factor in some Southern Cone countries (Argentina, Chile, and Uruguay); the second in the Caribbean and in Central America, Colombia, and República Bolivariana de Venezuela; and the third in the rest of the region (Lim and others 2012).

In several countries, high rates of overweight and obesity coexist with high rates of chronic malnutrition. Three of the four countries in the world with the highest percentage of overweight mothers and malnourished children are in LAC—Bolivia, Guatemala, and Nicaragua (Garret and Ruel 2003). Often, these conditions are related; for instance, low birthweight and child malnutrition have been associated with increases in the rates of hypertension, cardiovascular diseases, and diabetes in adults (WHO 2005).

Tobacco use remains among the first five health risk factors in the region, due to the DALYs lost attributed to it (Lim and others 2012). Nearly one in four adult men and one in seven adult women in the region smoke; smoking prevalence is also high among youth. Argentina, Bolivia, Chile, Cuba, Uruguay, and República Bolivariana de Venezuela are the countries in the region with the highest percentage of adults who are tobacco users (WHO 2011b).3 Alcohol abuse is the leading health risk factor in most Latin American and Caribbean countries. In fact, in 2010 alcohol use was estimated to be the leading health risk factor in all LAC subregions, with the exception of the Caribbean and of countries such as Argentina, Chile, and Uruguay, where alcohol ranked among the first five risk factors (Lim and others 2012). WHO ranked Belize, Ecuador, Guatemala, Mexico, Nicaragua, and Paraguay as the region’s countries with the highest alcohol-related health risk. These countries have the highest consumption of alcohol per drinker and the largest percentage of drinkers reporting binge drinking (WHO 2011c). Alcohol abuse not only increases the risk of developing some NCDs, but it also increases the risk of injuries, including those related to traffic accidents and violence.

### International Experience in Multisectoral Interventions to Prevent Health Risk Factors: Overcoming Governance Challenges Involved in Their Design and Implementation

These changes in lifestyle and in the disease profile in the region present important demands on policymakers. Many of the interventions needed to prevent some of the negative economic and health impacts of NCDs go beyond the health sector and beyond interventions that it traditionally delivers. Thus, health-sector policymakers not only must ensure that the prevention, control, and surveillance of these diseases take place within the sector but also must ensure that multisectoral preventive interventions are implemented. Improving diet, increasing physical activity, and reducing to-
bacco use and alcohol abuse require the concerted effort of various stakeholders working in multiple sectors (see table O.1). In addition to the public sector’s participation, the private sector and civil society also must participate. Given the involvement of so many stakeholders, often holding opposing views, policymakers and other health advocates must cope with various challenges in the governance of the decision-making process of these interventions.

Despite these challenges, there are many promising or successful international experiences, including promising examples in LAC, such as are listed in table O.1. The table’s second column classifies the different groups of interventions to improve nutrition, promote physical activity, and reduce tobacco use and alcohol abuse, according to their cost-effectiveness following WHO (2011a). Most interventions included in the table are those that WHO (2011a) considers as “best buys,” in that they are “cost-effective, low cost, and can be implemented in low resource settings”; the majority of these aim at controlling tobacco use and alcohol abuse, but some target improving diet. Other cost-effective interventions, as well as effective interventions whose cost-effectiveness evidence remains limited, are also listed in the table.

In order to learn from these successful or promising international examples, it is important to understand the processes whereby they were developed and implemented. To that end, it is important to examine the major stakeholders who influenced and shaped policy decisions, their positions, incentives faced, and strategies used; the institutional arrangements that framed the decision-making process; public perception of the policies; interaction between different stakeholders during the decision-making and implementation process; and lessons learned from these experiences. Table O.2 maps the main stakeholders, their position and strategies, and the results obtained for some of the policies reviewed.

### Main Stakeholders

Many different stakeholders participate in the design and implementation of interventions aimed at improving diet, promoting physical activity, and reducing tobacco use and alcohol abuse (table O.1 and table O.2). In policies aimed at improving diet, many government actors outside the ministries of health or local health authorities have played important roles, such as ministries of agriculture, institutes of industrial technology, and consumer protection agencies (e.g., Food and Drug Administration [FDA], United States). The food industry also has actively participated, sometimes opposing government actions, sometimes working with the government to advance public health goals. Restaurant associations and the advertising industry also have become involved. In many policies to promote physical activity, local authorities (e.g., cities, municipalities, and communities) had leading roles in their design and implementation, particularly local transportation, sports and recreation, and urban-planning agencies. In tobacco- and alcohol-control policies, various governmental agencies were important players, not just those within the health sector, but also agencies in agriculture, commerce, economy, and finance sectors, as well as the legislative branch of government. In tobacco- and alcohol-control policies, the role of civil society organizations has been particularly important and effective in advocating for and supporting control policies. In both alcohol- and tobacco-control policies, particularly in the case of tobacco control, industry and
producers can become stakeholders who effectively oppose control efforts.

The mobilization toward a public health goal does not necessarily originate with the government, but can arise with external interest groups that advocate for reform. These groups can be provider groups, such as doctors or nurses; consumer groups; or groups advocating for specific issues, such as preventing underage drinking (the United States), reducing tobacco use (Uruguay and Argentina), or temporarily closing roads to motor vehicles for recreational activities (Bogotá, Colombia). These groups’ legislative success depends on various factors, including their ability to convince and mobilize enough political players and to develop sound, evidenced-based solutions to public health challenges.

Governments and health advocates face no shortage of difficulties in promoting healthy living. On the one hand, companies and businesses tend to resist measures they view as overly intrusive or that could lower their profits; on the other, citizens may oppose the idea because they may feel that it infringes on their personal liberties or lifestyle, or that it tells them how to live. Some of these stakeholders can be very powerful in terms of the resources they can bring to bear in opposing these policies. This is particularly so regarding the transnational tobacco, alcohol, and food and beverage industries. Efforts to improve public health by reducing salt intake, eliminating trans fats from processed foods, levying taxes on alcohol, adding bike lanes, or banning smoking in public places, are far from immune to such opposition.

In the design and implementation of these policies, policymakers, politicians, and other health advocates have been able to overcome the different governance challenges. This has required, among other things, intense dialogue and negotiation with all parties involved, strong coordination mechanisms, the assessment and mobilization of public opinion, the use of information and research to steer public opinion and important stakeholders, strong leadership of politicians and policymakers, and taking advantage of favorable conditions for the design and implementation of these policies.

As a result of the government’s initiating a dialogue, an industry may develop its own guidelines and standards to improve public health. Such was the case in the United Kingdom, when the food manufacturers developed their own nutritional labeling standards (Traffic Light System [TLS]).

Because these voluntary actions can be ineffective, policymakers have had to impose regulations to replace them. In Europe, Canada, and the United States, early voluntary nutrition labeling actions failed to meet government standards and expectations, leading governments to switch to mandatory guidelines. In New York City, encouraging restaurants to voluntarily
provide customers with nutrition information in plain sight also proved ineffective, and the city mandated regulation. Industry-led initiatives to pursue public health goals and prevent NCDs also have proven to be less satisfactory in the case of food advertising. For example, industry guidelines restricting inappropriate advertising, such as promoting unhealthy foods to children, proved weak and resulted in low levels of adherence across the industry. This led the U.K. government to impose statutory regulations that restricted advertising for unhealthy foods by limiting the hours during which ads for foods high in fat, sugar, and salt could be aired on television (Hastings and Cairn 2010).

Sometimes the interplay between the government and the sector it seeks to regulate can be highly confrontational, and governments should be prepared for this. The regulation of the tobacco industry is one such example. Until recently, the tobacco industry was one of the most powerful industries in the consumer market. It is not a coincidence, then, that tobacco-control policies sometimes took decades to take effect and, in the success stories reviewed here, required the commitment of many political players. The steadfastness of policymakers, coupled with popular support, becomes even more critical in tobacco-producing countries such as Brazil and Argentina. But even those countries that have successfully reduced tobacco prevalence through strong control policies still face hurdles, as does Uruguay. In 2010, Phillip Morris International brought to the International Centre for Settlement of Investment Disputes (ICSID) an arbitration procedure against the Government of Uruguay for its tobacco-control policies, specifically for the requirement that 80 percent of the packages display health warnings and for the prohibition for companies to differentiate their brands across products.

Most successful efforts required strong coordination among the many participating stakeholders. Often, this coordination was made possible through the leadership of ministries of health and through institutional arrangements that favored such coordination. The role of the health sector has been key in many of the examples reviewed. Often it initiated the dialogue among relevant actors and ensured coordination among them. Such was the case in Argentina’s agreements to reduce sodium and the revision of the country’s Food Code to reduce trans fats in processed foods. To this end, a Ministry of Health (MOH) initiative created a National Commission to Eliminate Trans Fats and Reduce Salt that included several public and business organizations, scientific associations, and civil society groups. Similarly in Uruguay, at the request of the MOH, the National Alliance for Tobacco Control (ANCT) was established; this coordinating entity comprised government agencies, parastatal organizations, international organizations, academic institutions, and nongovernmental organizations (NGOs). Finally, in the case of the Ciclovía in Bogotá, Colombia, the creation early on of the Ciclovía multisectoral committee (composed of bicycle activists, the police, the Traffic and Transport Department, and the National Cycling Federation) bolstered its development.

Policymakers and health advocates in general often gauge and mobilize public opinion in support of health promotion policies and ensure their design and implementation. For instance, while the regulation to reduce trans fats was being discussed in New York City, the city government provided constant and persuasive messages to the public on the links between trans fats and coronary heart disease; this con-
certed information campaign contributed to garner public support for the regulation. The policy to promote smoke-free environments in Uruguay also was accompanied by strong communication campaigns to ensure public support. Similarly, in the city of Diadema, Brazil, through education campaigns and discussions with alcohol retailers, public opinion quickly turned favorable to alcohol restriction policies (Pacific Institute for Research and Evaluation 2004).

In many of these ventures, research played a critical role in the adoption of population-wide preventive interventions. Independent research institutions were fundamental in moving policies forward, and their participation often represented the turning point toward reform. A solid and convincing research base is indispensable for shaping public opinion and raising support for policies. In the United Kingdom, for example, the decision to create a statutory regulation on advertising foods to children was influenced by research that found an association between advertising and children’s food preferences and by a study showing that a large percentage of the expenditure on food advertising during children’s air time was for foods high in fat, sugar, and salt (Hastings, Stead, and McDermott 2003). In Brazil, the National Cancer Association organized meetings and conferences following the circulation of alarming data on the health consequences of tobacco consumption (Da Costa and Goldfarb 2003), but that research needs to be communicated effectively to policymakers and the public. Both in the United Kingdom and in Brazil, civil society groups played a crucial role in publicizing that data and raising awareness among the population.

Whether an initiative is community-based or national in scope, whether it tackles obesity, enforces alcohol restrictions, or limits tobacco use, the leadership and political commitment of a few key political figures has been at the heart of many of the successful cases. For example, Brazil and Uruguay are countries where a group of committed politicians and policymakers, supported by strong advocacy groups, effectively fought efforts from tobacco lobbyists and put in place comprehensive and effective tobacco-control policies. In Brazil, which is a major tobacco producer, the leadership and commitment of key political players, such as the director of the National Institute of Cancer, Marcos Moraes, and the then-Minister of Health, Jose Serra, were crucial in leading the country along the path of tobacco control. In Uruguay, President Tabaré Vasquez played an important role in moving policies forward. In Bogotá, Colombia, the continuous effort of two mayors, Antanas Mockus and Enrique Peñaloz, was behind the consolidation of the city’s built environment. The leadership of New York City Mayor Michael Bloomberg also deserves mention as an important factor behind the healthy lifestyle initiatives in that city.

Often, policymakers’ engagement is shaped by the advocacy and persuasion of civil society groups. Such was the case for policies involving the Minimum Legal Drinking Age (MLDA) in the United States. One organization in particular, Mothers Against Drunk Driving (MADD), founded by the mother of a victim of a repeat drunk driver, was fundamental in convincing politicians and policymakers, including then-President Ronald Reagan, to pass a bill that awarded highway funds to states with anti-drunk-driving measures in place (Grant 2011).

Taking advantage of favorable conditions or moments has also been key in the successful enactment and implementation of some of
these policies. In the case of tobacco control, the international context created by the Framework Convention on Tobacco Control (FCTC) has facilitated the adoption of tobacco-control policies worldwide. The signing and ratification of the FCTC in Uruguay gave strong impetus to that country’s tobacco-control policies. Similarly, Colombia’s decentralization process made it possible for elected mayors to independently pursue policies that changed Bogotá’s built environment.

The Unfinished Agenda

Given LAC’s disease profile and the existing evidence on cost-effective interventions to prevent NCDs at the population level, it is important for the region’s countries to strengthen their multisectoral efforts to reduce health risk factors, particularly those targeting tobacco use and alcohol abuse. Although there are several cost-effective interventions to decrease exposure to tobacco use and alcohol abuse, there are fewer measures intended to improve diet and promote physical activity, with the exception of interventions aimed at decreasing the intake of sodium and trans fats. Thus, controlling tobacco use and, particularly, alcohol abuse, the main health risk factors in most of the region, should be the main priority. That said, given the importance of overweight and obesity as a risk factor, the region’s countries also should experiment with different programs and policies aimed at stopping the increase in BMI and even to reverse it.

The region has seen several examples of successful or promising interventions to promote healthy living, such as the agreements between the government and industry to reduce sodium and the reform of the Food Code to reduce trans fats in processed foods in Argentina; the establishment of a built environment that promotes physical activity in Bogotá, Colombia; the national agreement for food health in Mexico (Strategy against Overweight and Obesity); and tobacco-control policies in Uruguay (table O.1). And there are additional examples: at both the local and national levels, groups of motivated and deeply committed policymakers and health advocates have effectively countered opposition and been able to put in place effective and long-lasting policies to prevent NCDs.

Despite these successful and promising examples, however, there is scant evidence of ongoing activities to fight NCDs at the population level in LAC, with the exception of tobacco control. Much remains to be done in the region to improve diet, promote physical activity, and reduce tobacco use and alcohol abuse.

For example, even though Argentina, Brazil, Chile, Costa Rica, and Mexico are pursuing reductions in the intake of sodium and trans fats, these efforts are the exception, rather than the rule. Moreover, these measures have yet to be consolidated and evaluated. And the region is only starting to design and implement community-based interventions to prevent and control overweight and obesity. Although halting the increasing trend in the percentage of overweight and obese persons has proven difficult across the globe, there are some policies that have proven effective in improving diet and promoting physical activity. Since nutrition habits start very early on in life, and since a growing number of children in the region are overweight, interventions at the school level would be important to consider and evaluate.

An example worthy of closer examination was Mexico’s National Agreement for Food Health, a promising blueprint for action in the fight against obesity. With high rates of obesity in the country, the government set up a comprehensive strategic plan that involved the
collaboration of multiple actors, including different government agencies, the private sector, civil society, and academia. The government intended to reduce overweight and obesity by increasing opportunities for physical activity and improving the population’s diet. According to the plan, increased physical activity was to be pursued throughout schools, workplaces, neighborhoods, and communities. The plan also sought to ban trans fats and to implement programs across different sectors of society to encourage a greater consumption of fruits, vegetables, and grains.

Some of the region’s cities are implementing policies aimed at building environments that facilitate physical activity. For example, many cities in the region have Ciclovías, sustainable public transportation systems, and/or bike routes. One of the best examples of this approach is in Bogotá, Colombia. Mostly, though, these efforts concentrate in large urban centers and in upper-middle-income countries. In the case of Ciclovías, for instance, although a majority of countries have at least one, most are in one or two large urban centers. Only Colombia, Brazil, Mexico, and Peru have several active ones.

In terms of tobacco control, almost all the region’s countries have ratified the FCTC and have passed laws and regulations accordingly. But often these laws are not fully enforced. Moreover, there is also much improvement to be done in terms of fiscal policies, since many countries still have room to increase taxes on tobacco products. In 2010, in only 4 out of 32 countries for which data was available, did taxes represent more than 70 percent of the price of the most frequently sold brand of cigarettes.

Most countries have in place some cost-effective interventions needed to control alcohol abuse, but often these are not adequately enforced either (WHO 2011b; Monteiro 2007). For instance, most countries in the region have laws on blood-alcohol concentration levels and restrictions on hours when alcohol can be sold, but their enforcement is inconsistent. In addition, because there are many gaps in these laws, particularly in terms of restricting alcohol sales, legislation needs to be strengthened. As mentioned earlier, alcohol abuse is the leading health risk factor in the region, as it increases the risk of injuries and of developing NCDs. Despite this, information about comprehensive strategies to control alcohol abuse in the region is scanty. In the literature review conducted for this study, only two good examples were found of comprehensive strategies, both at the local level: initiatives in the cities of Diadema and Paulina in Brazil.

Because some multisectoral interventions to prevent health risk factors are more effective at the regional level, it is important that regional and subregional approaches to promote healthy living be developed. This is true for fiscal policies, particularly tobacco and alcohol taxation policies. Further, harmonizing tobacco and alcohol pricing (through tax levels) at the regional level would reduce the incentive for smuggling. And harmonizing tobacco advertising bans and nutrition labels would also make these policies more effective. There are some subregional efforts under way in this regard, such as the work by Common Market of the South (MERCOSUR) countries in nutritional labeling and the work of the intergovernmental Commission for Tobacco Control, which also is part of MERCOSUR.

Strengthening the countries’ surveillance systems should be part of any strategy to prevent and control NCDs. There is little information on some health risk factors and, when it is
available, it is not standardized and thus is difficult to compare. This is particularly true for information on sedentary lifestyle, overweight and obesity, abnormal blood-glucose levels, high blood pressure, and high blood-lipid levels. Some countries do not even have available data on tobacco use and alcohol abuse. Information on the prevalence of NCDs, although available for most countries, is usually based on administrative data, which makes it very difficult to disaggregate by socioeconomic group, rural or urban residence, or level of education. This, in turn, makes it difficult to target interventions to groups that need it most.

Little research and evaluation has been conducted on existing policies and interventions in LAC countries. This is particularly important in the case of policies aimed at improving diet and promoting physical activity, as there is less international evidence on cost-effective interventions targeting these risk factors. Project Guide for Useful Interventions for Physical Activity (GUIA), an initiative funded by the U.S. Centers for Disease Control and Prevention (CDC), is attempting to fill this void for physical inactivity. Yet, as important as this project is in shedding light on current physical activity interventions in the region, it is not enough. In order for the region’s governments to execute meaningful plans to reduce NCDs, it is crucial that they themselves establish an overview of the current situation, demonstrating the strengths and weaknesses of ongoing programs and identifying where more action is needed. In addition, international and regional experiences have shown the importance of research, not only for evidence-based policymaking, but also to enlist the public’s support for health promotion policies.
### Table 0.1. International Examples of Multisectoral Interventions Designed to Reduce Noncommunicable Disease Risk Factors

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Cost-effectiveness</th>
<th>Intervention</th>
<th>Examples</th>
<th>Sectors involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unhealthy diet</td>
<td></td>
<td>Salt-reduction strategies</td>
<td>North Karelia, Finland, community program subsequently extended nationwide. Argentina, agreements with the food industry to reduce sodium in processed foods.</td>
<td>Agriculture, health, food industry, food retail industry, advertising industry, restaurant associations, city governments, the legislature, others.</td>
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<td></td>
<td>Best buy&lt;sup&gt;a&lt;/sup&gt;</td>
<td>Replacing trans fats</td>
<td>New York City, ban on trans fats. Denmark, legislation regulating trans fat levels in processed foods. Puerto Rico, ban on trans fats. Argentina, reform of the Food Code to regulate amount of trans fats in processed foods.</td>
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<tr>
<td>Other cost-effective&lt;sup&gt;b&lt;/sup&gt;</td>
<td></td>
<td>Regulating advertising on marketing of foods and beverages high in salt, fat, and sugar, especially to children</td>
<td>United Kingdom, statutory regulation on advertising</td>
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<td></td>
<td>Taxes and subsidies to promote healthy diets</td>
<td>Poland, elimination of butter and lard subsidies.</td>
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<tr>
<td>Physical inactivity</td>
<td>Effective with insufficient evidence on its cost-effectiveness&lt;sup&gt;c&lt;/sup&gt;</td>
<td>Modifying the built environment to increase physical activity</td>
<td>New York City, bike lanes and bike paths. Bogotá, Colombia, sustainable public transportation, Ciclovía, CicloRutas, and outdoor gyms.</td>
<td>City governments, urban planning, transport, health, civil society organizations (CSOs), and the media.</td>
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<tr>
<td>Risk factor</td>
<td>Cost-effectiveness</td>
<td>Intervention</td>
<td>Examples</td>
<td>Sectors involved</td>
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<td>Community based programs to improve nutrition and increase physical activity</td>
<td>Effective with insufficient evidence on its cost-effectiveness.</td>
<td>Work-based programs</td>
<td>United States, &quot;Treatwell 5-a-Day&quot; program to increase fruit and vegetable consumption.</td>
<td>Agriculture, health, food industry, food retail industry, schools, work places, food retailers, others.</td>
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<td></td>
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<td>School-based programs</td>
<td>United States, Child and Adolescent Trial for Cardiovascular Health (CATCH).</td>
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<td>United States, Pathways (randomized control study among Native American school children).</td>
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<td>Other community-based programs</td>
<td>North Karelia, Finland, decreasing salt and fat consumption and increasing fruit and vegetable consumption.</td>
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<td>Europe, EPODE.</td>
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<td>Tobacco use</td>
<td>Best buys¹</td>
<td>Fiscal Measures</td>
<td>Several successful examples worldwide.</td>
<td>Finance, health, agriculture, legislature, international organizations, tobacco industry, farmers, CSOs.</td>
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<td>Banning smoking in public places.</td>
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<td>Raising awareness and increasing knowledge about dangers of tobacco use.</td>
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<td>Enforcing bans on tobacco advertising, promotion and sponsorship.</td>
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</table>
### Table: Risk factor Cost-effectiveness Intervention Examples Sectors involved

<table>
<thead>
<tr>
<th>Risk factor</th>
<th>Cost-effectiveness</th>
<th>Intervention</th>
<th>Examples</th>
<th>Sectors involved</th>
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</thead>
<tbody>
<tr>
<td>Alcohol abuse</td>
<td>Best buys&lt;sup&gt;a&lt;/sup&gt;</td>
<td><strong>Fiscal Policies</strong> Restrictions on availability and access to alcohol</td>
<td>USSR, Gorbachev anti-alcohol legislation.</td>
<td>Federal and state governments, city governments, health sector, police, agriculture, alcoholic-beverage industry, and CSO.</td>
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<td>Limiting the hours of alcohol sales</td>
<td>Australia, Halls Creek Aboriginal town limit of alcohol sales.</td>
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<td></td>
<td>Australia, Halls Creek Aboriginal town limit of alcohol sales.</td>
<td>New Zealand, liquor bans and limitations on alcohol-sale hours.</td>
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<td></td>
<td>Other cost-effective efforts&lt;sup&gt;b&lt;/sup&gt;</td>
<td>Age restrictions on alcohol purchase and sale</td>
<td>United States, raising the Minimum Legal Drinking Age (MLDA).</td>
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<td><strong>BAC&lt;sup&gt;c&lt;/sup&gt;</strong></td>
<td>United States, “Checkpoint Tennessee” program to decrease drunk driving</td>
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Note: The table includes most of the programs reviewed for this study. The cost-effectiveness classification in the second column of the table refers to the intervention in general (in the abstract) as per WHO (2011a). It does not necessarily refer to each particular example provided of each intervention.

EPODE = Ensemble Prevenons l’Obesite Des Enfants (Together Let’s Prevent Childhood Obesity); LAC = Latin America and the Caribbean.

- **Best buys** are interventions that WHO (2011a) considers as “cost-effective, low cost, and can be implemented in low resource settings.”
- **Other cost-effective efforts** are other cost-effective interventions that are not among WHO’s “best buys.”
- These are effective interventions for which there is insufficient evidence on their cost-effectiveness.
- Blood alcohol concentration.
### Table 0.2. Design and Implementation of Population-based Preventive Policies, by Risk Factor.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Key stakeholders</th>
<th>Positions</th>
<th>Strategies</th>
<th>Outputs or outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>An unhealthy diet</td>
<td>Salt and saturated fat reduction strategies in North Karelia, Finland.</td>
<td>Local government, health services, schools, social services, NGOs, supermarkets, food industry, community leaders, and media. Ministries of Agriculture and of Commerce National Nutrition Council</td>
<td>The government: reducing salt intake benefits the population’s health. The food industry: salt is an inexpensive way to add taste and to preserve food. Ministries of Agriculture and of Commerce: support to farmers and businesses affected by the change in consumption patterns. Dairy farmers: reduction of dairy consumption has negative economic effect. Ministries of Agriculture and of Commerce financed a collaborative project between berry farmers, the berry industry, and commercial and health authorities to find innovative ways and new product development to promote berry consumption and help dairy farmers switch to berry production.</td>
<td>Output: 20 percent decrease in salt intake in 20 years. Outcome: Decreased cardiovascular disease rates by 73 percent in North Karelia between 1971 and 1995.</td>
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<tr>
<td>Intervention</td>
<td>Key stakeholders</td>
<td>Positions</td>
<td>Strategies</td>
<td>Outputs or outcomes</td>
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<td>Agreements with industry to reduce sodium in processed foods and to amend the food code to regulate trans fats in Argentina</td>
<td>MOH: Ministry of Health</td>
<td>MOH: protect the population against harmful effect of excessive sodium and trans fats.</td>
<td>MOH: (i) Coordinated the process, (ii) articulated actions with other public agencies, (iii) negotiated actions with the private sector, and (iv) disseminated information to consumers.</td>
<td>Output: 8,000 bakeries have signed agreements to reduce salt in bread.</td>
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<td>INAL: National Food Institute</td>
<td>INAL: as part of the Ministry, held similar position.</td>
<td>INAL: Contributed regulatory, technological, and monitoring knowledge. With INTI, MALF, and COPAL, it designed a manual to help small and medium enterprises to eliminate trans fats in their production processes.</td>
<td>In addition, more than 20 large companies have signed agreements with the Government to reduce sodium in several processed foods.</td>
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<td>INTI: National Institute of Industrial Technology</td>
<td>INTI: similar position to the Ministry, but with a few disagreements.</td>
<td>INTI: In terms of sodium, it provides training to bakeries. In the case of trans fats, it presents and disseminates evidence on the viability of replacing trans fats and sodium in food.</td>
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<td>COPAL: (Coordinator for Food Product Industries), which included FAIPA (Argentinean Federation of Baked Products Industries) and ASAGA (Argentinean Association of Fats and Oils)</td>
<td>COPAL/FAIPA/ASAGA: representing the industry wanted to avoid sudden implementation of policies that could be costly and respond to demands from public for healthier foods.</td>
<td>COPAL/ASAGA: Organized meetings with companies to agree on the terms and goals to be discussed with the MOH. Collected and delivered information on sodium content in food. Through ASAGA, it contributed technical know-how to replace trans fats and organized meetings with companies to agree on the terms and goals to be discussed with the MOH. It also helped design the manual for small and medium size enterprises with INTI and MALF.</td>
<td>Outcomes: Both policies still need to be fully monitored and their impact evaluated.</td>
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<tr>
<td>Intervention</td>
<td>Key stakeholders</td>
<td>Positions</td>
<td>Strategies</td>
<td>Outputs or outcomes</td>
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<tr>
<td>Replacing trans fats in New York City, United States</td>
<td>New York City Board of Health, New York State Restaurant Association (NYSRA)</td>
<td><strong>The government:</strong> reducing trans fat intake benefits the population’s health. <strong>NYSRA:</strong> changing production processes is costly</td>
<td><strong>Board of Health:</strong> (1) First strategy was to convince restaurants to voluntarily reduce trans fats. City provided training for this. When this failed, strategy moved to ban trans fats. (2) To address restaurants concerns, the city gave an extension to reach goal of reducing trans fat levels to 0.5 grams per serving. (3) Effective communication campaign linking trans fats to coronary heart disease</td>
<td>This regulation is enforced. The city has fines of up to US$ 2,000 for noncompliance.</td>
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<tr>
<td>Physical inactivity</td>
<td>New York City Department of Transportation (NYC DOT), Neighbors for Better Bike Lanes and Seniors for Safety, Businesses, The public</td>
<td>NYC DOT: bike lanes promote environmental sustainability, attract businesses and tourism, and increase physical activity. Neighbors for Better Bike Lanes and Seniors for Safety: Both sued NYC DOT, charging that DOT inflated the number of lanes used and understated the number of accidents. Businesses: bike lanes would inconvenience city drivers, would limit parking for deliveries, and would hinder sales. The public: A poll showed a higher than 60 percent support for bike lanes</td>
<td>NYC DOT made all information available, showing that the increase in bike lanes actually reduced the number of pedestrian killed in pedestrian-bike accidents.</td>
<td>N/A</td>
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<tr>
<td>Intervention</td>
<td>Key stakeholders</td>
<td>Positions</td>
<td>Strategies</td>
<td>Outputs or outcomes</td>
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<td>Tobacco use</td>
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<td>Tobacco control policies, Uruguay</td>
<td>The presidency: Supported tobacco control</td>
<td>The presidency: Enacted several executive decrees to fast track tobacco control policies.</td>
<td>From 2006 to 2009 there was a 10 percentage point decline the prevalence of daily smokers among people 15 to 64 years old in urban centers (95 percent of population)</td>
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<td>Ministry of Health (MOH) and, since 2005, the Tobacco Control Program</td>
<td>MOH: Supported tobacco control</td>
<td>The Alliance: lobbied in Parliament for tobacco control; worked towards the ratification of the FCTC; and provided lawmakers with scientific evidence on the extent of the tobacco problem.</td>
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<td>National Alliance for Tobacco Control, which includes the MOH, and several parastatals, international organizations, NGOs, CSOs, and others.</td>
<td>Alliance: Strong advocate of tobacco control policies</td>
<td>MOH and National Tobacco Control Program, since 2005: launched broad media campaign to ensure public support of the smoke-free environment decree; developed and launched the country’s controls and, at the national level, coordinated its efforts with the other groups that were developing policies; and checks policy’s compliance.</td>
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<td></td>
<td>The tobacco industry.</td>
<td>The tobacco industry: tried to avoid these policies.</td>
<td>The tobacco industry: (i) When Uruguay became a smoke-free country in 2006, the industry claimed the controls limited “freedom” and smokers’ “rights;” (ii) further, when parliament debated the tobacco law, it lobbied lawmakers to reject it; (iii) finally, it used litigation at national and international levels. In 2008, it filed judicial and administrative lawsuits in the country against all the regulations. In 2012, it requested arbitration to the International Centre for Settlement of Investment Disputes (World Bank).</td>
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<td>Trade associations of bars, restaurants, casinos, and businesses.</td>
<td>Trade associations of bars, restaurants, casinos, and businesses: Originally opposed the smoke-free environments as they thought it would have negative economic impacts on them. They also wanted to ensure transparency in the implementation of penalties for non-compliance with smoke free environments.</td>
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<td>Intervention</td>
<td>Key stakeholders</td>
<td>Positions</td>
<td>Strategies</td>
<td>Outputs or outcomes</td>
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<td>New York City Smoke-free Air Act (the ban was combined with a tax increase).</td>
<td>NYC Board of Health Tobacco industry New York Nightlife Association. Empire State Restaurant and Tavern Association. Public.</td>
<td>The New York City Board of Health: measure would reduce exposure to second-hand smoke. The tobacco industry: measure would lead to loss of revenues. New York Nightlife Association and Empire State Restaurant and Tavern Association: the ban would harm the city’s economy by decreasing profits on the city’s bars and restaurants. The public: poll showed a 59 percent approval rate of the ban among NYC residents.</td>
<td><strong>New York Nightlife Association and the Empire State Restaurant and Tavern Association:</strong> A study prepared for the associations stated that, following the ban, staffing had been reduced by 16 percent in bars, hotels, and nightclubs, and that three-fourths of bars and restaurants had experienced a 30 percent decline in patronage (Ridgewood Economic Associates 2004). <strong>The tobacco industry:</strong> it financed the restaurant and bar associations’ opposition to the ban. <strong>The New York City Board of Health:</strong> sponsored an evaluation that contradicted the associations’ findings. Its study found that, despite the smoking ban, the city had experienced increases in jobs, liquor licenses, and business tax payments since the law had taken effect. Moreover, data from the city’s Department of Finance found that, from April 2003 to January 2004, city restaurant revenues had increased by about US$ 1.4 million, compared to the same period the year earlier (Elliott 2004).</td>
<td>After the ban and the tax increase, smoking decreased by 11% (from 21.6% to 19.2%) between 2002 and 2003, following the intervention. The decrease occurred in all five boroughs across all age groups, race/ethnicities, education levels, and gender. Almost half of all respondents attributed the air free act, and the decreased exposure to smoke, as the primary reason for the decrease in smoking (Frieden and others 2005).</td>
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<td>Intervention</td>
<td>Key stakeholders</td>
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<td>Strategies</td>
<td>Outputs or outcomes</td>
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<tr>
<td>Alcohol abuse</td>
<td></td>
<td></td>
<td>Ministries of Finance and of Trade and the Central Planning Commission: Opposed the law because it drastically reduced revenues from alcohol sales of government distilleries and from excise taxes. Health authorities: wanted to reduce the burden of disease created by alcohol abuse.</td>
<td>Between 1985 and 1987, years when the anti-tobacco policy was in effect, male life expectancy in Russia increased from 61.7 to 64.9, and female life expectancy increased from 73 to 74.3. In contrast, from 1988 to 1994, after the legislation was rescinded, male life expectancy decreased to 57.6 and female life expectancy to 71 years (Leon and others 1997).</td>
</tr>
<tr>
<td>Intervention</td>
<td>Key stakeholders</td>
<td>Positions</td>
<td>Strategies</td>
<td>Outputs or outcomes</td>
</tr>
<tr>
<td>--------------</td>
<td>------------------</td>
<td>-----------</td>
<td>------------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>
| U.S. National Minimum Drinking Age Act increased the minimum legal drinking age (MLDA) to 21 years. | Advocacy groups such as Mothers Against Drunk Driving, Different Congress representative, Alcohol industry, President, Public | **Advocacy groups:** wanted to increase the MLDA to reduce traffic accidents produce by drunk driving.  
**Congressional representatives:** Two house representatives introduced a bill to increase MLDA to 21; some senators opposed it, sustaining that it violated the Constitution, as it ran against principles of federalism; in their view this should be a responsibility of the states.  
**The alcohol industry:** opposed the measure, as it would reduce sales.  
**The president:** originally opposed the federal mandate, but eventually supported measures to increase MLDA.  
**The public:** strong support for the measure. | **Advocacy groups:** presented a large body of research showing the benefits of increasing MLDA, particularly in regard to the dramatic increase in fatal accidents following less restrictive alcohol policies. |
References


the Empire State Restaurant and Tavern Association, May 12.


Notes

1. There are also cost-effective clinical interventions to control some of the biological or intermediate risk factors. However, they are not the focus of this document.

2. Data comes from WHO’s Global Health Observatory Data Repository on Tobacco.


4. A ciclovía is a program that temporarily closes streets to motor vehicles and offers safe and free spaces for recreation and physical activity.

5. For additional information on Ciclovías, visit http://www.cicloviasrecreativas.org/en/map.
PREVENTION OF HEALTH RISK FACTORS IN LATIN AMERICA AND THE CARIBBEAN: Governance of Five Multisectoral Efforts
CHAPTER 1.

Policies for the Elimination of Trans Fats and the Reduction of Sodium Consumption in Argentina

MARÍA EUGENIA BARBIERI, FOR THE NATIONAL MINISTRY OF HEALTH OF ARGENTINA

This case study describes how Argentina has advanced in designing and implementing policies to eliminate trans fats and reducing the consumption of sodium in its population. Its content is based on published materials on the subject and interviews with key stakeholders of both initiatives.

Context

According to World Health Organization (WHO) estimates, NCDs represent 80% of total deaths and 76% of DALYs in Argentina (WHO, 2009). Moreover, according to data from the Directorate of Health Statistics and Information (DEIS from its Spanish acronym), the leading cause of death in 2010 was cardiovascular disease, followed by cancer (DEIS, 2011).

In 2008, WHO developed the Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases, in order to (a) monitor and analyze the determinants of chronic NCDs in order to guide the policies that control them; (b) reduce the level of exposure to common chronic NCD risk factors; and (c) strengthen the care for people with chronic NCDs by means of standards and cost-effective guides (WHO, 2008). Based on these guidelines, as well as with the Pan American Health Organization’s (PAHO) Regional Strategy for the Prevention and Control of Noncommunicable Chronic Diseases, Argentina created a similar national strategy through Ministerial Resolution 1083/09.

In the context of this strategy, various actions are being carried out to reduce the prevalence of risk factors and mortality and to improve access and quality of care. Actions designed to promote a healthy diet also has been
implemented, given that nutrition has been established as a key determinant of chronic NCDs that can be modified. Indeed, increasing evidence shows that changes in eating habits can have both positive and negative effects on a person’s health throughout his or her life course. Moreover, changes in the diet can have long-term effects, such as the likelihood of developing cancer, diabetes, or cardiovascular diseases (WHO, 2003).

Argentina has launched two activities dealing with nutrition problems: the first, “Argentina 2014 Free from Trans Fats,” a program designed to gradually replace trans fats in the diet; and “Less Salt, More Life,” which aims to reduce sodium consumption.” Both strategies are coupled by campaigns promoting fruit and vegetable consumption and physical activity.

Consumption of Trans Fats and Sodium in Argentina

Diets worldwide are currently undergoing a “nutritional transition,” characterized by high consumption of saturated fats, sugars, and salt (such as milk, meats, refined grains, and processed foods) and reduced intake of complex carbohydrates, fibers, leafy greens, other vegetables, and legumes. Such dietary habits contribute to hypertension, higher cholesterol, diabetes, overweight, and obesity (WHO, 2008, 2003; OPS, 2007).

In terms of trans fats, evidence shows that their consumption increases the risk of coronary disease and diabetes (Hu, 2001, 1997; Brunner, 2007). That said, evidence also shows that there are proven ways to eliminate their use in prepared food, which would be a cost-effective way to prevent cardiovascular diseases (OPS, 2008). It is estimated that a reduction of 2% in the consumption of trans fats would avoid between 30,000–130,000 cases of ischemic heart disease each year in Mexico, Central America, and South America and a reduction of 4% would prevent twice that number (Mozaffarian, 2008).

Regarding sodium consumption, studies have demonstrated a causal relationship between salt intake and cardiovascular disease and stroke, as well as a greater risk of hypertension (OMS, 2007). Evidence also has shown that small reductions in salt intake during four or more weeks significantly lower blood pressure, in both persons with normal blood pressure and in those with high blood pressure (He, 2004). In Argentina, it is estimated that lower sodium in processed foods could decrease the incidence of coronary disease by 10%, myocardial infarctions by 7.3%, strokes by 11.8%, death from coronary disease by 6.5%, and deaths from all causes by 2.5%. Moreover, reducing sodium in food would decrease spending in health, by preventing those health problems linked to its consumption (Ministerio de Salud de la Nación, 2010).

The National Risk Factors Surveys (ENFR, for its Spanish acronym), conducted in Argentina in 2005 and 2009, sheds light on salt consumption in the country’s population. At the national level in 2009, 25.3% of the population always added salt to food after it was cooked, representing an increase compared to the 23.1% figure recorded in 2005. An analysis by age group (conducted in 2009) showed a higher prevalence of salt consumption among 18–24-year-olds, with 32.9% of this age group adding it to their foods, and lower percentages for age groups older than 50—14.7% for the 50–64 age group and 18.4% for those 65 and older (Table 1.1) (Ministerio de Salud de la Nación, 2011, 2006).
Table 1.1. Prevalence of salt consumption (always or almost always) by age group, Argentina, 2005 and 2009 (in percentages).

<table>
<thead>
<tr>
<th>Year</th>
<th>Grupos de edad (en años)</th>
<th>18–24</th>
<th>25–34</th>
<th>35–49</th>
<th>50–64</th>
<th>65 and older</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td></td>
<td>33.5</td>
<td>29.1</td>
<td>22.3</td>
<td>17.0</td>
<td>12.5</td>
<td>23.1</td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td>32.9</td>
<td>31.1</td>
<td>26.7</td>
<td>19.5</td>
<td>14.8</td>
<td>25.3</td>
</tr>
<tr>
<td>Variation</td>
<td></td>
<td>-1.8</td>
<td>6.9</td>
<td>19.7</td>
<td>14.7</td>
<td>18.4</td>
<td>9.5</td>
</tr>
</tbody>
</table>

*Source: Author, based on data from the National Risk Factors Survey, 2005 and 2009.*

The 2009 and 2005 ENFRs also help to analyze the variables associated with the consumption of trans fats and sodium, because they gather information on cholesterol, blood pressure, diabetes, and bodyweight in adults (Table 1.2). Nationwide in 2009, 29.1% of the population reported having high cholesterol, an increase of 4.3% over 2005. Those older than 65 reported the highest levels (39.7%), followed by 50–64-year-olds (39%); 18–24-year olds accounted for only 13% of the cases, and those 25–34 years old, for 16.4%. All age groups showed increases, especially those 35–49 years old.

The ENFRs collected bodyweight information through respondents’ self-reporting. According to the surveys, 18% of Argentina’s population was obese in 2009. This represents a 23.3% increase over the 14.6% figure recorded in 2005. In regard to age groups, those 50–64 years old showed the highest percentage of obesity (27.3%); the ENFRs also highlighted the increase in obesity among those 18–24 years old since the 2005 survey.

In 2009, 34.8% of the population reported having high blood pressure, a slightly higher percentage than that seen in 2005 (34.5%). Those 65 years and older had the highest prevalence at 63%, an increase of 7.1% over the 2005 figure (55.8%). In fact, the prevalence of high blood pressure was directly related to age.

The percentage of population that reported having diabetes or high blood glucose in 2009 was 9.6%, a value higher than that recorded in 2005 (8.4%). Prevalence was higher in older groups, with 19.0% among those over 65, compared to 3.6% among those 18–24. An important decrease in the prevalence of diabetes among those under 34 was also observed between 2005 and 2009.
Table 1.2. Prevalence of high cholesterol, obesity, hypertension, and diabetes, Argentina, 2005 and 2009 (in percentages).

<table>
<thead>
<tr>
<th>Variable</th>
<th>Year/variation</th>
<th>Age groups (in years)</th>
<th>18–24</th>
<th>25–34</th>
<th>35–49</th>
<th>50–64</th>
<th>65 and older</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>High cholesterol</td>
<td>2005</td>
<td>11.9</td>
<td>15.3</td>
<td>22.0</td>
<td>37.3</td>
<td>38.0</td>
<td>27.9</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>13.0</td>
<td>16.4</td>
<td>24.1</td>
<td>39.0</td>
<td>39.7</td>
<td>29.1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Variation</td>
<td>9.2</td>
<td>7.2</td>
<td>9.5</td>
<td>4.6</td>
<td>4.5</td>
<td>4.3</td>
<td></td>
</tr>
<tr>
<td>Obesity</td>
<td>2005</td>
<td>3.9</td>
<td>10.4</td>
<td>16.9</td>
<td>22.8</td>
<td>17.7</td>
<td>14.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>6.6</td>
<td>12.8</td>
<td>21.1</td>
<td>27.3</td>
<td>20.1</td>
<td>18.0</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Variation</td>
<td>69.2</td>
<td>23.1</td>
<td>24.9</td>
<td>19.7</td>
<td>13.6</td>
<td>23.3</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>2005</td>
<td>13.9</td>
<td>21.3</td>
<td>30.2</td>
<td>47.4</td>
<td>58.8</td>
<td>34.5</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>14.2</td>
<td>20.2</td>
<td>28.9</td>
<td>47.2</td>
<td>63.0</td>
<td>34.8</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Variation</td>
<td>2.2</td>
<td>-5.2</td>
<td>-4.3</td>
<td>-0.4</td>
<td>7.1</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>2005</td>
<td>4.7</td>
<td>6.7</td>
<td>7.8</td>
<td>17.2</td>
<td>20.4</td>
<td>8.4</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2009</td>
<td>3.6</td>
<td>4.3</td>
<td>7.9</td>
<td>15.1</td>
<td>19.0</td>
<td>9.6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Variation</td>
<td>-23.4</td>
<td>-35.8</td>
<td>1.3</td>
<td>-12.2</td>
<td>-6.9</td>
<td>14.3</td>
<td></td>
</tr>
</tbody>
</table>


Information from the 2005 and 2009 ENFRs shows that obesity, diabetes, and high cholesterol increased, while high blood pressure remained relatively constant, which is consistent with an unhealthy diet and an increase in physical inactivity. These risk factors are also more prevalent among populations at highest risk, with lower incomes, lower levels of education, and lower prospects of having access to health care in case of illness (Ferrante, 2011).

Policies: Actions Designed to Eliminate Trans Fats and Decrease the Consumption of Sodium in the Diet

Argentina, through its Ministry of Health and pursuing an inter-sectoral approach, called on different sectors involved in the regulation, production, and distribution of food to come up with joint actions designed to reduce trans fats and lower sodium consumption in the population’s diet. However, the approach adopted for each of these targets was different. In the case of sodium, the government sought industry’s self-regulation through the signing of voluntary agreements, while for trans fats, an amendment of the Food Code was agreed upon, which became effective in December 2010.

Approaches differed because the food industry was already working to replace the trans fats, given that the technical feasibility, foreign experience, research/development, and existing substitutes were already available to do so. In fact, 70% of the sector’s companies are already pursuing retrofitting. In regards to sodium, the situation is more complex, because this ingredient is found in many processed foods, there is less awareness of its effects (such as
There is with trans fats), its substitution is more difficult, and more technical know-how is needed to find alternatives and parameters for acceptable sodium levels in food.

The strategies are carried out within the framework of the National Commission to Eliminate Trans Fats and Reduce Salt, which was created at the Ministry of Health’s initiative; the Commission is made up of several public organizations, chambers of commerce, scientific associations, and civil society groups (Box 1.1).

### Box 1.1
**Participating Institutions in the National Commission to Eliminate Trans Fats and Reduce Salt**

- Ministry of Health
- Ministry of Agriculture, Livestock, and Fisheries
- Ministry of Social Development
- Ministry of Science and Technology
- Ministry of Economy
- National Institute of Industrial Technology (INTI)
- National Food Institute (INAL)
- Argentinian Federation of Baked Products Industry (FAIPA)
- Coordinator of Food Products Industries (COPAL)
- Argentinian Association of Fats and Oils (ASAGA)
- Chambers of commerce
- Workers’ cooperatives
- Universities and scientific societies
- Consumer associations

*Source: Argentina’s Ministry of Health*

Although addressing the problem of trans fats and sodium in Argentinians’ diet began in full force in 2008, the Ministry of Health had launched some efforts in 2004, as requested by the Program for the Prevention of Heart Attacks in Argentina (PROPIA) at the National University of La Plata (UNLP). The program’s purpose is to reduce the number of deaths and patients due to atherosclerosis (heart attacks) through actions focused on a healthy diet, physical activity, and anti-smoking campaigns. Within this framework, WHO’s Global Strategy on Diet, Physical Activity, and Health (2008) came under discussion, particularly those issues dealing with food content and the necessary actions to move the initiative forward. Some projects were also financed with funds from the Health Surveillance and Disease Control (VIGI+A) Program, such as the one designed to reduce salt in artisanal breads, which fell under the responsibility of the National Institute of Industrial Technology (INTI).5
Eliminating Trans Fats

Overwhelming evidence about the effects of trans fats on health led to a recommendation to eliminate their consumption (WHO 2004). Then, in 2007, the Pan American Health Organization (PAHO) created the Trans Fats-Free Americas working group to evaluate trans fats’ effect on nutrition and health and discuss practical steps to gradually eliminate them from food. In 2008, the group issued the Declaration of Rio de Janeiro, Trans Fat-Free Americas in which it suggested the following (OPS, 2008):

1. Replacing trans fats in processed foods and using a concentration of no more than 2% total fat in oils and margarines, and no more than 5% in processed foods.
2. Compulsory nutritional labeling of processed foods, including a statement of the content of trans fatty acids.
3. Developing education programs on different types of fats and the way to read labels, and on applying the information in everyday life.
4. Forming national working groups with the participation of industry, the scientific community, and public health authorities.

In 2008, the Ministry of Health adopted a leading role in the implementation of measures to eliminate trans fat convening a national meeting to begin applying the Rio recommendations. Participants included representatives from State agencies, academia, and industry, who endorsed the formation of various working commissions (Secretaría de Políticas, Regulación e Institutos y Secretaría de Agricultura, Ganadería y Pesca, 2010). They include the:

1. Academic-Scientific Commission, coordinated by UNLP;
2. Regulation-Legislation Commission, coordinated by the National Food Institute (INAL); 6

In August 2008, the Regulation-Legislation Commission began its work to amend the Food Code, prepare a manual with recommendations for small and medium enterprises, and develop consumer guides on healthy eating habits. The commission was made up of several public agencies and representatives from the food industry. INAL, the former Secretariat of Agriculture, Livestock, Fisheries, and Food (current Ministry of Agriculture, Livestock, and Fisheries), the Ministry of Health, and INTI were among the participating public agencies. Industry representatives included the Coordinator of Food Products Industries (COPAL), a business association for chambers of commerce, food and beverage companies, and the Argentinian Association of Fats and Oils (ASAGA), an entity formed by technicians and companies involved in the production and processing of fats, oils, and byproducts which was already working on ways to substitute other products for trans fats.

Amendments to Argentina’s Food Code relied on other countries’ experiences. For example, in 2006, Denmark limited trans fats to 2% of the total content of fats in all marketed foods and, that same year, Canada recommended that trans fats should not exceed 2% of total fat content in vegetable oils and spreadable margarines, nor 5% of other foods (OPS, 2008). The joint effort between public agencies and the food-industry representatives made it possible to reach an agreement to reduce trans fats and prepare an amendment to the Food Code,
after approval by the National Food Commission (CONAL), which was reflected in Article No. 155 tris, chapter III, of the Argentine Food Code, which established that (Código Alimentario Argentino, 1969):

“The content of industrially-produced trans fatty acids in food should not exceed: 2% of total fats in vegetable oils and margarines for direct consumption and 5% of total fats in the rest of foods. These limits do not apply to fats from ruminants, including milk fat.”

The article was incorporated by resolution No. 137/10 and No. 941/10 of the Secretariat of Policies, Regulation, and Institutes (Ministry of Health) and the former Secretariat of Agriculture, Livestock, and Fisheries, and Food (current Ministry of Agriculture, Livestock, and Fisheries), in December 2010. The resolution also sets a two-year timetable for modifying vegetable oils and margarines for direct consumption and up to four years for other foods from December 2010), when the resolution entered into effect (OPS, 2008).

While the terms for replacing trans fats run their course, work is under way in two areas: i) disseminating information to small and medium industries, which will face greater difficulties in meeting the standard, as they lack the financial and technical resources to begin retrofitting; and ii) launching campaigns to educate consumers about healthy diets. With respect to the first, a guide was prepared on recommendations and strategies to replace trans fats for healthier alternatives (Ministerio de Salud de la Nación, 2011). With regard to consumers, materials were developed to report on health effects and how to read food labels so as to identify the presence of trans fats. It should be noted that, based on MERCOSUR resolution GMC No. 46/03, adopted in August 2006, the presence of trans fats must be stated on product labels.

At the end of the adjustment period in 2014, it is expected that the monitoring of the measure’s compliance and its effects will begin. To this end, the Ministry of Health and INAL are working to strengthen the food control system in the areas of monitoring, audit and lab.

Reducing Sodium

WHO’s 2004 Global Strategy on Diet, Physical Activity, and Health also recommended limiting sodium consumption from any origin. For its part, PAHO issued the Political Declaration for the Reduction of Cardiovascular Diseases in the Americas, which set the population’s reduction of salt intake in food to a goal of under 5 grams per person per day by 2020; Argentina agreed to these parameters (OPS, 2009).

In 2010, the Ministry of Health addressed this topic, establishing the initiative “Less Salt, More Life,” which aims to lower salt consumption as a way to reduce cardiovascular, cerebrovascular, and kidney diseases. The strategy is based on three components:

1. Public awareness on the need to lower salt intake.
2. Progressive reduction of salt in processed foods through agreements with the food industry.
3. Reduction of salt content in artisanal bread.

Reducing Sodium in Processed Foods

The joint effort between public and private entities involved in food production is a key element of any strategy designed to reduce sodium consumption, since it is estimated that more than 60% of salt intake comes from processed foods (Ministerio de Salud de la Nación, 2011). Given this, the Ministry of Health and the Ministry of Agriculture, Livestock, and Fisheries agreed with COPAL and the food industry companies...
and chambers of commerce on pursuing a progressive and voluntary reduction of sodium content in food. To this end, four food groups were selected: meat products and byproducts; farinaceous foods (cookies, baked goods, and snacks); dairy products; and soups, dressings, and canned foods. These products were selected on the basis of three criteria: their high consumption by the population, their high sodium content, and the ease of reducing sodium in them. Nonetheless, setting goals for each of these four groups has been difficult, given the wide range of products involved in each category. As a result, specific goals were set based on technological feasibility, consumer acceptance, impact on health, and weight of the products in the market. The Ministry of Health; the Ministry of Agriculture, Livestock, and Fisheries; INTI; INAL; COPAL; and the chambers of commerce participated in this task within the framework of the National Commission to Eliminate Trans Fats and Reduce Salt.

The established goals set progressive sodium reductions from 5% to 15% over the maximum values measured or over higher levels than the established average. In terms of the category “soups, dressings, and canned foods,” agreements were only reached for soups; in terms of dairy products, agreements only were reached for cheese. These objectives should be met within two years, and it is expected that with this voluntary, progressive strategy, WHO’s goal of 5 grams of average salt consumption per person per day will be achieved by 2020 (Mozaffarian, 2008; OMS, 2007, 2004; He, 2004; Ministerio de Salud de la Nación, 2010, 2011, 2006; Ferrante, 2009; OPS, 2008; Secretaría de Políticas, Regulación e Institutos y Secretaría de Agricultura, Ganadería y Pesca, 2010; Código Alimentario Argentino, 1969). Table 1.3 shows the goals agreed upon for each product.

Table 1.3. Selected foods and goals for voluntary, progressive sodium reduction, Argentina.

<table>
<thead>
<tr>
<th>Meat products and byproducts</th>
<th>Sodium reduction goal</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Included products</strong></td>
<td></td>
</tr>
<tr>
<td>Cold cuts, cooked sausages, sausage, and uncooked meats</td>
<td>At a minimum a 8% reduction of maximum sodium content in 100 gr of product (1,300 mg), reaching a value of 1,196 mg</td>
</tr>
<tr>
<td>Cooked salted meats, including sausage, salami, mortadela, cooked ham, cooked cold meats, and black blood sausage</td>
<td></td>
</tr>
<tr>
<td>Dry sausages, including salami, pork sausages, and “sorpresata.”</td>
<td>At a minimum a 5% reduction of maximum sodium content in 100 gr of product (2,000 mg), reaching a value of 1,900 mg</td>
</tr>
<tr>
<td>Fresh sausages</td>
<td>At a minimum 5% reduction of maximum sodium content in 100 gr of product (1,000 mg), reaching a value of 950 mg</td>
</tr>
<tr>
<td>Fresh meats: hamburgers</td>
<td>At a minimum a 15% reduction of maximum sodium content in 100 gr of product (1,000 mg), reaching a value of 850 mg</td>
</tr>
<tr>
<td>Breaded chicken, including nuggets, tidbits, chicken breasts, drumsticks and thighs, medallions, “chickenitos” and “formitas”</td>
<td>At a minimum an 8% reduction of maximum sodium content in 100 gr of product (800 mg), reaching a value of 736 mg</td>
</tr>
</tbody>
</table>
### Farinaceous (starchy) products

<table>
<thead>
<tr>
<th>Included products</th>
<th>Sodium reduction goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crackers with bran</td>
<td>At a minimum, 5% sodium content in foods over 600 mg/100g</td>
</tr>
<tr>
<td>Crackers without bran</td>
<td></td>
</tr>
<tr>
<td>Crackers (snacks)</td>
<td>At a minimum, 5% sodium content in foods over 990 mg/100g</td>
</tr>
<tr>
<td>Snacks</td>
<td>Sodium content of all marketed products must not exceed 950 mg/100g</td>
</tr>
<tr>
<td>Sweet dry cookies</td>
<td>At a minimum, 5% sodium content in foods over 310 mg/100g</td>
</tr>
<tr>
<td>Sweet cookies with filling</td>
<td>At a minimum, 5% sodium content in foods over 320 mg/100g</td>
</tr>
<tr>
<td>Bread products with bran</td>
<td>At a minimum, 5% sodium content in foods over 450 mg/100g</td>
</tr>
<tr>
<td>Bread products without bran</td>
<td></td>
</tr>
<tr>
<td>Frozen bread products</td>
<td></td>
</tr>
</tbody>
</table>

### Dairy products (cheese)

<table>
<thead>
<tr>
<th>Included products</th>
<th>Sodium reduction goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cream cheese</td>
<td>At the very least, 5% sodium content in cream cheeses over 558 mg Na/100 g</td>
</tr>
<tr>
<td>Quartirolo cheese</td>
<td>At the very least, 5% sodium content of Quartirolo cheese over 496 mg Na/100 g</td>
</tr>
<tr>
<td>Dambo cheese</td>
<td>At the very least, 5% sodium content of Dambo cheese over 542 mg Na/100 g</td>
</tr>
<tr>
<td>Mozzarella cheese</td>
<td>At the very least, 5% sodium content of Mozzarella cheese over 510 mg Na/100 g</td>
</tr>
<tr>
<td>Port Salut cheese</td>
<td>At the very least, 5% sodium content of Port Salut cheese over 536 mg Na/100 g</td>
</tr>
<tr>
<td>Tybo cheese</td>
<td>At the very least, 5% sodium content of Tybo cheese over 625 mg Na/100 g</td>
</tr>
</tbody>
</table>
Soups

<table>
<thead>
<tr>
<th>Included products</th>
<th>Sodium reduction goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paste (cubes/tablets) and granulated broth</td>
<td>At the very least, 5% sodium content of any product with a value greater than 374 mg/100g</td>
</tr>
<tr>
<td>Clear soups</td>
<td>At the very least, 5% sodium content of any product with a value greater than 346 mg/100g</td>
</tr>
<tr>
<td>Cream soups</td>
<td>At the very least, 5% sodium content of any product with a value greater than 306 mg/100g</td>
</tr>
<tr>
<td>Instant soups</td>
<td>At the very least, 5% sodium content of any product with a value greater than 352 mg/100g</td>
</tr>
</tbody>
</table>

Source: Argentina’s Ministry of Health. Available at: http://msal.gov.ar/ent/MenosSalMasVida/PDF/Tabla%20de%20Alimentos%20seleccionados%20en%20los%20que%20se%20reducira%20sodio.pdf (Acceso el 18 de marzo de 2013)

As of this writing, 35 companies and chambers of commerce have adhered to the agreement, listing products on which they commit to work (Box 1.2). The Ministry of Health also has committed itself to developing a logo that the companies can use in their documents or institutional communication activities and to disseminating the list of participating companies.

Box 1.2. Chambers of commerce and companies that signed on to the agreements of voluntary sodium reduction in processed foods

- Arcor S.A.I.C.
- Bark S.A.
- Bimbo de Argentina S.A.
- Cafés La Virginia S.A.
- Cámara Argentina de la Industria de Chacinados y Afines (CAICHA)
- Cámara de Industriales de Productos Alimenticios (CIPA)
- Centro de la Industria Lechera
- Coordinadora de la Industria de Productos Alimenticios (COPAL)
- Compañía de Alimentos Fargo S.A.
- Frigorífico Ridhans S.A.
- Kraft Foods Argentina
- Mastellone Hermanos S.A.
- Molinos Cañuelas S.A.C.I.F.I.A.
- Molinos Río de La Plata S.A.
- Nestlé Argentina S.A.
- Quickfood S.A.
- Sancor Cooperativa Unidas Limitadas
There are plans to expand the list of products covered under the agreement, although they have not yet been selected. It is also expected that new companies will join the initiative.

To monitor the agreement, a two-pronged national strategy is being developed. The first component involves a multi-sectorial control commission made up of INAL; the Ministry of Agriculture, Livestock, and Fisheries; INTI; the Ministry of Health; and COPAL, that will collect and analyze indirect indicators, such as companies adhering to the agreement, a results-based decrease of sodium, and sworn statements by the companies. The second component, which will operate under INAL, involves a monitoring strategy that will function through a laboratory network that will evaluate the products. To this end, INAL and the Ministry of Health are working to strengthen the laboratory network’s technical capacities, equipment, and harmonization and articulation.

If companies do not comply with the agreement, they will have six months to do so, with help from facilitators. If no resolution is reached, the parties may voluntarily opt out of the agreement with no ill effect.

A study conducted by the Ministry of Health, assuming a 3-gram reduction of salt in the diet, estimated that the intervention would yield a net savings of US$ 3,765 million and a gain of 656,657 quality adjusted life years (QALYs) in the high effect scenario and of 401,659 QALYs in a low effect scenario. In addition there would be reductions in the incidence of heart disease (24.1%), acute myocardial infarction (21.6%), and
and stroke, and in mortality from coronary heart disease (19.9%) and from all causes (6.4%) (Ferrante, 2012). Another recently published study, also conducted by the Ministry, finds that the “Less Salt, More Life” initiative could have significant improvements on cardiovascular diseases in the coming 10 years. It is estimated that 19,000 deaths from all causes, 13,000 deaths due to acute myocardial infarction, and 10,000 deaths due to stroke could be prevented (Konfino, 2013).

The Strategy for Reducing Sodium in Baked Products

Bread consumption is an important source of salt intake in Argentina. It is estimated that, on average, 190 grams of bread are consumed by every person a day, with a salt content of 2%, contributing 4 grams of the 12 grams that an Argentinian is estimated to consume daily (25%) (Ferrante, 2012). Considering WHO’s proposed goal of limiting sodium consumption to 5 grams a day, measures clearly must be introduced to lower salt in bakery products.

In 2004, INTI, through the Center of Grains and Oleaginous Products, and the Argentinian Federation of Baked Products Industry (FAIPA), with the support of the Ministry of Health’s VIGI+A Program, launched a project to reduce sodium in baked products. The main aim was to evaluate the use of salt in artisanal bakeries, as well as to develop and transfer necessary technology and provide training and information to bakeries to help them prepare breads and other bakery products with less salt.

Initially, a survey was conducted in the 9-de-Julio area bakeries in the province of Buenos Aires, based on a pilot survey and a physicochemical analysis of bread samples. Results showed that when comparing the data from the interviews with those from the analyses, bakers reported using less salt than they actually did, and that most do not weigh the amount they use. Based on these results, an awareness raising effort was undertaken with the bakery sector, which consisted in meetings with bakeries to inform them about the importance of lowering the salt content and disseminating this information to local mass media outlets (newspapers, radio and television stations). Subsequent evaluations showed that this awareness campaign had reduced the salt content in bread (DEISA, 2011).

Later (in 2006), with financing from the Scientific Research Commission (CIC for its Spanish acronym) of the Province of Buenos Aires, a nutritional and sensory optimization project was conducted on bakery products. The results formed the basis of the report presented to CI Health-Centre for Chronic Disease Control, which in 2007 financed the “Impact of Salt Reduction in Processed Foods in Argentina” project. Results from this project led to the conclusion that consumers would not notice a reduction of the salt content between 15% (from 1.8% to 1.5%) to 30% (from 2% to 1.4%), but that this change could significantly benefit the public’s health (Ferrante, 2011; Apro, 2007).

In 2007, FAIPA and the Ministry of Health formalized their collaboration by entering into an agreement that aimed to promote healthy habits in the population and develop bakery products whose consumption has a positive impact on health and the quality of life. The agreement specifies communication strategies and consumer education, as well as technology transfers and training for the bakery sector for preparing breads and breaded products with lower sodium content. The agreement also aims to improve the nutritional value of breads and replace trans fats.8

Although a management change at the Ministry of Health in 2008 halted the activities
shared with FAIPA, these were renewed in 2009, with a project in the province of La Pampa, that conducted a broader epidemiological study with regard to the use and intake of salt, trans fats, and fiber through breaded products, in order to confirm their impact on health. Preliminary results are expected in 2014, at which time the study will be extended to the rest of the provinces (Apro, 2009).

Since 2010, the Ministry of Health, INTI, and FAIPA renewed their collaboration to produce artisanal bread with lower or no salt. The initiative involves providing technical assistance and technology transfer to bakeries, distribution of salt measuring cups (since it was observed that bakers did not measure the salt they used), and massive information dissemination on salt consumption.

That same year, the national contest “Less Salt, More Life” was launched, intended to reduce salt content in breads produced in artisanal bakeries; FAIPA and INTI supported the effort, and PAHO sponsored it. To participate, enrolled businesses had to prepare bread no more than 1.5% salt, as well as unsalted bread. Once enrolled, a bakery received a measuring cup, a poster letting consumers know that it was participating in the contest, and a poster showing how to prepare bread with less salt. When the registration period ended, the Ministry of Health held a lottery among participating bakeries to present 10 awards (consisting of supplies) throughout the country.

Leading Actors: Positions and Strategies

Eliminating Trans Fats: Leading Actors, Strategies and Positions

The Ministry of Health, persuaded by the evidence on the harm that trans fats have on the population’s health, spearheaded the discussions on measures to be undertaken to eliminate them. Although initial efforts in this regard had started in 2004, it was not until 2008 that this initiative gained strength. This was due to the fact that, early on, there were discussions within the Ministry regarding whether its role was to regulate or negotiate with the companies. It was thought the Ministry could only make recommendations to the population about which foods were healthier, without becoming involved in making such foods available.

The Ministry of Health began implementing the strategy by bringing together various actors (from both the public and the private sectors), which took on various roles. INAL, for example, one of the institutes of the National Administration of Drugs, Food, and Medical Technology (ANMAT) and a decentralized entity within the Ministry of Health, participated in the discussion of the measures because of its knowledge about regulations, technology, food labeling, and analytical verification. It also helped raise the issue at the provincial and municipal levels through the areas in which it operates, such as the National Food Protection Network (RENAPRA) and the Network of Food Protection Official Laboratories (RENALOA).

RENAPRA consists of about 1,000 agents who work in food regulatory entities (provincial and municipal) across the country with the aim of sharing information and experiences to identify best practices, build consensus on food control, and provide training opportunities. Issues on which to focus are proposed each month within the network, and one of them was trans fats, in order to place the issue on the agenda of other jurisdictions. For its part, RENALOA promotes the exchange of information to improve the quality of work in the food
analysis laboratories, and provides training programs to member laboratories; in this case, the goal was to focus on food control issues to achieve consensus among the provinces and municipalities.

INAL had already been invited by PAHO to participate in the “Trans Fat-Free Americas” group in 2007, and then, at the Ministry of Health’s request, it assumed the coordination of the working group that addressed the regulatory topic that led to modifying the Food Code. Further, it worked with the Ministry of Agriculture, Livestock, and Fisheries in communication activities, and with that Ministry and INTI to prepare a manual on how to redesign the production processes at small and medium enterprises.

The Ministry of Agriculture, Livestock, and Fisheries participated in the initiative as part of its goal to bring the importance of healthy diets to the fore, and to generate guidelines to that effect. This Ministry worked hand in hand with the Ministry of Health in this process, providing evidence on the technological feasibility of replacing trans fats. In addition, it played a leadership role in discussions on dietary standards, in that it participates in CONAL, the Codex Alimentarius Commission, and in the definition of dietary standards in MERCOSUR. The Ministry also worked in crafting the manual to facilitate the process in small and medium enterprises.

INTI collaborated with the Ministry of Health by participating in negotiations with companies by helping to prepare the manual to assist in the retrofitting of small and medium enterprises with regard to trans fats, as well as by providing evidence on the technological feasibility of replacing fats. Although INTI basically aligned itself with the Ministry of Health’s objectives, it also disagreed in how the strategy was being conducted. First, it requested that an institutional agreement between the INTI and the Ministry be developed, spelling out what INTI was expected to do and validating INTI’s role with the companies—to which they also provide advice—ensuring that the needs of the public sector hold sway. It demanded continuity of the policies, discussions regarding control measures, and a significant education strategy negotiated with the Ministry of Education. Finally, it called attention to the low participation of small and medium enterprises in the discussion of the measures.

The Ministry of Health also invited the private sector to participate in the debate. Although COPAL was invited to participate in the trans-fats process, the leading role was shifted to ASAGUA. The latter had been working on substituting fats in food and finding affordable technologies to do so, in light of the international standards that were being developed in this regard. ASAGUA met with companies to determine the feasibility of adopting necessary technological innovation and to set acceptable timetables for companies to make the change. In light of the difficulty faced by small and medium companies in adapting to the change, ASAGUA worked with other public sector participants in the initiative on developing recommended guidelines aimed at this industry sector.

Discussions regarding trans fats faced some initial resistance. Companies worried about costs. Early on, substitution alternatives were costly, with fats being the most expensive ingredient in the products. As the companies that provide fats were able to lower their prices, substitution became more feasible, although user companies also were required to adapt their production processes, which required both time and investments. Given this context, the possibility of discussing realistic time-
frames and goals with the Ministry was greatly valued.

In addition, concerns were raised regarding the ability of small and medium companies to meet deadlines for substituting trans fats in food, as well as the way in which compliance would be evaluated. The first issue was addressed through guidelines with recommendations on alternatives for replacing trans fats. The guidelines were developed by ASAGA, in collaboration with INAL, INTI, the Ministry of Agriculture, Livestock, and Fisheries, the Ministry of Health, and COPAL. Despite the availability of these guidelines, however, it remains difficult to have small and medium companies participate in the discussions.

Companies also worried about the variability of the analytical methods and capabilities of the laboratories that would control the compliance with trans fats standards. To address this concern, ASAGA worked on defining a common analytical method that all the laboratories would use. To this end, it requested the cooperation of INTI, the National Institute of Agricultural Technology (INTA, for its Spanish acronym), and INAL. As previously mentioned, the Ministry of Health is also engaged in defining an evaluation methodology.

Sodium Reduction: Leading Actors, Strategies and Positions

The Ministry of Health, as it did with trans fats, took the leadership role in implementing the strategy. Since 2004, the Ministry had been working on this issue, starting with reducing salt content in artisanal breads. It was not until 2008, however, that the strategy gained strength; up to that point, it was thought that the Ministry of Health could only make dietary recommendations, not become involved in marketing. There also was disagreement regarding the benefit of reducing salt: some argued that this would increase the incidence of goiter (as the consumption of iodized salt would diminish) and some viewed salt in food as a vehicle for incorporating other nutrients in the diet.

The strategy involved reaching agreements with industry for reducing the salt content in food, and it had broad participation of many public- and private-sector actors who worked hand in hand with the Ministry of Health in various ways.

INAL supported the initiative through the participation of its technicians in discussion sessions with chambers of commerce and companies regarding reduction measures and timeframes for each food group under consideration.

INTI focused on presenting and disseminating evidence on the technological feasibility of reducing sodium in food, training bakers on how to produce bread with lower salt content, and participating in negotiation meetings with companies. The Institute also brought to the table its joint work with FAIPA to lower the salt content in artisanal bread.

While INTI endorsed the Ministry of Health’s objectives, it disagreed with some aspects of the initiative. It called for stricter goals in terms of reducing sodium in food and greater control on how companies may use the agreements to position their products in the marketplace. As with trans fats, INTI urged continuity in the policies, discussions on enforcement methods, the implementation of a vigorous education strategy supported by the Ministry of Education, and greater involvement of small and medium companies in discussions regarding the measures.

The Ministry of Agriculture, Livestock, and Fisheries contributed technical and food regulation capabilities to the process. Its actions
focused on collaborating in the negotiations between the public and private sectors and on disseminating results and materials that emerged in the process through means such as newsletters, a dedicated webpage (www.alimentosargentinos.gob.ar), various publications, reports, fairs, and events of the agriculture and food sector. Communication activities carried out by this Ministry are extremely useful, because they are instrumental in positioning these provisions within the food and food-and-agriculture industries, especially in small and medium companies that are difficult to reach and who need greater assistance throughout the retrofitting process. The Ministry also provides counseling to small and medium companies.

Other participants invited to the discussions included the food production companies, which brought on board to discuss and reach consensus on the measures to be implemented. To this end, the Ministry of Health established contact with COPAL, a business association of more than 35 food and beverage companies, which represents all the food-and-beverage production sectors. COPAL coordinated the participation of companies and chambers of commerce in the process to reduce salt, and organized meetings to define goals and terms prior to the discussions with the Ministry of Health. It also provided information on the sodium content in foods.

The incentive that led companies to cooperate was that they were aware of an international trend to deal with this issue, and given the likelihood that regulations could be rapidly introduced without adequate time to adapt, also encouraged them to join the discussions and reach consensus on the measures. In fact, COPAL (as did ASAGA with trans fats) took advantage of the Ministry of Health’s willingness to discuss the measures and of the respectful environment and clear rules that prevailed throughout the process. The companies also understood that consumers increasingly demanded healthy food—given the awareness about the effects of diet on health—which made the discussion of adopting new techniques and retrofitting production processes essential.

Although the companies accepted the invitation to participate, some were reluctant at the beginning. They were concerned that reducing sodium would change the flavor of their products and they would lose their customers, especially if their competitors did not accept to participate in the agreements. They also worried about the alternatives available to preserve food. That said, the strategy of holding discussions by product groups and of negotiating different goals facilitated the dialogue.

Larger companies were concerned that because small and medium firms were unable to make the necessary retrofitting investments and did not feel pressured to do so because the likelihood of being inspected was low, unfair competition would be generated, with one sector being forced to invest while the other was not. They acknowledged, however, that medium and small companies needed support in the retrofitting process, but stated that this would be difficult to arrange because smaller enterprises are not grouped under an umbrella entity that can help them, live day to day, and do not have the time or technical/economic resources to discuss processes and goals. Given this scenario, they proposed that the state should play a leading role in providing information and helping to implement policies and measures, but this would mean that the Ministry of Health would have to undertake an enormous task, without having enough resources to iden-
tify and summon the many small and medium
food-sector firms.

Finally some companies questioned raised
doubts about how compliance with the agreed
goals would be monitored. The methods to
measure sodium concentrations have a wide
margin of error; and thus require large samples
to verify that goals have been met; in addition,
evaluation techniques are not always uniform.
To this end, COPAL is working on a proposal to
measure sodium whereby, in addition to the
laboratory evaluation of products, companies
would provide information about their prod-
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and consumers are increasingly calling for healthy food. Moreover, the inclusion of different actors opened the way for constituting a multi-sectorial working team that ultimately produced the amendments to the Food Code and the voluntary agreements, thus laying the foundation for future measures to promote healthy diets.

The process has revealed some weaknesses, however, such as insufficient resources to carry out mass information campaigns and to strengthen strategies designed to have more bakeries adopt “Less salt, more life” practices. In addition, small and medium enterprises only participated to a limited degree in the discussions, largely because they are scattered around the country and do not fall under an umbrella organization that could represent them and facilitate the negotiations. Further, it is unlikely that their owners or employees would have the time and resources to discuss these issues, and the Ministry of Health does not have the time or budget to bring all of them into the discussions.

With regard to the monitoring and evaluation of the new trans fats regulations and the agreements to reduce salt in food, a standardized methodology for the testing laboratories remains to be defined. Even though business associations have already advanced in this regard by forming their own working groups, the state agencies need to become more proactive in these essential activities.

And, while voluntary agreements have been reached on the sodium-reduction issue, the technical difficulties involved make it essential to develop regulations in the long term. The voluntary sodium-reduction agreement is a politically opportune effort for including the issue in the public agenda, but it has no enforcement mechanisms or penalties that can be applied when food producers do not comply.

Moreover, the Ministry of Health is concerned that as the compliance date nears, companies will ask for extensions, citing technical and legal issues. And whereas this would not be a problem with the elimination of trans fats—since most of the industry has begun retrofitting its processes—it could pose a problem with regard to sodium. Questions also might be raised about the capacity of the public sector to monitor and evaluate compliance, especially with respect to the availability and the ability of the laboratories to perform their tasks. The limited baseline information available also represents a problem, as does the fact that multinational companies’ global policies may not be consistent with the voluntary agreements signed in Argentina. Finally, other actors have pointed out that the strategies launched by the Ministry of Health could be halted, due to a change in management within the Ministry, as has already occurred.

Box 1.3 summarizes the strengths, opportunities, weaknesses, and threats affecting the sodium-reduction and elimination-of-trans-fats measures in Argentina.

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**Box 1.3. Strengths, Opportunities, Weaknesses, and Threats affecting the Trans-Fats-Elimination and Sodium-Reduction Measures**

**Strengths**
- Intersectoral dialogue and negotiation.
• Role of the Ministry of Health.
  - Leadership and coordination with other public entities.
  - Dialogue and negotiations with the private sector.
• Consumers view the public-private joint effort on behalf of the public’s health as a positive development, which helps improve the companies’ image.

Opportunities
• An international climate inclined to work on promoting healthy diets.
• Increasing consumer demand for healthy food.
• The creation of an intersectoral working group that led to modifying the Food Code.

Weaknesses
• Insufficient resources for launching mass campaigns to disseminate information and for strengthening strategies to bring more bakeries, as well as small and medium enterprises, on board.
• Small and medium enterprises are missing in the discussion about measures.
• Monitoring and evaluation: need for laboratory standardization to perform the tests.
• Sodium: the voluntary agreements do not have enforcement power.

Threats
• Companies may request extensions to achieve the goals (particularly with regard to reducing sodium).
• Monitoring and evaluation:
  - Questions about the capacity and availability of laboratories.
  - Limited baseline information.
• Transnational companies that set their policies at the global level can hinder the agreed upon agreements.
• Lack of policy continuity over time due to management changes.

Referencias


PREVENTION OF HEALTH RISK FACTORS IN LATIN AMERICA AND THE CARIBBEAN: Governance of Five Multisectoral Efforts


Notes

1 High cholesterol levels are based on self-reporting by respondents who had ever had their cholesterol measured, regardless of whether a physician, nurse, or other health professional had said the respondent had high cholesterol.

2 Body mass index (BMI) categories were defined as follows: normal weight, 18.5 to 24.9 kg/m2; overweight, 25 to 29.9 kg/m2; and obesity, 30 or more kg/m2.

3 The prevalence of hypertension was based on self-reporting; a physician, nurse, or other health professional had indicated at least once that the respondent had high blood pressure.

4 Diabetes levels were based on self-reporting by the respondents, for whom a physician, nurse, or other health professional had indicated the person had diabetes or “high blood sugar.”

5 The National Institute of Industrial Technology (INTI) is a decentralized national government agency that operates under the jurisdiction of the Ministry of Industry. Its mission is to generate and transfer industrial technology.

6 The National Food Institute is in charge of registering and controlling—within the scope of the National Drugs, Food, and Medical Technology Administration (ANMAT)—prepared foods, their inputs, use of domestic products, and materials that come in contact with food.

7 The campaign poster is available at: http://www.msal.gov.ar/argentina-saludable/media/Afiche%20grasas%20trans.pdf

8 For additional information, visit http://www.faipa.org.ar/Legales/convenio_min_de_salud.htm
PREVENTION OF HEALTH RISK FACTORS IN LATIN AMERICA AND THE CARIBBEAN: Governance of Five Multisectoral Efforts

Photography: Olga Sarmiento, Universidad de los Andes, Colombia
Bogotá, Colombia: A City with a Built Environment that Promotes Physical Activity

OLGA LUCÍA SARMIENTO, ADRIANA DÍAZ DEL CASTILLO H., AND ETHEL SEGURA DURÁN

This study describes a program and three urban infrastructures that could promote physical activity in Bogotá, Colombia: the Ciclovía, the CicloRutas, the TransMilenio, and outdoor gyms. The main objective is to report on the processes that led to their design and implementation and on the key actors that played a role to provide useful information that could lead to the development of similar policies, programs, and infrastructure projects in other cities.

Context

Medium-income countries, such as Colombia, are experiencing rapid economic, demographic, and nutritional transitions associated with the increased prevalence of chronic, noncommunicable diseases (NCDs) (Abegunde et al., 2007; Jacoby E., et al. 2003). In Colombia, mortality from cardiovascular diseases has doubled and mortality due to diabetes has tripled in the last 25 years (Ministerio de la Protección Social and Universidad de Antioquia, 2010). In addition, NCDs account for 76% of the burden of disease based on disability-adjusted life years (DALYs) (Acosta Ramírez et al., 2008).

Undoubtedly, promoting physical activity is critical for preventing NCDs. Evidence clearly shows that physical inactivity increases the risk for the leading NCDs worldwide. In 2008, 5.3 million of the 57 million deaths were attributed to physical inactivity (Lee et al., 2012). Physical inactivity is estimated to cause roughly 10% of colon cancer cases, 10% of breast cancer cases, 7% of type II diabetes mellitus cases, and 6% of coronary disease cases (Lee et al., 2012). Similarly, in Bogotá it was estimated that 7.6% of total mortality and 20.1% of mortality from NCDs from CNCDs was attributed to physical inactivity (Lobelo et al., 2006).
Prevalence of Physical Activity in Colombia and Bogotá

As is the case in most countries in the Americas, a significant percentage of Colombian adults lead sedentary lifestyles (Instituto Colombiano de Bienestar Familiar, 2010, 2006; World Health Organization, 2009). Among adult Colombians, only 53.5% meet the recommended physical activity levels, and 46.5% are inactive. Among adults who engage in physical activity, 19.9% meet physical activity recommendations during their leisure time, 33.8% walk as a means of transportation, and only 5.6% bicycle as a means of transportation. However, between 2005 and 2010, compliance with physical activity recommendations increased significantly. Trends observed between 2005 and 2010 show a significant increase in the prevalence of overall compliance with physical activity recommendations, from 50.1% to 53.5%. This increase comes at the expense of walking as a means of transportation, however, and in the category of "physical activity during leisure time" the prevalence of compliance with physical activity recommendations is actually lower. In Colombia physical activity as a means of transportation predominates over physical activity during leisure time, and walking predominates over bicycling (Instituto Colombiano de Bienestar Familiar, 2010). An effective and sustainable promotion of physical activity must encompass all dimensions of physical activity.

Bogotá’s compliance with the physical activity recommendations (57.8%) is higher than compliance at the national level. In the city, 18.3% of adults meet physical activity recommendations during their leisure time, while 40.5% walk at least 150 minutes per week as a means of transportation and 4.3% reports cycling at least 150 minutes per week as a means of transportation (Instituto Colombiano de Bienestar Familiar, 2010).

Determinants of Physical Activity among Adults in Colombia and in Bogotá

The socio-ecological model suggests that physical activity is related to individual, social, environmental, and political determinants (Sallis JF et al., 2008). These factors, in turn, vary depending on which physical activity category is being studied (i.e., during leisure time, as a means of transportation, as work, or in the home).

In Colombia, those meeting physical activity recommendations during leisure time are more likely to be male, young adults, with higher educational levels, living in high socio-economic neighborhoods, and less likely to be overweight (Instituto Colombiano de Bienestar Familiar, 2010). The built-environment factors associated with meeting physical activity recommendations during leisure time include access to parks, a sense of security, participation in the Ciclovía, and access to TransMilenio (TM) (Gomez et al., 2010a; Sarmiento et al., 2010a).

Studies have shown that walking as a means of transportation is associated with socio-demographic factors, such as lower socioeconomic status, being age 50 and older, being employed or looking for a job, and not owning a motor vehicle. Environmental factors associated with walking as a means of transportation include such urban attributes as higher connectivity and road density (kms of road/area in km²). The use of bicycles as a means of transportation has been associated with being male, having lower education, and living in a low socioeconomic neighborhood. Environmental factors associated to cycling for trans-
port include higher street density (Cervero et al., 2009).

**Bogotá Overview**

Bogotá is the country’s capital and administrative center. It is one of the five most populated cities of Latin America and the Caribbean, with more than 7.5 million inhabitants (16% of the Colombian population) and a population density of 4,100 people per km² (Departamento Administrativo Nacional de Estadística, 2005; Economist Intelligence Unit, 2010). The city sits on a plateau 2,630 meters above sea level (Alcaldía Mayor de Bogotá 2009); it has no seasonal changes and an average temperature of 14°C.

**Socioeconomic Information**

Bogotá is the eighth largest economy of Latin America, accounting for 26% of Colombia’s Gross Domestic Product (GDP) (Cámara de Comercio de Bogotá, 2011b). As do other Latin American cities, Bogotá faces challenges related to social inequality, as well as socio-political conditions due to the armed conflict. Since colonial times, Bogotá’s neighborhoods have been segregated in terms of space and access to services (Gómescásseres, 2003a; Programa de las Naciones Unidas para el Desarrollo, 2007). The city is divided into 20 administrative districts and it is stratified socioeconomically based on the characteristics of the home and its surrounding areas. In June 2011, 36.4% of households in Bogotá were classified as level 3 (medium-low), 36.3% as level 2 (low), 11.3% as level 4 (medium), 9% as level 1 (low-low), 5.5% as level 5 (medium-high) and 6 (high), and 1.3% as “without stratum” (Alcaldía Mayor de Bogotá and Departamento Administrativo de Planeación Distrital, 2011). In 2007, the Gini coefficient was 0.59 (compared to 0.58 for the national figure) (Alcaldía Mayor de Bogotá et al, 2007).

**Transportation and Green Areas in Bogotá**

Overall, Bogotá’s residents have the following transportation options: public transportation, TransMilenio (TM), taxis, private vehicles, motorbikes, bicycles, or walking. According to preliminary data from the 2011 transport survey, 46% of trips are on foot (versus 15% reported in 2009) and 50% involve motorized modalities (public transportation, TM, taxis, private vehicles, other). Public transport and TM account for 57% of total motorized trips. Private vehicles account for only 11% of total trips (21% of motorized trips) and bicycles account for 3%. Most non-motorized and public transport trips are made by residents of middle- and low-income strata (Secretaría Distrital de Movilidad, 2011).

As of this writing, Bogotá has 4.35 m² of green area per inhabitant, which includes a network of parks stratified according to size, coverage, and structure. Green areas help maintain the environmental balance and are a natural heritage that guarantees—partly—free space set aside for recreation (Alcaldía Mayor de Bogotá, 2004). When residential areas are built, 17% of the land must be set aside as green areas, representing a public and obligatory transfer as part of urbanization. The green areas set aside in major housing developments now have sports equipment in accordance of where they fall within the park stratification system. Local parks are classified according to their size and use (Instituto Distrital de Recreación y Deporte, 2011b) (Table 2.1).

In general, and for all types of parks in Bogotá, users are 52.2% male and 47.8% female. Adults between 18 and 59 years old are more likely to use them. Among users, 37% have incomes close to the minimum wage (approx-
approximately US$ 320 in 2013). Approximately 60% of users reported being satisfied with the parks overall condition. According to a 2005 study, 55% of users feel safe in the parks during the day (Instituto Distrital de Recreación y Deporte, 2011b).

**Table 2.1. Classification and Number of Parks in Bogotá**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Description</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regional</td>
<td>Large natural spaces with high environmental value</td>
<td>4</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>Open areas larger than 10 hectares, destined for recreation, sightseeing, and environmental uses.</td>
<td>15</td>
</tr>
<tr>
<td>Zonal</td>
<td>Open areas between 1 and 10 hectares that serve a group of neighborhoods for active recreation; they may include such equipment such as gyms, swimming pools, sports fields or courts, and skating rinks.</td>
<td>64</td>
</tr>
<tr>
<td>Local</td>
<td>Open areas for community recreational activities and meetings</td>
<td>3,168</td>
</tr>
<tr>
<td>Pocket-size</td>
<td>Open areas under 1,000 m².</td>
<td>1,768</td>
</tr>
</tbody>
</table>

*Source: Instituto Distrital de Recreación y Deporte: http://www.culturarecreacionydeporte.gov.co/portal/node/228 (last accessed on 20 March 2013).*

**Policies (Programs and Infrastructures): Ciclovía, CicloRutas, TransMilenio, and Outdoor Gyms**

**The Ciclovía Recreativa**

The Ciclovía Recreativa is a program that temporarily closes streets to vehicular traffic and opens them for allowing citizens to have a safe and free space to engage in recreation and sports (OPS, 2009).

**Photo 2.1. Bogotá’s Ciclovía (Boyacá Avenue).**

*Photo: Diana Fernández*

Bogotá’s Ciclovía operates every Sunday and holiday of the year, from 7 a.m. to 2 p.m. (72 events per year). Since 1999, it includes other events such as the “Nighttime Ciclovía,” which is held on the second Thursday of December, from 6 p.m. to 12 a.m. (Sarmiento et al., 2010b). Table 2.2 describes Ciclovía’s complementary activities.
Bogotá’s Ciclovía network encompasses 121 interconnected kilometers. An estimated 600,000 to 1.4 million persons use the Ciclovía in each Sunday event (8%–19% of the city’s population). Among similar Ciclovía programs worldwide, Bogotá’s is the longest and has the highest number of users. Most Ciclovía users are male, around 60% are adults 19–45 years old, and approximately 90% live in low and medium socioeconomic neighborhoods (Universidad Nacional, 2005; Torres, 2013).

Ciclovía’s annual cost is US$ 1.7 million (including materials, personnel, operations, and logistics), most of which comes from public resources (Díaz del Castillo et al., 2011).

The Ciclovía is managed by the District Recreation and Sports Institute (IDRD for its Spanish acronym). Its operation, maintenance, and evaluation require multisectoral work, however. Nine sectors were identified as being part of the program: recreation, culture, and sports; transportation and urban planning; governmental administration; security; marketing and services; academia and research; health; education; and the environmental sector (Díaz del Castillo et al., 2011).

The Ciclovía and Physical Activity
Bogotá’s Ciclovía is recognized for its potential public health benefits, which include promoting physical activity and other benefits such as building social capital, fostering the economic recovery of communities, and reducing environmental pollution by decreasing the number of motor vehicles and noise levels (Hoehner et al., 2008; Sarmiento et al., 2010a; Sarmiento and Behrentz, 2008).

Programs such as Bogotá’s Ciclovía, which run for seven hours at least once a week and that have many participants, help the population meeting with international weekly standards for physical activity levels. Based on Bogotá’s population size, number of users, and average minutes spent in the program, it is estimated that Bogotá’s Ciclovía provides the population with 13.64% of the recommended weekly minutes of physical activity (Sarmiento O.L. et al. 2010b). An estimated 40.5% of users report using the Ciclovía for at least three hours (Universidad Nacional, 2005). Ciclovía users say their activities include cycling (46.2%), walking (47.9%), and other activities (5.9%) (Montes et al. 2012).

It also was estimated that of the total number of adults who reported participating in the

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**Figure 2.2. Complementary Activities of Bogotá’s Ciclovía**

<table>
<thead>
<tr>
<th>Activity/program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreovía (physical activity sites)</td>
<td>Parks or plazas in public spaces along the route offer one-hour physical activity classes taught by instructors. There are currently 19 Recreovía areas operating during weekends: 17 on Tuesdays, Thursdays, and/or Wednesdays and 11 twice a week during the evening.</td>
</tr>
<tr>
<td>Service stations</td>
<td>Vendors along the route offer food and beverages, and there are bicycle-repair stations. The Secretariat of Social Integration selects vendors.</td>
</tr>
<tr>
<td>Children’s activities</td>
<td>Recreational activities and sports.</td>
</tr>
<tr>
<td>RAFI locations</td>
<td>These sites promote physical activity and healthy nutrition; they provide weight and height measurements to calculate BMIs. The District Recreation and Sports Institute IDRD operates RAFI locations.</td>
</tr>
</tbody>
</table>
Ciclovía in the previous month, 20% said they meet with physical activity recommendations by spending at least 30 minutes of physical activity during their leisure time at least five days a week (Sarmiento et al., 2010b). Most Ciclovía users (59.5%) meet physical activity recommendations (Torres et al., 2013). Another study also showed that women who reported participating regularly in the Ciclovía were most likely to engage in physical activity during their leisure time (Gomez et al., 2004). The average number of minutes of physical activity carried out during leisure time and by cycling by Ciclovía users is greater than that of the overall adult population of Bogotá (Figure 2.1).

**Figure 2.1. Average number of weekly physical activity minutes for users of Bogotá's Ciclovía, CicloRuta, TransMilenio, and parks.**

The program is cost-benefit (Montes et al., 2012). An evaluation of the program’s cost benefits, considering its potential health benefits through engaging the adult population in physical activity, estimated that for each dollar invested in the program, US$ 3 to US$ 4 could be saved in direct expenses in health care related with physical activity (Montes et al. 2012). This implies an annual gain of between US$ 13 million and US$ 30 million, depending on the number of adult users.

The CicloRutas Network

Bogotá’s CicloRutas network is an urban infrastructure that has permanent, dedicated bicycle lanes. These lanes may be located on sidewalks or clearly separated from the roadway (Alcaldía Mayor de Bogotá 2000).
According to data from the Urban Development Institute (IDU from its Spanish acronym), there were 344 kms of CicloRutas in 2010, representing the most extensive such network in Latin America (Instituto de Desarrollo Urbano, 2011a). The network has 1,640 bicycle racks that are free, under surveillance, and located in different parts of the city (at IPES or meeting points, and at TransMilenio stations). These racks location was intended to foster multimodal transportation between bicycle and mass-transport ridership. However, only 40% of CicloRutas users report having seen bicycle racks, and of these, only 19% use them (Segura, 2011). There also are more than 90 points of interruption in the network, which hinders connections and the transfer to mass transport (Segura, 2011).

Based on the 2004–2008 administrative data, 83,436 people use the CicloRutas daily (approximately 1% of the city’s residents) (Instituto de Desarrollo Urbano, 2008); most are young men (Alcaldía Mayor de Bogotá and Instituto de Desarrollo Urbano, 1999). The use of bicycles as a means of transportation is more prevalent among low and medium socioeconomic residents: 97% of bicycle trips are made by residents of stratum 1–3 and the trips reported by the poorer population are the longest. It should be noted that only 10% of those using bicycles for transportation own a car and only 2.2% own a motorcycle (Massink et al., 2011).

According to 2009 data, annual costs for the CicloRutas, including construction and maintenance costs, were around US$ 3 million, for a total investment of US$ 50 million (Instituto de Desarrollo Urbano, 2009). The CicloRutas network is managed primarily by the IDU, although their operation, maintenance, and evaluation require multisectoral work. The sectors involved are urban planning; transportation; public services; recreation, culture, and sports; and academia.9

The CicloRutas and Physical Activity
In high-income countries, CicloRutas and similar infrastructures are associated with the promotion of physical activity (Pucher et al., 2010). In Bogotá, studies of CicloRuta users show that 70% bicycle more than five days a week, 73%
bicycle because it offers a rapid means of transportation, and 13% use it for health reasons. Nearly one-fourth report that the CicloRutas infrastructure is an incentive to use bicycles as a means of transport (Segura, 2011). The average number of minutes spent carrying out physical activity during leisure time and cycling by CicloRuta users is greater than that of Bogotá’s adult population (Figure 2.1).

A 2010 cost-benefit analysis showed that for each US$ 1 invested in the CicloRutas, US$ 2.8 could be saved through health gains related to being physically active (Ricaurte, 2010). The reported benefit is less than that reported for Ciclovíás because the investment in infrastructure is not compensated by a large number of users.

The TransMilenio System

TransMilenio (TM) is a mass transport system of the bus rapid transit (BRT) type. Buses travel on dedicated lanes and operate in ways similar to rail-based systems, as TM has exclusive stations for its users (Peñalosa, 2002).

Picture 2.3: TransMilenio buses in Bogotá (Portal de las Américas).

Construction of the TM system began under the 1998–2001 administration. According to data from 2011, it encompasses 84 km of main routes and 895 km of lanes (Cámara de Comercio de Bogotá and Universidad de Los Andes, 2011; TransMilenio, 2011a). The network has 102 routes along the city’s main roadways, 82 feeder routes, 1,290 buses, and 114 stations (TransMilenio, 2011b). The system carries about 463 million passengers a year (2010 data), and the figure has steadily increased by 5% a year in the past years (TransMilenio, 2011a). The average number of TM passengers during rush hours is 192,936 (TransMilenio, 2011a). According to a 2010 survey, 82% of TM users reside in strata 2 and 3, and 93% do not own a vehicle (a profile similar to those using public transportation). The price of a ticket, as of December 2011, was $ 1,700 pesos (US$ 0.93) during peak hours Monday through Saturday, and $ 1,400 pesos (US$ 0.77) during off-peak periods, on Sundays and holidays. The price covers travel throughout the network (two daily trips for 20 days during peak...
hours represent 12% of the minimum wage in 2013).10

TM operates through a public-private partnership. The state provides the infrastructure (network trunks, stations, platforms, workshops, and complementary infrastructure) through the IDU, while seven private firms selected through public bidding (which are paid per kilometer covered)11 operate the system, and two private firms obtain concessions to operate the collection system12 (Cain et al., 2006; TransMilenio, 2011b). A public company, TransMilenio S.A., plans, manages, and controls the system. The system is financed through 3% of ticket fares and secondary activities, such as advertising at the stations (Hidalgo, in Leal and Bertini, 2003).

Regarding costs, Cain et al. (2006) estimated that Phase I infrastructure amounted to US$ 240 million (US$ 5.9 million per km²), financed from the gasoline tax (46%), national budget (20%), a World Bank loan (6%), and local funds (28%). Costs for Phase II were estimated at US$ 545 million (US$ 13.3 million per km²).13 Financing sources for this second phase included the national government (66%) and gasoline tax (34%). In the TM master plan, total costs were estimated at US$ 3.32 billion, which included vehicles and fare collections (Cain et al., 2006).

**TransMilenio and Physical Activity**

The link between TM and physical activity is that users must walk (or ride a bicycle) to reach the stations, which are approximately 500 meters apart, and they must also walk within the system.14 Thus, TM increases the likelihood that a person will walk for transportation. It is estimated that adults living in a neighborhood with one or two TM stations are more likely to walk for transportation, and so meet physical activity recommendations more than those who live in neighborhoods without TM stations (Cervero et al., 2009). On average, the number of minutes that TM users spend walking both as a means of transportation and for leisure activities is greater than that of Bogotá’s overall adult population (Figure 2.1).

**Outdoor Gyms**

Outdoor gyms consist of urban parks equipped with user-friendly and low-maintenance equipment for engaging in PA free of charge (Secretaría de Cultura, 2011).

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**Photo 2.4. Outdoor gym in Bogotá (El Virrey Park)**

*Photo: Ethel Segura*
Outdoor gyms were installed in six parks located in four of the city’s districts (2011 data). Three were metropolitan parks, two were zonal, and one was local. Some zonal parks in Engativá district have a few pieces of installed equipment. Each park has exercise equipment on which several people can simultaneously do warm-ups, muscular toning, stretching, and cardiovascular exercises (the amount of equipment depends on the park’s size/conditions). The aim is to use each piece of equipment for 10 minutes and, for parks with 11 pieces of equipment, do the entire cycle in 1 hour and 50 minutes (Instituto Distrital de Recreación y Deporte, 2011a).

In general, these gyms function through an agreement between the district and private enterprise. Private health sector firms (Colsanitas, a pre-paid health insurance company, and Novartis Laboratories), recreation and sports-sector firms (Athletic Colombia S.A., a company selling sports equipment), and two private cooperatives from the education sector donated some of the equipment, financed its installation, and, in some cases, maintain it. The rest of the pieces were installed and are managed by the IDRĐ; in the case of Engativá, they are managed locally.

The cost of the equipment at each site, land adaptation, and installation of 11 pieces fluctuated between US$ 25,000 and US$28,000 ($ 45 million $ 50 million Colombian pesos); the costs vary according to the parks’ conditions and the number of pieces of equipment.

Parks and Physical Activity

Many studies have linked the presence of green areas—including parks—with physical activity (Diez Roux et al., 2007; Duncan and Mummery, 2005; Gomez et al., 2010a, 2010b). Moreover, it was found that outdoor gyms in Los Angeles County (California, U.S.A.) could be cost-effective among a diverse population that includes a significant number of Latinos (Cohen et al., 2012). In Bogotá, studies of adults and seniors routinely show that the density of parks and their frequent use help residents meet recommendations of physical activity during leisure time (Gomez et al., 2010a, 2010b). The average number of minutes spent walking, both as a means of transportation and during leisure time by users of parks is greater than that of Bogotá’s overall adult population (Figure 2.1).

Policy Development and Leading Actors

The Ciclovía Recreativa


Most sources consulted for this study agree that the first Ciclovía event took place in 1974 (Alcaldía Mayor de Bogotá D.C. and Instituto Distrital de Cultura y Turismo, 2007; Díaz del Castillo et al., 2011; Gómescásseres, 2003a). This was mainly a private, independent event, involving a group of students who took over some of the city’s main streets with their bicycles. The transportation department gave its informal support by facilitating the closure of main streets. Various activists who had been organizing annual bicycle rides (starting in Bogotá) to promote bicycle use for recreation and well-being also participated in the event.

Two years after (in 1976), the department of traffic and transportation conducted an urban development study which recommended creating a temporary Ciclovía (Gómescásseres, 2003a). This idea then led to Decree 577 (during the Luis Prieto Ocampo administration) which formally defined the Ciclovía and designed four circuits on the main streets of both low- and high-income neighborhoods (Alcaldía Mayor de Bogotá, 1976; Alcaldía Mayor
de Bogotá D.C. et al., 2007). During these years, the Ciclovía continued to be an isolated event, however. According to those interviewed, this was because it lacked a defined organization, no entity was responsible for operating and promoting the program, and it was no longer a priority for the government in power at the time (Alcaldía Mayor de Bogotá D.C. et al., 2007). Activist groups continued to organize events on their own, and sought official support to achieve formal status. According to a member of the group, they did not receive support because the two administrations that followed had other priorities (such as constructing infrastructure, such as bridges, for automobile traffic). Nonetheless, the population’s initial acceptance of the Ciclovía concept revealed the need for public recreation spaces, which was later confirmed by its participation in other events, such as the National Bicycle Day in 1981 (Alcaldía Mayor de Bogotá D.C. et al., 2007).

In 1982, Mayor Augusto Ramírez Ocampo was elected to office (Dávila et al., 2001). The Mayor, based on documents of the time, believed that returning public space to citizens and creating opportunities for recreation for the most vulnerable, could help combat inequality (Ramírez, 1983; Ramírez, 2005). That year, the Ciclovía was formally inaugurated (Alcaldía Mayor de Bogotá D.C. et al., 2007; Gómescásseres, 2003a) and received broad media coverage encouraged by the participation of public figures. At that time, cycling had become popular in Colombia, fanned by the achievements of Colombian cyclists in international competitions. Citizens became fans, the media and private enterprises participated actively in promoting it, and the State invested in creating roads where cyclists could train. Some observers consider this phenomenon to be a first attempt to meet the public’s recreational needs and may have contributed to raise bicycles historically low status (Ciclismo al Día, 2012; Colombia es pasión, 2006; Gómescásseres, 2003b).

While it is possible that activists’ efforts may have helped to formalize the program, this cannot be confirmed in official documents. According to former Mayor Ramírez Ocampo, his interest was also sparked by his visits to New York, where he observed that some streets bordering Central Park were closed for bicycles. Thus, it cannot be precisely established how the idea was conceived, and it is common to assign many “parents” to Bogotá’s Ciclovía.

In the next two years, the Ciclovía continued to function weekly, managed by the traffic department, whose principal role was to close the streets. A Ciclovía multisectoral committee was established that included bicycle activists, the police, the Traffic and Transport Department, the Secretariat of Education, Coldeportes (the Colombian Institute for Recreation and Sports), and the National Cycling Federation (Alcaldía Mayor de Bogotá D.C. et al., 2007; Gómescásseres, 2003a). By 1984, the Ciclovía was 84 km long (personal communication, IDRD 2009).

**Key Actors**

Based on the previous description, the following actors played key roles during this phase:

- Civil society groups promoting bicycle use and a formal Ciclovía, which also participated in the multisectoral committee;
- Citizens who participated enthusiastically in the first events;
- The police, who facilitated the events, the Traffic and Transport Department, which conducted the Ciclovía’s study, the Secretariat of Education, Coldeportes, and the National Cycling Federation (which were
all represented in the multisectoral committee);

- The administration, which initially passed the decree along with the transit department, district planning, and public works. Later, the mayor decided to formally inaugurate the program.

**Change in Priorities (1985–1994)**

With the change in administration in 1984, priorities also changed. The program’s organizational structure stopped functioning, the traffic department was in charge of street closings (although this was not done regularly everywhere), and the police provided security. For some observers, limiting the traffic department’s function to street closings without a larger vision of what the program could be and without offering new services, brought the program to a standstill. It could be said that a program such as the Ciclovía was not a priority for the department in charge of traffic and transport. According to Gomescásseres (2003), during this time, the route was progressively shortened, interconnections ceased, and much of the program (80%) ran mainly in high-income areas. Thus, the Ciclovía began to lose its appeal and was used by a smaller percent of the public. According to some interviewees, the program was sustained mainly because citizens continued to use the Ciclovía and assumed responsibility for closing the streets, even those not officially sanctioned. By 1995, the Ciclovía had only 51 km (personal communication, IDRD 2009).

**Key Actors**

The following key actors played a role during this phase:

- The citizens, who continued to use the program and closed the streets;
- The traffic department and the police, who facilitated the program’s continuation, although without a clear organizational structure or much support from city administrations.


A new period in the program began with another change in the city administration, in 1995. Between 1995 and 2003, Bogotá had three different administrations (1995–1997, 2001–2003, and 1998–2000) which shared a vision regarding what the city should be for its citizens, and the relationship between Bogotá and its residents, emphasizing the promotion of new cultural practices and the transformation of the urban infrastructure (Pizano, 2003). Given this vision, the city experienced eight years in which urban transformations and the culture of citizenship were priorities for the government, and the Ciclovía became a space in which some of these ideas could play out (Alcaldía Mayor de Bogotá D.C. et al., 2007; Montezuma, 2003; Pizano, 2003).

This new vision for the city fostered a shift in the program towards an emphasis on recreation, the promotion of well-being, physical activity, and the proper use of free time, which led to the transfer of the management of the Ciclovía from the transportation sector to the recreation and sports sector, under the IDRD. It is impossible to precisely establish whether this change came from city hall or from IDRD officials; whatever the source, this change reinvigorated the program. Ciclovía was given a defined organizational and operational structure and offered new services to meet users’ needs. The changes included: i) assigning new personnel to manage the routes (Ciclovía caretakers); ii) entering into agreements with the police and Secretariat of Education whereby police officers and students would serve within the Ciclovía logistics team (Law 191/1995 and Resolution 4210/1996 set forth that
10% of those doing military service with the police should do so in the Ciclovía and that secondary-school students could fulfill their compulsory social service in the program; iii) increasing the system’s length (81 km in 1996 to 121 Km in 2000), reconnecting the north-south circuit to cover 70% of districts (Alcaldía Mayor de Bogotá D.C. et al. 2007), and installing permanent signals; iv) launching new activities (such as the Recreovía); v) designing a logo and brand for the program that would help consolidate it and gain the public’s ownership of the program; vi) extending the duration of events by two hours; and v) obtaining a small percentage of private financing. According to the IDRD, about 1.2 million persons participated in 1997, and by 2000, the Ciclovía had 121 km.

As mentioned above, several urban transformations occurred during this period. Unfortunately and paradoxically, the new TM system negatively affected the program because due to the development of TM infrastructure, the Ciclovía temporarily lost several important corridors, and with them, kilometers and connectivity (it went from 121 active kms to 97 during the Phase III construction). By 2013, however, Ciclovía’s access to one of these corridors was re-established, and with it, the original 121 km.

In 2007, two city councilmembers and two congressional representatives presented a draft agreement to the Council of Bogotá and a draft legislation to the Congress, declaring the Ciclovía a national cultural heritage. The legislation sought to promote and protect the program, and guarantee the resources to maintain its quality and coverage (Rodríguez et al., 2007; Silva, 2007).

**Key Actors**
The following actors played a role during this phase:

- The citizens, who embraced the changes and continued using the program, which attracted large, weekly crowds;
- The recreation and sports sector, led by IDRD, which managed and transformed the program;
- City governments, which included the program and their new vision in their development plans and priorities;
- The security and education sectors, which established informal agreements to support the program;
- The urban planning and transportation sectors, which maintained the reads in good conditions and implemented the new transportation system;
- City council members and congressional representatives.

**Maintenance (2008 to the present)**
Although in the last five years the Ciclovía has not undergone major transformations, changes have been made that include the organization of street vendors, an increase in the number of Recreovía sites, offer of new services (such as RAFI points), and the need to adapt to the infrastructure works under way in the city since 1998. Currently, the operation, maintenance, and evaluation of the program involve various sectors. They include the recreation, culture, and sports sector (manages and leads the program through IDRD); the urban transportation and planning sector (conducts research on mobility and is responsible for the road network and for resolving connectivity problems in the Ciclovía while causing the least impact on vehicular traffic); the government (in charge of all city policies and oversees IDRD); the health sector (provides care in case of emergencies through a communication system of the district’s Center for the Regulation of Emergencies); the education sector (pro-
vides human resources through the participation of secondary-school students who carry out their compulsory social service in the program; the security sector (provides human resources through the participation of police cadets); the environment sector (its objectives and interests alight with benefits provided by the Ciclovía); the marketing and services sector (disseminates information to the means of communication, provides logistical support for the implementation of each event; and academia (which evaluates the program) (Meisel et al., 2013).

It should be mentioned that the health sector’s role has been insignificant in developing and consolidating the Ciclovía, because, from the beginning, the focus was on recreation and sports (and, in a way, social inclusion) and not on promoting healthy lifestyles. The recent recognition of the Ciclovía’s benefit to public health has come mainly from academia and multilateral organizations, and has manifested itself when Ciclovía was included in specific recommendations of the National Public Health Plan (Decree 3039/2007) and the Law on Obesity (1355/2009) as a strategy to prevent risk factors for chronic, non-communicable diseases.

Other Key Actors: Opponents and Barriers
Throughout its history, Ciclovía’s has had its opponents and barriers, mainly transportation priorities, private automobile owners, and businesses.

Regarding transportation, as mentioned earlier, the reduced kilometers and connections due to the TM construction had a temporary paradoxical effect that resulted from sustainable transport policies, compatible with the principles supporting the Ciclovía.

Regarding motor vehicles, in 2007–2008, a congressperson presented an amendment to a transportation law that included an article that proposed changing the Ciclovía schedule (from the current 7 a.m. to 2 p.m. to 5 a.m. to noon); it was argued that the Ciclovía negatively affected motor vehicle traffic, especially private vehicles. However, the community reacted forcefully: a group of activists mobilized—through social networks, the Internet, communications media, and petitions—to protest the reform, and the mayor and other civil servants also expressed their opposition to the change (Comité Cívico Pro Defensa de la Ciclovía, 2008; Peñalosa, 2008; Revista Cambio, 2008). Although the proposal was not passed, for other reasons, the public reaction showed the users’ rallying power. And, while some private-vehicle owners complain about road restrictions on Sundays (and during the nighttime Ciclovía), these concerns are only made in private or refer to isolated events.

The business sector’s opposition mainly dealt with the plans to expand the Ciclovía network of routes in the 1990s. The opposition mostly came from a commercial sector (shoe stores located along the main routes where the expansion was planned, represented by the National Federation of Business Owners [Fenalco]), which argued that the program threatened their businesses. The Administration in power at the time dealt with this opposition by submitting evidence of the impact of the program on the businesses through market studies carried out with the support of the Chamber of Commerce of Bogotá. Other strategies included workshops held with those potentially affected, the promotion of business alternatives that would be welcomed by Ciclovía users (for example, bicycle repair shops and food vendors), and the establishment of alternate parking lots. Most of those interviewed said that a decisive factor in the debate was the mayor’s decision to
continue the expansion plans, arguing that the public benefit overrides the private concerns, despite the complaints from the business community (El Tiempo, 1996b).

The CicloRutas Network


In part, the history of the design and implementation of Bogotá’s CicloRutas can be traced to the development plan, “Charting a City,” adopted during Mayor Mockus’s administration (1995–1998) (Alcaldía Mayor de Bogotá and Departamento Administrativo de Planeación Distrital, 1995). Since public space was one of its priorities, the plan included a permanent “ciclovía road network” that would provide a recreation environment and would also integrate the water system with the metropolitan green-area system (Instituto de Desarrollo Urbano, 2011a). The first corridor in the Fucha River canal was constructed in 1997 (Instituto de Desarrollo Urbano, 2003).

A year earlier (1996), the Japanese International Cooperation Agency (JICA) conducted a study of the Santa Fe de Bogotá urban transportation master plan, and recommended diversifying the city’s transportation modes and creating its intermodal articulation (Instituto de Desarrollo Urbano, 2003; Nair and Kumar, 2005). Although not all the recommendations were adopted, some were included subsequently as a background to the CicloRutas master plan three years later (Alcaldía Mayor de Bogotá et al., 1999).

Key Actors

The following actors played a role during this phase:

- The Mayor’s Office, which included the CicloRutas in its development plan;
- The planning sector, which carried out the first works through the IDU;
- JICA, which recommended an intermodal articulation for the city’s transportation systems.


When the city government changed in 1998, the CicloRuta began to be viewed less as an initiative that yielded environmental and recreational benefits and more as an opportunity for alternative transportation. As a result, among the list of priorities in Mayor Peñalosa’s development plan “For the Bogotá We All Want” was the construction of 80 km of CicloRutas that would connect to the main road network and the city’s main parks (Concejo de Bogotá et al., 1999). This idea was linked to the goal of “establishing transportation systems that would reduce trip times and provide a decent, comfortable, and efficient service that respected the urban setting and the environment” (Concejo de Bogotá, 1998).

That same year, a study for the CicloRutas Master Plan (PMC from the Spanish acronym) was conducted as a way to promote bicycle transportation; IDU contracted the study out to a private consortium. The plan set forth the necessary conceptual foundations, studies, actions, mechanisms, and policies for implementing and maintaining a 300.9-km CicloRutas network. Although the PMC focused on transportation, it considered the role of bicycling in promoting health, recreation, and sports (Alcaldía Mayor de Bogotá et al., 1999). Based on the PMC, the alternative transport project—CicloRuta—was incorporated into the Land-Use Management Plan as a component in the overall transportation system (Alcaldía Mayor de Bogotá, 2000; Cámara de Comercio de Bogotá, 2009). However, one of the PMC’s limitations is that it has not been regulated through an administrative decree.
During that same administration (1998–2001), further studies were carried out and 232.1 CicloRutas kms were constructed. The construction was facilitated by the renovation of roads and infrastructure undertaken for the TM system. Over the next three years, another 45 km were added: 33.6 km were the responsibility of the IDU and 11.4 km were linked to the recovery of water facilities by the Water Supply and Sewerage System Company of Bogotá (EAAB for its Spanish acronym) (Segura, 2011). The IDRD also participated, constructing 20.54 km. In 2002, the first maintenance phase was undertaken and in the following year, the World Bank granted a loan for investments in road connections, promotion, and optimization of the network (Instituto de Desarrollo Urbano, 2003).

**Key Actors**

The following actors played a role during this phase:
- Mayors’ offices, which included the CicloRutas in their city models;
- The urban planning sector, through the IDU, charged with executing the works and which arranged for the study that led to the PMC (conducted by a private company);
- The water supply and sewerage company;
- The Culture, Recreation, and Sports Institute (IDRD).

**Maintenance (2004 to the present)**

Between 2005 and 2006, CicloRutas were included in the Transportation Master Plan as non-motorized transportation strategies, and in the Public Spaces Master Plan as components of the cross-sectional public space sub-system. Although both master plans mention the potential health benefits of the CicloRutas network, those were not the main objectives nor do they involve the health sector in their design, implementation, and promotion (Alcaldía Mayor de Bogotá, 2005). More recently, however, the CicloRutas have been included in the Law on Obesity (1355/2009) as a strategy to prevent non-communicable diseases.

During the past two administrations (Garzón 2004–2007 and Moreno 2008–2010), the development plans included the construction of 76 km of CicloRutas (Alcaldía Mayor de Bogotá et al., 2004; Concejo de Bogotá, 2008). However, since these administrations did not make the works a priority (as did Mayor Peñalosa’s administration), they were limited to building CicloRutas in the intervened roads to comply with the provisions in the Land Use Plan, according to which all road construction must involve the road’s profile and, based on its type, must include the construction of one CicloRuta in the principal road network and one in the secondary road network (Decree 430/2004, Article 174).

The CicloRutas network includes an intersectoral component. Although responsibility for its maintenance rests primarily with the IDU, public utility companies are also involved, such as the EAAB, and the telephone company (ETB from its Spanish acronym), Codensa (the electric company), as well as the Transportation Secretariat (Instituto de Desarrollo Urbano, 2003). In 2006, an agreement was signed with the National Police to guarantee security along the network and conduct educational activities with users (Instituto de Desarrollo Urbano, 2009). University students and activists also organize caravans going to universities and workplaces using the CicloRutas, as a way to provide greater security and present the bicycle as a transport alternative for higher-income groups (Segura, 2011; Universidad de Los Andes, 2011). They also participate in political advocacy processes in support of bicycle use.
Key Actors
The following actors played a role during this phase:

- Transport and urban planning sectors, which included the CicloRutas in their master plans and participated in their execution and maintenance;
- Public utility companies (EEAB, ETB, and Codensa);
- The National Police;
- Bicycle activists.

Other Key Actors: Opponents, Strategies, and Barriers
During the construction of the first CicloRutas, some community organizations opposed it and publicized their complaints in the media. For example, some residents of the area around the Fucha River complained that the construction negatively affected the environment. The city tried to negotiate with them, by offering such concessions as the inclusion of a linear park that offered additional benefits. This was done so that, as with the Ciclovía, the CicloRutas would remain a priority (El Tiempo, 1996a).

When compared with the size of both the investment and the infrastructure, the number of CicloRutas’ users is low. According to the Segura study (2011) and data from Bogotá’s Chamber of Commerce, some of the reasons that explain the low usage are the network’s connectivity problems, its lack of articulation with other transport modalities, the lack of security, and insufficient bicycle racks. The fact that owning an automobile conveys higher status than riding a bicycle is a barrier for new users to begin to participate (Cámara de Comercio de Bogotá, 2009).

Further, the construction of the CicloRutas was not coupled with promotion and cultural campaigns about respecting cyclists or sufficient measures to reduce the rate of accidents and the insecurity caused by thefts (Cámara de Comercio de Bogotá, 2009). Even now, the CicloRutas are still not attractive or a real option to some population groups (women, high-income persons, children, and the elderly).

Another barrier is the lack of institutional coordination. The district does not have a lead entity in charge of promoting/facilitating bicycle use as a means of transportation. Nor is there a clear policy on bicycle use that integrates existing regulations; the PMC has not been included in any administrative act to support it within the city (rather, it serves only as a frame of reference) and it has not been integrated effectively to the Land Use Plan. Moreover, existing regulations do not consistently support bicycle use (for example, motor vehicles continue to be given precedence over cyclists) (Cámara de Comercio de Bogotá, 2009).

The TransMilenio System
Starting in the second half of the 20th century, discussions were held about constructing a metro system to solve the city’s transportation problems (Cain et al., 2006; Hidalgo, 2004; Leal et al., 2003; Lleras, 2003). With most local and national authorities favoring this alternative, roughly 10 attempts to construct such a system were undertaken between 1947 and 1997 (Lleras 2003). According to some authors, the attempts failed due to the high estimated costs, the lack of organizational capacity, and the opposition from public transport operators (Leal et al., 2003; Lleras, 2003).

In that context, the steps that led to the BRT system began in 1995, when the development plan “Charting a City” included integrating a potential metro with other projects, such as the metrobus and trunk-route system (Alcaldía
Mayor de Bogotá et al., 1995)\textsuperscript{21}. The next administration (1998–2001) also proposed integrating a metro system with a bus network that operated along dedicated lines. To this end, it considered the creation of the TransMilenio S.A. company (Concejo de Bogotá, 1998).\textsuperscript{22} According to Cán et al. (2006) and Gilbert (Cain et al., 2006; Gilbert, 2008), the metro option at that time was indefinitely postponed when it was clear that the costs exceeded the country’s finances and that a metro system would fall short of the city’s high demand. The authors note that, despite the national authorities’ reluctance, these reasons led the local authorities to prioritize the project that ultimately led to the TM system, based on more than 20 years of experience in Curitiba, Brazil.

In this way, as occurred with the creation of the CicloRutas, the decision to establish the TM system came out of a top-down approach in which the administration gave top priority to improving the transportation system. It project was financed through a percent of the gasoline tax, the district budget, a World Bank loan, and national budget resources (Hidalgo et al., 2007; Leal et al., 2003). TransMilenio S.A. was created in 1999. The project’s planning, design, and construction involved the participation of local and foreign companies (Cain et al., 2006) and feasibility studies took about 18 months (Leal et al., 2003).

At the onset, public transportation operators—who historically had exerted political and economic power in the city—objected to the plan. According to several authors, the situation was resolved when the city invited these operators to bid on contracts to operate the system (Gilbert, 2008; Hidalgo et al., 2007; Leal et al., 2003), which averted further protests or strikes. This shifted the relationship between the city and the transport operators (the new relationship based on concession contracts) and also changed the transportation economic model, which was framed as a subsidy to the infrastructure. Under the new scheme, transportation companies had to be licensed; in addition, fare collection was separated from operation (Sandoval, 2010). In April 2000, four companies established by local operators with ties to international investors were granted the concession to operate 470 new buses (Cain et al., 2006; Leal et al., 2003). In December 2000, TM’s Phase I officially began operations (Instituto de Desarrollo Urbano, 2011b). That same year, a Conpes\textsuperscript{23} document set the guidelines for the Urban Public Service of the Passenger Mass Transport System of Bogotá, as proof of the political will at the national level (Departamento Nacional de Planeación, 2000)

**Key Actors**
The following actors played a role during this phase:

- City administrations, which included trunk road networks in their development plans, integrating them to their priorities and vision, and finally made the decision to implement a BRT.
- Transportation companies.
- Urban planning and transport sectors.
- Private concessionaires.

**Development (2001 to the present)**

In 2002, four main routes were completed under Phase I. One year later, the system carried about 792,000 passengers each day (Hidalgo, 2004). The three Phase-II main routes were delivered and fully operational in December 2005 (Instituto de Desarrollo Urbano, 2011b). Initially, the plan set out to establish a network of 388 km, covering 85% of the city’s demand, to be built in eight stages and finished by 2016. Over time, the timetable and the projected phases have changed several...
times. Construction of the first part of Phase III was delayed several times and suffered cost overruns; it also was the focus of a corruption scandal in the city (El Tiempo, 2011b; Revista Semana, 2012; Revista Semana, 2010th). The appropriate design for one of the corridors (Avenida Carrera 7) has been the topic of several debates since 2007, involving experts, politicians, the media and the public (El Tiempo, 2007; Revista Semana 2007; Revista Semana, 2010b). As of this writing, additional resources are needed to finance the remaining stages and, once again, the debate on the relative benefits of a metro or a tram system versus those of the TM have resurfaced (Cain et al., 2006; Correa, 2012; Hidalgo, 2004; Leal et al., 2003; Metro en Bogotá, 2012).

The health sector, once again, did not have a role in the planning, design, implementation, or maintenance of the TM. Rather, its role has been limited to acting as a first responder in emergencies that may arise in the system. Only academia has explored TM’s potential to generate public health benefits (Cervero et al. 2009).

Key Actors

The following key actors played a role during this phase:

- City administrations, which continued building the system and participating in the debates about the design and changes to the initial plans.
- The urban planning and transportation sectors.
- Private concessionaires.
- The media.
- Citizens.
- Transportation, urban planning, and academic experts.

Other Key Actors: Opponents, Strategies, and Barriers

From the onset, the city’s transportation operators opposed the new transportation system for the changes it would bring to them (Gilbert, 2008; Hidalgo et al., 2007; Hidalgo, 2004; Santos 1999). And, although the city sought to include them in the bidding processes, according to Gilbert, this strategy favored large companies at the expense of the bus owners, which the experts and media criticized. Observers note that in the next phases the process was more democratic, but the concentration of investment in a few companies has been denounced (Gilbert 2006).

The TM has sparked objections and opponents. During the construction of Phase II in 2004, and again during the 2007 and 2011 mayoral campaigns, critics voiced their opposition in the media and in public debates (El Tiempo, 2007; Revista Semana, 2010a; Revista Semana, 2010b; Revista Semana, 2007). Citizens complained of the congestion generated by the works and the construction delays, of the rapid deterioration of the concrete slabs used in the system’s corridors (which led to large investments in maintenance and caused delays in travel times), of overcrowded buses and stations, of poor safety, and of costly fares (17% higher than that of common public transportation)2 (Cain et al., 2006; Gilbert, 2008; Hidalgo, et al. 2007). The same complaints were made by those who think their properties have been negatively affected by the construction of the system (El Tiempo, 2006). The associations of architects and urban planners have also expressed dissatisfaction with the effect of incomplete works on the city’s aesthetics (for example, the persistence of walls of demolished properties) (El Tiempo, 2011a). Moreover, as mentioned earlier, the benefits of the
TM over other mass transportation systems are still being debated (Dinero, 2012; Revista Semana, 2011).

Outdoor Gyms

**Beginnings (2009)**

Outdoor gyms were installed in Bogotá in 2009, when a private initiative promoted what had already been done in Spain, Portugal, and the United States. The timing coincided with studies conducted by the IDRD’s technical unit, which sought to promote the installation of new equipment in public spaces and the renewal of equipment installed in the parks, to respond to the needs of the different communities and age groups. The initiative was presented to the IDRD, and the private company installed equipment for four months in El Tunal Park as a sample of what could be offered. The equipment was extremely well received by the community, and when the company removed the equipment eight months later, citizens launched a mail-in protest campaign, demanding that the equipment be restored. The IDRD, prompted by the community’s demand, acquired equipment designed to its specifications, and installed it using private-sector resources within the framework of the 2008 Agreement 78 (Concejo de Bogotá D.C., 2002). This agreement established a tax exemption for companies that invest in the management, upkeep, or improvement of district parks by signing contracts with the IDRD.

This change, whereby the IDRD installed the equipment, also implied a different approach. The promotion company had initially offered outdoor equipment for senior citizens, while the IDRD adapted them so they could be used by different age groups and in various local conditions and parks sizes (for example, some of the smaller parks cannot hold 11 pieces of equipment). This adaptation was subject to feasibility studies, previous supply, and in accordance with master plans. This new perspective played out within a change in mindset at the IDRD compared to that of previous administrations; it was now thought that the design of infrastructure should be based on the needs of specific communities, not necessarily standardized throughout the city.

**Key Actors**

The following actors played a role during this phase:

- Citizens.
- The private sector.
- The culture, recreation, and sports sector—IDRD.

**Continuation (2010 to the present)**

In the following months, the IDRD encouraged private-sector companies to fund new equipment and its installation in the parks. This was based on the idea that it could benefit Bogotá’s residents in terms of physical activity, health, and well-being, and at the same time benefit the private sector by having it display a gesture of social responsibility (Instituto Distrital de Recreación y Deporte, 2011a). This outreach to the private sector involved two models. The first was a modification of IDRD’s “Adopt a Park” program. This initiative seeks a partnership between the community, private enterprises, and the district to restore and maintain the city’s parks through interinstitutional agreements that last one to three years (Instituto Distrital de Recreación y Deporte, 2010). This initiative allowed a company to adopt a park by providing exercise equipment for outdoor gyms. The second model involves donating equipment (without any maintenance commitment) within the framework of the 2008 Agreement 78 of 2002, described previously.
Outdoor equipment was installed in the next two years, donated by the international corporation of prepaid health care Colsanitas, Novartis Laboratories, Athletic Colombia S.A., and the IDRD. The pieces of equipment were installed in high-, medium-, and low-income neighborhoods in parks of various sizes, including parks in the metropolitan area, which serve a great many residents. The first equipment was imported, but installed by Colombian companies. Later, Colombian firms began to manufacture the equipment, based on IDRD designs (Agenda CM&, 2011). In 2011, new gym installations involved the participation of two cooperatives from the education sector and Engativá’s mayor’s office.

The equipment installation and upkeep fosters the community’s participation. The IDRD holds workshops with resident associations from neighborhoods to be affected, in order to identify their needs and preferences and raise awareness about the project. Feasibility studies also take into account the findings of earlier studies (such as those conducted by the National University or the Cultural Observatory) that present the public’s most pressing needs. Interviewees expressed that it was crucial for communities to take ownership of the equipment and help with its care. For example, a neighborhood association near one park has assumed monitoring the infrastructure to prevent vandalism.

As of this writing, the outdoor gyms function through intersectoral work that includes public-private partnerships that function within the previously detailed framework; the recreation, culture and sports, and the health and education sectors; and the public.

Key Actors
The following key actors played a role during this phase:

- Private enterprise dealing with health and education.
- The culture, recreation, and sports sector—IDRD.
- Citizens.

Other Key Actors: Opponents, Strategies, and Barriers

Neither the literature review nor the interviews were able to identify opponents to this initiative. In fact, residents (both in media coverage and in interviews) express enthusiastic support for the infrastructure. According to the interviewees, the greatest difficulty is raising funds for new equipment, and an important obstacle is guaranteeing that it is not vandalized. To prevent vandalism, the equipment has been produced with specific designs and placed in areas, such as larger parks, which can guarantee surveillance and the community’s participation. On the other hand, it is paradoxical that the technical requirements to install the equipment require hardening the areas (of the parks), which reduces the amount of green space. One strategy seeks a design that uses more environmentally friendly materials.

Factors that Influenced These Changes in Bogotá

The program’s implementation and the infrastructures’ construction or installations that are reported on in this study were influenced by the international, national, and local factors that are discussed below.

Urbanization and rapid growth: In the second half of the 20th century, Latin America experienced a rapid and massive urbanization process (Varela C 1998). Such vast changes pose major challenges for the cities, such as the need to ensure access to basic services to a growing population; a rise in unemployment,
poverty, and inequality; and a reduced standard of living (United Nations, 2008). Urban living also leads to a more sedentary lifestyle and to a diet rich in processed and high-calorie foods (PAHO, 2007). In Bogotá, annual growth between the 1950s and the 1990s was 6.5% (Varela, 1998), and in only nine years (1964–1973), the city’s population doubled (Instituto de Estudios Urbanos, 2011).

The population increase was coupled with an unplanned urban sprawl that affected public spaces, the equitable access to recreation and community activities, and the urban infrastructure serving the growing population, problems that were compounded by inequality and poverty, among others (Díaz del Castillo et al., 2011; Ramírez A 2005).

Cities in the global economy: The 1990s brought major changes at the global, national, and local levels. Globalization caused cities to gain importance as centers of production, and had to compete for foreign investment, and adapt to the investors’ standards (Bushnell, 2007; Díaz del Castillo et al., 2011). This included transforming the urban environment and providing services, as well as addressing growing concerns about the environmental impact of production and economic activities. Thus, the concepts of sustainable cities, strategic planning, quality of urban life, and environmentalism gathered importance (Carrión, 2001). In Bogotá, the consolidation of the Ciclovia, the implementation of the CicloRutas and the TM system, and the increase in the number of parks, were part of—and also were influenced by—this new way of viewing the city.

Political and administrative changes in Colombia and Bogotá: In Colombia, the 1990s also ushered in significant reforms, including the adoption of a new constitution and a neoliberal economic model. The country also lived through an escalation of violence, drug trafficking, urban terrorism, and the forced displacement of people to the main cities (Bushnell, 2007; Dávila and Gilbert, 2001; Mosquera, 2010).

Among other changes, the 1991 Constitution consolidated a decentralized process that had been under way for several years and created a special scheme for Bogotá, granting it greater political and administrative autonomy and establishing fixed terms for mayors (Bushnell, 2007; Dávila et al., 2001; Mockus et al., 1997). Changes also included the consideration of recreation, sports, and leisure time as rights of all citizens, and required that their infrastructure be democratic, charging the State with their promotion and supervision (República de Colombia, 1991).

Further, a new statute made Bogotá a decentralized district, with greater potential for efficiency, an administrative organization, greater autonomy for its leaders, new opportunities for citizen participation, new duties and responsibilities for city districts, and a larger budget25,26 (Dávila et al. 2001; Mockus et al. 1997; Pizano 2003). Prior to these changes, the city’s political-administrative circumstances were less favorable. For example, the country’s mayors were not elected by popular vote until 1988, terms of office were irregular and short, and mayors had low credibility. Moreover, the city’s budget did not cover the needs associated with the rapid growth (Bushnell, 2007; Dávila et al., 2001). The new scheme gave Bogotá greater autonomy for promoting the comprehensive development of its area and for improving its residents’ quality of life. (República de Colombia, 1993).

City administrations that shared a vision for the city and its citizens: As previously men-
tioned, several independent administrations (1995–1997, 2001–2003, and 1998–2000) shared a vision for the city and the citizenry that focused on urban transformations and citizenship culture (Pizano, 2003). In addition, several factors came together to facilitate the process, such as the fact that the first Mockus Administration did not execute the total budget, providing the next administration with enough resources to carry out its plans. Further, in 1997, Mayor Peñalosa was elected along with a city council that supported his proposals. Thus, the Development Plan “For the Bogotá We All Want” (1998–2000) was included in the council’s Agreement 06 of 1998.

Such shared priorities made it possible for the city to carry on several changes. These included the recovery and appropriation of public space, the creation of a new public transportation system, and the promotion of alternative means of transportation (Montezuma, 2003; Parra et al., 2007). Beginning in 2004, however, the administrations in power had other priorities (Alcaldía Mayor de Bogotá and Departamento Administrativo de Planeación Distrital, 2004), and the urban transformation process lost steam.

Lessons Learned

This section describes the lessons learned and puts forth recommendations about these programs and infrastructures, so they can be duplicated in other contexts, cities, or countries and can serve to promote physical activity.

Multisectoral work: The Ciclovía, CicloRutas, TransMilenio, and outdoor gyms are all examples of multisectoral work, although they may entail differing levels of formal agreements and numbers of participants. In all four cases, the health sector played a secondary—nearly invisible—role in promoting physical activity. As such, these are clear examples of the need for the health sector to build on the experiences or programs of other sectors, mainly those of recreation, culture, sports, transportation, and urban planning.

Including the health sector in urban planning: It is recommended that the health sector’s perspective be included in the planning and evaluation stages of urban planning processes.27

Including health indicators: It is important to include indicators of public-health benefit in the design, evaluation, and monitoring of urban development programs. To this end, it is recommended that the transportation and urban-planning sectors consider the effects that their interventions may have on physical activity and that they work with the health sector to evaluate them. Specifically, the inclusion of indicators that measure the level of physical activity reported by users of the Ciclovía program, CicloRutas, TM, and outdoor gyms in the transportation and leisure time dimensions is recommended.

Using existing infrastructure: The Ciclovía and its parallel programs (Recreovía), along with the outdoor gyms, demonstrate that it is possible to maximize resource utilization if existing urban infrastructure is used to promote physical activity and if public-private partnerships are fostered. The fact that these program’s and infrastructure’s benefits go beyond physical activity, makes it easier to foster a collaborative environment involving other sectors, such as recreation, social integration, transportation, culture, and tourism.

The public space’s potential: The cases reviewed here are examples of how strategies designed to improve public spaces and to foster their ownership by citizens can be used to enhance health by encouraging physical activity. However, such efforts must be accompanied by
comprehensive interventions that guarantee safety, equity, and real opportunities for different age groups (children, adolescents, adults and seniors) and for those with disabilities.

Guaranteeing sustainability: The CicloRutas and TM illustrate how this type of initiative require that they be sustained through several city administrations, to ensure that they do not cease to evolve. Cities must consider these initiatives in the short-, medium-, and long-term, but administrations also must stay flexible enough to be able to incorporate new technology and state-of-the-art changes. The implementation of new coordinated and comprehensive infrastructure will lead to greater efficiency than isolated interventions.

Institutional strengthening: These cases also illustrate the need to strengthen and coordinate institutions in order to achieve common objectives. As competencies, resources, and management are strengthened, there will be greater coordination among them for implementing multisectoral projects.

Political will and citizen participation: Regarding the Ciclovía, CicloRutas, and TM, history has shown how the leadership, commitment, and political will of city leaders who shared a vision for the city were key at the beginning of the process and ultimately led to their implementation. Plans were executed because they were an important part of their agendas and priorities, responded to specific needs in the city (such as transportation, inequity, recreation, and availability of resources) and were consistent with city models pursued through several administrations. In terms of the Ciclovía, although some interested civil groups launched some initiatives at the beginning of the process, it was the changes in administration that made it possible for the program to grow and be sustained.

The community, in turn, has supported the Ciclovía and the outdoor gyms simply by using them, frequently and in great numbers. This ongoing, strong support makes it very difficult for government officials to go against the popular tide and risk political consequences. A community that takes ownership of programs and infrastructures is willing to fight for them against initiatives that may erode them. Both governmental actors and interest groups were (and are) necessary, but neither is sufficient by itself.

Promoting different dimensions of physical activity: Bogotá experience also illustrates that the promotion of physical activity must involve several of its dimensions, such as engaging in physical activity during leisure time and bicycling or walking for transportation. These strategies still need to be strengthened and promoted more widely. Moreover, there is a need to undertake comprehensive interventions that address issues such as safety, the high status that society accords to private vehicles, inequality, and a lack of easy connection with other means of transportation. In a city such as Bogotá, where currently only 11% of trips are made in private vehicles, it is critical to improve the social marketing strategies and to make infrastructure more efficient, so that trips now made by walking, cycling, and public transportation are not replaced by the use of private vehicles.

Factors that facilitated or hindered the design and implementation of the Ciclovía as a way to promote physical activity: The factors that facilitated the design and implementation of the Ciclovía include i) a multisectoral approach with clear leadership promoting it, which in this case has been the recreation and sports sector (IDRD); ii) political will; iii) citizens’ participation; and iv) social marketing of
Factors that impeded it include i) changes in the government’s priorities that did not ensure its continuity; ii) private automobiles; iii) transportation priorities; and iv) nearby businesses.

Factors that facilitated or hindered the design and implementation of CicloRutas as a way to promote physical activity: The factors that promoted the design and implementation of the CicloRutas include i) a vision for Bogotá that focused on sustainable transportation models; ii) a development plan that considered them a priority and allocated sufficient resources to them; and iii) changes to the road network that fostered the interchange between transportation modes, specifically, incorporating the full road profile in the building of new roads and TM infrastructure, including sidewalks, partitions, and CicloRutas (with tree planting and laying underground networks). The factors that hindered it include i) inconsistent interventions that lead to interrupted circuits and discourage their use; ii) a lack of visible leadership directly responsible for coordinating the design, implementation, and monitoring of the infrastructure; iii) inconsistent transportation priorities (with greater weight given to automobiles than to bicycles); iv) poor road safety and crime; v) the bicycle’s low status as a transportation alternative; and iv) inadequate financing for maintenance.

Factors that facilitated or hindered the design and implementation of the TM as a way to promote physical activity: The factors that promoted the design and implementation of the TM include i) partnerships between the public and private sectors to the benefit of both; and ii) widespread public use and ownership of the program. The factors that hindered the design and implementation of outdoor gyms include i) inadequate financing to install new equipment and ii) risk of vandalism.

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Notes

1  The recommendation is to carry out 150 minutes of moderate physical activity per week, or 75 minutes of vigorous activity per week (US Department of Health and Human Services, 2008).

2  Bogota’s urban area accounts for 33% of the city’s total area and concentrates 90% of the population. The program and infrastructures described in this document are targeted at the urban population.

3  Bogotá received approximately 12% (2 million) of the displaced population from 2000–2006 (Cámara de Comercio de Bogotá, 2007).

4  These characteristics include the location of the home’s entry within the block; condition of street pavement; street access; size of the façade; whether the home has sidewalks and porches; and construction materials used in the façades, garages, and roofs.

5  The GINI coefficient is a measure of inequality that ranges between 0 (total equality) and 1 (total inequality).

6  Public transportation, which has been available in some form since the 1950s, is privately operated and run by private companies that are responsible for certain routes, which are assigned through licenses. Traditionally, these companies have had significant political and economic power in the city. Bus owners are usually small operators or independent drivers affiliated to these companies. Owners’ profits depend on the number of passengers they carry, which has led to what is known as the “penny war.” Most of the system functions without established stops and the level of user satisfaction was 29% in 2010 (Cain et al., 2006; Gilbert, 2008; Lleras, 2003; Cámara de Comercio de Bogotá 2011a).

7  It should be noted that through District Decree 1098, issued in 2000, Bogotá established a “car-free day,” which is celebrated on the first thursday of February each year. The day starts at 6:30 a.m. and ends at 7:30 p.m. In 2003, Bogotá participated in the international campaign of “car-free day,” along with 3,000 other cities (Decree No. 297, issued in 2003).

8  The 2005 National University study estimated that 41% of users spend more than three hours in the Ciclovia; 33% walk or run, 49% bicycle, and 38% skate
or use some other type of wheels (Universidad Nacional, 2005).

9 Academia’s participation involves conducting evaluations.

10 The 2013 legal minimum monthly wage was $589,500 pesos (US$ 323), with $70,500 (US$ 38.64) of transportation aid; the latter pays for about 42 TM trips during peak hours.

11 Operators are responsible for procuring and running the vehicles, hiring personnel, and managing maintenance yards and parking (TransMilenio, 2011a).

12 Private concessionaires are in charge of logistics for operating the system, supplying the equipment, selling tickets, processing information, and maintaining the collection equipment (TransMilenio, 2011a).

13 The increased cost was due to greater investment in infrastructure and to modifications in the surrounding public space (Cain et al., 2006).

14 Although the idea of having users walk to the TM stations was included in its design, it was not conceived from a health perspective or to promote physical activity, but rather as a cultural change.

15 This section is an adaptation of Díaz del Castillo et al., 2011.

16 For example, the Ciclovía involved the citizens’ use of public space, and to equally weight the needs of pedestrians and those of motor vehicles, which was consistent with promoting bicycling as alternative means of transportation; it also provided a setting where the culture of citizenship could be promoted.

17 Even today, those interviewed remember the slogan “Bogotá does not have an ocean, but it has the Ciclovía,” which they view as a very successful marketing strategy.

18 The health sector’s role is circumscribed to providing emergency care to Ciclovía users who may need it.

19 The health sector is mentioned only in the paragraph 29 of the Transportation Master Plan, where it establishes that the district entities in charge of the environment, health, and transportation must establish cooperation mechanisms to carry out public health campaigns.

20 Bogotá’s vehicle fleet in Bogotá has steadily increased in recent years, despite measures to discourage vehicle use (Acevedo et al. 2009).

21 These proposals sought to improve previous failed attempts with the trunk road of Avenida Caracas.

22 These proposals were part of the transportation and public space priorities of the administration, which included promoting non-motorized transport, providing disincentives for using private vehicles, and recovering public space. (Montezuma, 2005). The construction of TM stimulated the renovation of the urban infrastructure within its area and around its stations (Caín et al. 2006).

23 Conpes: from the Spanish acronym Concejo Nacional de Política Económica y Social (National Council of Economic and Social Policy)

24 Even though the 2012–2015 administration lowered the non-peak fare, it is still higher than that of the common public transportation.

25 Although Bogotá has the highest taxes in the country, these revenues are distributed nationally; thus, not all of these taxes contribute to the city’s budget.

26 Several of these processes occurred during the administration of Jaime Castro (1992–1994), and some authors note that these decisions opened the way for the changes that followed (Pizano, 2003 and Dávila and Gilbert 2001).

27 The infrastructure described in this document can also have negative health externalities in terms of environmental pollution and a lack of traffic safety. Thus, it is necessary to take account of these aspects in urban planning processes, with the participation of the health sector.
Chapter 3.

Mexico’s National Agreement on Food Health: Strategy Against Overweight and Obesity

EVELYNE RODRÍGUEZ

The objective of this study is to document the design and negotiation process of Mexico’s National Agreement on Food Health: Strategy Against Overweight and Obesity (known as ANSA for its Spanish acronym). Furthermore, it seeks lessons from the process that could be useful to Mexico and other countries in the development and implementation of similar policies. In addition to the ANSA, there are two documents that are part of the same effort and whose content, preparation, and negotiation are also discussed here: the Technical Bases of the National Agreement on Food Health (hereinafter Technical Bases) and the General Guidelines for the Sale or Distribution of Food and Beverages in School Consumption Facilities in Basic Education Schools (hereinafter the Guidelines), issued by the Secretaries of Public Health and Education, a document derived from the actions agreed upon in the ANSA for the Secretariat of Public Education. Some exceptions should be pointed out regarding this study: first, an attempt was made to reflect the opinions of the different actors who participated in the process and that were interviewed, these opinions were not totally in agreement. The interviews were not recorded, thus any error in the transcription or interpretation of the observations is the responsibility of the author.

Context

In January 2010, the Government of Mexico launched the National Agreement on Food Health: Strategy Against Overweight and Obesity (ANSA), the first national multisectoral strategy developed to tackle these two problems. One of the main public health challenges is the high prevalence of overweight and obesity among Mexico’s population. According to the National Public Health Institute (INSP), obesity is the main modifiable risk factor in chronic non-communicable diseases (CNCD) such as diabetes mellitus and cardiovascular diseases, which are among the leading causes of mortal-
ty in the country. The prevalence of overweight and obesity in Mexico has significantly increased in the last three decades. In the case of obesity, such rapid increase is among the most documented worldwide.

In 2008, it was estimated that the costs attributable to obesity in Mexico were equivalent to 13% of total health expenditures (0.3% of gross domestic product [GDP]). It was also pointed out that if no cost-effective interventions are implemented to prevent and control obesity and its comorbidities (hypertension, type-2 diabetes mellitus, cardiovascular diseases, breast cancer and colorectal cancer), direct costs could double and indirect costs could triple in just one decade (INSP 2012).

The most recent information on the prevalence of overweight and obesity in Mexico corresponds to the National Health and Nutrition Survey 2012 (ENSANUT 2012),¹ which points out that:

i. 9.7% of children under 5 of both sexes are overweight or obese and 23.8% are at risk of overweight.

ii. 34.4% of school-age minors (5 to 11 years old) of both sexes are overweight or obese: 19.5% of boys are overweight and 17.4% are obese, while for girls the percentages are 20.2% and 11.8%, respectively.

iii. 35% of adolescents (12 to 19 years old) are overweight or obese: 19.6% of men are overweight and 14.5% obese, while for women the percentages are 23.7% and 12.1%, respectively.

iv. 71.3% of adults (over 20 years of age) are overweight or obese: in men, the percentages are 42.6% overweight and 26.8% obese, while for women the figures are 35.5% and 37.5%, respectively.

Figure 3.1 also shows that the combined prevalence rates of overweight and obesity increased from 2006 to 2012 for children under five, although not for school-age children (5 to 11 years old). These prevalence rates also increased for both men and women 12 years old and older.
Figure 3.1. Prevalence rates of overweight and obesity in different age groups, 1988-2012

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1998</th>
<th>1999</th>
<th>2006</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preschoolers (under 5 years old)</td>
<td>7.8%</td>
<td>8.8%</td>
<td>8.3%</td>
<td>9.7%</td>
</tr>
<tr>
<td>School-age children (5 to 11 years)</td>
<td>34.8%</td>
<td>34.4%</td>
<td>33.2%</td>
<td>34.9%</td>
</tr>
<tr>
<td>Adolescents (12 to 19 years)</td>
<td>24.9%</td>
<td>34.4%</td>
<td>34.9%</td>
<td>69.8%</td>
</tr>
<tr>
<td>Adults</td>
<td>71.3%</td>
<td>69.8%</td>
<td>34.4%</td>
<td>34.9%</td>
</tr>
</tbody>
</table>

Source: Rodríguez and Pasillas (2013), based on INSP, 2012; INSP, 2006; and ENSANUT 2012.

Note 1: The 2006 datum on adults was obtained through the calculation of a weighted average of the prevalence rates of adult women and men, since the INSP 2006 shows only the prevalence rates by gender, but not the total.

Note 2: The National Nutrition Survey of 1988 and 1999 collected only information on childbearing-age women: 12 to 49 years old.

The Policy: ANSA, Technical Bases, and General Guidelines

National Agreement on Food Health/Strategy Against Overweight and Obesity

Within this context, the Secretariat of Health (SS) signed the National Agreement on Food Health: Strategy Against Overweight and Obesity (henceforth ANSA or Agreement). The ANSA is the first national multisectoral strategy with multidisciplinary actions that takes into account different environmental and personal determinants, aimed at reversing the obesity epidemic and its associated chronic diseases. The Agreement was signed by public sector agencies and entities and industrial representatives with the following goals for 2012:

- Reverse, among children 2 to 5 years old, the growth of the prevalence of overweight and obesity to less than in 2006.
- Stop, among the population 5 to 19 years old, the advance in the prevalence of overweight and obesity.
- Slow the growth of the prevalence of overweight and obesity among the adult population.

To this end, the ANSA established the following 10 priority objectives:

1. Promote physical activity among the population in school, workplace, community, and recreational environments with the collaboration of public, private, and social sectors.
2. Increase the availability, access, and consumption of safe drinking water.
3. Decrease the consumption of sugars and fats in drinks.
4. Increase daily intake of fruits and vegetables, legumes, whole grain cereals, and fiber in the diet by making these foods more available, more accessible, and by promoting their consumption.

5. Improve the population’s decision-making capacity about proper diet through nutrition labeling that is useful and easily understood, and through the promotion of literacy in nutrition and health.

6. Promote and protect exclusive breast-feeding until six months of age and appropriate complementary feeding beyond 6 months old.

7. Decrease the consumption of sugar and other caloric sweeteners added to foods, by, among other measures, increasing the availability and accessibility of food with reduced or no added caloric sweeteners.

8. Provide guidance to the population on recommended portion sizes in home food preparation and make processed foods that allow for this accessible and available, including smaller portions sizes in restaurants and food outlets.

9. Reduce daily intake of saturated fats in the diet and minimize trans fats from industrial sources.

10. Reduce daily sodium intake by lowering the amount of added sodium and increasing the availability and accessibility of products with low or no sodium.

The general Agreement signed in January 2010 is a document that, among other things, i) summarizes the financial and social costs of overweight and obesity; the causes of overweight and obesity, and the goals for 2012 agreed upon with federal agencies, the industry, and social organizations; ii) defines a National Forum for the Prevention of Overweight and Obesity made up of public agencies; national business organizations (food and non-alcoholic beverages, agricultural products, industrialization, marketing, food sale and consumption); national academic institutions (related to nutrition, physical activity, and social and economic aspects on the subject); the national municipal representation in health, and social organizations (national representatives of the health professions, unions, and civil society), and iii) describes the role of the industry, the municipalities, civil society, academia, and professional and union organizations. With respect to the involvement of the food industry, the Agreement indicates that the latter provides coordination mechanisms to advance innovation of products, better information to the consumer on the nutrient composition of food, and voluntary measures to regulate advertising aimed at children, without establishing specific commitments. The Agreement also points out that the involvement of the food industry is crucial in decreasing the consumption of sugar and fat in non-alcoholic beverages, sugar added in food, the size of portions, and the consumption of saturated fats as well as to eliminate the production of trans fats and limit the amount of sodium added to food. Annex 3.1 describes the aforementioned actions by agency in the ANSA.

Technical Bases of the National Agreement on Food Health

The Technical Bases of the ANSA, is a document that, among others, i) describes the conceptual framework; ii) provides an extensive diagnosis of the problems, including some international experiences on how to deal with them; iii) introduces the basic strategy, stating the vision, the goals for 2012 and its objectives in a much more precise manner than the General Agree-
ment, and iv) develops the proposed policies and actions to combat overweight and obesity.

General Guidelines for the Sale or Distribution of Food and Beverages in School Consumption Facilities in Basic Education Schools and Single Annex

The General Guidelines, which became effective on January 1, 2011 with a gradual implementation mechanism, aim at ensuring that the foods that are prepared and sold at schools contribute to a healthy diet. These Guidelines were issued as a secretarial agreement between the Secretariat of Health (SS) and the Secretariat of Public Education (SEP), in compliance with the commitments made by the SEP in the ANSA, and are a compulsory official regulation for all public and private basic education schools that, among others, i) establishes the nutrient criteria that regulate the type of food and beverages recommended for consumption and sale in the schools as well as those that should not be distributed (both for industrialized and non-industrialized food prepared by the school cafeterias), and ii) creates a School Food Facility Committee to monitor the preparation, management, consumption, and sale of food and beverages within the schools. For a critical analysis of the Guidelines, see Flores Huerta et al. (2011), and for a description of the rationale, see Hernández and Martínez (2011).

Policy-making Process: Main Stakeholders and the Negotiation Process

This section describes some efforts and actions related to the ANSA that were carried out prior to its signing. In addition, Annex 3.2 includes other previous actions that were not part of the strategy to materialize the Agreement, but that can also provide a context of the efforts and the discussions on overweight and obesity at the end of 2008.

In 2008, through the Department of Disease Prevention and Health Promotion, the SS began work to support and design the ANSA. First, it carried out an estimation of the financial costs of chronic diseases through the Economic Analysis Unit of the SS and secondly, it requested the support of the INSP to outline the general characteristics of what could become a national strategy, identifying actions and objectives based on the risks of obesity, and proposing viable recommendations. To this end, the INSP group, led by the Research Center on Nutrition and Health, and based on the ENSANUT results: i) made the diagnosis of the evolution of overweight and obesity in Mexico, identified risk factors and the burden of disease; ii) reviewed the Mexican experience regarding prevention and care of obesity and chronic noncommunicable diseases, such as the one carried out by PrevenIMSS, as well as foreign experiences; iii) compiled the international recommendations (among them the WHO recommendations) and those of the different Mexican medical societies, such as the Mexican Diabetes Association, and iv) examined and generated evidence supporting the recommendations through the review or updating of the specialized literature, meta-analysis and systematic revisions of literature such as that of the Global Fund for Cancer Research (Global Fund for Cancer Research, 2007).

The INSP together with the SS prepared the document “Bases for a State Policy to Prevent Obesity,” and outlined proposals for general actions to prevent overweight and obesity. A preliminary and confidential version of this document and the proposed actions by agency were reviewed in December 2008 in a work-
shop of experts organized by the SS through the Disease Prevention and Health Promotion Department and the INSP (Secretariat of Health 2010).

Main Stakeholders

As can be inferred from the description of the ANSA objectives, the Agreement proposed objectives whose compliance could not be achieved only by actions that fall under the responsibility of the Secretariat of Health nor even of the agencies and entities of the Federal Government. This is the case because the objectives involved behavior changes at the personal level and changes in the supply of food both at the industrial and restaurant levels.

As was previously described, the Agreement establishes the targets and general goals and describes the actions without specifying any specific action for the industrial sector. In turn, the Technical Bases detail the annual activities and goals by agency and entity per year but only through 2012. The Agreement was signed in January 2010 by 14 agencies and entities of the federal public sector and 4 organizations representing the food industry. The Technical Bases established 117 activities with 249 actions, designating responsibilities per Secretariat and entity, which were only agreed to by the representatives of the Federal Government. Subsequently, in August 2010, the Agreement was published along with the general Guidelines for the Sale or Distribution of Food and Beverages in School Consumption Facilities in Basic Education Schools, issued by the secretaries of Public Education and Health.

The ANSA was subscribed by the incumbents of the following agencies and public entities:

- Secretariat of Health (SS)
- Secretariat of Agriculture, Livestock, Rural Development, Fisheries, and Nutrition (SAGARPA)
- Secretariat of National Defense (SEDENA)
- Secretariat of Social Development (SEDESOL)
- Secretariat of the Economy (SE)
- Office of the Consumer Federal Public Prosecutor (PROFECO)
- Secretariat of Public Education (SEP)
- National Commission of Physical Culture and Sports (CONADE)
- Secretariat of Finance and Public Credit (SHCP)
- Secretariat of the Navy (SEMAR)
- Secretariat of Labor and Social Welfare (STPS)
- National Water Commission (CONAGUA)
- National System for Comprehensive Family Development (SNDIF)
- Mexican Social Security Institute (IMSS)
- Institute for Social Security and Services for State Workers (ISSSTE)
- Mexican Petroleum (PEMEX)
- Center for Research in Nutrition and Health National Institute of Public Health (INSP), as representative of the academic institutions
- Business Coordination Council (CCE)
- Confederation of Industrial Chambers (CONCAMIN)
- National Chamber of Transformation Industries (CANACINTRA)
- Mexican Council of Consumer Products Industries (ConMEXICO)

Even though several agencies and social organizations signed the Agreement, the main stakeholders and their roles are detailed in table 3.1. With respect to the public sector, the leading role in the design and negotiation of the ANSA was the Secretariat of Health, with
significant technical support from the National Institute of Public Health (INSP), an agency of the SS. The Coordination of the Social Cabinet under the Presidency played an important role in convening the other federal agencies for the discussion and signing of the Agreement. In regard to the Guidelines, the principal negotiators were the SEP, the SS and the Secretariat of the Economy both the central unit (and regulatory entity) as its agency COFEMER, with respect to the approval of the regulations; SAGARPA also participated in these negotiations.

The leading role on the part of the industry was taken by the Mexican Council of Consumer Products Industries (ConMEXICO). ConMEXICO is the organization representing the industry which groups 43 major companies from different industries, mostly food and beverages (among them Coca Cola, Pepsico, Nestle, Bimbo, Danone, Alpura, Barcel and Kelloggs). Among its functions is representing the industry before State agencies. Although other social organizations participated (CONCAMIN, COPARMEX, CCE, CNA), ConMEXICO represented the views of the entire industry.

During negotiations of the Agreement, the Technical Bases, or the Guidelines there was not involvement of organizations representing consumers or parents. Neither was the Congress or individual lawmakers involved, although at the time of the Agreement there were several reform initiatives related to obesity in Congress. Furthermore, the media did not play a relevant role.

### Table 3.1. Main Stakeholders and their Responsibilities

<table>
<thead>
<tr>
<th>Institution departments or units</th>
<th>Roles and responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Secretariat of Health</strong></td>
<td>Design the proposed Agreement; conduct its negotiations within the executive branch and with industry. Responsible for monitoring.</td>
</tr>
<tr>
<td>• Secretary</td>
<td></td>
</tr>
<tr>
<td>• Undersecretariat for Prevention and Health</td>
<td></td>
</tr>
<tr>
<td>• General Directorate of Health Promotion</td>
<td></td>
</tr>
<tr>
<td>• Strategy and Development Directorate of Healthy Environments</td>
<td></td>
</tr>
<tr>
<td>• Coordination of Advisers of the Secretary</td>
<td></td>
</tr>
<tr>
<td>• Coordinating Unit for Vinculation and Social Participation</td>
<td></td>
</tr>
<tr>
<td><strong>Secretariat of Public Education</strong></td>
<td>Negotiation of the Guidelines with the Secretariat of Health. Responsible for implementation. Program School-Health</td>
</tr>
<tr>
<td>• The Secretary</td>
<td></td>
</tr>
<tr>
<td>• Secretariat for Basic Education</td>
<td></td>
</tr>
<tr>
<td>• General Directorate of Development</td>
<td></td>
</tr>
<tr>
<td>• Management and Educational Innovation</td>
<td></td>
</tr>
<tr>
<td>Institution departments or units</td>
<td>Roles and responsibilities</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td>National Institute of Public Health</td>
<td>Design of specific recommendations to the Agreement.</td>
</tr>
<tr>
<td>- Center for Research in Nutrition and Health</td>
<td>Generation of technical evidence for the design and negotiation of the Agreement.</td>
</tr>
<tr>
<td>- Center for Research in Nutrition and Health</td>
<td>Participation in negotiating tables with industry; providing technical support to the Secretariat of Health.</td>
</tr>
<tr>
<td>Secretariat of the Economy</td>
<td>Participated in the negotiation of the Guidelines with industry, along with the secretariats of Health and of Public Education.</td>
</tr>
<tr>
<td>- Undersecretariat of Industry and Trade</td>
<td></td>
</tr>
<tr>
<td>Federal Commission for Regulatory Improvement (COFEMER)</td>
<td>Responsible for approving federal regulations that impact the private sector. It approved the Guidelines.</td>
</tr>
<tr>
<td>- Improvement (COFEMER)</td>
<td></td>
</tr>
<tr>
<td>Presidency of the Republic</td>
<td>Called on federal government secretariats and agencies to discuss the Agreement.</td>
</tr>
<tr>
<td>- Social Cabinet</td>
<td></td>
</tr>
<tr>
<td>Mexican Council of Consumer Products Industries (ConMEXICO)</td>
<td>Leader of the industry’s position in the negotiation of the ANSA and the Guidelines.</td>
</tr>
<tr>
<td>CONCAMIN, COPARMEX, CCE, CNA</td>
<td>Negotiation of the Guidelines</td>
</tr>
</tbody>
</table>

Discussion and Negotiation Processes of the ANSA and the Technical Bases

In 2008 the SS, through the Disease Prevention and Health Promotion Under Secretariat, began work to support and design the ANSA. In December of that year, it held an experts’ workshop to review the document “Bases for a State Policy for the Prevention of Obesity.” In March 2009, the SS had a proposal of the Agreement, which integrated the content of what would become the Agreement and the Technical Bases. Furthermore, in January 2009, the SS announced the 5-Step Strategy as a “basic instrument that... makes it possible to reverse the trends of the epidemiological problem.” The ANSA was signed in January 2010, the Technical Bases in February, and the Guidelines in August of that same year. The signing of these documents implied discussions and negotiations both within the Federal Executive, and with the industry and the states, during which four major discussion and negotiation processes were identified.

**Discussion within the SS**

Within the SS, two approaches were suggested to deal with the overweight and obesity epidemic. The first one refers to the 5-Steps Strategy that emphasizes individual responsibility. The Steps are: 1) Become active, 2) Drink water, 3) Eat fruits and vegetables, 4) Control yourself, and 5) Share with friends and family. This strategy was promoted and supported by the Coordination of Advisers of the SS Secretary and had been launched in January 2009 by the Health Secretary, who announced that “The 5-Step Program has been conceived as that basic instrument that will allow us to conquer health, be the originator not only of individual but also of family and social well-being and, thus, reverse the trends of the epidemiological problem and direct the country to the adoption of a healthy lifestyle”; the promotion of this strategy remained among the activities of the
ANSA under the responsibility of the SS. The second approach was supported by the Disease Prevention and Health Promotion Under Secretariat, which promoted the General Agreement, under the premise that in addition to individual responsibility, we live and we socialize in an obesogenic environment, with obesity being a multifactorial problem whose attention surpasses the sphere of action of the health sector.  

These two approaches affected the SS in its discussions and negotiations with other agencies and with the industry. They also affected ANSA institutionally, by making CONACRO the entity responsible for monitoring the Agreement, instead of establishing the National Forum for the Prevention of Overweight and Obesity made up of the different actors (public, private, academic, and social sectors) as agreed and explicitly defined in the ANSA.

**Negotiation of the ANSA and the Technical Bases within the Executive at Federal Level**

Based on the “Bases for a State Policy for the Prevention of Obesity” document, the SS submitted a proposal to the social cabinet to have an agreement on obesity and the actions proposed by agency, which was approved generally in March 2009. The agreement originally proposed was much more ambitious than the one which was finally signed. The SS with support from the social cabinet convened the different responsible agencies at the level of Under Secretaries to discuss the proposed actions. The principal secretariats convened were: Labor and Social Welfare (STPS), Public Education (SEP), Economy (SE), Finance and Public Credit (SHCP), Social Development (SEDESOL) and Agriculture, Livestock, Rural Development, Fisheries, and Nutrition (SAGARPA). From this initial meeting, as reported by the SS, only the SEP showed real interest and participation in the Agreement, including at the level of the head of the secretariat. The rest of the secretariats saw obesity as the responsibility of the SS which was reflected in much less ambitious goals than those originally proposed by the SS. It should be noted that the cost of implementation of these actions was not estimated nor were additional budgetary resources allocated to them.

These processes led to the agreement of 117 activities with 249 actions to be carried out by different agencies and entities: 12 activities refer to regulatory changes, with different degrees of specificity; 5 activities, to substantive changes in programs; and the rest have to do with the promotion of actions for the general population or for workers of each agency which do not represent significant changes in the task of the agencies.

There were proposals originally presented by the SS which did not lead to consensus with the corresponding agencies, among them were: the updating of nutritional labeling standards (SE), fiscal incentives and taxes on beverages (SHCP), changes in the supply of products through the Diconsa stores network (SEDESOL-Diconsa), change from whole milk to skim milk in Liconsa (Sedesol-Liconsa), changes in the food supplements of Oportunidades (Sedesol-Oportunidades), construction standards for public spaces (Sedesol), and promotion of sale of skim dairy products (SAGARPA). For example, the SS proposed the establishment of a tax and fiscal incentive scheme but SHCP’s commitment was stated as “Analyze financial instruments to promote healthy food consumption.”

The SS brought up the issue persistently to the National Health Council, made up of the 32 secretaries of health of the states and chaired by the Secretary of Health of the Federal Government.
Negotiation of the ANSA by the SS with the Industry

The final outcome of the negotiation was the agreement with the industry of only the general objectives of the ANSA and the formation of working groups to address the issues where the role of the industry was key: sodium, fats, sugars, advertising, and communication. There are differences of opinion between the SS and the industry with respect to additional agreements. According to Hernández (2012), the SS agreed on with the industry the additional following actions:

- Gradual reduction of sugar, sodium, and saturated fat in industrialized foods.
- Reduction of the size of portions offered in industrialized food and in restaurants.
- Signing of international commitments to limit advertising to minors.
- Joint effort to develop a labeling that helps consumers to select the best option with regard to their food and health.
- Elimination of trans fats of industrial origin.
- Code of Self-regulation of Food and Non-alcoholic Beverages Advertising Aimed at Child Audiences (Code PABI).

However, the food industry states that it recognizes the problem and assumes its shared responsibility only on four lines of action:

- Continue with the innovation and development process of new products, and explore the possibilities of reformulating existing product lines to offer more and better options to consumers.
- Provide consumers more and clearer information on the nutrient composition of food and non-alcoholic beverages at their disposal.
- Adopt, as it already has been doing with the PABI Code, voluntary measures in the marketing and advertising of food and non-alcoholic beverages, especially the advertising aimed at children.
- Continue to promote physical activity, sports, and healthy lifestyles among the Mexican population, including the workplace, among other actions (ConMEXICO, 2010; Zabludovsky, 2010).

The process was exhausting for both parties (including the INSP researchers). This situation was exacerbated in the negotiation of the Guidelines described in the following section. Following are some characteristics of this process:

1. The SS convened and negotiated the ANSA with the industry through its corporate structures. The SS did not convene the SE to this negotiation (Federal Government agency responsible for relations with the industry), a factor that would turn out to be fundamental in the later negotiation of the Guidelines.

2. Work groups were formed with concrete objectives and terms, which were suspended due to the sanitary alert caused by the H1N1 influenza. According to the SS, among the rules established to work with the industry were: proposals had to be supported, representatives at the meetings could not be changed, attendees had to have the endorsement of the organizations and once an agreement had been reached it was no longer open to discussion.

3. The negotiation tables discussed the 10 objectives of the ANSA and a wording that consensually seemed appropriate to the industry. There were objectives in which agreement was rapidly arrived at, for example, promotion of water consumption and physical activity. Agreement was more complicated in those that were related to the consumption of sugar, saturated fatty...
acids, and sodium, in which the industry requested more evidence.

4. During the negotiation, the INSP acted as the technical adviser of the SS, contributing the supporting evidence for the proposals of the SS and taking a place at the negotiating tables. The process was also exhausting for the INSP researchers, who went from a scheme of “researchers” to that of “almost negotiators”, among others, attending the meetings and preparing responses to the objections that were on the tables; although always in the presence of an official from the SS.

5. On the part of the industry, their participation was largely of people associated with the regulatory areas and relations with government, and only occasionally were there technical staff and nutritionists. This implied that the discussion did not focus on technical issues (not even as regards to lipids, as pointed out by one of the interviewees).

6. One of the arguments of the industry was that most of the evidence for establishing the contribution to overweight and obesity in the development of chronic diseases and their potential burden, as well as on the cost-effectiveness or impact of the actions to prevent and to serve these programs, corresponded to the international sphere and, in some cases, the proof was not conclusive (Sassi et al., 2009).

7. Due to the complexity of the negotiation and in order to have the Agreement signed in the terms originally proposed, on several occasions the SS tried to replace the dialogue of ConMEXICO with that of the principal companies, which was not an effective strategy.

8. In accordance with the SS, the industry had a delaying strategy and through different pressure groups (lobbying) tried to impede and delay the signature of the ANSA.

State and Municipal Authorities

After its announcement at the federal level, the ANSA was presented at the National Conference of Governors (CONAGO), where the Declaration for Food Health was approved on March 23, 2010, to be added to the National Strategy Against Overweight and Obesity. Such Declaration recognizes that “overweight, obesity, and their complications constitute a priority public health problem that requires the implementation of a multisectoral national policy, as well as the collaboration and consensus of the three levels of government and state their will to strengthen its content, so that in its respective scopes of action, assist in the execution and achievement of the ANSA targets and goals.”

The Agreement was also taken before the Mexican Network of Healthy Municipalities, which adhered to the ANSA with the Signature of the Declaration of the Mexican Network of Municipalities for Health and the State Networks of Municipalities for Health, April 7, 2010 (Censia 2010).

ANSA Follow-up, Transparency, and Evaluation Mechanisms

In February 2010, less than one month after the signing of the ANSA, it was established that the agency that would evaluate and follow-up the commitments established in the Agreement would be the National Council for the Prevention and Control of Chronic Non-communicable Diseases (CONACRO), a council created in that same month through an agreement of the SS and made up of only agencies of the Federal Government.
The formation of this Council is not what was expected in the ANSA or in the Technical Bases, this follow-up and evaluation is one of the weakest aspects of the Agreement. The Technical Bases stated as the main recommendation of the experts, the creation of a coordination mechanism in the form of a “National Board for the Prevention of Obesity”, appointed directly by the President of the Republic and formed by experts in the field and representatives of the different sectors involved, (p. 61). The ANSA established the creation of the National Forum for the Prevention of Overweight and Obesity made up by public agencies, major national business associations (food and non-alcoholic beverages, agricultural production, industrialization, marketing, sale and food consumption), national academic institutions (related to nutrition, physical activity, and social and economic aspects on the issue), national municipal representation in health, and social organizations (national representatives of the health professions, unions, and civil society organized for the issue). This Forum was not created.

Thus, an institutional entity with the presence of the principal governmental, industrial and academic actors was not established to monitor the ANSA and allow an opportunity for discussion and work on an issue that will certainly require numerous negotiations in the future. In reality, CONACRO has not performed well in the monitoring of the ANSA.

The fact that CONACRO has been assigned the responsibility of following up the ANSA is partly the result of the existence of two approaches within the SS throughout this process. CONACRO came into being in the context of the 5-Step Strategy and not of the ANSA.

Upon publication of the ANSA, the General Directorate of Health Promotion assumed its follow-up, according to one of the interviewees, “with little high-level institutional support.”

On the other hand, even though evaluation was included as a component in the ANSA, a monitoring and evaluation scheme was not foreseen either for the ANSA nor for the specific actions (including the Guidelines discussed below); nor was an indicator system developed beyond the physical goals. Thus, to date an external evaluation has not taken place and neither is public information available on the achievement of the goals. This is a major weakness of the Agreement.

Discussion and Negotiation of the General Guidelines for the Sale or Distribution of Food and Beverages in School Consumption Facilities in Basic Education Schools

Following the signing of the Agreement, work began to draft the Guidelines, which were derived from the commitments of the SEP in the ANSA. After periodic meetings with the SS and the SEP, the INSP developed a proposal with gradual implementation mechanisms. The SEP and the SS convened a meeting to discuss this proposal with state education and health authorities. These two secretariats also sent, prior to their negotiation and agreement with the industry and to its publication, their proposed Guidelines to the Federal Commission for Regulatory Improvement (COFEMER). COFEMER is an agency of the SE whose mandate is to analyze and dictate the regulations that the Federal Government agencies wish to issue to guarantee that its impact in terms of social benefits are greater than its costs. To this end, before issuing its resolution, it must submit the draft regulations to a public consultation process and establish a period to receive
comments from the interested parties and also publicize its decision.

The negotiation and agreement with state education and health authorities were necessary given their decentralized nature in Mexico. With respect to the food and beverages industry, the proposal included some restrictions to the sale of processed products at basic education schools. Among others, it included a ban on the sale of sugared beverages and the development of new presentations that complied with the standards which included regulations on energy density. The negotiations with the state authorities and with the industry occurred simultaneously. In the case of the negotiation with the state authorities, the presentation and discussion of the Guidelines was carried out jointly by the SEP and the SS, with the state secretaries of health and education, conveying both the impact of overweight and obesity on health and the effects of malnutrition on learning disabilities. Local industries also advocated their arguments with regard to the ANSA with their state authorities.

In turn, the Guidelines negotiation process with the food industry was particularly complex and exhausting. The public sector was represented by the SS, SEP, and INSP (as technical support). Subsequently, and at the request of the industry once it became familiar with the Guidelines, the Presidency and the SE also participated in the negotiation, and the SS contracted ITAM for the financial aspects, later incorporating researchers from other institutions, such as the Ibero-American University and the INNSZ for the technical aspects. On the part of the industry, mainly the same structures of corporate representation participated as for the ANSA and ConMEXICO also played a leadership role. The SS and the industry had just finished the ANSA negotiation process which had left the environment and the relations fractured. In the Guidelines, the SEP played an active role at the level of its incumbent with regard to the school environment.

This process promoted a better relationship between the SS and the SEP, the establishment of a work institutional framework between the two, as well as greater prioritization of the health issue for the SEP vis-à-vis the constant demands from different institutions to incorporate subjects into the curriculum or in the school area. The intersectoral relationship between the SEP and the SS is not new, but during the administration of President Calderón, and in particular in this process, was strengthened and institutionalized—identified as one of the strengths. In 2008 the SS and the SEP had published the Specific Action Program 2007-2012 School and Health (see Secretariat of Health 2009). The Guidelines were included within the Action Program in the school context published in 2011.6

In order to provide a context of the importance of school stores, it is worth mentioning that students spend on food and beverages at schools a total of 40,788 million pesos, of which 20,378 million correspond to sales of industrialized products. In public primary schools, 31% of the students consume food brought from home, another 31% buys it at school, and 36% brings food from home and also buys it at school (SEP, 2010).

Following are some of the characteristics and elements of the Guidelines negotiation process with the industry. Some of them are also applicable to the ANSA negotiation process:
1. Discussions of the Guidelines held by SS and SEP with the industry were largely with their corporate structures.
2. The process was complex and exhausting for both parties. Establishing restrictions
to the sale of processed products was necessarily going to imply a complex process, but may be it was much more so due to the absence of a previous negotiation strategy that: i) incorporated from the beginning and at all the meetings all the key actors; ii) ensured a vision and single position of the Federal Government; iii) included an assessment of the economic impact of the measures and of alternative measures; iv) established clear monitoring, enforcement, and evaluation mechanisms; and v) established an institutional negotiation framework for the Guidelines but also of the discussions, follow-up and evaluation that allowed continuity of the work beyond the publication of the regulation, not only until 2012 but also into the next administration and in the medium term. This complicated the negotiation but also debilitated the possibility of continuing the work with the industry once the Guidelines were signed.

3. As mentioned earlier, after the ANSA was signed, the National Forum for the Prevention of Overweight and Obesity was not created. Thus, there was no institutional entity for the discussion of the Guidelines.

4. At the beginning of the negotiation, the Federal Government did not have a single position before industry nor pre-established negotiation mechanisms and limits for its different secretariats for dialogue with the industry on these subjects. Neither were there clear instructions within the Executive during the process; one of the interviewees pointed out that “there were moments during the negotiation in which government officials felt alone.”

5. When the Guidelines were initially presented to the industry, they were given a one-week time frame to submit their observations. The industry requested the intervention of the SE from the Presidency, as it perceived that a decision had deliberately been made to present them a fait accompli. It was at that time that, through instructions from the Presidency, the principal negotiation forum took place in the facilities of the SE. The way the involvement of the SE came to be—at the request of the industry and instructions from the Presidency and not from a previous invitation of the SS—generated the perception in the SS and the SEP of the SE as “supporter of the industry”; however, this perception was not shared by the SE.

6. The main concerns of the industry with respect to the non-technical parts of the original proposal, for the most part presented to COFEMER in the drafting process of the Guidelines, were the following:
   a. That the economic impact of the measures had been left out.
   b. That the Guidelines did not include the subjects of implementation nor established a clear mechanism to ensure the evaluation, monitoring, and enforce-ability of the measures, nor the entity that would be responsible for this.
   c. That the proposal included restrictions only to the sale of processed food within schools but not of the unprocessed food prepared and sold in the school cooperatives. Nor did it incorporate restrictions to the sale of food product in the surrounding areas of the schools. The foregoing, coupled with the absence of enforcement mechanisms of the Guidelines at the level of the cooperatives and of the schools, in the opinion of the industry, would nullify the impact of restricting and limiting the sale of pro-
cessed food products and presentations in schools.

In Mexico, school cooperatives are responsible for the preparation and sale of food in the schools, both processed products as well as others that are prepared and sold in situ. These cooperatives are businesses owned by parents and teachers, and represent an important source of income for the schools and for those who operate them. According to the SEP, the annual amount of food sales in public schools amounts to approximately 60,000 million pesos. The majority of the children buy something at school daily, on average spending some 12 pesos daily. The gains of the cooperatives are an important resource for the schools, which is partly earmarked to school maintenance, since schools do not have budgetary resources allocated for current expenditures. According to the industry, 80% of what is sold at schools is prepared by the cooperatives and only 20% is of an industrial nature; the industrialized products sold by the cooperatives, for the most part are not supplied directly from the companies but from grocery stores.

Furthermore, around the schools all types of products are also sold (including just outside school doors with informal sellers not subject to any kind of regulation). Given the full availability of all kinds of products, not only in grocery stores but literally just outside school doors, and that there are no restrictions to the products that schoolchildren can introduce or consume at school, the industry was concerned of what colloquially was referred to as the “potato-traffic” (referring to the introduction into the school of French fries, or of products in which the sale or the type of products was limited within the school facilities).

d. According to the industry, sales within the school environment are not significant. Thus, more than the economic impact of the proposal on the specific school market was the reputation-type problem that could lead to the stigmatization of industrial products. The industry was not willing to accept that food be labeled as good or bad, if it meets the prevailing standards and insisted that there are not good or bad products, but good or bad habits.

e. The lack of foresight, valuation, or incorporation of alternative or additional actions, such as extending school schedules to expand physical activity in the schools, which for the most part is limited to one hour per week; establish box lunches for all schoolchildren and close the school cooperatives, or ensure complete availability of drinking water; nor was there discussion of actions to promote the change of habits. The industry perceived a heavy emphasis on environmental issues (changes of relative prices, taxes, availability of products, etc.) rather than in change of habits.

f. The foregoing gave the perception to the food industry that in the overweight and obesity problem “only the industry was expected to pay”, that the vision was short-term, and that a comprehensive plan was lacking.

7. As a negotiation mechanism, the industry requested the creation of an institutional
committee to bring together all the players “pact type”7 for the negotiation and subsequent follow-up. An institutional entity that invited all the stakeholders, with an independent secretariat, with a shared diagnosis and negotiation and evaluation mechanisms, that would also test pilot programs. The Director of ConMEXICO is a reputed negotiator in Mexico, thus this request derived from trying to generate institutional conditions for the negotiation of the Guidelines and for later discussions, based on his experience.8

8. ConMEXICO offered a nutritional labeling as a voluntary standard and the integration of a trust fund to finance actions in the schools.

9. In this context, the main task of the SE was to incorporate the financial cost of the proposed measures in the discussion, and to look for implementation mechanisms that were more adequate in terms of the economic impact of the measures.

10. Thus, although the proposal originally did not consider the economic and implementation issues, these were being addressed throughout the negotiation at the request of the industry and the SE. Such situation made the process more complex, because part of the argument was being developed in response to the industry.

11. The SS and the SEP (as with the ANSA) were technically supported by the INSP and researchers from other institutions (such as the INNSZ, the Ibero-American University and the medical societies). Furthermore, to respond to the arguments of the industry on the economic impact of the Guidelines, which were considered disproportionate, the ITAM was contracted to evaluate the economic impact of the proposals to, as stated by one of the interviewees, “demonstrate that they were not going to bankrupt the industry.” According to the INSP, its support was very important because the proposals were supported by evidence and international recommendations, particularly those of WHO were very useful since it could be argued that Mexico as a member had the moral obligation to apply them. The INSP also pointed out that the industry approved the participation of researchers that did not work in public institutions.

12. On the negotiating tables, as well as in the case of the ANSA, the industry was largely represented by those responsible for the regulatory areas and liaison with the government and only sporadically experts on nutrition. Thus, more than to argue on the technical specifications proposals of the products, the main concerns of the industry were those described in point 6. Regarding the technical aspects, according to the SS the main arguments of the industry were that there was no relevant information for Mexico, without making specific proposals, which was perceived as a delaying tactic. Although, in the opinion of the INSP, the arguments of the industry did indeed proved relevant with respect to food technology.

13. Furthermore, neither consumers nor the parents or lawmakers participated in the discussions. In the case of Mexico, neither parents’ nor consumer associations are very active entities.

14. In the decision-making process of the Guidelines, COFEMER received 864 observations from business organizations, companies, associations, individuals and others,9 each one receiving direct responses from the SEP and the SS. The private sector also submitted observations both
from its organizations and food industry and beverage companies, and from private associations, companies, and primary sector producers, in particular from milk and sugarcane producers. Following is a description of the main categories of observations and some of the associated arguments (SEP 2010).

- **Economic:** Among others, the change in presentations and portions would imply adaptation costs in packaging and in the production chain; there would be a loss in sales at schools and in general (both because of the reduction in demand in schools and due to the stigmatization of the products), which would affect employment and small and medium enterprises (SMEs). The foregoing would affect the value of the brands and competition. They also questioned the restrictions to consumer choices, the informal trade around the schools and the lack of availability of drinking water. The industries that commented were particularly those related to the production and sale of beverages, sugar, and milk.10

- **Legal:** The observations focused on questioning the legal basis of the draft provisions, particularly because the general Agreement was not of a legal or regulatory nature and, accordingly, could not be the legal support for the Guidelines; they also stated that they violated individual guarantees.11

- **Health and nutrition:** There were observations with respect to the definition of food and beverages and to the proposal to certify schools as free from sweetened beverages and food.12

- **Educational issues:** The observations referred to the need to train parents and teachers and modifying the curriculum in order to promote healthy habits among the students; the absence of drinking water at schools, as well as adequate facilities for hygienic food preparation and areas to carry out physical activity; that children have too many opportunities to consume food; the lack of capacity at the school level to identify the quality of food as proposed in the Guidelines; proposals to involve nutritionists in the implementation of the food standards at schools and for teachers to supervise what the children bring for lunch, and elimination of the certification of schools. Furthermore, there were concerns over the sale of products banned in areas close to the schools and the fear that implementation of the guidelines and its enforcement could generate bureaucracy, corruption, and complex procedures for the concession of school stores.13

15. Some of the answers of the SEP and the SS to the arguments of the industry are as follows (SEP, 2010).

- **Financial costs for the industry upon effectiveness of the Guidelines:** The industry is prepared to carry out these modifications since it is characterized by carrying out frequent packing modifications and presentation portions. Some of the products with characteristics adequate for school facilities are already available in others distribution channels. No price increases of the products are expected due to the low share school sales represent to the industries, or effects on the employment level of the industry, or a high impact in the SMEs; neither are reductions in the sale of the industry’s products to the schools. In addition, the opinion of the Federal Commission on Competition (CFC) was requested and it pointed out that the measures are
not discriminatory nor create exclusive advantages. In one of the answers it pointed out how the Bimbo group announced that it was reducing trans fats, fats, sugars, and salt in its products, as well as producing smaller portions. With regard to consumption of non-caloric sweeteners, the CFC expressed that the scientific evidence on the subject is not conclusive, thus consumption of these products will be allowed only in high schools.

- **Reputacional effect**: The observation is only partially probable, since it has been observed that children exert an important influence on the consumption decisions of their families. However, there will not be a change in the total demand for food and beverages, but rather a modification in their composition, giving special importance to products low in calories and fats. The drafting of the Guidelines was modified to avoid negative qualifications of the products. With respect to possible damage to the value of the brands, it was argued that companies have faced similar regulations in other countries, such as the case of beverages, Coca Cola being today the most valuable brand in the world of beverages and food industry.

- **Availability of drinking water**: The industry includes in its products portfolio bottled drinking water, a product that does not have any restriction in the Guidelines, thus it can be easily distributed in the cooperatives and meet the hydration needs of the students, regardless of the availability of drinking water in the schools. In addition, it is mentioned that solving this problem is not the exclusive competence of the SEP, since the provision of services to the schools is the responsibility of the municipalities. The actions underway by the SEP include promoting the consumption of drinking water in the program of studies and, through the National Institute of Educational Physical Infrastructure, developing the technical standard for the installation of drinking water fountains in schools and promotion of the availability of simple portable water in the schools that do not have drinking water fountains. The construction project of drinking water fountains “will be gradual in order to manage to serve the largest possible number of schools in the medium term” (p. 641).

- **Informal trade outside the schools**: Operation conditions of the schools restrict students to go to external sale points during the school day. Joint efforts with the authorities are expected to remove the informal trade from the proximity of the schools.

- **Costs to the sugar industry**: The Guidelines do not completely eliminate the content of sugars and other caloric sweeteners. Since schools only represent 3% of the food and beverage industry the effect would be marginal and would help reduce the deficit in the national production.

- **Supervision and surveillance**: The Guidelines do not refer to supervision by the authorities but rather by the School Consumption Committee. The Guidelines do not intend to explicitly detail the supervision procedure, but rather to regulate the operation of school consumption facilities.

- **Physical activity promotion**: The PACE includes the promotion of physical activity. The draft Guidelines included that the teaching staff would be in charge of explaining to the students the importance of physical activity and sports. Furthermore the SS promotes, among others, “5 Steps for
Your Health”, while the SEP and the CONADE have made commitments to facilitate physical activity in the school environment. The Guidelines are not an isolated measure.

- Benefits of the Guidelines: The financial impact was analyzed longitudinally in a period of 100 years. A savings potential of approximately 30,000 million pesos of 2008 was estimated, both by direct savings derived from the reduction in the medical care expenditure and by indirect savings derived from the gain in productivity by years of avoided death and additional healthy years of life.

Based on the arguments of the parties, COFEMER issued its decision contained in 180 pages which may be consulted at: wwwapps.cofemer.gob.mx/COFEMERAPPS/scd_expediente_3.asp?id=01/0596/10061.

Finally, the intensity of the negotiation of the Guidelines resulted in a loss to follow-up of the general Agreement.

As a result of the negotiation process, the original proposal underwent modifications and some elements—such as limiting the sale of food based on an energy density criterion—were replaced with others. With respect to caloric beverages, the proposal completely restricted the sale of all caloric beverages (including nectars) but the final Guidelines only restricts the sale of beverages in primary schools, but allow them in their “light” version in secondary schools. Modifications were also made to the draft to avoid stigmatizing, give a negative qualification, or highlighting certain products, establishing only “what it is recommended due to its composition and because it encourages or favors that the consumer develop habits for a good diet.” Furthermore, the certification of schools free of sweetened beverages and food was eliminated from the Guidelines, since it would lead to con-ceiving sugar as detrimental (SEP, 2010). The institutional entity to negotiate and follow-up, which the ANSA sought to establish as requested by the industry, was not created.

After the approval of COFEMER, in August 2010 the SS and the SEP published the General Guidelines in the Official Journal of the Federation through a secretarial agreement between the two secretariats.

As can be observed from the brief description of the negotiation of the Guidelines, the decision-making process of COFEMER compelled making explicit the assumptions of costs, benefits, and complementary measures, both by the industry and the authorities. It would be important to perform an ex-post evaluation of the development/evolution of these variables.

Program of Action in the School Context

The Guidelines were subsequently included within the Program of Action in the School Context (PACE) published in 2011 by the SEP, together with the SS, consisting of three components:

a. Health promotion and education whose objective is the development of competencies so that children learn to make decisions on what food and beverages to consume, and the physical activity they perform, through the modification of textbooks, teacher training, and guidance to parents.

b. Actions to promote greater physical activity as far as possible in schools, for example through guidance to physical education teachers and physical activities during school recesses.

c. Access and availability of healthy food and beverages in the terms established in the Guidelines.

According to the SEP in the period 2007-2012, a “golden stage” came into being in relations between the SEP and the SS: they came to
an agreement regarding the priorities (on what can really be done in the schools) and in being more mindful regarding the goals, taking into account the restrictions of the education sector. Also, the SS agreed that it could not go alone to the schools without the previous agreement of the SEP and that it needed the support and negotiation of the SEP. Thus, both institutions agreed on joint work plans and for the first time jointly convened the decentralized services and held national intersectoral meetings.

One of the “apex moments” of the relation was during the H1N1 influenza emergency, where the role of the schools was essential.

As corollary, it is observed that despite this strengthened relationship between the SEP and the SS, specific resources for the “School-Health Program” were not allocated, there is no specific responsible area within the SEP for this program nor were resources allocated to ensure the availability of drinking water in all the schools.

Technical Analysis of the Guidelines

The technical analysis of the Guidelines carried out by Flores Huerta et al. (2011), points out among its strengths and weaknesses the following:

Strengths

- Recognition of school as obesogenic environment that the authorities may change for a healthy one with political will, through the educational community.
- Having adopted as a regular strategy that the school store purchase/sell food and beverages, processed or natural, that fulfill with the technically correct established requirements. These products will reach extracurricular areas in the entire national territory.
- Incorporate the participation of the school community, through the Social Participation School Councils (formed by parents, teachers, former students and members of the community) to monitor and ensure that the schools’ stores operate in accordance with the provisions. Include specifically at least one nutrient and one health objective with regard to the development of healthy eating habits, to be consistent with the educational mission of the school.

Weaknesses

- The target population does not participate actively in achieving a healthy diet.
- The consumption establishments by the simple fact of selling healthy products (either food or beverages, processed or natural), will not develop healthy habits. The students, depending on their resources and hunger, may acquire or buy one or more portions.
- The actions are not integrated in an ecological model following the factors that encourage that the students of a primary school ingest a larger number of calories than they spend.
- It does not include—because it is not the issue although it is mentioned—actions to promote the development of physical activity habits, exercise, and recreational activities for the children.
- No consideration is given to the times or the spaces to eat, or the importance of making the meals an opportunity to share and enjoy the food.
- The consumption facilities are uniform, without considering if the site where the school is located offers utilities such as water, electricity, and drainage, or if there is space for an installation of this nature. There is the possibility of establishing minimums for categories of facilities according to the services that are available, the size,
and site of the locality and of the location of the school.

- It mentions that the facility can sell water, but nothing is said about the school having drinking water fountains for the children.
- There is no mention of an implementation program or a consolidation model and mid- and long-term evaluations.
- There is not mention of how the purchase/sale of unhealthy food sold in the surrounding areas of the school competing with the mission of a healthy diet of the school will be regulated.

What has happened after the ANSA?

There is no public and consolidated information on the follow-up of the ANSA, the Technical Bases, and the Guidelines. Below is a description of what could be compiled from different sources with regard to what has happened after these documents were signed:

**Achievement of goals on the prevalence of overweight and obesity by age groups:** With the available information in the ENSANUT 2012, we still do not know whether these goals were met. However, as already pointed out, to date the public results report increases from 2006 to 2012 in the prevalence rates of obesity and overweight in children under 5, in adolescents aged 12 to 19, and in adults 20 years old and above. Furthermore, due to the absence of an evaluation framework of the ANSA, it cannot be known whether the results are attributable to the ANSA.

**Monitoring and evaluation:** There is no public information available regarding compliance on the part of the secretariats or the impact of the measures, or their effectiveness, based on changes in behavior and risk factors and coverage. Neither was a basal survey of anthropometric measures been made in schools that would allow making an evaluation into the future. The two studies that have been done on the Guidelines are based solely on the opinion of different actors on the processes.

**Compliance of the activities and actions of the secretariats:** Without a public evaluation scheme of the ANSA it is difficult to know its degree of implementation and its impact. Recently the organization *El Poder del Consumidor* (The Power of the Consumer), based on information obtained from the secretariats through the Federal Institute of Access to Information (IFAI), announced that most of the commitments assumed by the various governmental secretariats have not been fulfilled (*El Poder del Consumidor*, 2012). Also Boatman et al. (2012) point out that the ANSA has been only partially fulfilled since, for example, the Front/Top Labeling standard has not been met.

**Changes in programs:** The major changes in governmental programs are the improvement in the quality of school breakfasts and the substitution of whole milk to semi-skimmed milk in Liconsa:

- **School breakfasts.** The quality of its content has improved. In a 2-year period, the use of reduced-fat milk went from 41.4% to 89.7%; the combination of two or more whole grain cereals from 44% to 96.6%; vegetable or fruit from 13.8% to 58.6%; two or more legumes from 89.7% to 100%, and without sugar, from 17.2% to 48.24% (Hernández, 2012).
- **Liconsa.** Initiated the substitution of whole milk to semi-skimmed.

**Advertising aimed at children, applying the PABI code:** The PABI Code (Art. 16) establishes that the Council of Self-regulation and Advertising Ethics, CONAR will make a four-month evaluation of food and non-alcoholic beverages advertisements aimed at children. These
reports should be sent to the Disease Prevention and Health Promotion Under Secretariat of the SS and to PROFECO. According to Barros (2012), from December 2008 to 2011, compliance of on air advertising went from 8% to 91%. Mexican child sees an average of 4 hours daily of television and in that period would be exposed to approximately 15 spots of food and beverages. These reports, however, do not appear in the CONAR Webpage and could not be found in open sources.

**Evaluation of the 5-Steps Strategy: An external evaluation of results and impact has not been made** (Barquera et al., 2012).

**Other actions:** No national education campaign to improve eating habits has been undertaken. The health strategy does not emphasize the importance of primary care, nor where information and counseling can be obtained on changes in lifestyles and chronic disease prevention, although there are national prevention programs, such as PrevenIMSS, PrevenISSSTE, and Línea de Vida (Lifeline). On the other hand, the dairy product market has not turned to low-fat products.

**Actions of the industry – products in the schools:** The industry generated specific presentations for schools, which are also sold in grocery stores. It is worth stating that the industry publicized these products with legends that stated “they fulfill with school food guidelines established by the SEP and the SS.” In the opinion of the SE, the share of these products in the market is very small, which could lead to their disappearance.

**Other actions of the industry:** In accordance with ConMEXICO, the industry has increased the variety and presentations of their products, and plans to modify the labels so that they contain clearer information. In January 2012, it initiated the implementation of a voluntary nutrient labeling system (“Check and select, keys nutrition”) (For a critique of this system, see Barquera et al., (2012)).

**Application of the Guidelines:** According to Ciscomani (2012), the application of the nutrients criteria corresponding to stage 1 (school cycle 2010-2011) and Stage II (2011-2012) was carried out. In the 2012-2013 school cycle application of the criteria established for Stage III was initiated. With the support of the INSP, the lists of products that meet the nutrient criteria established in the Guidelines for each stage were prepared.

**Evaluation of the Guidelines:** As indicated before, a system of indicators, monitoring, or evaluation for the Guidelines was not designed. Neither was a baseline established in the schools. According to the SEP, an evaluation would be made on the implementation of the Guidelines in 2012 on: the operation of the control agencies; implementation; participation of parents and teachers; attachment to the availability and dietary intake and, in general, operation of the strategy. Such evaluation would be carried out by the INSP. Although it is commendable to perform an external evaluation, it is considered that the fact that it be carried out by the same institution that designed the Guidelines may present conflict of interest problems and of credibility of the evaluation. Ciscomani (2012) states that, in order to assess the progress in the application of the Guidelines, two studies were carried out that point out the following strengths and challenges:

**Strengths**
- It was possible to raise awareness of the actors of the school community on the problem of obesity and overweight, which they identify as the main reason for the development of the Guidelines.
• The school community is aware of the criteria that the schools should follow to implement the Guidelines.
• A high proportion of actors (80 to 95%) regard the inclusion of fruits and vegetables as the basis of a healthy lunch.
• Between 40 and 60% of the actors know that pure water should be included as part of a healthy lunch.
• 90% of the actors perceived changes in the supply of food and around 50% in beverage sales.
• 65.1% of food providers of primary schools and 76.5% in secondary schools report having carried out changes in their practices to improve the diet of the students and achieve compliance of the Guidelines.
• More than 60% of the schools have drinking water sources.
• Great progress is also reported in the survey of Guidelines Stage II with respect to the ENSE 2012, since the availability of vegetables, fruits and non-fried processed food has increased considerably, while the availability of fried food, sweetened beverages, milk, and fruit juices decreased. The lunches that students bring from home consist mainly of non-fried food and drinking water instead of beverages in the case of primary schools.

Challenges

• Increase the involvement of parents in the actions being carried out in the schools to implement the Guidelines and encourage physical activity.
• There is still high consumption of sweetened beverages and refreshments vis-à-vis consumption of potable simple water, especially in secondary schools, as well as sweet appetizers in secondary schools and salted appetizers in primary schools.
• Among the main obstacles to the implementation of the Guidelines, the informants considered those having to do more with the home environment than with the school, such as the lack of interest on the part of the parents and unhealthy family habits in case of primary schools. In secondary schools, the opinion was that children prefer to eat junk food.

These studies, however, are based only on the opinion of different actors on the processes. One of the interviewees also pointed out that there could be important implementation problems of the Guidelines, stating that, although at most schools there are no carbonated beverages for sale, there are indeed juices in large containers. This said, they do observe “less fried food, use of cream and butter.”

Written materials generated from the Guidelines: The following materials were published and distributed, among others: i) Manual for the preparation and hygiene of food and beverages in cafeterias of basic education schools; ii) Guidelines for the regulation of the sale of food and beverages at basic education schools. Guide for administrators and educators; and iii) Preparation of school lunches and an appropriate diet. Manual for mothers and parents and the entire family.
Conclusions and Lessons Learned

Three basic documents resulted from this process: The ANSA, The technical Bases, and the Guidelines. Of the three, the Guidelines are the most visible and legally solid document, and also the one containing the most substantive and lasting actions derived from the ANSA. The ANSA and the Technical Bases are general policy documents that establish, for the first time, actions and multisectoral goals for the prevention of these problems. The activities and actions included in these two instruments correspond only to the federal administration and the goals were established only through 2012. The greatest changes are concentrated in the SEP and the SS, and on the quality improvement of school breakfasts. There were not budgeted or earmarked budgetary resources for the actions contained in the ANSA and the Technical Bases whose compliance implied additional resources. As stated by one of the interviewees from the SS, the “ANSA remained in the minimum acceptable, [while] the Guidelines did indeed remained at the level of European countries.” The three documents suffer from the absence of indicators systems, of a monitoring and evaluation scheme, and of enforceability mechanisms.

The main challenge is continuity of this Agreement as a multisectoral policy and as the platform to invite the different actors, monitor, and evaluate what has already been agreed upon and discuss and agree on new actions—or, at least, an entity with this same orientation. It should be noted that the administrative changes that have occurred in the SS based on the signing of the ANSA, as well as the change in federal administration, also point in this direction.

Following are some of the principal strengths and weaknesses of the ANSA, the Technical Bases, and the Guidelines. The objective of this section is to identify lessons and areas of opportunity moving forward for Mexico that could also be useful to other countries considering implementing similar initiatives. Barquera et al. (2012) and Rivera et al. (2012) also provide observations in this regard.

Strengths

First strategy/multisectoral initiative for the prevention of obesity. The promotion of healthier nutrition and greater physical activity necessarily require intersectoral work and the participation of industry and society.

Positioning of the obesity issue. The Agreement generated visibility and awareness of the issue within the Federal Executive, and made it possible to position the subject on the agenda. It also generated sensitivity in the industry and greater awareness that this would be a recurrent subject and of growing importance in the future.

Generation of a good base document that gave leadership to the Secretariat of Health on an issue whose main actions are not under its scope of action. Obesity is a multifactorial problem and its prevention and care requires actions that transcend the functions and responsibilities of the SS.

Diagnosis and estimations of the costs of overweight and obesity. The ANSA was based on a good diagnosis of the problem, a review of the literature and of the experiences and most relevant recommendations at the national and international levels.

Involvement of technical experts. The involvement of the INSP and other institutions and experts in the analysis, scientific evaluation of the proposals, and preparation of the recom-
mendations. Although the INSP played a key role providing technical support, as an entity of the Federal Government it was sometimes perceived as a pro-government entity, not necessarily objective. This perception changed with the incorporation of researchers from other institutions.

Formation of working groups made up of different agencies of the civil service and the private sector; those responsible for the food production chain, under the leadership of the SS.

Awareness and greater responsibility on the part of the industry, upon foreseeing that this will be an issue of growing importance. Although the initiative of the ANSA mobilized the companies, the fact that an institutional follow-up entity was not created—with the involvement of the different actors—it lost momentum and a window of opportunity was perhaps wasted.

Strengthening of SEP-SS relations. The leadership of the SEP and its partnership with the SS regarding the actions in the school environment resulted in a more robust and institutional relationship between the two secretariats, and in giving greater prioritization to the issue of health in the school environment. Thus, for example, according to the SEP, health was included for the first time as a thematic guide in teacher training. Also the joint convening and negotiation with the state education authorities should be highlighted.

Public consultation process. The public consultation process on the Guidelines, that by law COFEMER had to carry out, facilitated the submission of objections, observations or proposals to this document by all interested parties, compelling authorities to answer promptly each of them. The design of the process tries to ensure that the social benefits of the regulation are greater than their costs.

Weaknesses

Design. The ANSA is a general policy paper with general goals and targets for the reduction of overweight and obesity only up to 2012. The actions committed in the Agreement and its Technical Bases are not sufficient to meet the 10 objectives of the Agreement, nor include commitments on the part of the industry; there are not adequate mechanisms foreseen to continue with the negotiation of new actions that facilitate meeting these objectives.

Temporary nature of the Agreement. The Agreement established goals only to 2012, but not at the mid- and long-term. It was designed as a short-term instrument and it was not planned as a mechanism after the administration of President Calderón. This imposes important legal challenges on its continuation, since it would imply the renegotiation and establishment of actions and goals with other terms.

Institutional follow-up and discussion entity. Although the text of the ANSA included the creation of a forum with the participation of the main actors (including government, industry and academia, among others), such entity was not established. Thus, there were no established entities nor institutional mechanisms of this nature with support at the highest level, that allow and encourage the parties to monitor what was agreed upon, and to continue with the discussions and agreements on a problem that without a doubt will need coordinated efforts and discussions and additional actions in the short, medium and long term, from the government, the industry, and civil society, at the community level, family, and individual. The creation of a forum of this type would also allow a more orderly discussion of the initiatives of the Legislative branch to combat overweight and obesity.
The CONACRO, assigned with the monitoring responsibility and made up of only federal entities, has not been effective in concrete actions. The responsibility for operational follow-up fell on the General Directorate of Health Promotion, with little high-level institutional support.

This situation also generated little visibility of the ANSA after it was signed and did not allow maintaining the negotiation momentum with the industry. These elements hinder the continuity of the ANSA and/or of specific efforts. Maintaining a multisectoral policy of this magnitude requires sustained efforts in the long run, institutional support with specific resources, and a group devoted to this and with solid top-level support.

Staff turnover (common in Mexico during changes of administration or of incumbents in the secretariats) make it necessary to establish formal entities that meet periodically thus increasing the probability of continuity. One of the interviewees pointed out that “ANSA has not been very visible and is easy to let it die.” Thus, a lesson of this process is the importance of creating and strengthening institutional mechanisms and entities to perform monitoring and long-term negotiation, with the participation of the main stakeholders.

Monitoring and evaluation. No accountability schemes, monitoring or evaluation of the ANSA, the Technical Bases or the Guidelines were established to make it possible to know whether the actions are being fulfilled or if there have been implementation problems, or to ascribe results in the desired direction to the proposed actions. This can hinder the negotiation in the future with other secretariats of the Federal Government and even with the industry. On this matter, it is this matter it is fundamental to be transparent regarding the costs and the impact of the interventions, as pointed out by González Pier (2012), COFEMER, and Fundación Chespirito (2012) and Flores Huerta et al. (2011). The lesson would be the importance of including, from the design, the accountability schemes, monitoring and evaluation—including external evaluation.

Compulsory nature and enforceability. There are not enforceability mechanisms of the actions that imply consequences in case of non-implementation or noncompliance. The foregoing, coupled with the absence of follow-up and accountability mechanisms that allow to know whether the commitments are being met (and lack of budgetary allocation), decreases the incentives for compliance of the same.

Measurement of the budgetary cost and allocation of the priorities and actions of the Agreement in the public budgets of the secretariats. The implementation cost was not calculated nor was there a budgetary allocation in the responsible secretariats to ensure that resources were available and earmarked to carry out the proposed actions.

Lack of internal alignment of the Secretariat of Health with respect to the strategy to combat overweight and obesity throughout the process. This debilitated the negotiation process, the design, and the follow-up mechanisms.

Negotiation strategy. There was no negotiation strategy previously established with all the relevant institutional actors to establish a common front by the Federal Executive, in particular with the industry. Neither was there a strategy or mechanisms to continue to negotiate in the future in what undoubtedly will be a long and constant process. However, in actions as those included in the ANSA, it is complex for authorities to strike an adequate balance between unilateral decisions by the authority and negotiating.
The negotiation left the parties exhausted and fractured relations. After the launch of the ANSA and the issuance of the Guidelines, work with the industry declined in intensity and level. With the turnover of civil servants with the new government, there will surely be opportunities to resume or reestablish the joint efforts, provided this is one of the priorities of the SS. However, it is probable that the momentum with the industry, continuity, and part of the learning may have been partly lost. One of the lessons of the ANSA is the importance of safeguarding the negotiation processes in light of complex negotiations and regulations that are difficult to implement and enforce.

**School setting.** With respect to the weaknesses/challenges of the actions in school settings related to overweight and obesity, including those of the Guidelines:

- **Actual class hours and possibilities of physical activity at school.** The actual class hours and accordingly of learning opportunities in the classroom are only four. In addition, the majority of the schools do not have adequate spaces for physical activity. Only 40 percent of the public schools have a physical education teacher. At primary schools there is, on average, a 40-minute weekly physical education class, of which only 9 minutes are of moderate or intense activity.

- **Resources for compliance of the actions.** The School and Health Program does not have assigned resources, thus resources from other programs and actions must be reassigned to comply with the actions of this Program in terms of educational materials and training, among others. Thus, in the future, the importance of this program will depend on the prioritization of the official on duty and of the strength of the relationship between the SS and the SEP.

- **Availability of drinking water at schools.** There is no availability of free drinking water at all schools, either in drinking water fountains or demijohns and no resources were earmarked to ensure its availability. The SEP considers that there is availability of drinking water in the schools whenever there is water for sale even when there are no drinking water fountains or demijohns.

- **Impact of the possible loss of profits of school cooperatives.** The profits of school cooperatives are an important resource for schools to cover their maintenance costs because there are no earmarked budgetary resources for the schools’ current expenditure. Resources for the education sector were not quantified, projected, or subsequently assigned in the Strategy to cover the potential loss of resources from school cooperatives with the entry into force of the Guidelines. If the Guidelines turn into lower sales in the cooperatives (or the cooperatives perceive it could happen), this could lead to noncompliance of the Guidelines on the part of the cooperatives and/or a negative impact on maintenance and current expenditure of the schools and, accordingly, the quality of education offered. Thus, the incentives are not aligned at the school level.

- **The sale of food and beverages in the surrounding areas of the schools and the probabilities that students may introduce any product to the same.** In the surrounding areas of the schools (as close as outside the front door), there are frequently informal merchants who sell all sorts of products and are not subject to any regulation.
Annex 3.1. Some of the actions to prevent and reduce overweight and obesity established in the Strategy Against Overweight and Obesity, by Secretariat

**Health sector:**
- Promote sectoral programs
- Update standards and regulations on food and advertising
- Support breastfeeding and nutrient literacy
- Promote the incorporation of potable simple water into school breakfasts and pantries
- Train state and municipal DIF on healthy school food options
- Promote physical activity in all settings
- Train health professionals in counseling on appropriate eating habits

**Secretariat of Public Education:**
- Promote physical activity among schoolchildren for at least 30 minutes daily
- Encourage gender equality in sports
- Promote, through the program of studies, consumption of drinking water and nutrient literacy
- Guarantee the installation of drinking water fountains in public schools
- Promote and facilitate the availability of water and non-alcoholic beverages with low caloric content in collaboration with the food industry
- Develop guidelines for school food suppliers to decrease sugar consumption
- Promote a Secretarial Agreement for the sale of food and beverages in school stores or cooperatives of basic education schools for a healthy school diet

**Secretariat of Labor and Social Welfare:**
- Promote physical activity and appropriate eating habits in the workplace
- Monitor compliance of the standards related to the availability of free drinking water
- Advocate breastfeeding and review legislation to promote it among working mothers

**Secretariat of Social Development:**
- Rescue parks and public spaces to carry out physical activity
- Promote participation in physical activity among youth in the Opportunities Program
- Promote the availability of reduced-fat milk
- Carry out educational activities on nutritional counseling

**Secretariat of Economy:**
- Create support frameworks for the distribution chains and access to fruits, vegetables, legumes, and whole grains
- Update the standards and support the SS to issue a NMX on “educational labeling”
- Disseminate information on healthy products markets to the industry

**Secretariat of Agriculture, Livestock, Rural Development, Fishing, and Food:**
- Promote alternative uses of sugarcane
- Improve the supply of skimmed dairy products
- Attend structural support problems for agricultural, livestock, and fishery foods
- Strengthen the 5 a Day program to support consumption of fruits and vegetables

**Treasury and Public Credit Secretariat:**
- Analyze treasury instruments to promote healthy food consumption

**National Water Commission:**
- Encourage the supply of simple potable water in vulnerable areas

Source: ANSA, p. 27.
Annex 3.2. General work prior to the establishment of the ANSA

In 2004, Mexico signed the Global Strategy on Healthy Diet, Physical Activity, and Health for the prevention of chronic diseases of the World Health Organization (WHO). This strategy contains recommendations on food and diet (both for demand and supply) as well as on physical activity. The WHO technical report on nutrition, diet, and chronic disease prevention contains a complete analysis of the available scientific information.

In 2006, at the beginning of the administration of President Felipe Calderón (2006-2012), the Secretariat of Health prepared an intersectoral strategy for chronic diseases. The Sectoral Health Program 2007-2012 (PROSESA) established as one of the lines of action for disease prevention and control, to promote a comprehensive policy for the prevention and control of overweight, obesity, Diabetes Mellitus and cardio and brain vascular illnesses (Line of action 2.12 of the strategy 2), without setting specific goals with regard to overweight and obesity.17 In turn, the National Health Program 2007-2012 (PRONASA) recognized overweight and obesity as one of the principal risk factors faced by the Mexican population and the health system, associated to several of the leading causes of death in the country. Thus, both documents recognize the transition of diseases and the generation of these by aging and exposure to risks related to unhealthy life styles, and point out as the leading causes of death both for men and women to non-communicable illnesses such as Diabetes Mellitus and cerebrovascular ischemic heart diseases, that share factors such as a poor diet, overweight, high cholesterol levels, hypertension, smoking, and a sedentary lifestyle (Secretaría de Salud, 2007; Coneval, 2010).

In 2007, the SS initiated the construction and operation of the Medical Specialties Units (UNEMEs), in order to provide specialized services in a single unit for specific conditions (e.g. facilities that provide comprehensive services), among them overweight, cardiovascular risk, and diabetes mellitus (UNEME SoRiD).18 At the beginning of 2008, the health secretary convened an expert committee to develop the “Recommendations on the Consumption of Beverages for the Mexican Population,” aimed at consumers, health professionals, and the governmental sector. Up to that time the nutritional guides had focused on food, however, the ingestion of energy from beverages (mainly sweetened beverages, juices, whole milk and alcohol among male adults) represents 21% of total consumption of energy among Mexican adolescents and adults (the highest in the world). This document provided a diagnosis and recommended water consumption in the first place, followed by beverages without or with low caloric content and skim milk over those of greater caloric content or sweetened, including artificial sweeteners. The experts also included recommendations on quantities for each category of beverages and illustrated patterns of healthy consumption for adults of both sexes. Among the directives proposed by this Committee are: the availability of drinking water and restriction of sweetened beverages in schools; the use of skim milk in school breakfasts; regulation of the sale of beverages in cafeterias and vending machines in facilities of the health sector; promote the sale of milk and yogurt with low fat content or fat-free instead of whole milk; as well as recommendations on subsidies and taxes to change the relative prices of the products and of advertising and labeling.
In February 2008, the SS announced that, because of their high caloric content, school breakfasts would be replaced throughout the country, except in the 125 municipalities with greater marginalization, as part of the reorientation of the Comprehensive Strategy of Food Assistance (EIASA) of the National System for the Comprehensive Development of the Family (SNDIF) to respond to the rapid epidemiological and food transition. The main changes in the program would be the substitution of whole milk with reduced-fat or skim milk, and of cookies and peanut brittle, with food prepared with whole grains and fruits (Figueroa, 2008). Toward the end of 2008, the new EIASA Guidelines were published, modifying the content of cold breakfasts, hot breakfasts, and school foods to, among others: i) consider the dietary culture of the region to take advantage of the products of the area; ii) offer in hot and cold breakfasts reduced-fat milk instead of whole cow milk; iii) increase the size of the part of whole grains in cold breakfasts (from 30 to 60 grams) and offer the alternative of other seeds, and iv) eliminate consumption of sweet bread and dessert (Coneval, 2010; SNDIF, 2008).

Furthermore, in September 2008, at the initiative of the industry and the SSA, the Self-regulation Code of Food and Non-alcoholic Beverages Advertising Targeting Children (PABI Code) was signed, which became effective on January 1, 2009. According to its text, this Code “is consonant with the principles that guide the private sector with regard to health protection and is framed in the recommendations of the World Health Organization established in the Global Strategy on Diet, Physical Activity, and Health.” Monitoring and implementation of this Code is the responsibility of the Council of Self-regulation and Advertising Ethics (CONAR), made up of members of the food and non-alcoholic beverages industry.

On the other hand, starting in October-November 2008 the Social Milk Supply Program (PASL) of LICONSA modified the milk formula and fat content by 33%, to contribute to the prevention of the overweight problems in the population (Coneval, 2010).

Also in 2008, the SS gathered a group of experts to work in the Comprehensive Nutrition Strategy of the beneficiary population of the Opportunities Human Development Program (EsIAN), which to date has not been implemented. Opportunities is a money transfers program for poor families provided members of the household visit the health clinic for preventive actions and attend school. It is the largest program against poverty in Mexico, both in coverage and in fiscal resources.

Obesity was also subject to recommendations by different entities from the SS. The National Evaluation Board of Social Policy (CONEVAL),20 in its Social Development Policy Evaluation Report 2008, recommended “developing an effective policy to contain, decrease, and prevent obesity in the country, with special attention to children.” As part of the analysis, it was observed that although the overweight and obesity problem is recognized in the national planning documents linked to the health sector, goals have yet to be considered aimed at their care and the reduction of its prevalence (Coneval, 2010).

In January 2009, the Health Secretary announced the launching of the 5 Steps Program as a “basic instrument that will allow us to conquer health, to be directly responsible of individual, family, and social well-being, thus, making it possible to reverse the trends of the epidemiological problem and guide the country to the adoption of a healthy lifestyle.” To
this end, the SS signed an agreement with the French Program EPODE that, according to the SS, has been the most successful in Europe in the prevention of child obesity. In announcing this Program, the Secretary stated that "[...] we have been working this in a multi-secretariat manner in the Social Cabinet, where the SEP, ... the Labor Secretariat, ... SEMARNAT, ... the Agriculture Secretariat meet to see what each secretariat could do in this global program to contain obesity and overweight and we have been advised and we are implementing part of this strategy, an European strategy called EPODE ... whose results are impressive, the difference between the cities where the strategy was adopted and those that did not, it is radical with regard to decreasing overweight and obesity and this truly has an incidence and a very positive effect with regard to the global aspects of the quality of life of the people, as to the financing quality of the health system."22 

Furthermore, in 2008 the SS and the SEP published the Specific Program of Action 2007-2012 School and Health.23 This program considers schoolchildren from the basic level up to the higher level and seeks to affect the health determinants to impact efficiently on some of the health problems that were considered a priority in Health Sectoral Program 2007-2012 (maternal mortality, infant mortality, cervical cancer, auditory disability, dengue, family planning, vaccine-preventable diseases, diabetes mellitus, overweight and obesity, addictions, injuries due to road accidents, breast cancer, HIV/AIDS, and mental health disorders); through the implementation of the actions included in the guaranteed Package of prevention and promotion services for better health. Included within the challenges of this Program, are: "From an early age stop the chronic disease epidemics and injuries, brought about by overweight and obesity, due to beverage consumption and unhealthy eating habits, the lack of physical activity, and risky behavior and conditions." The general objective of this program is to "Carry out intersectoral, preventive, comprehensive, and effective interventions, with basic education children, adolescents and young adults of secondary and high school, to make it possible for them to develop the ability to have greater control over the causal determinants of their health, improve it, and thus increase learning achievement." One of its specific objectives is to: "Promote knowledge of healthy beverages, appropriate eating habits, and physical activity practices that generate habits and changes in children and youth and thus stop the increase of obesity and chronic degenerative diseases." The Program adopts strategies and specific lines of action, with annual goals until 2012. (It should be pointed out that prior to this program, the collaboration between the SEP and the SS occurred in the context of the Education and Health Intersectoral Program.)

Finally, it should be noted that the INSP, which at the request of the Secretariat provided support in outlining what would be the national strategy to combat overweight and obesity, had previously worked on the issue (as an institution and individually various members of the Nutrition in Health Research Center) and used part of that material in the preparation of its recommendations for the design of the strategy. Examples of these works are: the workshop the INSP organized in 2005 with the Institute of Medicine of the United States to develop a binational strategy for the prevention and control of obesity in Mexican children in the United States;24 the study carried out in Mexico City in 2005-2006, to quantify physical activity in schoolchildren and describe the school setting with regard to recreation and...
physical education classes;\textsuperscript{25} characterization of the school environment in public primary schools in Mexico City and 12 cities of the country, to establish the obesogenic context; consultation and the meeting of experts in 2008 to generate recommendations for nutrient guides at public primary schools;\textsuperscript{26} the pilot to evaluate the effect of changes in the environment and school policies and greater physical activity of the students in Mexico City schools;\textsuperscript{27} and the execution of the National Health Survey of Schoolchildren 2008, whose objective was to describe the health status, education, and living conditions of schoolchildren from public primary and secondary schools and to identify the main risk factors to health.\textsuperscript{28} Also, the INSP participated in the work of the Expert Committee convened by the SS that prepared the “Recommendations on the consumption of beverages for the Mexican population” in 2008.

This document would also serve as the basis to subsequently design the Guidelines in schools, in particular the identification of “the school environment as one of the probable causes for such high prevalence of overweight and obesity in which consumption of food and beverages with high energy density is promoted and the opportunities to carry out physical activity is restricted, resulting in an energy imbalance.”\textsuperscript{29} It should be pointed out that, as it will be seen below, the role of the INSP transcends this stage, by remaining as the main technical support of the SS throughout the discussion and negotiation process, not only generating documents but participating in the negotiations.

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Notes
1 Since at November 2012 the data of the ENSANUT 2012 had not yet been published, the information included
in this study was obtained from documents with general results, as well as from some presentations made by the National Public Health Institute (INSP) in the meeting on overweight and obesity results of the EN-SANUT held on November 21, 2012.

2 Researchers from the Ibero-American University and the Salvador Zubirán National Nutrition Institute (INNSZ) as well as from the academic and medical societies also participated.

3 Author’s summary of the presentation of the technical Bases of the Agreement.

4 Source: http://www.avm.org.mx/sitio/?p=469


7 The Pact is a reference to the Economic Growth Pacts used during the administrations of Presidents de la Madrid (1982-1988) and Salinas (1988-1994), in which the authorities met periodically with the representatives of the economic and social sectors and jointly agreed on the economic measures.

8 The director of ConMEXICO was responsible for the negotiation of the Free Trade Agreement between Mexico and the European Union and, in his private practice, he has advised governments, multilaterals and companies on trade and competitiveness.

9 Of the 864 observations received between June 10 through July 22 came from: 92 companies; 74 associations and business chambers; 54 social or public institutions; 27 teachers and school directors; 9 students; 79 parents and family members; 200 professionals and researchers, and 329 to other citizens. Of the total, in accordance with the SEP, 195 were against, 662 in favor, and 8 with no preference. Source: SEP (2010), a 778-page document of the SEP with the responses to each comment. Another source to read the observations as well as the final decision with the comments made by COFEMER is: wwwapps.cofemer.gob.mx/COFEMER-APPS/scd_expediente_3.asp?id=01/0596/100610.

10 The categories in which the observations related to the economic impact of the measures were classified were: packaging adaptation costs; effect on price for packaging cost; increase in child expenditures; effects on employment; restrictions in the freedom of choice of consumers; negative impact on SMES (small and medium enterprises); effect on loss of sales at schools; impact on total demand; effects on the production chain; cost for lost sales at schools; effect on the total demand, by brand; effect on the value of the brands; influence on children on consumption decisions; effects on competition; elasticity of demand; adaptation costs (reformulation); penetration of industrialized food at schools; availability of drinking water; adaptation cost (portion sizes); informal trade; contradictory to other policies; costs of the sugar industry; effect on the beverage industry; and, effect on the dairy industry.

11 The categories in which the observations related to the legal basis were classified were aimed at: that the omission of the Guidelines breaks with Article 3 point ii of the Agreement of Regulatory Quality; the lack of basis for the issuance of the general Guidelines and violation to individual guarantees; and, to add legal precepts to the foundation of the draft provisions.

12 The categories in which the health- and nutrition-related observations were classified were those that question the certification of schools free from sweetened beverages and food; they question the definition of food; they refer to interference with the Federal Law of Protection to the Consumer; they refer to sanctions; those related to Mexican official standards; those related to supervision and surveillance; to the omission of the food list; to conflicts with the national agreement on food health; to the health promotion and education components and the promotion of physical activation; to legal instruments of an international nature; and, the good drinking Pitcher.

13 The categories in which the observations related to the educational issues were classified were: the need to train parents and teachers so that they promote healthy habits in the students; the need for modifications to the curriculum.

14 Available at: http://www.sep.gob.mx/es/sep1/salud_alimentaria#.UfaudawzJBk

15 Source: http://journalmex.wordpress.com/2011/05/18/solo-40-de-escuelas-publicas-tienen-un-maestro-de-educacion-fisica/

16 Source: http://www.avm.org.mx/sitio/?page_id=63

17 In contrast, both the PRONASA and the PROSESA have as one of their goals for 2012 to reduce by 20% the prevalence of malnutrition in children under 5 that present underweight for their height in the 100 municipalities with the lower human development index.

18 Source: Presentation of PowerPoint of the SS: UNEMES-Medical Specialties Units. Available in: http://portal.salud.gob.mx/descargas/pdf/unemes07.pdf. In that year the SS announced the construction of 50 UNEMEs SoRiD throughout the country.

19 The PABI Code is available at: http://www.promocion.salud.gob.mx/dgps/descargas1/programas/codigo_pabi.pdf

20 The National Evaluation Board of Social Development Policy (CONEVAL) is a decentralized public agency of the Federal Civil Service, with autonomy and technical capability to generate objective information on the situation of the social policy and the measurement of pov-
Property in Mexico that allows improving decision-making on the matter. Source: http://web.coneval.gob.mx/quienessomos/Paginas/Quienes-Somos.aspx.


26 Recommendations for nutritional guides in public primary schools – Characterization of the school environment in primary schools of states of the Mexican republic and recommendations for a “healthy school lunch.” INSP, 2010.


28 The methodology and the results are in the National Health Survey in Schoolchildren, April 2010, preliminary version. Ed. Teresa Shamah.

29 Source: Recommendations for nutritional guides in public primary schools – Characterization of the school environment in primary schools of states of the Mexican republic and recommendations for a “healthy school lunch.” INSP.
PREVENTION OF HEALTH RISK FACTORS IN LATIN AMERICA AND THE CARIBBEAN: Governance of Five Multisectoral Efforts

Photography: Cortesía del Fondo Nacional de Recursos, República Oriental del Uruguay
This study documents advances in the design and implementation of Uruguay’s tobacco control policies in the last decade. The policies mainly aimed at complying with the country’s commitments from its ratification of WHO’s Framework Convention on Tobacco Control (FCTC). Initially, an interdisciplinary and inter-institutional team worked to implement tobacco-free environments. Nearly at the same time, work began on designing interventions for complying with the rest of the Convention’s provisions. Within three years, the treaty’s most important articles had been implemented. The implementation of Uruguay’s tobacco control policies, especially during the last decade, has brought about a significant decrease in tobacco-consumption indicators, both in adults and in young persons, with a greater impact seen in women and among those with higher education levels.

Context

In Uruguay, noncommunicable diseases account for more than 60% of deaths each year. Of these, 14.5% (some 13 deaths each day) are attributed to tobacco consumption, and they are distributed as follows: 4.9% to cancer, 28.7% to respiratory diseases, 28.0% to cardiovascular diseases, and the remaining 8.0% to second-hand smoke (Sandoya, 2011).

According to the 2006 Global Cancer Atlas (Globocan), Uruguay was the Latin American country with the highest mortality from lung cancer that year. The report highlights that lung cancer is “the leading cause of death from cancer in Uruguayan men,” and that 90% of lung cancer is attributable to tobacco. The incidence of lung cancer mortality for women at that time was on the rise, due to an increase in tobacco consumption among women in the previous decades, the mortality rate from lung cancer in women, adjusted by age, rose more than 3% each year.

According to The Tobacco Atlas (4th edition, 2011), Uruguay ranks as the leading country in Latin America for deaths due to tobacco among men (within the 20.0% to 24.9% range).
Prevalence of Tobacco Consumption in the Overall Population

In order to obtain comparable measurements of the prevalence of tobacco consumption over time, based on micro-data from some surveys conducted between 1998 and 2011, and to determine which similarities they shared in their sample and methodological designs, adjustments were made to ensure that the geographic area and the population age group under study would coincide across all surveys (Table 4.4), figure 4.1 shows trends in prevalence of current smokers in five urban areas.

Table 4.1. Selected surveys for comparing the prevalence of tobacco consumption and consumption of other drugs over time, Uruguay, various years.  

<table>
<thead>
<tr>
<th>Description</th>
<th>Year</th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>Second National Survey on Drug Consumptionb (JND)</td>
<td>1998</td>
<td>15 to 64</td>
</tr>
<tr>
<td>Third National Survey on Drug Consumptionc (JND)</td>
<td>2001</td>
<td>15 to 64</td>
</tr>
<tr>
<td>Fourth National Survey on Drug Consumptiond (JND)</td>
<td>2006</td>
<td>15 to 64</td>
</tr>
<tr>
<td>Global Adult Tobacco Survey (GATS-MSP-INE)</td>
<td>2009</td>
<td>15 to 64</td>
</tr>
<tr>
<td>Continuous Household Surveye (INE)</td>
<td>2011</td>
<td>15 to 64</td>
</tr>
</tbody>
</table>

a The five surveys were conducted in locations with 5,000 or more residents.
b Segunda Encuesta Nacional de Prevalencia de Consumo de Drogas
c Tercera Encuesta Nacional de Prevalencia de Consumo de Drogas
d Cuarta Encuesta Nacional de Prevalencia de Consumo de Drogas
e Encuesta Continua de Hogares

Figure 4.1. Variation in the prevalence of current smokers (daily and occasional), according to five urban surveys, Uruguay, 1998–2011.

Source: Author, based on data from the National Institute for Statistics (INE, for its Spanish acronym), the Global Adult Tobacco Survey (GATS), and the National Board of Drugs (JND, for its Spanish acronym).
As shown in Figure 4.2, although the prevalence figures for daily smokers were similar between 2001 and 2006, in 2009 they plummeted compared to 2006—10 percentage points, with a variation nearing 30% (see Table 4.1 for details on the comparability of this information).

Given the clear progress Uruguay had made in tobacco control, the country was invited to participate in the Global Adult Tobacco Survey (GATS), to measure and study the impact of the country’s policies. The survey, conducted in 2009, is the most important assessment on tobacco consumption carried out in the country, not only because of the number of cases, but because it was the first nationwide survey (for example, up to that time, no tobacco-consumption studies had been conducted in rural areas). According to the survey’s results, in 2009, 25% of persons 15 years old and older nationwide smoke every day or occasionally (20.4% and 4.5%, respectively; 30.7% males and 19.8% females).

The average number of cigarettes consumed by daily smokers was 15 cigarettes per day, greater in men than in women. On average, young smokers (20–34 years old) began smoking at age 16; only 11.2% of this age group began smoking at age 20 or older. For additional details on the socioeconomic characteristics of the smoking population, see Annex 4.1.

Regarding exposure to second-hand smoke, GATS found that 40.8% of persons 15–24 years old are exposed to second-hand smoke at home, a figure 11% greater than that of persons of any age group exposed to second-hand smoke (Figure 4.3).
Prevalence of Tobacco Consumption among Physicians

Results from two nationwide surveys aimed at practicing physicians nationwide, coordinated by the Medical Union of Uruguay (2001 and 2007), and from another survey conducted in 2011 by the Research Center for the Smoking Epidemic, highlight one of the main concerns: raising awareness among health professionals regarding their tobacco consumption.

The leading results from the above-mentioned surveys show a trend toward decreasing tobacco consumption among health professionals in Uruguay—while in 2001 the prevalence was 27%, in 2007 it decreased to 17%, and in 2011 it dropped further to 9.8% (CIET, 2011).

Exposure to Second-hand Smoke According to the 2006 Expanded National Household Survey (ENHA)

In 2006, Uruguay was one of 31 countries that participated in an international study designed to evaluate the second-hand smoke exposure of children and women in their homes. Among the leading findings is the fact that two or more smokers lived in 26% of households, of whom 86% smoked in the home and 91% smoked in front of children (Wipfli et al., 2008). According to another study conducted that year, 24% had been exposed to second-hand smoke at home and 36.2% at work in the seven days prior to the survey (Ministerio de Salud Pública, 2006). GATS data show that in 2009, 29% of interviewees had been exposed to second-hand smoke at home in the week prior to the survey, and 16.5% had been exposed at work in the 30 days prior to the survey.

According to the 2006 Expanded National Household Survey (ENHA, for its Spanish acronym), even when there is no information on second-hand smoke exposure in the home, it is possible to identify households that include smokers and that also include minors under 15 years old. For the country as a whole, 39.2% of

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*Source: Author, based on data from the 2009 Global Adult Tobacco Survey (GATS).*
households fit that category. When household income level (per-capita income quintiles) is taken into consideration, marked differences are seen between households in the first quintile (highest income level) and those in the fifth quintile (lowest income level). While nearly 70% of lowest-income-level households include smokers and minors, only 13% of highest-income-level households do.

The relative weight that minors in households with smokers bear depending on the income level, also is clear in observing family life-cycle stages, which can be considered as a wake-up call when planning and designing prevention campaigns intended to decrease exposure to second-hand smoke in the home (Table 4.2).

Table 4.2. Percentage of households with smokers, by family life-cycle stage, and by income quintiles 1 and 5, Uruguay, 2006.

<table>
<thead>
<tr>
<th>Stage (age of the children)</th>
<th>Households with smokers (%) (according to ENHA 2006)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quintile 1</td>
</tr>
<tr>
<td>Family initiation (under 6 years old)</td>
<td>10.3</td>
</tr>
<tr>
<td>Expansion (under 12 years old)</td>
<td>20.8</td>
</tr>
<tr>
<td>Consolidation (12–18 years old)</td>
<td>44.4</td>
</tr>
<tr>
<td>Departure (18 and older)</td>
<td>12.8</td>
</tr>
<tr>
<td>Empty nest (couple without children, woman older than 45 years)</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Source: Author, based on data from the Expanded National Household Survey (ENHA).

Socioeconomic Impact of Tobacco

According to results from the 2009 GATS, Uruguayan smokers spent an average of 20% of that year’s minimum wage to purchase cigarettes. The impact of spending on tobacco on household budgets varies greatly if the wide differences in income across the country are taken into consideration, with the impact being much greater among society’s poorer sectors. And yet, the lower the cost of loose tobacco used to manufacture cigarettes, the more tobacco consumption is promoted and the greater its access (mainly among the young).

In terms of tax revenues, funds collected through the specific domestic tax (IMESI, for its Spanish acronym) in 2005 reached nearly US$ 70 million, while by the end of 2009, the annual revenue collected from IMESI, plus that of the value added tax (VAT), reached US$ 190 million. The tax contribution of the tobacco industry as a whole barely exceeds a one-half percentage point of the total gross domestic product (GDP).

The costs to the country from tobacco consumption far exceed what is collected in taxes. Considering that health costs represent, overall, between 7% and 11% of GDP in the MERCOSUR countries, in 2003 it was estimated that the health costs linked to smoking would represent about one percentage point of GDP in any given year. In Uruguay, this rate amounts to some US$ 150 million per year in direct costs (Ramos, 2006), to which indirect costs from
higher work absenteeism and social-security costs due to disability should be added.

Development and Implementation of Uruguay’s Anti-tobacco Policy

The Pioneers
In the 1950s, when the first international studies demonstrating the damage caused by tobacco consumption began to appear, pioneers such as Doctor José Saralegui (first) and Professor Helmut Kasdorf (subsequently) began to work on tobacco control. In the 1950s Dr. Saralegui conducted surveys on the smoking prevalence among secondary school students and civil servants. Then, in the 1970s, experiencing an advanced epidemiological transition, Uruguay had one of the highest mortality rates from cancer in the world. Helmut Kasdorf, working through nongovernmental organizations (NGOs) such as the Uruguayan League of Volunteers for the Education, Prevention, and Control of Cancer (LUVEC) and then through the Anti-smoking Commission of Uruguay (CATU), began to provide information to authorities in order to limit where smoking would be allowed and to control tobacco advertising.

Alliances and the First Anti-tobacco Measures and Policies
The first polyclinic to treat smoking began to operate in 1988 at Medical Clinic “A” of the University of the Republic’ School of Medicine, led by Professor Milton Portos in the Hospital de Clínicas. With the support of the Pan American Health Organization (PAHO) and the Latin American Coordinating Committee on Smoking Control (CLACCTA, for its Spanish acronym), educational activities aimed at primary- and secondary-education teachers were organized as a way to reduce the prevalence of tobacco consumption and delay its initiation among children and adolescents.

In 1994, the first course on smoking for post-graduates, “Tobacco and Health,” was introduced, and the School of Medicine of the University of the Republic was declared a “Smoke-free Building.” That same year, the Honorary Commission for the Fight against Cancer (CHLCC, for its Spanish acronym), working from the university’s area of social education, began to disseminate information to the population and to work with different institutions to implement 100% smoke-free environments. In addition, the area of professional technical training carried out research on youth, and in 1999 began to conduct a series of courses and academic seminars aimed at health professionals. At the same time, the Honorary Commission for Cardiovascular Health worked on population-based education and coordinated the first “Quit and Win” contests. The aforementioned institutions began to coordinate tasks with the support of the Pan American Health Organization (PAHO).

In 2000, at the request of the Ministry of Public Health’s General Directorate of Health (DIGESA, for its Spanish acronym), a nongovernmental organization was created—the National Alliance for Tobacco Control (ANCT, for its Spanish acronym), which was made up of governmental, parastatal, international, academic, and nongovernmental organizations. The institutions conforming the Alliance were: the Pan American Health Organization (Uruguay Country Office), the Ministry of Public Health, the Montevideo City Hall, the Honorary Commission for the Fight against Cancer, the Honorary Commission for Cardiovascular Health, the Medical Union of Uruguay, the Medical Federation Outside of Montevideo, the University of the Republic (School of Medicine-Hospital de
Clinicas-Clínica Médica A), Uruguayan Passive Smokers (an nongovernmental organization), and the Uruguayan Society of Family Physicians (SUMEFA, for its Spanish acronym).

The creation of the Alliance made it possible for these institutions to coordinate their work to reduce the morbidity and mortality due to tobacco-related diseases, to unify criteria, and to optimize human and material resources.

The various governmental and nongovernmental organizations worked together on sustained lobbying activities, and, as a result, the discussion about tobacco consumption from a public health perspective was for the first time positioned in the news media and in the political arena. This, in turn, gave visibility to the Uruguay’s growing movement on tobacco, and led to a greater awareness about the extent of the problem both among health-policy decision-makers and the population as a whole. In 2002, the Senate’s Public Health Commission for the first time met with members of the recently created ANCT, who formally presented the Alliance as an organization and stated their concern over the smoking epidemic in the country.

The different institutions that made up the ANCT also lobbied individually, which launched a collective demand from governmental and civil-society institutions to ratify the Framework Convention on Tobacco Control (FCTC); the Convention was ratified in 2004. Uruguay was one of first 40 countries to ratify the FCTC and the first one to do so in South America. The Alliance played a significant role in ratifying the Convention, and the country’s legislative advances earned Uruguay recognition from PAHO/WHO during the 2005 World No Tobacco Day. The Alliance’s early work sparked a shift in society’s conceptualization of the “smoking” problem.

**Strengthening and Consolidation of Anti-tobacco Activities**

Initially, the process began by providing information on the extent of the tobacco problem at every level (population, professional, business, political, and the mass media); this effort was followed by advocacy work for signing onto and subsequent ratification of the Framework Convention in Parliament. During this phase, the Alliance, in addition to its population-based campaigns, also conducted workshops with journalists, health-service administrators, and those responsible for human resources in government agencies. Furthermore, activities designed to provide scientifically sound information on the smoking epidemic to policymakers and political-party representatives proved to be an important strategy in raising these group’s awareness about the problem.

Many of the institutions that formed part of the Alliance, command the highest political and academic respect in the health field. It was within the Alliance that the working strategies were developed, with each institution providing human and material resources, from their positions of greatest strength. The richness and diversity of its members made it possible for the Alliance to broaden the exchange and address all the intervention levels. The work was charted during weekly or biweekly meetings where full consensus was sought—each delegate was free to propose any idea, which was then fully discussed. Once agreement was reached, tasks were assigned, thus transforming ideas into action. The work within the Alliance was key for preserving the balance of power, as well as for engaging the commitment of the participants and the absence of vying for a limelight among most of the delegates.

The inter- and multidisciplinary approach offered by the Alliance, as well as its indepen-
dence from party politics, was critical in confronting a problem that requires that social, economic, health, and other factors be addressed in order to arrive at the most effective scenario for raising the population’s awareness of the issue. The Alliance spearheaded this process, strengthening and broadening its capacity for action and impact. The broad range of organizations that came under its umbrella—state, parastatal, and civil society—many of which had excellent reputations and social recognition, facilitated the securing of funds, public visibility, and the positioning the issue in society.

In 2004 the Ministry of Public Health created the National Advisory Commission for Tobacco Control, a governmental entity under the Ministry and made up of governmental, public nongovernmental institutions, and representatives of medical associations, to advise the Ministry in all tobacco control matters. Since then, the Commission has contributed information that has served as the basis for resolutions and legislative and regulatory projects that the Ministry launched during the period.

In 2005, the National Program for Tobacco Control (PNCT, for its Spanish acronym) created within the Ministry of Public Health was intended to be the focal point for national-level tobacco control policies. The PNCT has been responsible for planning, developing, and implementing all tobacco control policies that the country has carried out since then, and has generated ideas and launched the most important activities in tobacco control.

The PNCT is charged with ensuring compliance with the regulation; to this end, a cadre of specially trained inspectors are deployed throughout the country to carry out this task. Results are entered into a database that gathers the information and classifies it by geographical area, activity, and category of violation. Based on these data, the Ministry then imposes the appropriate fines, after prior consultation with the PNCT and the Advisory Commission.

At the regional and international levels the PNCT is the focal point representing the country in MERCOSUR’s Intergovernmental Commission for Tobacco Control and at WHO and FCTC Secretariat meetings. It is important to point out that, at the regional level, the PNCT has advised and provided information to various Latin American countries as they develop their tobacco control policies and work on their implementation processes.

Upon ratification of the FCTC and the creation of the National Program for Tobacco Control, Uruguay implemented a vigorous tobacco control policy that translated into a comprehensive package of measures, whose linchpin was the implementation of 100% smoke-free environments. This measure does away with the sense that smoking is “normal,” discourages ever starting to smoke (and decreases smoking), and fosters smoking cessation attempts. All the measures were supported by information campaigns before, during, and after the law became effective.

In May 2005, coinciding with “World No Tobacco Day,” the Executive Branch approved several decrees, such as provisions to raise tobacco taxes; the use of graphics in the health warnings that already took up half of both main sides of cigarette packets; a ban on misleading terms such as “light,” “ultra-light,” or “smooth” cigarettes; and a ban on advertising, promotion, and sponsorship of tobacco products associated with sports activities. Significantly, the Executive Branch pursued fast-track regulation regarding tobacco consumption, marketing, and advertising: approval of decrees.
One of the greatest hurdles in preparing to implement smoke-free environments was persuading the associations of bars, restaurants, and casinos, as well as businesses in general, to support the measures. Reaching consensus with these players was fundamental in facilitating the implementation of the measures designed to achieve smoke-free spaces. From the onset, it was made clear that establishing 100% smoke-free environments was a high-level political decision. As a result, the measure itself never was in question, discussions only dealt with what would be the best way to carry it out for all those involved.

Businessmen had been given distorted information concerning the economic consequences that they would sustain—information provided by the tobacco industry. Mutual trust had to be built by providing these groups with scientific proof so they could begin to accept the change. A significant event occurred when the owners of the major commercial areas conducted their own surveys among their clients to ascertain their opinion on the smoke-free environments and whether the measure would affect their patronage of those commercial centers. The results demonstrated that more than 80% of respondents supported the measure, including smokers. Finally, business associations which strongly supported the implementation of anti-tobacco measures, became one of the strongest allies in the process.

In addition, much work was done with transportation business owners and union members; the latter vigorously resisted the proposed changes. Dialogue centered on aspects dealing with occupational health, and an agreement was reached to provide treatment through the public health system to all smokers who requested it. It was made clear that penalties would be imposed on drivers who smoked in the vehicles.

Two intense campaigns dealing with the new anti-tobacco measures were launched: one prior to the date in which the measure would go into effect, on 1 March 2006, and the other subsequently, beginning in April 2006. The first campaign, called “One Million Thanks,” involved collecting signatures thanking smokers for quitting smoking in enclosed spaces beginning on the enforcement date, 1 March. The campaign set a goal of one million signatures to be collected, but the campaign actually collected 1.3 million signatures in 45 days. The objective was achieved and, in addition, the campaign accomplished a very important mobilization function with the entire population and the communications media, demonstrating the high degree of involvement with and acceptance of smoke-free environments. The second campaign, called “Tobacco-Smoke-Free Uruguay,” began in April 2006, immediately after the smoke-free-environments measure went into effect. The campaign relied on information about the benefits of smoke-free air: it raised awareness about the rights of nonsmokers and offered treatment to smokers who wanted to quit. Both campaigns stressed the positive and never stigmatized smokers, so that the campaigns would be viewed as including smokers and nonsmokers alike.

As stated earlier, on 1 March 2006 the ban on smoking in all enclosed public spaces and work areas, as well as in outdoor areas of any health or educational center, went into effect. Ministry of Public Health teams also began to inspect compliance at this time.

At that stage of the implementation process, the political context was favorable to the measures: on the one hand, the party in power had guaranteed parliamentary backing because it
held the majority in both chambers; on the other, one of the lawmakers that spearheaded the process in parliament (a physician completely committed to the issue) belonged to the leading opposition party. Finally, the remainder of the political spectrum included representatives who supported these measures.

Also in 2007, the debate on a comprehensive draft legislation on tobacco control began in parliament, culminating with the approval of Law 18,256 on 6 March 2008. This law incorporated decrees already in effect and added measures such as the ban on advertising, promotion, and sponsorship of tobacco products and the requirement to provide diagnosis and treatment for tobacco addiction at the primary care level throughout the health services; these decrees and new measures together rendered this legislation into a comprehensive package of convergent measures that mutually reinforce each other.

In 2010, an increase in tobacco taxes increased the price of tobacco products. Inflation and variations in the population’s purchasing power make it necessary to periodically adjust the price of these products. Figure 4.4 shows how the price of tobacco products diverges from the consumer price index (CPI).

**Figure 4.4. Evolution of the price of cigarettes, Uruguay, 2004–2010.**

![Price of cigarettes](figure.png)

**Source:** National Institute of Statistics (Instituto Nacional de Estadística [INE]).

**The Political and Parliamentary Initiative**

During the approval process for Law 18,256, various government and civil-society institutions carried out significant advocacy work with parliamentarians. Lawmakers were provided with information and scientific evidence about the issues that would be discussed, so that they would have these materials in hand during the debate. This effort covered every representative, regardless of political affiliation.

Uruguay has had parliamentarians who were physicians, which was important for the advocacy work. Having the support of par-
The Parliamentary Debate

In 2005, at the time a new administration assumed power in the country, the National Program for Tobacco Control was established within the Ministry of Public Health. The government, which had sent the draft legislation to parliament, held the majority in both parliamentary chambers. Even so, opposition parties participated in drafting the legislation, and their agreement with wording resulted in the support of a vast majority of politicians for the initiative. Another important factor was the fact that the country’s president was an oncologist with firm convictions on health, which led him to involve his party in the Framework Convention’s proclamations, which later were used for approving the law.

In the years prior to the approval of the legislation’s final wording, four draft bills dealing with tobacco control were submitted. Upon reaching consensus, these were consolidated into a single piece of legislation that incorporated the best of each bill; this allowed the discussion about smoking in Uruguay to occur within the framework of State policy.

The draft bills can be grouped in two broad categories. On the one hand, there were those bills submitted by lawmakers from with the main opposition parties, which included basic elements of the Framework Convention, among them the banning of advertising, standards dealing with smuggling, education, health promotion, and treatment of disease. On the other, the Executive Branch’s draft legislation and another one submitted by a member of parliament from the opposition dealt with issues that targeted the establishment of 100% smoke-free environments; the setting of violations, fines, and education standards; and raising awareness about tobacco, smoking prevention, and treatment of tobacco dependence. As can be seen, the first group of bills did not include the establishment of smoke-free environments, and the second group did not include a ban on advertising.

The work conducted at the commission level was enhanced by the contribution of organizations that were invited to put forward their views on the issue. The intervention of the Ministry of Public Health’s National Program for Tobacco Control, was particularly important, as was the participation of many scientific and nongovernmental organizations. All these institutions attempted to explain the importance of tobacco control and urged parliamentarians that measures be consolidated to achieve this in Uruguay. For the most part, Program representatives were active participants in the discussions and figured prominently in the media.

The tobacco industry also had an opportunity to meet with parliamentarians and present its viewpoint on the matter, frequently attending sessions of parliament’s commissions on health and requesting meetings with individual lawmakers. During those meetings they expressed concern over the impact that an advertising ban would have on the local industry, over the labor sources for personnel actively working in the industry, and over the difficulties they saw in implementing 100% smoke-free environments.

Tobacco-industry workers, grouped under the Tobacco Trade Union, expressed their mis-
givings about the potential loss of jobs as a result of the implementation of the regulations, as well as about the effect that tobacco smuggling would have on them. The discussion then aimed at unifying the four draft bills and, with the agreement of their sponsors, a single draft legislation emerged, which was brought to a vote at the plenary session in each parliamentary chamber.

Discussions in the House of Representatives and in the Senate considered various opinions regarding the smoking ban in enclosed spaces, in that this measure could damage the tourism industry, which is extremely important in the country. Questions also were raised regarding the State’s authority to intervene in public life by regulating the behavior of individuals in public spaces. The tobacco industry, which was familiar with this line of reasoning, used the mass media to claim that freedom of choice was being curtailed by restricting smoking areas.

A group of parliamentarians also was made aware of the complaint of some media outlets and publicity agencies, which claimed that their profits from creating and selling publicity products would be harmed, and proposed that advertising at points of sale be allowed. In short, the total ban on advertising became a broad prohibition, in that it had the support of most of the votes in parliament.

After parliamentary deliberations, agreement was reached on the law’s wording, which included a comprehensive package of measures that echoed the main provisions of WHO’s Framework Convention. This text was voted on by lawmakers from every political party, and became Law 18,256, approved on March 2008. (The text can be seen at: http://www.parlamento.gub.uy/Leyes/AccesoTexto-Ley.asp?Ley=18256&Anchor [last accessed on 26 March 2013].

Leading Actors that Supported Tobacco Control

The main actors in Uruguay’s fight against tobacco consumption between 2000 and 2004 were the institutions within the National Alliance for Tobacco Control (ANCT) that were previously mentioned.

The Alliance’s objectives were to unify criteria, work within a network, promote participation and dialogue with the different social actors and their organizations, and pursue advocacy work with policymakers, the communications media, and the overall population. With the creation of the Ministry of Public Health’s National Program for Tobacco Control in 2005, the Alliance launched a broad coordination and cooperation effort aimed at developing an implementation plan for the tobacco control policies related to the FCTC. The Alliance operated until 2006. The following paragraphs briefly describe the role each institution within the Alliance played and the power sources for each.

Pan American Health Organization (PAHO): through its country office in Uruguay, the Organization provided critical financial and technical support. It also supported the Alliance’s representatives attendance at world congresses and preparatory meetings of the FCTC in Geneva. The contributions of Dr. Julio González Molina were decisive for obtaining support from international organizations.

Ministry of Public Health: the Ministry participated in the Alliance from its beginning, initially through its delegates, and then through the National Program for Tobacco Control and through an advisory commission made up of different institutions. The Ministry served as
the headquarters for the Alliance and, based on the agreements reached in that venue, became the spokesperson for conveying the demands of the institutions in favor of tobacco control before executive branch agencies and legislative-branch representatives.

In its legal capacity of policing the population's health, the Ministry created the Tobacco Control Advisory Commission, whose function is to advise it on all matters of tobacco control. The Commission is made up of delegates from the Ministry of Public Health, the National Board on Drugs, the Montevideo City Hall, the School of Medicine, the Honorary Commission to Fight against Cancer, the Honorary Commission for Cardiovascular Health, the Medical Union of Uruguay, and the Medical Federation outside of Montevideo. Civil-society's role in this Commission deserves special mention: it functions as an external control for policymakers, in that it has a freedom to act that allows it to be critical or even differ from the government's positions.

**The National Program for Tobacco Control:** the Program was created by the Ministry of Public Health in 2004 and, since then, has functioned as the national focal point for the development and implementation of tobacco control policies. The Program drew up and articulated the strategies for preventing the onset of smoking and for dealing with diseases related to tobacco dependence. It also worked on the rehabilitation and treatment of tobacco dependence, in line with provisions within the Framework Convention. In 2009, the Program coordinated the group working to develop the National Guidelines for Dealing with Smoking, which are aimed at all health workers and whose recommendations are compulsory, in accordance with existing legislation.

**Montevideo’s Municipality:** The Montevideo City Hall has a Health Division that manages neighborhood polyclinics at the primary-health-care level, where services are free. Income for the Mayor’s Office comes from various taxes. During the implementation of activities against tobacco consumption, the Office, with the support of institutions such as the School of Medicine and the Honorary Commission to Fight Cancer, carried out an anti-tobacco advocacy campaign within its walls, going on to become one of the first institutions that attained a 100% smoke-free environment, even before the national regulations took effect. Simultaneously, within the Health Division, professional staff received training to help fellow officers quit smoking, and health team professionals were trained on how to offer treatment in neighborhood polyclinics.

**The Honorary Commission to Fight Cancer:** This Commission, which was established by law in 1989, was declared of national interest in the fight against cancer. From a legal standpoint it is a parastatal statutory body that is not part of the Ministry of Public Health, although it must report to it on its activities; its main source of income comes from tobacco and alcohol taxes. The Commission’s board of directors includes representatives of highly respected academic and political institutions that work to fight cancer, can set educational policies in both the public and professional arenas, and have significant revenues under their control. From the onset, the Commission worked in public education and in providing technical and professional training through promotion and education campaigns designed to increase the number of smoke-free environments. It was the first institution to offer post-graduate courses to health professionals on such topics as the promotion, prevention, diagnosis, treat-
ment, and control of tobacco, and also carried out research on smoking among young people. The Commission’s materials have become extremely important, not merely those that have been used in campaigns against cancer, but also a series of useful tools that have educational applications in this regard. In fact, WHO has used posters designed by the Commission, and this institution has received recognition on more than one occasion for the development of these tools.

Honorary Commission for Cardiovascular Health: This Commission was created by law in 1994, at the time that all activities intended to control risk factors for cardiovascular disease were declared of national interest. From a legal standpoint, the Commission is a parastatal entity that is not part of the Ministry of Public Health, but must report to it on its activities; most of the entity’s revenue comes from tobacco and alcohol taxes. The Commission’s board of directors includes delegates from the Executive Branch, particularly from the Ministry of Public Health; representatives from academia, as well as from professional and trade associations that are involved in cardiology; and other civil-society organizations. The Commission also includes a delegate from the Social Security Office (Banco de Previsión Social), the social security institution that provides coverage for social risks such as accidents and illness.

Among its objectives, the Commission promotes, coordinates, and develops plans and programs for the prevention, early diagnosis, treatment, and rehabilitation of those affected by cardiovascular diseases. It also fosters basic epidemiological and operational research, and promotes the exchange with specialized centers and international organizations in order to train and upgrade the skills of the staff assigned to the programs. The Commission’s primary focus involves working with primary education professionals. It has developed brochures and guidelines on the risk for cardiovascular disease, and was responsible for coordinating and carrying out the anti-smoking contest “Quit and Win” (Deje y Gane).

The Medical Union of Uruguay: This association is a collective of working physicians and medical students in their last year of school. Its objectives include the defense of the moral and material interests of its members and, more broadly, of all physicians in Uruguay; supporting the deepening of professional culture; the enhancement of physicians’ technical profile and continuing education; and the improvement of all of the country’s health structures. The Union is financed through member contributions, and wields the influence that comes from the participation of Uruguay’s entire medical corps. In terms of health matters that call for broad political consideration, its judgment holds sway, because its opinions generate much interest from the mass media. The Union concentrates on lobbying by interviewing senators, house representatives, and various governmental authorities and policymakers, relying on the weight that its union members confer on its knowledge about tobacco control.

Medical Federation Outside of Montevideo: The Federation is a union that brings together all physicians who work outside the city of Montevideo. It provides health care to more than 680,000 members through a health service network of 23 institutions distributed throughout the country. Its objectives include promoting the full development of physicians’ practice in the country’s interior; and ensuring that the population receives health services provided through a structured health care system managed by its affiliated physicians.
In addition to the health promotion and disease work carried by its member health care centers, the Federation took it upon itself to include, within its continuing medical education, training for the health team on tobacco consumption control, thereby educating specialists who later became responsible for specialized-treatment polyclinics throughout the country’s departments.

University of the Republic: This public and free university provides training for technical health care personnel through its school of medicine and manages and operates the Hospital de Clínicas, Uruguay’s only university hospital. The university’s size and structure ranks it as the country’s main academic center. It accounts for about 90% of Uruguay’s enrollment in tertiary education. The university is financed with funds from the national treasury. Its school of medicine and, more specifically, its internal medicine unit (Medical Clinic A) at the Hospital de Clínicas, offered undergraduate education, treatment to smokers, and research. In 2009, a curriculum change led to the inclusion of the topic of smoking in the introductory study course.

Uruguayan Passive Smokers: This NGO fought for the rights of nonsmokers. It disseminated standards to civil-service employees as they were developed, and denounced violators.

The Tobacco Industry

Tobacco Farming in Uruguay

Tobacco farming accounts for only a small portion of the country’s agricultural production; moreover, its importance has been decreasing in recent years. Tobacco production is concentrated to the country’s north (along the border with Brazil), mainly in the departments of Rivera and Artigas; tobacco is farmed as monoculture, and cultivation is entirely linked to the Monte Paz S.A. company.

A leading consequence of the Monte Paz hegemony is that it has altered the forms of production and the relationship with tobacco farmers. The company completely controls the harvesting and planting of the raw material, by providing financing and supplying production inputs, controlling the harvesting process and quality, and purchasing the farmers’ entire tobacco crop. This has led to a co-dependency between the producers and the company, which guarantees investment and income for the families devoted to tobacco production.

Although the company ultimately sets the price, each crop is subject to climatic conditions and their effect on the quality of the raw material. This dependency and loyalty that the farmers have with Monte Paz, gives them economic security, in that the company finances the inputs and purchases the total production. In this regard the farmers’ commercial relationship with the tobacco company may be, in some cases, more attractive than the retrofitting and assistance plans that the Uruguayan government can offer.

That said, the economic benefit for farmers may be relative. Their earnings from each harvest (about US$ 3,000 each year) often represents the family’s only income for the year, but when translated into monthly income, it is significantly lower than the national minimum wage (roughly US$ 350 in January 2012). It should be noted that tobacco producers account for 10% of the raw material used by Monte Paz, which shows the scant importance that this industry has on the country’s employment indicators.

Current estimates put the number of families devoted to tobacco farming at approxi-
mately 150. In general, these families are of medium-low socioeconomic status, and they rarely supplement their income by working in the region’s main harvests.

Although for several years there has been consensus regarding the advisability of retrofitting or diversifying these producers, the productive and commercial nature in which they are locked limits such a possibility, at least in the short term. As of today the retrofitting has not happened, even in a scenario that could be seen as favorable for such an initiative, given the implementation of tobacco control measures that has occurred in recent years.

The area devoted to tobacco farming barely represents 0.04% of Uruguay’s total farming area (2003 data). As a result, most of the tobacco used in the national cigarette production is imported and does not come from domestic cultivation. This means that the tobacco farming sector is of little economic consequence to the country, in terms of the value of tobacco production, it depends on the price set by Monte Paz, the main national tobacco company, once the quality of the raw material has been certified. According to the last agricultural census, the value of the harvested ton is estimated at US$ 1,000.

The Tobacco Industry in Uruguay: Position and Strategies

For many years there have been only three companies engaged in the manufacturing and marketing of tobacco in Uruguay: Monte Paz, S.A., the only national company, and two multinationals, British American Tobacco (BAT) and Philip Morris (Abal Hermanos). Since the 1980s, Monte Paz, S.A., has had the largest market share in terms of the production, industrialization, and sale of tobacco products. As with tobacco farming, the tobacco manufacturing and marketing sector also represents a small part of the overall industrial sector, accounting for 2.3% of the gross national production. BAT is only involved in the marketing of cigarettes, not in production, since all the products it sells are imported. And Philip Morris closed its cigarette manufacturing plant in Uruguay in October 2011, citing economic disadvantages as a result of the health measures aimed at diminishing tobacco consumption in Uruguay; the company continues to sell its products in the country, however, which it imports already manufactured. The tobacco industry as a whole employs only 3 out of every 1,000 workers in the Uruguayan manufacturing sector (Ramos, 2006).

The Tobacco Industry’s Reaction to the Tobacco Control Measures

When the anti-smoking measures were implemented in Uruguay, the country’s tobacco industry reacted by attempting to avoid or minimize their impact. As Uruguay became a smoke-free country, the tobacco industry attempted to seed dissent among the public by raising such issues as smokers’ “freedom” and “rights.” Tobacco companies published articles in the local press, citing the example of countries such as Chile, the Netherlands, and Spain, where there were designated smoking areas within enclosed spaces and expressing the opinion that “all unnecessary bans would squander freedom.” “Why don’t we preserve that freedom in Uruguay?,” they asked.

On the other hand, the Ministry of Public Health and various organizations working on tobacco control countered with the following arguments:

- Smoking is an addictive disease and, as a result, the smoker consumes the product
because it is addicted to the that substance and is not free to choose.

- Smoking is not prohibited; it is regulated for public health reasons. Smokers cannot smoke in enclosed spaces, because having 100% smoke-free spaces is the only effective way of protecting people from the risks caused by exposure to said smoke.

Health Warnings, which Were Poorly Received by Tobacco Companies

The implementation of health warnings also was opposed by the tobacco industry. Tobacco companies used a variety of strategies:

- They argued that printing the images in the boxes on time and as required posed technical difficulties, and they asked for long extensions. However, by the time the regulation came into force the graphics were already in the market.

- They tried to influence public opinion through the press, by stating that the type of images used stigmatized smokers and denigrated manufacturers. At no point, however, did they deny that tobacco consumption produced the effects depicted in the graphics, nor did they claim that the graphics presented false information.

- They tried to weaken the message by preparing alternative images and offering them as substitutes for the graphics approved by the Ministry of Public Health. They never denied the effectiveness of the health warnings in diminishing tobacco consumption.

Reaction of Tobacco Companies to the Advertising Ban

The tobacco industry also resisted the ban on publicity, promotion, and sponsorship of tobacco products, as did some other groups (for example, advertising agencies and kiosks where cigarettes were sold). The industry attempted to avoid the prohibition by conducting banned promotions (such as giving out free cigarette samples to young people), carrying out publicity without the counter-publicity required by the regulation (for example, by using promoters at points of sale), using the brand's colors in different objects or businesses, and, more directly, by carrying out specifically prohibited publicity.

Advocacy and Litigation Efforts of Tobacco Companies to Forestall the New Measures

Somewhat later, when the various drafts were presented for the approval of a tobacco control law in parliament, the tobacco industry continued to lobby lawmakers. Their main arguments during parliamentary discussions were: 1) the measures infringed on individual rights, ii) the smoking ban in enclosed spaces could harm the tourism industry, and iii) the measures would have repercussions on the ability of the national tobacco industry to compete with the international industry—the national industry argued that a total advertising ban would hurt it specifically, in that multinational tobacco companies would be able to advertise in other countries.

Finally, the tobacco industry used litigation as a tool to oppose the implementation of the tobacco control policies, both at the national and international levels. At the national level, since 2008, all the companies that comprise Uruguay's tobacco industry have countered all tobacco control regulations by filing judicial and administrative lawsuits. Abal Hermanos, representing Philip Morris in Uruguay, as well as British American Tobacco (BAT) and Monte Paz, filed lawsuits against different smoking-control regulations.

As their first legal action against the tobacco control policies, BAT and Abal Hermanos filed appeals in contentious administrative proceedings aimed at immediately obstructing the implementation of Ordinance 514/2008.
The companies argued that the ordinance was unlawful because the measure, in mandating that graphics cover 50% of cigarette packages and requiring a single presentation for each brand, restricted these companies' basic rights, such as their right to use their brands and designs, the right to work, and the right of trade and of industry, thereby causing serious economic harm to tobacco companies and to their workers.

Both the courts of first instance and the appellate courts that heard the cases recognized the Ministry of Public Health's powers to regulate health policy, and found that none of the regulations were excessive and that they were justified. Abal Hermanos filed a lawsuit with the Supreme Court, claiming that articles 9 and 24 of Law 18,256 were unconstitutional. The company argued that these articles violated the principles of legality and of separation of powers, because the power to limit rights cannot be delegated to the executive branch, as it rests with the legislative branch, for reasons of broad interest. In addition, the brand was being indirectly expropriated without compensation, given the size of the pictograms; moreover, the rights pertaining to work, production, industry, branding, and commerce also would be limited.

In November 2010 the Supreme Court issued its opinion: it rejected the claim for unconstitutionality and expressly recognized the powers of the executive branch and of the Ministry of Public Health to regulate matters of health; it also stated that many laws, such as this one, require complementary executive branch regulations for their practical enforcement.

All the tobacco companies questioned the legality of Decree 284/08, Ordinance 514/08, 287/09, ordinances 466/09 and 374/011 in the contentious administrative tribunal, using the same arguments that they had used when they questioned the decrees’ constitutionality, stating that they infringed on rights and that the executive branch was usurping powers that rested with the legislative branch, that it expropriated the brand name and limited its use—by decree—when it stipulated the size of the pictograms, and that these graphics were demeaning and exceeded the State’s aims. In response to the tobacco industry’s position, the Contentious Administrative Tribunal, as had the Supreme Court before it, acknowledged the Ministry of Public Health’s regulatory authority in health matters, and also made reference to the country’s commitment to comply with WHO’s Framework Convention on Tobacco Control, which was approved and ratified by law, and the State’s duty to protect the population’s health to avoid the thousands of deaths due to smoking each year.

**The Tobacco Companies Appeal the Implementation of Tobacco Control Measures to International Bodies**

In 2010, Philip Morris Brands Sarl (Switzerland), Philip Morris Products, and Abal Hermanos brought an arbitration request to the International Centre for Settlement of Investment Disputes (ICSID). Switzerland and Uruguay have an investment protection Agreement and both are members of the ICSID.

Philip Morris based its request on the Uruguayan government’s alleged breach of the Investment Promotion and Protection Treaty signed between it and Switzerland in 1991, by having passed Ordinance 514 (2008), which provides for the single presentation of each tobacco product trade name, and Decree 287/09 (2009), which establishes the size of the pictograms (80% of both main faces of cigarette packages).

The companies argued that their free-trade and industry rights had been violated; that the
pictograms degraded their brand name, and that Uruguay would be expropriating their brand by requiring that the pictograms cover 80% of the surface of each main sides of the package, thereby violating Philip Morris’ autonomy in the use of its brand name.

Uruguay, in turn, claimed its sovereign right to establish public health policies designed to protect its population against the unavoidable threat to health caused by tobacco consumption. Furthermore, the country held that the right to health, by being intimately linked to the right to life, should be regarded as a fundamental human right and, therefore, measures must be established to regulate the marketing of a product harmful to health.

Early in the arbitration process brought forth by Philip Morris to the ICSID, and prior to the analysis of the underlying issue, the Uruguayan State in 2011 presented a “jurisdictional objection” waiver, arguing that according to a previous claim submitted by Uruguay, the legal requirements that the 1991 treaty requires had not been complied with, thereby nullifying the arbitration request.

Factors that Favored the Implementation of the Tobacco control Measures

The success of the measures designed to decrease smoking in Uruguay, whose origins can be traced to the 1990s, was due to the convergence of various factors that created a favorable environment for implementing such policies. Among the most important are the following:

- The country’s epidemiological profile, whereby noncommunicable diseases are the main cause of morbidity and mortality.
- The establishment of the National Alliance for Tobacco Control, made up of governmental and civil-society organizations.
- The creation of the National Program for Tobacco Control within the Ministry of Public Health.
- The existence of the Honorary Commission to Fight Against Cancer and the Honorary Commission for Cardiovascular Health, which are fully consolidated, autonomous, and deeply committed to health promotion and disease prevention.
- The diplomatic commitment Uruguay entered into by signing an international agreement, such as the Framework Convention on Tobacco Control.
- The characteristics of the country’s political regime: a unitary and presidential form of government, and a long tradition of broad participation of all political parties in the generation of agreements that lead to State policies.
- A political context that favored change and the establishment of new State policies.
- The strong commitment of the then-president of the country, a medical oncologist, who assumed office in March 2005.
- The active participation of lawmakers from the opposition parties throughout the process.
- The existence of a critical mass of trained health professionals committed to tobacco control.
- A population extremely well informed on the harm from tobacco consumption.

Results Beyond Decreasing the Prevalence of Smoking

Public Opinion

The results of various public opinion studies on tobacco consumption in Uruguay, as well as on research on the tobacco control measures, are presented below. The information collect-
ed provides an overview on how the collective consciousness regarding tobacco, its risks, and the policies implemented evolved. It also shows how a culture shift came about in terms of the population's beliefs and attitudes regarding tobacco consumption.

According to National Board of Drugs (JND) data, in 2002, 11% of the surveyed population referred to cigarettes as drugs, but only 3% considered tobacco among dangerous drugs. By 2006, six months after the smoke-free environment regulation went into effect, the Pan American Health Organization (PAHO) conducted an opinion study to assess the population's knowledge and attitudes regarding the measure. Results from that study showed that 98% of the population was aware of the regulation and 80% supported it. Widespread acceptance held true across all sociocultural strata, and was consistent among men and women and within and outside Montevideo; even two-thirds of smokers approved of the measure.

In terms of exposure to second-hand smoke, 92% of the surveyed population considered that exposure to second-hand smoke is very dangerous (57%) or dangerous (35%). Interestingly, 87% of the smokers also consider that this exposure is very dangerous (46%) or dangerous (41%).

Similarly, 95% of respondents felt that all workers have the right to work in a smoke-free environment and 92% defended the right of children to breathe smoke-free air at home. Among smokers, the figures were 92% and 87%, respectively.

Regarding the policies implemented since 2005, 58% of the population considered that the decree is fully complied with and 30% felt that it was partially complied with; among smokers, the figures were 61% and 27%, respectively. In terms of supporting the decree, 63% of smokers approved of it and 86% of nonsmokers did. With regard to the decree possibly affecting the frequency with which people went out, 70% of respondents stated that they would go out as frequently as before and 10% stated they go out more frequently than before; among smokers, the figures were 63% and 12%, respectively.

In analyzing the data from the Global Youth Tobacco Survey for that same year, 88.2% of respondents acknowledged the negative effects of cigarettes and 83.4% of those surveyed favored the smoking ban in public places.

Regarding whether environmental tobacco smoke is detrimental to health, slightly more than 70% of all young people surveyed agreed, compared with 60.2% of young smokers. Finally, there is parity in whether quitting smoking helps to lose weight: 52.6% of respondents and 52.2% of smokers consider that it does.

Environmental Pollution

In 2002 a study was conducted in seven Latin American countries to measure nicotine levels in the air from tobacco use in enclosed places. In Uruguay, high pollution levels were found in 95% of sites surveyed. The study was repeated in 2007, regulations requiring 100% smoke-free environments had been implemented; results show a 91% reduction in air pollution levels (2002: 0.75 µg/m³ – 2007: 0.07 µg/m³).

A series of studies was also conducted to evaluate pollution levels by measuring the concentration of particles smaller than 2.5μ in the air of enclosed places used by the public. In 2005, an average concentration of 210 micrograms/m³ in Uruguay, rising to 314 in bars and restaurants, even though international standards establish a maximum level of 50 micrograms/m³ for health risk. Results for 2007 found that the average concentration had de-
creased to 18 micrograms/m³, representing a 90% reduction in pollution in enclosed spaces.

**Lessons Learned**

The joint work between the government and civil society was key in the effort to control tobacco consumption in Uruguay; as important was the participation of an inter-institutional and multidisciplinary group that brought various skills to bear upon the process, committed its human and financial resources, and worked towards arriving at consensus. Maintaining communication with the population also was essential: keeping the population informed and making it aware of the damage from tobacco use, while insisting on the benefits of not consuming tobacco through positive messages that did not stigmatize smokers, brought about a greater public acceptance of all the measures.

The use of large pictograms with powerful images and direct and clear messages, also proved to be effective. In selecting the images, it is important to rely on qualitative studies aimed at the target population. For example, images showing persons were more effective than those that are merely symbolic.

Selecting an overarching element—in this case, “smoke-free environments”—was not only effective, but enabled other intervention levels to be incorporated. In fact, establishing these healthy environments as the policy’s main thread turned out to be one of the most important successes: it “denormalized” smoking, fostered the desire to quit smoking, decreased consumption among those that continued to smoke, helped those who were abstaining continue to not smoke, and represented a significant change in social behavior.

The simultaneous application of a comprehensive group of measures contributed to the success of the project, by generating synergism among them and potentiating each measure’s impact. The importance of establishing clear and transparent monitoring procedures also was demonstrated, along with effective controls for measuring compliance with the regulations and the application of severe economic sanctions to violators. Regulations that were not monitored turned into mere wishful thinking.

The development of “national clinical guidelines” also was found to be useful in the fight against smoking. These guidelines covered all health workers—not just medical staff—and they were mandatory in light of the regulation in force. Even in the health sector it is important to offer universal and free access to treatment for tobacco dependence, both in public and private primary health care services.

Finally, considering the impact of the measures on the prevalence of tobacco consumption once the implementation process concluded, two population groups stood out: the group at low socioeconomic and educational status, and adolescents. The first, because it was more resistant to lowering prevalence compared to the population as a whole; the second, because it is precisely in this age group where the epidemic is replicated, as each year a fresh generation of adolescents acquires new roles and, therefore, is at risk of beginning to consume tobacco.

**The Unfinished Agenda in Uruguay’s Tobacco Control**

Even though compliance with the measures designed to decrease tobacco consumption has been highly satisfactory, the monitoring and control mechanisms needed to sustain them and increase their compliance nationwide need to be strengthened. Recently, health authorities submitted to parliament draft legislation in-
tended to eliminate the last remaining publicity for cigarettes—advertising at points of sale. Enacting this law will be an uphill battle, however.

The Uruguayan State has the responsibility to ensure the sustainability of health promotion and tobacco-consumption-prevention campaigns. Each year, new waves of young people enter the market for cigarettes, which makes it necessary to launch initiatives designed to evaluate the reach and quality of care, and the results of treatment units for smoking cessation.

Finally, work remains to be done in conducting research, particularly to determine the morbidity and mortality burden attributed to smoking, as well as the years of healthy life lost due to disability. Such studies must be complemented with research on the economic burden that these smoking consequences place on the health and social-security systems.

The increase in prices of tobacco products must accompany economic variables such as purchasing power (given increases in people’s income level) and inflation. Therefore, the increases should be regular and frequent.

**Annex 4.1. Characteristics of the smoking population by socioeconomic level**

An index was developed for analyzing GATS-survey data that allowed the population under study to be classified according to socioeconomic status, even though the Global Adult Tobacco Survey (GATS) questionnaire did not include questions about personal or household income. Through this index it has been possible to demonstrate the complex relationship between a person’s socioeconomic status and tobacco consumption. In fact, a higher prevalence of tobacco consumption is seen in the group at the lowest socioeconomic level.

**Figure A.4.1. Tobacco consumption by socioeconomic-level index (INSE, for its Spanish acronym), Uruguay, 2009.**

![Tobacco consumption by socioeconomic-level index](image)

**Source:** Global Adult Tobacco Survey (GATS), 2009.

**Sociodemographic Characteristics of the Smoking Population**

As a way to characterize the smoking population and be able to identify relevant aspects in the evolution of smoking prevalence between 2006 and the 2009 GATS survey, other data sources that have researched the subject may be analyzed. One of them is the **Expand-**
ed National Household Survey (ENHA, for its Spanish acronym) conducted by Uruguay’s National Statistics Institute in 2006. This research, which covered a three-month period, collected information on approximately 23,000 households and 70,000 persons throughout the country. Although it is impossible to compare, without qualification, the point estimate of the prevalence of tobacco consumption—given the methodological differences between these surveys—important measures confirmed in both surveys can be observed. Understanding the characteristics of the smoking population was essential in order to efficiently and effectively target campaigns and interventions.

**Prevalence of Tobacco Consumption by Employment Status**

Both ENHA 2006 and GATS 2009 show similar findings: the inactive population (understood as the unemployed who are not seeking employment) had the lowest percentage of current smokers, while a considerable percentage smoked among the unemployed population (those looking for a job).

On the other hand, the fact that between the first survey and the second there was an increase in the relative weight of smokers among the total number of the unemployed deserves mention.

The unemployed population is far from homogeneous: it is integrated by men, women, and persons of different ages, educational levels, and socioeconomic status. Women, the young, and those with low educational and income levels tend to be over-represented among the unemployed. According to data from Uruguay’s National Institute of Statistics (INE, for its Spanish acronym), the country’s unemployment rate has been decreasing in recent years, and there also have been changes in the socio-demographic composition of the unemployed population. Both of these factors should be considered in observing data from these surveys (Table A.4.1).

**Table A.4.1. Employment status in current smokers, Uruguay, 2006 and 2009.**

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Current smokers (%)</th>
<th>ENHA, 2006</th>
<th>GATS, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employed</td>
<td></td>
<td>30.9</td>
<td>29.0</td>
</tr>
<tr>
<td>Unemployed</td>
<td></td>
<td>34.4</td>
<td>55.5</td>
</tr>
<tr>
<td>Inactive</td>
<td></td>
<td>14.2</td>
<td>14.3</td>
</tr>
</tbody>
</table>


The same trend holds in analyzing data by sex, although women’s figures are always lower.
Table A.4.2. Employment status among current smokers, by sex, Uruguay, 2006 and 2009.

<table>
<thead>
<tr>
<th>Employment status</th>
<th>Current smokers</th>
<th>ENHA, 2006</th>
<th>GATS, 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Men</td>
</tr>
<tr>
<td>Employed</td>
<td>35.5</td>
<td>24.9</td>
<td>33.8</td>
</tr>
<tr>
<td>Unemployed</td>
<td>36.2</td>
<td>33.2</td>
<td>65.4</td>
</tr>
<tr>
<td>Inactive</td>
<td>18.1</td>
<td>12.5</td>
<td>15.4</td>
</tr>
</tbody>
</table>


Prevalence of Tobacco Consumption According to Educational Level

Both surveys show some relationship between years of schooling and the prevalence of tobacco consumption, with lower percentages of smokers among those with tertiary education; the prevalence is greater among persons with only basic or less educational attainment. The relationship is less clear when analyzing the data by sex, with women with only primary educational levels showing the lowest percentage after women with tertiary education.

Comparing the data from ENHA 2006 and GATS 2009 makes it possible to state that, between 2006 and 2009: i) the prevalence of smokers increased in both men and women who had only primary education; ii) the prevalence decreased among women with tertiary education and increased among men with that level of education; and iii) decreased among both men and women with intermediate educational levels (Table A.4.3).

Table A.4.3. Evolution of the percentage of current smokers (persons 25 years old and older), by educational level, Uruguay, 2006 and 2009.

<table>
<thead>
<tr>
<th>Educational level</th>
<th>Current smokers</th>
<th>ENHA 2006</th>
<th>GATS 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Men</td>
<td>Women</td>
<td>Total</td>
</tr>
<tr>
<td>Primary</td>
<td>33.0</td>
<td>15.4</td>
<td>23.3</td>
</tr>
<tr>
<td>Basic cycle</td>
<td>36.4</td>
<td>24.6</td>
<td>30.3</td>
</tr>
<tr>
<td>Secondary</td>
<td>29.2</td>
<td>22.0</td>
<td>25.5</td>
</tr>
<tr>
<td>Tertiary</td>
<td>18.3</td>
<td>17.9</td>
<td>18.0</td>
</tr>
</tbody>
</table>

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4 October 2006
http://www0.parlamento.gub.uy/distribuidos/AccesoDistribuidos.asp?Url=/distribuidos/
1 In the distribution by type of disease, deaths due to tobacco consumption account for 100%.

2 Members of the National Party, the main opposition party, had approximately 40% representation in Parliament.

3 The National Party and the Colorado Party

4 Youth 13-15 years old who attend middle school.

5 A 32-country comparison of tobacco smoke derived particle levels in indoor public places. A Hyland, MJ Travers, C Dressler et al. Tobacco Control 2008;17:159-165

6 The technical team responsible for the research validated the index.
Tobacco Control Policies in Argentina

MARÍA EUGENIA BARBIERI, FOR ARGENTINA’S MINISTRY OF HEALTH

This case study documents Argentina’s advancements in the design and implementation of tobacco control policies since the National Program for Tobacco Control (PNCT, for its Spanish acronym) was launched in 2003. Argentina’s experience shows how a country can make progress in implementing control measures, despite resistance and even when the country has yet to ratify the Framework Convention on Tobacco Control (FCTC). Three elements lie at the heart of these advances. On the one hand, the Ministry of Health engaged in a strategy that sought to work toward mobilizing, raising awareness among, and empowering other actors, both within the Ministry and in other State sectors. On the other, a myriad of civil-society organizations coordinated their work to continuously advocate for and inform on the importance of this issue. Finally, an approach of working with subnational-level to enact laws and ordinances that set forth recommended measures for tobacco control played a significant role.

Context

In Argentina, noncommunicable diseases (NCDs) account for 80% of deaths and 76% of the Disability-Adjusted Life Years (DALYs) (OMS, 2009). Tobacco consumption is responsible for 40,591 deaths a year, representing 13.6% of all deaths in persons older than 35. It is estimated that 111 persons die each day from tobacco consumption. Cancer accounts for 31% of deaths, followed by cardiovascular diseases (30%) and respiratory diseases (27%). Of the total deaths attributed to tobacco use, men account for 71% and women, for 29% (Pichon-Riviere et al., 2013).

According to disease-burden figures, an estimated 824,804 DALYs are lost each year due to tobacco use, with 35.5% representing premature mortality and 64.5% to lives lived with varying degrees of disability. While men sustain the greatest burden (67% of years of healthy life lost), the rising trend in tobacco consumption among women, especially younger ones, may shift this trend (Rossi et al., 2004). In addition, an estimated 926,878 quality-ad-
justed life years (QALYs) are lost each year. This total is the sum of years lost due to premature death (73%) and years of productive life lost due to disability (27%). The greater proportion of years of life lost due to premature death are due to lung cancer (23%), chronic obstructive pulmonary disease (21%), ischemic heart disease, and stroke (13%) (Pichon-Riviere et al., 2013).

Deaths from tobacco consumption could be prevented, however, provided that highly effective interventions be widely implemented. Indeed, there is strong evidence of the significant impact that strategies such as raising tobacco taxes, disseminating information about the risks of smoking, banning smoking in public places and work sites, outlawing tobacco advertising, and providing access to resources to reduce or eliminate tobacco consumption (OMS, 2011; Chaloupka et al., 2001).

Up to 2003, Argentina’s tobacco control had been weak, but this changed that year when the National Tobacco Control Program was launched. The Program rests on a comprehensive policy that reflects Argentina’s situation, dealing with the leading principles that determine the country’s high level of tobacco consumption: easy access to products, widespread positive images associated with smoking, high exposure to second-hand smoke, and the health services’ limited capacity to treat smokers.

Although the Program was launched, several tobacco control laws were rejected (Sebrie et al., 2005; Committee on economic, social and cultural rights, 2011). Moreover, even though the President signed the WHO Framework Convention on Tobacco Control (FCTC) in 2003, the Convention has yet to be ratified even after 31 bills to this end had been introduced in the National Congress (17 in the Senate and 14 in the Chamber of Representatives). Nonetheless, the Program has made some gains, such as the approval of tobacco control legislation at the provincial and municipal levels, and more recently, the enactment of National Law No. 26,687. Useful information also has been generated for decision-makers (such as epidemiological studies and research on the impact of interventions), and work has been undertaken on regulating access to cigarettes, promoting healthy lifestyles, creating smoke-free environments, and developing services to help those who want to stop smoking.

**Tobacco Consumption in Argentina**

In the last 14 years, tobacco consumption in Argentina has decreased: for example, in 1999, the Secretariat of Planning for the Prevention of Drug Abuse and the Fight against Drug Trafficking (SEDRONAR, for its Spanish acronym) estimated that 39.8% of the population 16–64 years old smoked. According to the National Surveys of Risk Factors (ENFR, for its Spanish acronym) conducted in 2005 and 2009, the prevalence of tobacco consumption declined from 29.7% in the first year to 27.1% in the second year, for a reduction of 8.8% in the intervening four years (Table 5.1). When persons over 65 were excluded, the prevalence was 30.1% in 2009, compared to 33.4% in 2005. In 2009, persons 25–34 years old had the highest prevalence of tobacco consumption, while in 2005, 18–24-year-olds showed the highest rate. Although smoking decreased in those under 49, there was an obvious increase among those over 50. The over-50 age group had the highest number of persons who quit using tobacco in both 2005 and 2009 (about 26%) (Ministry of Health, 2011, 2006).
Table 5.1. Prevalence of tobacco consumption, by age group, Argentina, 2005 and 2009.

<table>
<thead>
<tr>
<th>Year</th>
<th>Age groups</th>
<th>18 to 24</th>
<th>25 to 34</th>
<th>35 to 49</th>
<th>50 to 64</th>
<th>65 and older</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td></td>
<td>36.1</td>
<td>34.6</td>
<td>35.8</td>
<td>26.8</td>
<td>8.9</td>
<td>29.7</td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td>28.8</td>
<td>33.3</td>
<td>30.3</td>
<td>27.9</td>
<td>10.2</td>
<td>27.1</td>
</tr>
<tr>
<td>Var. %</td>
<td></td>
<td>-20.2</td>
<td>-3.8</td>
<td>-15.4</td>
<td>4.1</td>
<td>14.6</td>
<td>-8.8</td>
</tr>
</tbody>
</table>

Source: Author, based on data from the 2005 and 2009 National Risk Factor Surveys.

The 2012 Global Adult Tobacco Survey (GATS) shows that the prevalence of smoking among persons older than 18 decreased to 21.4%, equivalent to 700,000 fewer smokers than in 2009 and almost one million fewer smokers than in 1999. In considering the population older than 16, 22.3% of that age group stated that they consumed tobacco in 2012, with higher rates in males than in women (29.6% and 15.7%, respectively). Among cigarette smokers, most smoked daily (17.1%). The age group 25–34 years old was the age group with the highest rate of cigarette consumption (28.2%) (Ministry of Health, 2013).

Although consumption is declining among those over 18, tobacco consumption among adolescents is of great concern, because this group is considered a key market niche for the tobacco industry (Committee on economic, social and cultural rights, 2011). According to the results of the last Global Youth Tobacco Survey (GYTS) conducted in Argentina in 2012, 22.0% of adolescents between 13 and 15 years old smoke, and 43.7% said they had tried smoking it at least once. Of current smokers, 47.3% said they bought their cigarettes at a kiosk, store, or street vendor, and 81.5% were not denied the product because of their age. Further, it was observed that—unlike in adults—the highest prevalence among adolescents is among girls (20.2% in girls compared to 23.7% in boys) (Ministry of Health, 2013).

Another survey, conducted in 2002 by the Ministry of Health in five large urban centers (Buenos Aires, Rosario, Córdoba, Mendoza, and Tucumán) among school adolescents 12–18 years old, found that 3 out of every 10 were smokers at the time of the survey; the prevalence among girls was greater than among boys, and almost half who reported having tried cigarettes said they first smoked when they were 12 or 13 (Ministry of Health, 2002).

Argentina also has history of high levels of exposure to second-hand smoke. A 2002-2003 study of public areas in several Latin American cities found that Argentina (along with Uruguay) had the highest levels of exposure (Navas-Acien et al., 2002-2003). According to the ENFR 2009 survey, second-hand smoke exposure declined to 40.4%, from the 52.0% recorded in the ENFR 2005 survey. In 2009, the sites with greater exposure were bars and restaurants (46%), workplaces (28.9%), and homes (25.6%), levels that make it even more imperative to enact legislation to create 100% smoke-free environments. In fact, the survey showed that in jurisdictions that have such laws, exposure was lower. The 2012 Global Adult Tobacco Survey (GATS) shows a slightly higher percentage of exposure (46.8%), although this figure should be considered cau-
tiously, considering that it is an indicator that has methodological differences. Exposure in 2012 was greatest in nightclubs (86.2%), followed by universities (40.9%), public buildings (24.5%), restaurants (23.2%), and educational facilities (23.1%). Moreover, 31.6% reports being exposed at work and 33.0%, being exposed at home (Ministry of Health, 2013). According to results from the 2012 Global Youth Tobacco Survey (GYTS), 43.7% of adolescents (13–15 years old) was exposed to second-hand smoke at home, with levels of exposure decreasing compared to the 2007 survey (54.7%) (Ministry of Health, 2013).

The economic impact of the tobacco epidemic in Argentina

Tobacco consumption imposes a significant economic burden on the countries due to the cost of caring for the sick and the loss of productivity due to disease and premature death. It is estimated that in high-income countries, the annual cost of health care attributed to smoking can range from a 6% to a 15% of total expenditures in health (OPS, 2000).

In Argentina, it was estimated that the cost of care for tobacco-related diseases in 2003 was approximately US$ 1.5 million, which represents 15% of total health expenditures, greatly exceeding all tobacco taxes for that year, which amounted to US$ 848 million (Bruni, 2005), a daily expenditure of some US$ 4 million to treat pathologies linked to tobacco consumption. Moreover, figures for 2006 show that the cost of care soared to US$ 2.3 million, again exceeding the US$ 1.4 million collected in taxes that year (Ministry of Health, 2008).

Other estimates seek to quantify the cost of mortality attributed to tobacco in adults older than 35 based on the loss of productivity. In 2000, there were 39,131 deaths attributed to tobacco in persons older than 35 years, representing an annual cost from loss of future income (due to premature death) of US$ 469 million, implying an expenditure of US$ 14 pesos per inhabitant, or 0.17% of that year’s gross domestic product (GDP). By 2003, costs had increased to US$ 184 million, representing 0.14% of that year’s GDP (Conte Grand et al., 2003).

A recent study estimated that providing care for diseases directly attributed to smoking represent a cost equivalent to 1% of Argentina’s GDP and 12% of the overall amount spent on health each year. The leading determinants for this high cost were: heart disease, cancer, and chronic obstructive pulmonary disease (Pi-chon-Riviere et al, 2013).

Tobacco production in Argentina

In 2010, global tobacco production was 7.1 million tons: 80% is produced in China, India, Brazil, the US, Turkey, Zimbabwe, and Malawi (Ministry of Agriculture, Livestock, and Fishing, 2011). Argentina accounted for 2% of the global production and represented 4% of the international trade (Corradini et al., 2004).

The country’s tobacco production is mainly concentrated in the northwest and northeast, accounting for 90% of the cultivated areas in the provinces of Jujuy, Salta, and Misiones. According to the 2009/2010 harvest data, the roughly 133,000 tons produced were distributed as follows: Jujuy, 37.2%; Salta, 34.5%; Misiones, 22.1%; Tucumán, 4.2%; Corrientes, 0.9%; Catamarca, 0.6%; and Chaco, 0.4%. In monetary terms, the 2009/2010 harvest exceeded US$ 386.6 million, including the Special Tobacco Fund (FET) (see Box 1.1), 7.3% more than the surpassing the 2008/2009 harvest by 7.3% and nearly doubling the 2004/2005 har-
vest; almost 80% of the harvest was concentrated in Jujuy and Salta.

In Argentina’s tobacco-growing sector there are 17,243 farmers who employ 49,517 persons; 15% of the farmers in Jujuy and Salta account for 70% of the country’s tobacco production and almost half the planted area (Table 5.2). Information on the size of tobacco plantations shows that 95% of producers own under five hectares and 50% of the cultivated surface, while 1% of producers have 28% of the surface planted with tobacco and account for 37% of the production (Corradini et al., 2005).

### Table 5.2. Tobacco growing sector—production, labor, and producers, Argentina, 2009-2010 harvest.

<table>
<thead>
<tr>
<th>Province</th>
<th>Area (en hectares)</th>
<th>Production (Kg)</th>
<th>Value in millions of US$ (storage price + FET*)</th>
<th>Labor force employed in the tobacco sector</th>
<th>Tobacco sector producers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Planted</td>
<td>Harvested</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jujuy</td>
<td>19,625</td>
<td>19,625</td>
<td>49,461,487</td>
<td>153.8</td>
<td>11,220</td>
</tr>
<tr>
<td>Salta</td>
<td>22,061</td>
<td>21,434</td>
<td>45,864,600</td>
<td>149.2</td>
<td>12,517</td>
</tr>
<tr>
<td>Misiones</td>
<td>28,581</td>
<td>19,192</td>
<td>29,412,975</td>
<td>79.6</td>
<td>21,134</td>
</tr>
<tr>
<td>Tucumán</td>
<td>4,239</td>
<td>4,021</td>
<td>5,631,765</td>
<td>0.4</td>
<td>2,548</td>
</tr>
<tr>
<td>Corrientes</td>
<td>2,552</td>
<td>2,331</td>
<td>1,167,698</td>
<td>1.7</td>
<td>1,268</td>
</tr>
<tr>
<td>Catamarca</td>
<td>661</td>
<td>487</td>
<td>778,249</td>
<td>0.4</td>
<td>498</td>
</tr>
<tr>
<td>Chaco</td>
<td>575</td>
<td>575</td>
<td>543,214</td>
<td>1.4</td>
<td>332</td>
</tr>
<tr>
<td>Total</td>
<td>78,294</td>
<td>67,665</td>
<td>132,859,988</td>
<td>386.6</td>
<td>49,517</td>
</tr>
</tbody>
</table>

Source: Author’s calculations based on data from the Ministry of Agriculture, Livestock, and Fishing.

Note: FET = Special Tobacco Fund.

Argentina exports almost 80% of its tobacco (Ministry of Agriculture, Livestock, and Fishing, 2011). In 2010, exports totaled US$ 306 million and amounted to 67 million kg, for a decrease of 18.6% in value and 25.5% in volume compared to the 2009 figures. In 2011, the situation was reversed, with the value of exports increasing by 28.2% and the volume by 21.6%, totaling US$ 392.9 million and 82 million kg.
Figure 5.1. Trends in tobacco exports in millions of US$ and in millions of kg. Argentina, 2006–2011

Cigarette sales depend on such variables as price, the population’s income, information on risks, or a ban on smoking in public places. Over the last 20 years, consumption in the country has dropped (Figure 5.2), but there have been many fluctuations during this period. For example, in 2001, consumption soared during the economic crisis, then ended in 2003 when the National Tobacco Control Program was introduced. After two years of decline, consumption again rose in 2006. This was because the price of cigarettes dropped an average 8% that year (or 16.9% in real terms) and the population’s real income rose (Bruni, 2005). Finally, consumption dropped again, beginning in 2008. It should be noted that the increase that occurred in 2006 reinforced the need to levy taxes to increase the price of cigarettes and, thus, decrease sales.

Source: Author based on data from the Ministry of Agriculture, Livestock, and Fishing.
Argentina’s tobacco industry (cigarette production and sales) is highly concentrated and privately owned. There are only two companies—Nobleza Piccardo (linked to British American Tobacco) and Massalin Particulares (a Philip Morris subsidiary)—representing 37.2% and 62.8%, respectively, of the invoiced segment of the market (González Rozada, 2006). It is estimated that in 2009, tobacco cultivation contributed 0.2% to the that year’s GNP (Ministry of Agriculture, Livestock, and Fishing, 2011).4

In terms of employment, the cultivation of tobacco in its entirety (primary and secondary activities) employed 170,754 workers, or 1% of the employed population at the national level. Regarding cultivation, it accounts for an estimated 1.9% of employment in the seven tobacco growing provinces: 5.1% in Misiones, 4.3% in Jujuy, and 2.5% in Salta (see Figure 5.3) (Ministry of Agriculture, Livestock, and Fishing, 2011).
Figure 5.3. Importance of tobacco cultivation employment over total employment in the Argentinian provinces of Misiones, Jujuy, Salta, Tucumán, Catamarca, Corrientes, and Chaco, 2010.

Source: Author, based on data from the Ministry of Agriculture, Livestock, and Fisheries.

These data show the importance of the tobacco sector in Argentina’s economy, particularly in some provinces. This weight makes it a privileged position when attempts are made to negotiate tobacco control policies, because it can effectively oppose the development of such measures.

Box 5.1. Argentina’s Special Tobacco Fund (FET, for its Spanish acronym).

Tobacco cultivation began to be promoted in Argentina in 1967, when the Tobacco Technological Fund was created, originally as a temporary and emergency measure. The 1978 Decree No. 19,800 established the Special Tobacco Fund (FET), which made the tobacco promotion policy permanent. PET is financed through a tobacco excise tax, representing approximately 7% of the retail price of each cigarette pack.

According to the law, 80% of the tax collected is for price supports to tobacco producers, which represents a subsidy; the remaining 20% goes to retrofitting, and diversification plans in the tobacco-growing provinces. However, Argentina began to reduce the subsidy in 1997, when it signed the Agricultural Agreement of the World Trade Organization (WTO); this agreement mandated that the internal assistance must be reduced by 13% within 10 years, beginning in 1995. At present, Argentina cannot provide more than US$ 75 million a year in direct subsidies to tobacco-growing activities.

The funds collected are allocated to the tobacco growing provinces based on the value of tobacco production. The Fund’s revenues increased 214% between 2006 and 2011, amounting to US$ 276 million in that last year. Most of the resources go to Jujuy and Salta, which receive more than 60%.
The Ministry of Agriculture, Livestock, and Fishing enforces the FET. Its functions are to peg the price of the varieties of tobacco and transfer the collection of the FET to the provinces, which are in charge paying the surcharge directly to producers. It also uses the remaining balances to finance the sector’s retrofitting plans. These plans include credit to tobacco producers, technological inputs, market studies, maintenance of payment systems, purchase of capital goods, technical assistance, training courses and institution building.

On many occasions between 1984 and 2004, the Executive Branch tried to reduce the transfers to the FET. For example, Decree 455 of 1999 provided for a 12% reduction, and the 2001 budget stipulated a 50% reduction; however, none went into effect. On the contrary, in 2008, Law 26,467 established measures to compensate the agro-industrial chain, the regional economies that depend on tobacco production, and the fiscal collection for the potential damage caused by the tobacco control measures, increasing the amount of the FET. The law was submitted along with another regulation on health measures (file 0039-EP-2008, presented to the Chamber of Representatives) signed by the President and the Ministry of Health. The latter was not approved, however.


Taxes on tobacco

The tax structure on cigarettes affects their sales price to consumers. It is estimated that 67.9% of the cigarette price to consumers represents various taxes and specifically assigned contributions (González Rozada, 2006). Table 5.3 shows the various taxes and rates.

Table 5.3. Tobacco taxes, rates, and fund allocation.

<table>
<thead>
<tr>
<th>Tax</th>
<th>Rate</th>
<th>Allocation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>60%</td>
<td>Nation-Provinces</td>
</tr>
<tr>
<td>VAT*</td>
<td>21%</td>
<td>Nation-Provinces</td>
</tr>
<tr>
<td>Supplementary emergency</td>
<td>7%</td>
<td>Social Welfare Fund (National)</td>
</tr>
<tr>
<td>FET</td>
<td>7.35% + $0.2112 per 20-cigarette pack</td>
<td>Primary sector</td>
</tr>
<tr>
<td>Gross income</td>
<td>1.5%–3.5%</td>
<td>Provinces</td>
</tr>
</tbody>
</table>

Source: Ministry of Agriculture, Livestock, and Fishing.21

* Value-added tax

Internal taxes are a single-phase tax to the final manufacturer. They are established by Law No. 24,674 and have a 60% rate on the final price of cigarettes, excluding the value-added tax (VAT) and the Supplementary Emergency Tax. The VAT was established by Law No. 23,349 and applies to all phases of production and distribution. On cigarettes, it levies a 21% rate on factory prices, plus the distribution margin.
The Supplementary Emergency Tax was established by Law No. 24,625 to finance social programs (especially health programs) within the Rural Change Program and the Social-Livestock Program. The rate of this tax is 7% and it is applied to the retail price, including the rest of the taxes involved in the final price.

The FET is an earmarked contribution established by Law No. 19,800, and is designed to meet the economic and social needs of the tobacco areas by imposing a rate of 7.35% on the final price prior to the VAT, internal taxes, and supplementary emergency tax, plus $0.2112 per 20-cigarette pack. The tax on gross income is earmarked for provincial financing, and is paid by the company, retail distributor, and retail vendor. The rate ranges from 1.5% to 3.5%, depending on the jurisdiction where the sales occur.

The tobacco sector and the Executive Branch, through the Ministry of Economy, agree on semi-annual collection goals, which are met through the revenues from internal taxes, the VAT, supplementary emergency taxes, and FET. In recent years, the collection goals increased, due to large price increases, from 4.0 billion pesos to 7.6 billion pesos between 2006 and 2010 (González Rozada, 2012).

If the State’s revenues from cigarette taxes do not reach the goal, the tobacco companies pay the State for the difference between the goal and the amount collected. If the collected taxes exceed the goal, the excess is transferred to the next fiscal period. This agreement also establishes that the Ministry of Economy does not create or modify any tax, contribution, fund, or surcharge on tobacco (González Rozada, 2012).

The tobacco industry also contributes to revenues with other taxes, such as export rights that amount to 10% for non-finished products (de-stemmed tobacco, tobacco leaves) and 5% for value-added products (cigarettes, cigarillos), and the taxes on the companies’ profits.

Table 5.4 shows the revenue from taxes on tobacco from 2006 to 2010, which amounted to almost 28.500 million pesos, for an annual average of 5.700 million pesos, or US$ 1.652 million. Internal taxes have the greatest participation on the total revenues (66%). With regard to the revenue goals, the tobacco sector’s agreement with the Ministry of Economy set the amount at approximately 26,400 million pesos (from 2006 to 2010), which was exceeded by 900 million pesos, for a total of 27,296 million pesos.

Regarding earmarked distributions, the central government is the main beneficiary, taking 50% of total revenues, while the remaining half is distributed among the provinces (39%) and tobacco producers (11%), through FET resources.

Table 5.4. Fiscal resources generated by the tobacco sector (in millions of pesos and millions of US$, Argentina, 2006–2010).

<table>
<thead>
<tr>
<th>Tax</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal</td>
<td>2,717</td>
<td>3,021</td>
<td>3,641</td>
<td>4,323</td>
<td>5,081</td>
</tr>
<tr>
<td>VAT</td>
<td>380</td>
<td>423</td>
<td>509</td>
<td>605</td>
<td>711</td>
</tr>
<tr>
<td>Supplementary emergency</td>
<td>398</td>
<td>447</td>
<td>555</td>
<td>658</td>
<td>786</td>
</tr>
<tr>
<td>FET</td>
<td>363</td>
<td>413</td>
<td>486</td>
<td>763</td>
<td>1,016</td>
</tr>
<tr>
<td>Tax</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Total tax agreement</td>
<td>3,858</td>
<td>4,304</td>
<td>5,191</td>
<td>6,349</td>
<td>7,594</td>
</tr>
<tr>
<td>Profits</td>
<td>20</td>
<td>51</td>
<td>49</td>
<td>58</td>
<td>69</td>
</tr>
<tr>
<td>Export rights</td>
<td>77</td>
<td>84</td>
<td>109</td>
<td>139</td>
<td>118</td>
</tr>
<tr>
<td>Total National</td>
<td>3,955</td>
<td>4,439</td>
<td>5,349</td>
<td>6,546</td>
<td>7,781</td>
</tr>
<tr>
<td>Gross income</td>
<td>55</td>
<td>61</td>
<td>74</td>
<td>87</td>
<td>103</td>
</tr>
<tr>
<td>Total collection</td>
<td>4,010</td>
<td>4,500</td>
<td>5,423</td>
<td>6,633</td>
<td>7,884</td>
</tr>
<tr>
<td>In US$</td>
<td>1,305</td>
<td>1,445</td>
<td>1,715</td>
<td>1,779</td>
<td>2,015</td>
</tr>
<tr>
<td>Earmarked distribution</td>
<td>2006</td>
<td>2007</td>
<td>2008</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Central government</td>
<td>2,054</td>
<td>2,303</td>
<td>2,793</td>
<td>3,324</td>
<td>3,875</td>
</tr>
<tr>
<td>Provincial governments</td>
<td>1,593</td>
<td>1,784</td>
<td>2,144</td>
<td>2,546</td>
<td>2,993</td>
</tr>
<tr>
<td>Producers/FET</td>
<td>363</td>
<td>413</td>
<td>486</td>
<td>763</td>
<td>1,026</td>
</tr>
<tr>
<td>Total</td>
<td>4,010</td>
<td>4,500</td>
<td>5,423</td>
<td>6,633</td>
<td>7,884</td>
</tr>
</tbody>
</table>


### International context for tobacco control: the FCTC

WHO’s Framework Convention on Tobacco Control (FCTC), adopted on 21 May 2003 by the World Health Assembly, is the first international legal instrument to respond to the smoking epidemic, becoming an effective and cost-effective solution to reduce the disease, death, and economic damage from tobacco consumption.

The FCTC recommends actions to reduce the demand and the supply of tobacco. The provisions designed to tackle demand are organized along two broad lines: i) price and fiscal measures, and ii) non-price measures, such as protection against second-hand smoke; education, communication, training and awareness programs, restrictions on tobacco ads, sponsorship and promotion, and new labeling of tobacco products. Those related to supply include i) strengthening laws to control the illegal trade of tobacco products, ii) banning sales to minors, and iii) supporting economically viable alternative for tobacco growers. The FCTC also lists actions related to environmental protection, technical and scientific cooperation, and the exchange of information.

By January 2012, 174 countries—representing nearly 85% of the world’s population—had ratified the FCTC, committing themselves to adopt and implement the Convention’s measures. Argentina has yet to ratify the Convention.

### Development of smoking-control strategies in Argentina

The nature of Argentina’s tobacco control policies is complex, in that the sector carries an important social and economic weight, particularly in producer provinces.

A study published by Sebrié, Barnoya, Pérez-Stable, and Glantz (2005) found, after reviewing tobacco industry internal documents, newspapers, local magazines, and draft legislation, and after interviewing key actors...
(lawmakers, Ministry of Health personnel, and tobacco-control spokespersons), that very similar strategies were used in Argentina to try to stop legislation that included tobacco-control measures as were used in the United States and other countries. For example, they created a weak voluntary self-regulating code that eliminated television ads since 2003, proposed less stringent draft legislations that neutralized or diverted attention from the good initiatives, promoting instead programs such as “Courtesy of Choice” in order to avoid the 100% smoke-free environments and smoking prevention programs for young people, in order to avoid stricter measures. Reports on the negative economic effects of such policies also were disseminated (Chalopka, 2001).

Until 2002, smoking-control policies in Argentina were limited. In 2003, however, with the Ministry of Health’s launching of the National Tobacco Control Program, this trend was reversed, as comprehensive policy was developed that included strategic actions to address the main issues related to tobacco consumption. The Program is described below, along with progress attained in the laws it promoted.

The National Tobacco Control Program

In 2003, the Ministry of Health began to work actively to launch some of the measures in the FCTC, thanks to a clear political decision by the then minister, who wanted to address the problem. Thus, with the 2003 Ministerial Resolution 236 and funding from the VIGI+A Program, the National Smoking Prevention and Control Program was introduced to sensitize and empower the population, promote the FCTC’s ratification, and approve national laws. Later, through the 2006 Ministerial Resolution 1124, it became the National Tobacco Control Program whose activities would be funded by the Ministry of Health (Ministry of Health, 2006).

The program’s strategy rests on a comprehensive approach to tackle the leading determinants of tobacco consumption—easy access to tobacco products, widespread positive images associated with smoking, high exposure to second-hand smoke, and limited capacity of the health services to help individuals to stop smoking. The interventions that are put in place act on those determinants and are coordinated in order to address all three dimensions of the tobacco problem: primary prevention, cessation, and protection of passive smokers. These interventions include: i) regulating access to tobacco, ii) promoting a lifestyle without tobacco, iii) promoting and regulating smoke-free environments, and iv) developing services and incentives to help smokers stop. (National Tobacco Control Program, 2012). Since 2011, the program also is responsible for implementing the National Legislation, which requires the establishment of a national registry for recording demands and violators of the law.

The purpose of regulating access is to prevent individuals from ever starting to smoke and to reduce consumption through economic barriers and measures that control the way tobacco products are distributed. Specifically, it would increase the price of and tax on tobacco products, regulate the minimum size of the units sold, prevent the sale of loose cigarettes, ban sales by and to people under 18, and stop the sale through vending machines or other means that give children easy access.

The last three aspects were incorporated into National Law No. 26,867, although the law did not address the issue of prices and taxes. To address pricing and taxation, the Ministry has supported economic studies that estimate the price elasticity of cigarette consumption and
the effects on tax revenues. For example, a 2004 study conducted with PAHO support showed that long-term cigarette price-demand elasticity in Argentina was -0.265, which implies that a 10% increase in the sales price would reduce consumption by 2.65%. This result is similar to the one found in high-income countries (-0.25 to -0.50). As for the effects on fiscal revenues, it found that taxes could increase up to 102% and in so doing, improve tax revenues (González Rozada, 2006). The Ministry also promoted studies to follow up on draft legislation.

The promotion of a tobacco-free lifestyle disseminates messages that discourage tobacco consumption and prevent persons from ever starting to consume tobacco. Specifically, the goal is to set standards that restrict, as much as possible, advertising, promotion, or sponsorship of tobacco products; avoid misinformation aimed at consumers (such as using terms as “light” or “smooth” cigarettes); provide messages with strong health warnings on cigarette packs; disseminate messages to counter cigarette ads; recast smoking as an addiction; and incorporate smoking prevention and control of exposure to second-hand smoke into the educational system.

On the one hand, some of these issues were addressed in the National Law, such as banning misleading words such as “light” or “smooth,” and placing graphic health warnings on cigarette packs. On the other, the Ministry of Health is still working on other measures, such as the evaluation of different national, provincial, and municipal laws to totally ban tobacco ads, promotion, and sponsorship. Further, it continues to prepare and disseminate communication and teaching materials, conducts studies on tobacco marketing and ads, and organizes school competitions on the issue.

The Ministry of Health has also worked extensively to promote 100% smoke-free environments as a way to protect persons from second-hand smoke. In this regard, it has promoted the establishment of smoke-free environments in public and private institutions, collective-use spaces, transportation, and homes, and has set standards that ban smoking in work environments and enclosed public areas.

To this end, it has i) created a National Registry of Smoke-Free Companies and Institutions that in 2012 listed 1,252 subscribers, including private enterprises, municipalities, public agencies, schools, hospitals, and national universities; ii) trained multipliers and prepared good practices guides, manuals, and training or communications materials to encourage more institutions to establish smoke-free environments; iii) provided technical assistance to provinces and municipalities on how to introduce legislation on smoke-free environments; iv) disseminated information; and iv) conducted studies and evaluations on the creation of smoke-free environments, the public’s acceptance of them, and their benefits to health.

The National Program has cooperated with the Argentinian Network of Healthy Municipalities to promote smoke-free municipalities. To this end, it has provided training and technical and economic assistance so municipalities can meet the requirements to be considered 100% smoke-free. It also distributed materials at various events and devoted a section of its website to the creation of smoke-free municipalities.

The Essential Public Health Functions (Ephf) project also has provided funds. This initiative involves a consensual planning process between the central and the provincial governments as a way to continue making
progress through administrative commitments and incentives known as “public health activities” (PHA), which are based on the provinces’ specific needs and the national programs’ goals. This approach represents a results-based financial transfer from the central government to the provinces, based on their reaching the goals set in the health indicators.

Public Health Activity 45 serves to certify smoke-free environments. Under it, projects have been financed to bring more public institutions into the National Registry of Smoke-Free Institutions, particularly health and education facilities. This has been a crucial move; in the early stages, participating institutions came mainly from the private sector, and this effort highlighted the need to provide assistance to public institutions to bolster their efforts to implement these measures.

Finally, the National Program promotes smoking cessation, through efforts such as: i) establishing a free telephone service to help smokers quit; ii) launching “Quit and Win” contests; iii) setting up a Web page to support smokers who want to quit; iv) disseminating national guidelines on treatment of tobacco addiction, which have been endorsed by more than 35 national scientific institutions, academia, and professionals; v) training health teams on how to treat tobacco addiction; and vi) disseminating information to the general public.

These activities involve strategies that sustain the program, such as: (1) social, multisectoral, and intergovernmental participation; (2) mass communication; (3) education and training; (4) promotion of local projects; (5) the conduct of studies and research; and (6) surveillance. In broad terms, these strategies have generated three basic inputs for carrying out the program’s activities: (1) information to guide and evaluate decision-making; (2) a network of civil-society organizations, the scientific community, the media, and provincial and municipal health agencies working to support and expand program activities; and (c) public awareness and empowerment.

The National Tobacco Control Law

Enacting legislation is a basic step, which, combined with other simultaneous measures, lead to compliance with the Program’s four intervention areas. It was only until June 2011, however, and after various attempts, that the National Congress approved Law No. 26,687, which regulates the advertising, promotion, and consumption of tobacco products. The law’s key aspects include:

- Promoting 100% smoke-free environments by banning smoking in all public or private enclosed spaces, including casinos, bingos, bars, restaurants, theaters, museums, libraries, public transportation, covered stadiums, and workplaces.
- Banning advertising, promotion, and sponsorship of cigarettes or tobacco products in the media and on public thoroughfares.
- Including graphic health warnings and banning the use of misleading terms such as “light,” “smooth,” “low tar content.”
- Banning cigarette sales to minors, whether loose or in packs, in educational, health, or recreational establishments.

According to a Ministry of Health study, the full implementation and compliance with the measures set forth in National Law 26,687 could prevent 7,500 deaths due to coronary heart disease, 16,900 acute myocardial infarctions, and 4,400 strokes between 2012 and 2020. Annual percent reduction would be 3% for coronary heart disease, 3% for acute myocardial infarctions and 1% for stroke. While
this positive effect would reach all of society, the group that would derive the most benefit would be males under 55 years old, who are the age group that have the highest tendency for suffering from cardiovascular disease and suffer the greatest mortality from those diseases (Konfino et al., 2012).

**Provincial legislation and municipal ordinances**

The enactment of the National Law was a major step in advancing smoking-control policies, although many initiatives already had been introduced at the subnational level. For example, some provinces have had laws in place since the 1990s (Chubut in 1992 and Formosa in 1994, reviewed in 2011 after adhering to the National Law). Beginning in 2005, several provinces began approving smoking control laws with technical support from the Ministry of Health. Córdoba, Santa Fe, Tucumán, the City of Buenos Aires, Río Negro, Chaco, Corrientes, Tierra del Fuego, San Juan, and San Luis were the pioneering provinces. Altogether, 21 provinces out of 24 have tobacco control laws. The laws vary (see Annex 5.1). Overall, they promote smoke-free environments, but some also ban advertising, promotion, and sponsorship of tobacco products, or sales to minors. In terms of smoke-free environments, some provinces have enacted strict laws, such as Córdoba, Santa Fe, Tucumán, Neuquén, and the City of Buenos Aires (based on Law No. 3718 passed 2010). Some jurisdictions make exempt some locations, however, such as gambling rooms and casinos; entertainment sites that do not admit anyone under 18; mental health centers; prisons; reserved smoking areas in bars, restaurants, or coffeehouses; and smokers’ clubs. To a lesser extent, some laws allow establishments to define their smoking areas (for example, Santa Cruz lets industrial, commercial, or service establishments choose whether or not to apply the smoking ban). Fourteen provinces enacted articles about advertising, promotion, and sponsorship of tobacco products. Most prohibit direct or indirect ads and sponsorship during sports or cultural events; they also forbid the use of clothing that advertise the tobacco companies at those events. Legislation in some provinces, such as Río Negro, Santa Cruz, Catamarca, and Chubut, allow certain types of ads, provided they state that consuming tobacco harms health.

In addition, some municipalities have enacted smoke-free regulations, applied in 47 municipal ordinances (see Annex 5.2). Some initiatives have been successful, such as that of Bahía Blanca, in the province of Buenos Aires. That city launched a mass media campaign to announce that an ordinance was passed that would create 100% smoke-free environments and guarantee their compliance. Although the regulation was to be introduced gradually for different types of establishments, it would ultimately include all eating establishments, malls, bars, pubs, discotheques, and gambling rooms. For each stage, the issuance and its associated actions would be announced in the media. Before the end of the implementation process, the establishments were visited, materials on smoke-free environments were distributed, along with “no smoking allowed” posters, and awareness-raising sessions were held with those in charge to encourage their cooperation. Bahía Blanca is one of the Argentine jurisdictions with the highest level of compliance with the 100% smoke-free standard (ALIAR, 2011).
In some provinces that lack smoking laws, some municipalities have introduced ordinances, such as the capital city of Salta and Tala (Salta), San Salvador de Jujuy (Jujuy), and Jardín América (Misiones).

As a result of these actions, many provinces have consolidated their smoking control programs, promoting their application and compliance. For example, the city of Neuquén experienced a significant reduction in both exposure to second-hand smoke and respiratory symptoms (from 57.5% to 28.8%) and irritation (86.3% to 37.5%) after the law was introduced (Schoi et al., 2010). Further, a study shows that in Santa Fe province, there was a 28.3% reduction in hospitalizations for acute coronary syndrome after the smoke-free environment law was implemented (Ministry of Health, 2009). It was also shown that 100% smoke-free laws in the City of Buenos Aires, Córdoba, Santa Fe, and Tucumán have not negatively affected sales in bars and restaurants; in fact, in the City of Buenos Aires there may have been an increase in such sales (González Rozada et al., 2008).

**Box 5.2. When to apply national legislation and when to apply provincial laws, and municipal ordinances**

A basic legal principle holds that the standards from higher-level jurisdictions prevail over those from lower levels. If there were any incompatibility, the national standard prevails over the provincial law, or the provincial one prevails over the municipal one. Nevertheless, if the standards protect a human right, as with tobacco controls that protect health, according to the international treaties, the more protective measure is the one that holds sway.

As a result, it is understood that the National Tobacco Control Law No. 26,687 sets the standard, which means that in all provinces or municipalities without laws establishing 100% or a lesser degree smoke-free environments, the National Law must be applied. In provinces or municipalities that already have enacted laws, the highest standard regarding public health will prevail, be it national, provincial, or municipal.

*Source: Smoke-free Partnership-Argentina (ALIAR, for its Spanish acronym).*

**Discussions on the ratification of the Framework Convention**

Some studies suggest that the failure to ratify the FCTC was due to the tobacco industry’s lobbying strategies, pursued by tobacco producers, aimed at lawmakers and Ministry of Economy officials (Mejia et al., 2008; Barnova and Glantz, 2002). The industry’s arguments focused on the potential damage that ratifying the Convention would have on tobacco production, employment, and collection of the FET, which is considered as the small producers’ main support. These conclusions are based on interviews with key sector actors; and analysis of newspaper coverage, tobacco industry documents, and legislation and other documents presented to the National Congress (Mejia et al., 2008).

The arguments of those potentially affected can be inferred from legislation presented to
the National Congress. The Chamber of Representatives also submitted resolutions that asked for more information about the FCTC’s effects on tobacco production. In 2005 in particular (file: 3843-D-05), the Executive Branch was asked to analyze whether ratifying the FCTC would adversely affect Argentina’s tobacco producers or workers, and whether the Government had plans to provide support and financial aid to pursue alternative activities for tobacco growers (request report to the Executive Branch, 2005a). In the same year, another project (file: 4805-D-05) requested that the Executive Branch report on the number employed by the industry, the revenue obtained by the national treasury from cigarette taxes, and whether any measures existed to offset the effects that the FCTC could have on both (request report to the Executive Branch, 2005b).

In 2005, the Chamber of Senators presented nine initiatives requesting non-adherence to the FCTC (seven of the resolutions) or asking for additional information on the above-mentioned effects. For example, Draft Resolution 2868/05, submitted by 10 legislators, asked lawmakers to reject the FCTC, because it would affect tobacco production, eradicate tobacco farming, and negatively affect the FET (Draft Resolution, 2003).

The Ministry of Agriculture recently published a document (“Regional Impact of the FCTC: Quantification of the Economic and Social Impact in the Tobacco Producing Provinces”) that shows the economic and social relevance (in terms of production level, value chain, consumption, employment, tax collection, and exports) of tobacco cultivation in several provinces, claiming that all these factors would be affected if the FCTC were ratified (Ministry of Agriculture, Livestock, and Fishing, 2011).

The arguments outlined above make it possible to infer that the legislators’ decision to not ratify the FCTC was due to industry objections about the loss of the FET, viewed as the small producers’ main means of support, and the economic damage that reduced consumption would have on tobacco producers. However, some studies show that these arguments cannot be fully sustained (ALIAR, 2010).

According to a study conducted by the Torcuato Di Tella University, FET funds do not necessarily benefit small producers; rather, they are distributed based on the value of the production each province generates. For example, Salta and Jujuy, which are the major producers, receive two-thirds of the funds. But in these provinces, a few large producers account for most of the tobacco farming, so the FET benefits them, not the small farmers (Alonso et al., 2010). According to the most recent Ministry of Agriculture data, in 2011, 65.4% of FET resources were allocated to Salta (35%) and Jujuy (30.4%). These provinces account for 15.1% of total tobacco producers, with an average of 17.2 hectares planted per producer (13.0 in Salta and 21.4 in Jujuy), which is the highest in the country (Table 5.5).
Table 5.5. Distribution of Special Tobacco Fund (FET) monies (in millions of US$ and as a %), Argentina, 2011.

<table>
<thead>
<tr>
<th>Province</th>
<th>Execution of FET funds</th>
<th>Producers</th>
<th>Planted area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In millions of US$</td>
<td>Total</td>
<td>%</td>
</tr>
<tr>
<td>Salta</td>
<td>96.6</td>
<td>1,691</td>
<td>9.8</td>
</tr>
<tr>
<td>Jujuy</td>
<td>83.9</td>
<td>915</td>
<td>5.3</td>
</tr>
<tr>
<td>Misiones</td>
<td>67.9</td>
<td>11,310</td>
<td>65.6</td>
</tr>
<tr>
<td>Tucumán</td>
<td>12.4</td>
<td>1,582</td>
<td>9.2</td>
</tr>
<tr>
<td>Corrientes</td>
<td>9.9</td>
<td>1,414</td>
<td>8.2</td>
</tr>
<tr>
<td>Chaco</td>
<td>3.9</td>
<td>184</td>
<td>1.1</td>
</tr>
<tr>
<td>Catamarca</td>
<td>1.2</td>
<td>147</td>
<td>0.9</td>
</tr>
<tr>
<td>Total</td>
<td>275.9</td>
<td>17,243</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: Ministry of Agriculture, Livestock, and Fishing.

The Di Tella University study also estimates the effects that the control measures would have over the FET collections. According to projections, were a comprehensive policy to be implemented, FET collections would drop by 50% between 2005 and 2025. However, the amount in US dollars collected in 2025 would exceed that collected in 2005 by 23%. Further, these estimates suggest that it would be sufficient to increase the price of a pack of cigarettes by only US$ 0.30 in the next 15 years, in order to prevent FET revenues from dropping (Alonso et al., 2010).

Ratifying the FCTC would not bring about the end of the FET, either; in fact, the Fund has been limited since Argentina signed the World Trade Organization’s (WTO) Agricultural Agreement. According to this agreement, the country cannot earmark more than US$ 75 million annually in direct subsidies to tobacco-growers. For this reason, direct subsidies (amounts paid producers for surcharges) decreased in recent years and resources allocated toward modernizing programs for tobacco growers have increased (Alonso et al., 2010). These resources also could be used for retrofitting programs, as proposed by the Framework Convention’s in Article 17, which urges countries to foster economically viable alternatives for workers, farmers and, ultimately, small tobacco vendors.

Interestingly, although ratification could mean a reduced domestic consumption, this would not directly affect the producers’ income, because 80% of their tobacco harvest is exported. Moreover, the impact would not be immediate, since any change in consumption occurs in the medium- and long-term, giving producers time to adopt economically viable alternatives.

Other key actors: the Coalition for Ratifying the FCTC in Argentina

Civil-society organization has played an important role in advancing toward tobacco-control. On the whole, these organizations play five roles: advocacy, coalition building, information dissemination, compliance monitoring, and
service delivery (Mercet Champagne, et al., 2010). In Argentina, civil society has matured and worked effectively and collaboratively to counteract the tobacco industry’s lobbying (see Box 5.3).

**Box 5.3. Leading civil-society groups in Argentina.**

- Coalition for the Ratification of the FCTC by Argentina
- Argentinian Anti-Smoking Union (UATA, for its Spanish acronym)
- Argentinian Tobacco Association (AsAT, for its Spanish acronym)
- Smoke-Free Partnership—Argentina (ALIAR, for its Spanish acronym)
- Inter-American Heart Foundation Argentina (FIC-Argentina, for its Spanish acronym)

*Source:* Mercet Champagne et al., 2010.

The Smoke-Free Partnership-Argentina (ALIAR) is one of the most prominent entities. Created in 2007 as a coalition of more than 100 groups working to enact tobacco control legislation and, especially, establishing 100% smoke-free environments countrywide. In addition to medical organizations, it also includes human rights and environmental groups, as well as associations of health professionals and the catering sector, and communications organizations. It has contributed scientific evidence about the economic and health impacts of smoke-free environments, and has evaluated compliance with the standards by monitoring air quality and public opinion, positioning itself as a reliable source of information.

Other organizations also have made significant contributions to the development of activities for smoking control. For example, the Argentine Anti-Smoking Union (UATA), created in 1987 and with more than 300 members, advocates for new generations of non-smokers. It works through discourse and the dissemination of information to promote tobacco-control activities and coordinates educational activities and programs. The Argentinian Tobacco Association (AsAT), a scientific entity created in 2006, is composed of health professionals and others dealing with smoking from different perspectives (journalists, educators, public opinion makers, etc.). The Association is organized into commissions on education, the print media, youth, Web pages, bulletins, policies, and interinstitutional relations.

The Inter-American Heart Foundation-Argentina (FIC Argentina) also has played a part. Created in 2009, the Foundation is associated with the Inter-American Heart Foundation, a group that works in most of the Region’s countries. It works from a comprehensive view of public health and tackles projects through an interdisciplinary perspective (medicine, law, economy, and social work). It focuses on promoting legislation and public policies, and it also develops educational and training activities targeted at the community at large and at specific audiences such as the health sector, the media, and civil-society organizations. It also is involved in numerous research projects.

In December 2009, the Coalition for the Ratification of the FCTC was formed, representing a milestone in civil-society organization. The
coalition harnesses the efforts of nearly 70 NGOs and scientific associations that promote tobacco control, it works closely with the Ministry of Health’s National Tobacco Program and in developing a strategy to get the FCTC ratified.

**Discussions about the National Law**

The Coalition pursued a strategy based on advocacy, mass-media campaigns, training of journalists, public events, public demonstrations at the National Congress to demand ratification, and disseminating materials to lawmakers on why the issues linked to smoking are critical. These strategies bore fruit when Daniel Filmus, senator for the City of Buenos Aires, included the tobacco issue in his agenda and brought together civil groups, representatives of the National Program, physicians, economists, lawyers, and the tobacco companies in two hearings. In one, people affected by tobacco consumption also participated, describing the health problems they suffer due to their addiction to tobacco. On 16 February 2010, the senator proposed legislation to ratify WHO’s Framework Convention on Tobacco Control (file 3430/09). Tobacco industry lobbyists once again stopped the bill from being approved, however. They also presented the same arguments that misrepresented the FCTC, claiming that it would affect the regional economies, eliminate the FET, and ban tobacco production.

After this setback, the Coalition warned against such delays and about some lawmakers’ plans to propose weak tobacco control laws. It also requested interviews with the country’s president, minister of health, and heads of parliamentary blocs to enlist their support and commitment to the ratification of the FCTC and the approval of a strong national law on tobacco control.

Given industry’s historically close ties with lawmakers and the executive branch, the group also discussed the likelihood that the FCTC would not be ratified. It considered, instead, negotiating national legislation that included three health protection measures that were also within the FCTC: i) creating 100% smoke-free environments; ii) banning advertising, promotion, and sponsorship of and by tobacco products; and iii) having graphic health warnings on cigarette packs.

By addressing the legislation from a health perspective, and making it clear that the tobacco subsidy would not be eliminated, the cooperation between the tobacco industry (cigarette production and sale) and the producers was ruptured. And so, in June 2010, Senator Filmus submitted new draft legislation for a tobacco-control law, which received support from the National Program. This regulation rested on two previous draft legislations submitted by the Ministry of Health in 2006 and 2008.

Along with the 2010 proposed law, four more pieces of draft legislation were submitted, three from lawmakers representing tobacco provinces (Salta, Tucumán, and Jujuy), which included several concessions such as separate smoking areas, ventilation requirements for enclosed spaces (in bars and restaurants), minor warnings on cigarette packs (with no graphics), and only partial prohibitions on advertising.

Negotiations continued between smoking-control advocates and those who backed the weaker laws. Again, Coalition representatives worked with the senator’s advisors, insisting that smoke-free environments and graphic warnings on the packages were non-negotiable. They ultimately yielded on the issue of advertisements, however, which led to the following exceptions to Article 6 of the law:
Exceptions to the ban on advertising or promotion carried out:

a. within points of sale or retailing of tobacco products, in accordance with the provisions of the regulation of the present law;

b. in commercial publications targeted solely to people or institutions involved in the growing, manufacture, import, export, distribution, deposit, and sale of tobacco products;

c. through direct communications to persons over 18 years old, if and when prior consent has been obtained and his/her age has been confirmed.

This is precisely one of law’s weakest features, because it leaves the law open to interpretation, especially regarding inset “c,” on the direct communication with those older than 18. This provision does not align with the FCTC’s recommendations, nor does the lack of regulation on tobacco taxes and prices. Moreover, the law does not ensure that smoking-cessation programs or adequate treatment for tobacco dependency will be in place, nor does it prevent the tobacco industry from interfering with tobacco control policies. Finally, it does not include sustainable alternatives for tobacco farming and environmental protection.

Moreover, the FCTC considers that it is critical to enlist international cooperation on technology transfer, knowledge, financial assistance, technical assistance, research, monitoring, and information exchange. It also emphasizes the cooperation among national organizations, and regional and international intergovernmental groups in the effort to control illegal tobacco sales, advertising, and the promotion of smoking across national borders.

The adoption of the National Law is not a substitute for ratifying the FCTC. That said, however, the law does represent a huge step in developing smoking-control policies in Argentina, especially after long years of advocating such a measure. Even though the FCTC has yet to be ratified and even without a national legislation (as of 2011), activities have been implemented that decreased smoking prevalence by 18% between 1999 and 2012—the equivalent of some one million fewer smokers. This decrease is also seen in the adolescent population, according to the Global Youth Tobacco Survey. The implementation of various smoke-free provisions has decreased the exposure to second-hand smoke, especially in bars and restaurants. In addition, a national surveillance system has been developed within the Ministry of Health, which has made it possible to implement the Global Youth Tobacco Survey; Argentina is one of four Latin American countries that has done so. Finally, these gains should be viewed as important, even without the ratification of the FCTC, and should give an idea of the additional benefits that the country’s public health would gain if this international convention were to be ratified.

Lessons learned

The main lesson to be drawn from Argentina’s experience is that progress can be made in advancing tobacco-control policies even in light of difficulties, such as the meager support from other departments and the importance that the tobacco sector has in the country, especially in some provinces. Working at subnational governmental levels (a bottom-up strategy), obtaining the cooperation and support of other organizations, and launching public awareness campaigns for 10 years made it possible to obtain significant gains, despite the roadblocks. It also shows that, even without the FCTC measures being adopted, laws were enacted to cre-
ate 100% smoke-free environments in many locales.

While there are some issues still pending, efforts to date have led to the creation of multisectoral and multidisciplinary networks (such as the Coalition for the Ratification of the FCTC), empowered actors who can create greater demands for action, and signed provincial, municipal, and national laws.

**Conclusions**

Tobacco consumption in Argentina is responsible for 40,000 deaths a year and the loss of 824,804 DALYs. Although overall smoking declined the last 14 years, tobacco use among adolescents is a matter for serious concern. In addition, a study estimated that diseases associated with tobacco consumption represent 15% of national health expenditures, far greater than the tobacco taxes collected in the year of the study.

Tobacco-control policies in Argentina have been historically weak. This began to change in 2003, however, when the National Tobacco Control Program was created, in order to develop a comprehensive policy that seeks to have an effect on the leading consumption determinants: easy access, widespread positive images associated with tobacco consumption, high exposure to second-hand smoke, and the health services’ low capacity to treat smoking-related disorders or to promote smoking-cessation programs.

Since the Program was introduced, much progress has been made in tobacco control. There have been 100% smoke-free environments created, studies have been conducted that have contributed valuable information for the Program’s management, tobacco-control legislation has been enacted in most provinces and in several municipalities, smoking-cessation services have been strengthened, a national tobacco law has been adopted, and sensitization and awareness-raising activities on the issue have been carried out.

Civil society organizations, with support from the Ministry of Health, also have played a significant role in the fight against tobacco for many years. Their work has included advocacy, coalition building, information dissemination, surveillance, and service delivery. In particular, they have played a key role in getting the National Law approved, working through a coalition of associations that have fought for implementing measures to combat the tobacco epidemic.

Argentina’s experience is an example of how controls can be introduced, even in the face of resistance and even though the FCTC had not been ratified. Key to the success was the Ministry of Health’s strategy to mobilize, sensitize, and empower other actors; reaching out to other players through such entities as MERCOSUR’s Intergovernmental Commission; and coordinating the work of organizations that have long advocated for, cooperated in, and informed about the importance of addressing this issue. The strategy has also been key at the provincial and local levels, generating various laws and ordinances that set forth tobacco control measures.

Challenges remain, however, such as ratifying the FCTC, banning all forms of tobacco advertising and sponsorship, designing a tax policy that increases the price of tobacco products to decrease consumption and dissuade youths from starting in the most effective way possible. That said, the actions undertaken over the past 10 years have opened the way for a more optimistic scenario in which to discuss tobacco-control future measures.
## Annex 5.1. Provincial laws for tobacco control, Argentina.

<table>
<thead>
<tr>
<th>Province</th>
<th>Law No.</th>
<th>Year</th>
<th>Smoke-free environments</th>
<th>Tobacco advertising, promotion, and sponsorship</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ciudad de Buenos Aires (CABA)</strong></td>
<td>1,799 modified by Law 3718 of 2010</td>
<td>2005 and 2010</td>
<td>Bans smoking in public and private enclosed spaces but allows reserving certain areas for smoking, such as party rooms, dance venues, restaurants, bars or cafeterias, and shopping malls/galleries. With the approval of Law Nº 3718, CBA establishes 100% smoke-free environments.</td>
<td>Banning of ads and government sponsorship of the CBA events that encourage tobacco consumption or that associate smoking with improved sports performance.</td>
</tr>
<tr>
<td><strong>Córdoba</strong></td>
<td>9,113</td>
<td>2005</td>
<td>Bans smoking in public-sector premises, factories, health and education institutions (public and private), recreation and entertainment areas for children, public transportation, theaters, cinemas, concert halls, enclosed sports stadiums, and restaurants. There are no exceptions.</td>
<td>Banning of ads that associate smoking with sports performance, their posting in public agencies, recreational spaces, student media, and free distribution of samples.</td>
</tr>
<tr>
<td><strong>Santa Fe</strong></td>
<td>12,432</td>
<td>2005</td>
<td>No person may smoke or hold lighted tobacco products in enclosed interior areas of any workplace, public or private. This includes public buildings, whether or not they offer services to the public, and all public or private agencies, whatever their purpose (health, educational, commercial, cultural, services, etc.). Means of public transportation are also included. There are no exceptions.</td>
<td>Banning all direct and indirect ads, sponsorship of sports and cultural events, and participants wearing clothing that advertises companies associated with tobacco.</td>
</tr>
<tr>
<td><strong>Tucumán</strong></td>
<td>7,575</td>
<td>2005</td>
<td>Smoking is banned in health and education facilities (public and private), public agencies, enclosed or semi-enclosed entertainment settings, public transportation, and all enclosed public or private settings (e.g., museums, banks, cinemas, bars, theaters, stores, etc.). There are no exceptions.</td>
<td>Adjusted to the terms of National Law 23,344</td>
</tr>
</tbody>
</table>

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*a* Includes a wide variety of indoor and outdoor spaces, including public and private buildings.
<table>
<thead>
<tr>
<th>Province</th>
<th>Law No.</th>
<th>Year</th>
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<th>Tobacco advertising, promotion, and sponsorship</th>
</tr>
</thead>
</table>
| Province of Buenos Aires<sup>a</sup> | 13,894 modified by Law 14,381 of 2012 | 2008 and 2012 | Smoking is banned in all enclosed spaces in public agencies, workplaces in general, public transportation, and private spaces with access to the public.  
Exempted are smokers’ clubs and cigar stores, outpatient mental health centers and detention centers.                                                                                                      | Banning of ads and promotion in the media, public thoroughfares, and in all public spaces. Ads are exempted within points of sale and in publications related to the sector.  
Patronage and sponsorship of sports, recreational, and cultural events are prohibited, as is the wearing of clothing with tobacco ads in these events.                                                                 |
| Entre Ríos             | 9,862                            | 2008      | Smoking is banned in all public or private enclosed environments with access to the public. It also includes common areas in enclosed settings: hallways, stairs, restrooms, and foyers.  
Exempt from this prohibition are mental health centers with inpatient facilities, prisons and penitentiaries, casinos and gambling sites, party rooms (when exclusively used for private events), and tobacco tasting points of sale. | —                                                                                                                                                                                                                                                                                                                                 |
| La Rioja<sup>b</sup>   | Law 7,525 of 2003, modified by Law 8,870 of 2010 | 2010      | Smoking is banned in all public sector areas, in enclosed places in private areas with access to the public (e.g. health care centers, theaters, cinemas, etc.), and in public transportation. There are no exceptions.                                                                 | Subject to National Law 23,344. Ads are banned that associate smoking with sports performance.  
Ads are banned in public agencies as are tobacco promotion and ads in amusement parks, plazas, parks, fairs, exhibits and/or sports events open to persons under 18 years old.                                                                                                     |
<table>
<thead>
<tr>
<th>Province</th>
<th>Law No.</th>
<th>Year</th>
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</thead>
<tbody>
<tr>
<td>Mendoza</td>
<td>7,790</td>
<td>2007</td>
<td>Smoking is banned in any enclosed space (public or private) that has access to the public. Exempted are mental health centers and detention centers, party rooms when used for private functions, gambling/game rooms under the provincial gambling and casinos authority, and private gambling rooms and casinos.</td>
<td>—</td>
</tr>
<tr>
<td>Neuquén</td>
<td>2,572</td>
<td>2007</td>
<td>Smoking is banned in all enclosed areas of public administration buildings and vehicles, any enclosed establishment (commercial, industrial or service sector) used by the public, and in all public transportation. There are no exceptions.</td>
<td>—</td>
</tr>
<tr>
<td>Río Negro</td>
<td>Law 3,986 of 2005, modified by Law 4,714 of 2011</td>
<td>2005 and 2011</td>
<td>Smoking is banned in public sector agencies (whether or not they provide services), in private entities with customer services, in places where food is handled and sold, in public transportation, in areas where flammable substances are handled, in television programs, and in eateries or entertainment centers.</td>
<td>All ads that associate smoking with improved sports performance are banned. All tobacco ads or promotions in any media must state that tobacco consumption is detrimental to health and is addictive.</td>
</tr>
<tr>
<td>Chaco</td>
<td>3,515</td>
<td>2005</td>
<td>Smoking is banned in public sector offices, public transportation, public and private entertainment sites, industrial, commercial, and service establishments that people visit may opt to permit or ban smoking, stating this clearly at the buildings’ entrances.</td>
<td>All ads related to tobacco consumption must comply with National Law 23,344.</td>
</tr>
<tr>
<td>Corrientes</td>
<td>5,537</td>
<td>2004</td>
<td>Smoking is banned in public sector offices and premises, medical care centers, exhibition rooms, convention sites, museums, banks, educational establishments, waiting rooms, and public transport. However, authorities (of public and private offices) may establish areas where people can smoke.</td>
<td>—</td>
</tr>
<tr>
<td>Province</td>
<td>Law No.</td>
<td>Year</td>
<td>Smoke-free environments</td>
<td>Tobacco advertising, promotion, and sponsorship</td>
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<tr>
<td>Tierra del Fuego</td>
<td>175</td>
<td>2004</td>
<td>Smoking is banned in all areas of public sector agencies whether or not they offer services to the public, and in means of transport. Each agency may designate an area where smokers can smoke, but must place a sign stating that cigarette smoking is detrimental to health.</td>
<td>—</td>
</tr>
<tr>
<td>Formosa&lt;sup&gt;a&lt;/sup&gt;</td>
<td>1,103</td>
<td>1994 and 2011</td>
<td>Smoking is banned in public sector establishments, those offering patient care, public transportation, enclosed and semi-enclosed entertainment places, and places that sell fuel. When technical conditions regarding the safety, health, and respect for non-smokers allow, a smokers’ area may be designated, with highly visible signs. Adjusts provisions of Article 2 of National Law 23,344</td>
<td></td>
</tr>
<tr>
<td>San Juan</td>
<td>7,595</td>
<td>2005</td>
<td>Smoking is banned in public administration and public corporation offices and premises, in public transportation, in enclosed premises for public use, and signs must be displayed warning that “In this place, smoking is prohibited according to Law No. 7595.” The Executive Branch may stipulate exceptions.</td>
<td>—</td>
</tr>
<tr>
<td>Santa Cruz&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2,964</td>
<td>2007</td>
<td>Smoking is banned in all enclosed areas of public sector agencies (although smoking areas may be designated), in public transportation, recreational areas (e.g. cinemas, theaters, stadiums), educational and health establishments (public and private), television programs, and workplaces with flammable substances. Direct and indirect ads that target people under 18 are banned, along with sponsorship of sports and cultural events by tobacco companies; clothing worn by participants may not contain tobacco ads. All tobacco ads, promotion, and sponsorship not prohibited by the Law, must contain health warnings.</td>
<td>—</td>
</tr>
<tr>
<td>Province</td>
<td>Law No.</td>
<td>Year</td>
<td>Smoke-free environments</td>
<td>Tobacco advertising, promotion, and sponsorship</td>
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<tr>
<td>Catamarca</td>
<td>5,223</td>
<td>2007</td>
<td>Smoking is banned in public buildings, private agencies that provide services, health and education centers, public transportation, restaurants, bars, cafeterias, bus terminals, shopping malls, theaters, cinemas, cultural centers, among others. Exempted are places of general public use, and dance venues where those under 18 are not allowed in. Restaurants and bars may set aside a maximum of 30% of the area for smokers.</td>
<td>Banning of all ads that associate smoking with improved sports performance. Any tobacco ad or promotion must state that tobacco is detrimental to health and causes addiction.</td>
</tr>
<tr>
<td>Santiago del Estero</td>
<td>6,962</td>
<td>2009</td>
<td>Smoking is banned in public and private enclosed spaces where there is public access. Mental health and detention centers, smokers’ clubs, party rooms for private functions, and entertainment sites authorized by the province which do not allow entrance to people under 18 are exempted. These areas must have ventilation systems.</td>
<td>—</td>
</tr>
<tr>
<td>San Luis</td>
<td>IX-0326 in 2004 and subsequent approval in 2010 of Law No. III-073</td>
<td>2004 and 2010</td>
<td>Smoking is banned in public sector establishments, educational and health facilities, private places of a public nature (e.g. malls and stores, restaurants, bars, discotheques, supermarkets, and libraries, among others), and in public transportation. Penitentiary centers, prisons, and police detention sites are exempted.</td>
<td></td>
</tr>
<tr>
<td>Province</td>
<td>Law No.</td>
<td>Year</td>
<td>Smoke-free environments</td>
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<tr>
<td>La Pampa</td>
<td>2,563</td>
<td>2010</td>
<td>Smoking is banned in workplaces, clubs, auditoriums, malls, places that handle food, public transportation, elevators, telephone booths, ATMs, enclosed urban spaces, areas where flammable substances are handled, and social welfare or recreation centers frequented by people under 18. Areas designated for smokers at workplaces, mental health centers and detention centers where smoking areas can be designated, and smokers’ clubs are exempted.</td>
<td></td>
</tr>
<tr>
<td>Chubut</td>
<td>3,775</td>
<td>1992</td>
<td>Smoking is banned in public sector establishments, educational and health facilities, public transport, and in the presence of children and pregnant women.</td>
<td>All tobacco promotions must prominently state that “Smoking is Detrimental to Health.”</td>
</tr>
</tbody>
</table>

Source: Author; based on information in provincial legislation.

* Health warnings are not included.

* Sales to persons younger than 18 years old is forbidden.

<table>
<thead>
<tr>
<th>Province</th>
<th>Ordinances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corrientes (2)</td>
<td>Corrientes (capital)–Curuzú Cuata</td>
</tr>
<tr>
<td>Chaco (1)</td>
<td>Barranqueras</td>
</tr>
<tr>
<td>Chubut (3)</td>
<td>Esquel–Trelew–Puerto Madryn</td>
</tr>
<tr>
<td>Entre Ríos (5)</td>
<td>La Paz – Santa Rosa de Villaguay–Gualeguaychú–Urdinarrain–Chajari</td>
</tr>
<tr>
<td>Jujuy (1)</td>
<td>San Salvador de Jujuy</td>
</tr>
<tr>
<td>La Pampa (1)</td>
<td>Santa Rosa</td>
</tr>
<tr>
<td>Mendoza (2)</td>
<td>Mendoza (capital)–Lavalle</td>
</tr>
<tr>
<td>Misiones (1)</td>
<td>Jardín América</td>
</tr>
<tr>
<td>Neuquén (1)</td>
<td>Neuquén (capital)</td>
</tr>
<tr>
<td>Salta (2)</td>
<td>Salta–Tala</td>
</tr>
<tr>
<td>San Juan (5)</td>
<td>Angaco–San Juan Capital–Caucete–Calingasta–Rivadavia</td>
</tr>
<tr>
<td>San Luis (3)</td>
<td>Juana Koslay–Mercedes –Villa Merlo</td>
</tr>
<tr>
<td>Santa Cruz (1)</td>
<td>Río Gallegos</td>
</tr>
<tr>
<td>Tierra del Fuego (2)</td>
<td>Río Grande–Ushuaia</td>
</tr>
</tbody>
</table>

Source: Ministry of Health.
References

ALIAR. Por qué Argentina necesita el Convenio Marco para el Control del Tabaco. Documento informativo. Available at: http://www.aliarargentina.org/images/stories/Documentos/fact_sheet_por_que_arg_necesita_el_cmct.pdf (last accessed on 8 April 2013).


———. Ejecución mensual del presupuesto del FET - Ejercicio 2011.

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OPS. La epidemia de tabaquismo. Los gobiernos y los aspectos económicos del control


Notes


2. Prevalence is defined as those who have consumed more than 100 cigarettes in their lifetimes and currently smoke

3. The study assessed the direct cost of caring for diseases attributed to tobacco. Among the mortality considered were deaths from lung cancer, chronic obstructive pulmonary disease, acute myocardial infarction, and stroke (CVA), which represented almost 70% of all the deaths attributed to smoking.

4. In 2002, three multinationals (Japan Tobacco, Philip Morris, and British American Tobacco) controlled the tobacco market; their combined income was over US$ 121 billion. This amount is greater than the combined GDPs of Albania, Bahrain, Belize, Bolivia, Botswana, Cambodia, Cameroon, Estonia, Georgia, Ghana, Hon-

5 The VIGI+A Program was a Ministry of Health program designed to strengthen surveillance and disease control, as well as promote health; it had World Bank financing.

6 To be incorporated in the registry, an institution must meet the following requirements: (1) all of its enclosed spaces must be smoke-free, and smoking is banned not only in enclosed spaces, but also in open areas near the buildings’ air vents; (2) all the institution’s vehicles must be smoke-free; (3) all institution events must be smoke-free; (4) all institutional levels (employees, managers, owners) and visitors (suppliers, clients, etc.) must comply with the regulation; (5) no tobacco products are to be sold in the premises (kiosks or internal bars); and (6) there are to be no ash-trays, except at the institution’s entrances so that smokers can discard cigarette butts. Accreditation is valid for two years.

7 Municipalities must meet the following requirements: have an ordinance creating 100% smoke-free public space; make all its buildings and facilities 100% smoke-free; ban the sale of tobacco in its buildings and facilities; require that all its events be smoke-free; exercise leadership in tobacco control; and periodically carry out media campaigns to promote tobacco-free environments and lifestyles.

8 Available at: http://www.msal.gov.ar/tabaco/index.php/informacion-para-profesionales/ambientes-libres-de-humo/municipios

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