Physical Activity, Sedentary Time, and Obesity in an International Sample of Children

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ABSTRACT


Methods: The sample included 6539 children age 9–11 yr. Times in MVPA, VPA, and sedentary behaviors were assessed by accelerometer. The body mass index (BMI; kg m$^{-2}$) was used to classify children as obese based on z-scores ($\geq +2$ SD) from World Health Organization reference data.

Results: The mean (SD) times spent in MVPA, VPA, and sedentary behavior were 60 (25) min d$^{-1}$, 18 (11) min d$^{-1}$, and 513 (69) min d$^{-1}$, respectively. The overall proportion of the sample that was obese ranged from 5.2% to 24.6% across sites. The odds ratios for obesity were significant for MVPA (0.49; 95% CI, 0.44–0.55), VPA (0.41; 0.37–0.46), and sedentary time (1.19; 1.08–1.30) in the overall sample. The associations of MVPA and VPA with obesity were significant in all 12 sites, whereas the association between sedentary time and obesity was significant in five of the 12 sites. There was a significant difference in BMI z-scores across tertiles of MVPA ($P < 0.001$) but not across tertiles of sedentary time in a mutually adjusted model. The results of receiver operating characteristic curve analyses for obesity indicated that the optimal thresholds for MVPA (area under the curve [AUC], 0.64), VPA (AUC, 0.67) and sedentary behavior (AUC, 0.57) were 55 (95% CI, 50–64) min d$^{-1}$, 14 (11–16) min d$^{-1}$, and 482 (455–535) min d$^{-1}$, respectively.

Conclusions: Greater MVPA and VPA were both associated with lower odds of obesity independent of sedentary behavior. Sedentary time was positively associated with obesity, but not independent of MVPA. Attaining at least 55 min d$^{-1}$ of MVPA is associated with lower obesity in this multinational sample of children, which supports current guidelines. Key Words: OVERWEIGHT, PEDIATRICS, EPIDEMIOLOGY, LIFESTYLE, INTERNATIONAL

Global physical activity guidelines as well as those for the United States call for a minimum of 60 min d$^{-1}$ of moderate-to-vigorous physical activity (MVPA) for health benefits in school-age children (32,33). These guidelines are largely based on evidence linking physical activity and outcomes such as physical fitness, bone health, and markers of cardiovascular and metabolic health in childhood (32,33). Recent reviews indicate that the cross-sectional association between physical activity and adiposity is modest in children (11,22) and that further research is required to determine the amount of physical activity needed to prevent the development of excess adiposity during childhood (22).

In addition to the health-enhancing effects of physical activity, recent studies have shown a negative association between sedentary behaviors (sitting, TV viewing, etc.) and health outcomes in adults (9,25). The available evidence...
also indicates an association between sedentary behavior, especially TV viewing, and health in children and youth (18,26). Given that only a weak association exists between MVPA and sedentary behavior (20), it is important to better understand the independent effects of these behaviors on obesity in children.

Most existing evidence on associations between physical activity, sedentary behavior, and obesity in children has relied on subjective (self-reported) measures of the exposure variable (11). Although largely limited to North America and Europe, the objective assessment of physical activity and sedentary behavior using accelerometry has recently allowed for large-scale studies to examine associations with health status in children (1,6).

Given the lack of comparative objective data on the relationship between physical activity, sedentary behavior and obesity in international samples, the purpose of this study was to examine the associations of MVPA, vigorous physical activity (VPA) and sedentary behavior with obesity in 9- to 11-yr-old children from countries that differ in stages of epidemiologic transition, and to identify the optimal thresholds of MVPA, VPA and sedentary time that are associated with obesity.

METHODS

Study design. The International Study of Childhood Obesity, Lifestyle and the Environment (ISCOLE) is a cross-sectional, multinational study designed to determine the relationships between lifestyle behaviors and obesity in children in 12 study sites located in Australia, Brazil, Canada, China, Colombia, Finland, India, Kenya, Portugal, South Africa, United Kingdom, and the United States. These countries represent a range of economic development (low to high income) and human development index (0.509 in Kenya to 0.929 in Australia) (12). The institutional review board at the Pennington Biomedical Research Center (coordinating center) approved the overarching protocol, and the institutional/ethical review boards at each participating institution also approved the local protocol. Written informed consent was obtained from parents or legal guardians, and child assent was also obtained as required by local institutional/ethical review boards before participation in the study.

The standardization of the study protocol across sites, a rigorous system of training and certification of study personnel, the use of a Web-based data entry system, and centralized data management and analysis at the coordinating center ensured the quality of data collected (12). Data were collected from September 2011 through December 2013.

Participants. The ISCOLE study includes 7372 children age 9–11 yr. However, a total of 31 participants were missing data on body mass index (BMI) and a further 802 participants were missing data from accelerometry, resulting in an analytic sample size of 6539. Participants with missing BMI or accelerometry data did not differ in age from the analytic sample, but those missing accelerometry had a higher mean BMI z-score (0.62) compared to the analytic sample (0.46).

The primary sampling frame was schools, and this sampling frame was typically stratified by an indicator of socioeconomic status to maximize variability within sites (12). By design, the within-site samples were not intended to be nationally representative.

Measurements. Times spent in MVPA, VPA, and sedentary behavior were obtained from 24-h waist-worn accelerometer. An Actigraph GT3X+ accelerometer (Pensacola, FL, USA) was worn at the waist on an elasticized belt on the right mid-axillary line. Participants were encouraged to wear the accelerometer 24 h day−1 (removing only for water-related activities) for at least 7 d (plus an initial familiarization day and the morning of the final day), including weekend days. We have previously shown that this protocol increases wear-time compliance compared to previous studies; and overall, the mean wear time at the US ISCOLE site was 22.6 h day−1 (30). The minimal amount of accelerometer data that was considered acceptable for inclusion in the sample was 4 d with at least 10 h of waking wear time per day, including at least one weekend day. After exclusion of the total sleep episode time (2,29) and nonwear time (any sequence of at least 20 consecutive minutes of zero activity counts) (16), MVPA was defined as all activity 574 or more counts per 15 s, VPA was defined as activity 1003 or more counts per 15 s, and sedentary time was defined as all movement 25 or less counts per 15 s (8,28).

Body height and body mass were measured using standard procedures across all study sites. Body height was measured without shoes using a Seca 213 portable stadiometer (Hamburg, Germany), with the head in the Frankfurt Plane. Body mass was determined with a portable Tanita SC-240 scale (Arlington Heights, IL, USA), after all outer clothing and shoes were removed. Each measurement was repeated, and the average was used for analysis (a third measurement was obtained if the first two measurements were greater than 0.5 cm or 0.5 kg apart for height and body mass, respectively, and the average of the two closest measurements was used in analyses). Body mass index (kg m−2) was calculated, and BMI z-scores were computed using age- and sex-specific reference data from the World Health Organization (4). Participants were classified as obese (BMI z-score > +2 SD) or nonobese (BMI z-score ≤ +2 SD).

Statistical analysis. Means and SD were computed for variables by study site and by sex for participants with complete measurements. Differences between boys and girls were determined using unpaired t-tests for continuous variables. Associations between MVPA, VPA, sedentary time, and obesity (0, no; 1, yes) were assessed in odds ratios calculated using generalized linear mixed models (SAS version 9.3, PROC GLMMIX). Study sites were considered to have fixed effects, and schools nested within study sites were viewed as having random effects. The denominator degrees of freedom for statistical tests pertaining to fixed effects were calculated using the Satterthwaite approximation (30).
were calculated using the Kenward and Roger approximation (13). Times in MVPA, VPA, and sedentary time were standardized, such that odds ratios are expressed per SD of each variable (MVPA, 25 min; VPA, 10 min; sedentary time, 70 min). Mean daily waking wear time was included as a covariate in all models, and in all models that included both boys and girls, sex was also included as a covariate. A subsequent linear mixed model (PROC MIXED) was used to examine the combined effects of MVPA and sedentary time on BMI z-scores, with both MVPA and sedentary time categorized into sex-specific tertiles.

Receiver operating characteristic (ROC) curves were used to select thresholds of MVPA, VPA, and sedentary time associated with obesity. The area under the curve (AUC) is considered a measure of the use of the predictor variable and represents the trade-off between the correct identification of high-risk (obese) individuals (sensitivity) and the correct identification of low-risk (nonobese) individuals (specificity). An AUC of 1 indicates the ability to perfectly distinguish between obese and nonobese participants, whereas an AUC of 0.5 indicates no greater predictive ability than chance alone.

The optimal threshold was determined from the Youden index (21), which is the maximum value of \( J \):

\[
J = \text{ sensitivity} + \text{ specificity} - 1
\]

Statistical significance of differences in AUCs between MVPA, VPA, and sedentary time was assessed by using the nonparametric approach of DeLong et al. (5).

In addition to the primary analyses, two sets of sensitivity analyses were conducted. First, the associations were reanalyzed using the MVPA threshold of Treuth et al. (27) (3000 counts per minute) rather than the Evenson et al. (8) threshold used in the primary analysis. Previous work has shown that the prevalence of obesity is similar among children when comparing the WHO growth reference versus the United States Centers for Disease Control and Prevention (CDC) cut points (24). However, as an additional sensitivity analysis, the associations in the present study were reanalyzed after reclassifying participants as obese and nonobese using the CDC age- and sex-specific BMI thresholds (≥95th percentile) (14).

Data management and calculations for statistical inferences were conducted using SAS version 9.3 (SAS Institute, Cary, NC). The ROC analyses and comparisons of ROC curves were performed using MedCalc Statistical Software version 13 (MedCalc Software bvba, Ostend, Belgium). The level of significance was set at \( P < 0.05 \).

RESULTS

The mean (SD) waking wear time in the sample was 14.8 (0.9) h d\(^{-1} \), which ranged from 14.1 to 15.2 h d\(^{-1} \) across the 12 sites. The descriptive characteristics of the study sample are provided in Table 1, stratified by study site. The mean (SD) age of the total sample was 10.4 (0.6) yr, and the mean (SD) times spent in MVPA, VPA, and sedentary behavior were 60 (25) min d\(^{-1} \), 18 (11) min d\(^{-1} \), and 513 (69) min d\(^{-1} \), respectively. The mean MVPA time ranged from 45 min d\(^{-1} \) in China to 71 min d\(^{-1} \) in Kenya and Finland, the mean VPA time ranged from 13 min d\(^{-1} \) in India and China to 23 min d\(^{-1} \) in Finland, and the mean sedentary time ranged from 477 min d\(^{-1} \) in Australia to 565 min d\(^{-1} \) in China. The overall proportion of obese participants was 12.4% and ranged from 5.2% to 24.6% across the sites. Table 2 presents descriptive characteristics of boys and girls. Overall, boys and girls did not significantly differ in mean height, body mass, or BMI; however, BMI z-scores were significantly greater in the boys than in the girls. Furthermore, the boys spent significantly more time in MVPA and VPA; whereas the girls spent significantly more time in sedentary behaviors.

Figure 1 presents the combined associations of MVPA and sedentary time with BMI z-scores. In both boys and girls, there was a significant decreasing trend for BMI z-scores across increasing tertiles of MVPA (\( P < 0.001 \)), but the trend across tertiles of sedentary behavior was not significant. Similar trends in BMI z-score were observed across tertiles of VPA and sedentary time (results not shown).

<table>
<thead>
<tr>
<th>Country (site)</th>
<th>No. of Participants</th>
<th>Mean (SD)</th>
<th>BMI (kg m(^{-2} ))</th>
<th>Sedentary Time (min d(^{-1} ))</th>
<th>MVPA (min d(^{-1} ))</th>
<th>VPA (min d(^{-1} ))</th>
<th>Obesity* (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australia (Adelaide)</td>
<td>225 266</td>
<td>10.7 (0.4)</td>
<td>144.7 (7.2)</td>
<td>39.8 (9.3)</td>
<td>18.8 (3.3)</td>
<td>477 (60)</td>
<td>56 (23)</td>
</tr>
<tr>
<td>Brazil (Sao Paulo)</td>
<td>241 252</td>
<td>10.5 (0.5)</td>
<td>143.7 (7.3)</td>
<td>41.1 (11.9)</td>
<td>19.7 (4.4)</td>
<td>500 (69)</td>
<td>59 (26)</td>
</tr>
<tr>
<td>Canada (Ottawa)</td>
<td>216 306</td>
<td>10.5 (0.4)</td>
<td>143.7 (7.1)</td>
<td>38.1 (9.2)</td>
<td>18.3 (3.3)</td>
<td>511 (63)</td>
<td>59 (19)</td>
</tr>
<tr>
<td>China (Tianjin)</td>
<td>261 240</td>
<td>9.9 (0.5)</td>
<td>141.3 (7.1)</td>
<td>38.2 (11.0)</td>
<td>18.9 (4.2)</td>
<td>565 (68)</td>
<td>45 (16)</td>
</tr>
<tr>
<td>Colombia (Bogota)</td>
<td>422 435</td>
<td>10.5 (0.6)</td>
<td>137.7 (7.0)</td>
<td>33.6 (7.0)</td>
<td>17.6 (2.5)</td>
<td>500 (67)</td>
<td>68 (25)</td>
</tr>
<tr>
<td>Finland (Helsinki, Espoo, and Vantaa)</td>
<td>231 269</td>
<td>10.5 (0.4)</td>
<td>142.2 (6.6)</td>
<td>37.1 (7.3)</td>
<td>17.7 (2.6)</td>
<td>531 (68)</td>
<td>71 (26)</td>
</tr>
<tr>
<td>India (Bangalore)</td>
<td>254 299</td>
<td>10.4 (0.5)</td>
<td>141.2 (6.8)</td>
<td>36.1 (8.5)</td>
<td>18.0 (3.3)</td>
<td>516 (67)</td>
<td>49 (21)</td>
</tr>
<tr>
<td>Kenya (Nairobi)</td>
<td>232 267</td>
<td>10.2 (0.7)</td>
<td>139.1 (7.4)</td>
<td>33.7 (8.3)</td>
<td>17.2 (3.1)</td>
<td>496 (66)</td>
<td>71 (31)</td>
</tr>
<tr>
<td>Portugal (Porto)</td>
<td>305 381</td>
<td>10.4 (0.3)</td>
<td>143.5 (6.8)</td>
<td>40.4 (9.2)</td>
<td>19.5 (3.4)</td>
<td>551 (62)</td>
<td>56 (22)</td>
</tr>
<tr>
<td>South Africa (Cape Town)</td>
<td>184 284</td>
<td>10.3 (0.7)</td>
<td>138.2 (7.4)</td>
<td>34.7 (9.0)</td>
<td>18.0 (3.6)</td>
<td>487 (65)</td>
<td>65 (26)</td>
</tr>
<tr>
<td>United Kingdom (Bath and NE Somerset)</td>
<td>211 267</td>
<td>10.9 (0.5)</td>
<td>145.0 (7.2)</td>
<td>39.2 (8.6)</td>
<td>18.5 (3.0)</td>
<td>497 (60)</td>
<td>63 (22)</td>
</tr>
<tr>
<td>United States (Baton Rouge)</td>
<td>203 288</td>
<td>9.9 (0.6)</td>
<td>140.9 (7.5)</td>
<td>37.9 (10.3)</td>
<td>18.9 (3.9)</td>
<td>521 (62)</td>
<td>50 (19)</td>
</tr>
</tbody>
</table>

Data are shown as mean (SD).

Sedentary time, MVPA, and VPA were measured with accelerometry and were defined as time spent at ≤25 counts/15 s, ≥574 counts/15 s, and ≥1003 counts/15 s, respectively.

*Obesity defined as BMI z-score > +2 from the WHO reference (4).
were measured with accelerometry and were defined as time spent at

Data are shown as mean (SD) unless otherwise stated. Sedentary time, MVPA, and VPA
data were measured with accelerometry and were defined as time spent at

In the boys (65 min

AUC for both MVPA and VPA

In the total sample and in both boys and girls, the

disorders demonstrated that time spent in MVPA was

was similar (0.27; 95% CI, 0.23–0.33), and the association be-

between MVPA and obesity remained significant in all 12 study

The results support the conclusion of the 2008 Physical

obesity was similar for MVPA (0.47; 95% CI, 0.42–0.53), VPA (0.38; 95% CI, 0.34–0.43), and sedentary time (1.18; 95% CI, 1.07–1.32) in

The results confirm the relationship between MVPA and obesity in US children

were measured with accelerometry and were defined as time spent at

The overall threshold for MVPA was

The overall threshold for VPA

between MVPA and obesity in children, and

The overall threshold for VPA was

between MVPA and obesity in different cul-

were measured with accelerometry and were defined as time spent at

The overall threshold for MVPA was

were measured with accelerometry and were defined as time spent at

was lower than the AUC for both MVPA and VPA ($P < 0.001$), and the AUC

The overall threshold for MVPA was

was significantly lower than the AUC for

was significantly lower than the AUC for

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

between MVPA and obesity was significant in all 12 study

and geographical settings. The relationship between sedentary time and obesity is weaker, not inde-

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

Results from the National Institute of Child Health and Hu-

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

Table 3. In the total sample and in both boys and girls, the

Figure 2 shows odds ratios for assessing the associations of

between MVPA and obesity across the

were measured with accelerometry and were defined as time spent at

between MVPA and obesity across the

FIGURE 1—Combined associations between MVPA, sedentary

between MVPA and obesity across the

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

were measured with accelerometry and were defined as time spent at

between MVPA and obesity in this multinational sample of children,

between MVPA and obesity in children, and

between MVPA and obesity in this multinational sample of children,

between MVPA and obesity in children, and

between MVPA and obesity in this multinational sample of children,

between MVPA and obesity in this multinational sample of children,

between MVPA and obesity in this multinational sample of children,
commercial devices such as wrist band physical activity monitors have proliferated in the marketplace (15). Whereas current physical activity recommendations were largely informed by studies relying on self-reported measures of physical activity, objective data such as those reported in the present study have the potential to inform future physical activity guidelines with real-world significance. However, there is a need for independent validation of new devices as they come into the market to ensure they are measuring what they purport to measure.

The results of the present study also support data from regional multinational studies that have objectively measured physical activity by accelerometry. Although limited to European children, time spent in MVPA was significantly inversely associated with body fatness (sum of skinfolds) in 1292 nine- to 10-yr-old children from four countries in the European Youth Heart Study (7). Results of cluster analyses among 766 10- to 12-yr-old European children participating in the ENERGY study indicated that both higher MVPA and lower sedentary time in girls was associated with lower BMI; however, MVPA was the dominant correlate in boys (3). Furthermore, ROC curve analyses among 2094 adolescents from the HELENA study in Europe identified an optimal threshold of 55 min·d⁻¹ for differentiating obese from normal weight youth, and their thresholds were similarly higher in the boys (56 min·d⁻¹) compared to the girls (49 min·d⁻¹) (17). This sex difference in physical activity levels associated with obesity has also been reported when using steps per day as a metric (31). The underlying mechanism for this sex difference is not understood; however, girls tend to have higher levels of percent body fat for a given BMI percentile (10), which could influence the associations with physical activity. The results of the present multinational study extend those of these smaller studies that were limited to European context and confirm that MVPA is a robust correlate of obesity in multiple economic and geographic settings.

The finding in the present study that time spent in MVPA was more consistently related to obesity than time spent in sedentary behavior supports results from the International Children’s Accelerometry Database (ICAD; n = 20,871), which indicated that MVPA, but not sedentary time, was associated with cardiometabolic risk factors, including waist circumference (6). The ICAD analysis provides a wealth of important information, although it is limited to data from studies conducted in the United States, Europe, and Brazil using different protocols (6). The present study expands upon these data by the use of a standardized protocol across the 12 sites from five different world regions and confirms that MVPA is more strongly related to obesity than sedentary behavior among 9- to 11-yr-old children. The reason for the lack of association between sedentary time and obesity

### TABLE 3. Results of ROC curve analyses for the associations among MVPA, VPA, sedentary time, and obesity in 6539 9- to 11-yr-old children.

<table>
<thead>
<tr>
<th></th>
<th>AUC (95% CI)</th>
<th>Youden Index</th>
<th>Threshold, min·d⁻¹ (95% CI)</th>
<th>Sensitivity (%)</th>
<th>Specificity (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MVPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys (n = 2985)</td>
<td>0.68 (0.67–0.70)</td>
<td>0.267</td>
<td>65 (55–75)</td>
<td>70</td>
<td>57</td>
</tr>
<tr>
<td>Girls (n = 3554)</td>
<td>0.66 (0.64–0.68)</td>
<td>0.246</td>
<td>49 (43–62)</td>
<td>70</td>
<td>55</td>
</tr>
<tr>
<td>Total (n = 6539)</td>
<td>0.64 (0.63–0.65)</td>
<td>0.207</td>
<td>55 (50–64)</td>
<td>65</td>
<td>55</td>
</tr>
<tr>
<td>VPA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys (n = 2985)</td>
<td>0.72 (0.70–0.73)</td>
<td>0.327</td>
<td>20 (16–22)</td>
<td>80</td>
<td>52</td>
</tr>
<tr>
<td>Girls (n = 3554)</td>
<td>0.68 (0.67–0.70)</td>
<td>0.280</td>
<td>11 (9–13)</td>
<td>62</td>
<td>66</td>
</tr>
<tr>
<td>Total (n = 6539)</td>
<td>0.67 (0.66–0.68)</td>
<td>0.247</td>
<td>14 (11–16)</td>
<td>63</td>
<td>62</td>
</tr>
<tr>
<td>Sedentary time</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys (n = 2985)</td>
<td>0.58 (0.56–0.60)</td>
<td>0.126</td>
<td>482 (455–554)</td>
<td>72</td>
<td>41</td>
</tr>
<tr>
<td>Girls (n = 3554)</td>
<td>0.57 (0.56–0.59)</td>
<td>0.113</td>
<td>497 (449–534)</td>
<td>74</td>
<td>38</td>
</tr>
<tr>
<td>Total (n = 6539)</td>
<td>0.57 (0.56–0.58)</td>
<td>0.101</td>
<td>482 (455–535)</td>
<td>75</td>
<td>35</td>
</tr>
</tbody>
</table>

*AUC significantly lower for sedentary time versus both VPA and MVPA, and AUC significantly lower MVPA versus vigorous physical activity in boys, girls, and the total sample (all P < 0.001). Comparison of ROC curves following the methods of DeLong et al. (5).*
in some countries is not known. Television viewing is one type of sedentary behavior that has been more strongly associated with obesity in children than global measures of overall sedentary time (26). Television viewing may be a more prominent activity in the developed countries, where an association was found (Australia, Canada, Colombia, South Africa, and the United States), which may partially explain the greater associations observed in these countries. However, more research is required to better understand associations among indicators of specific sedentary behaviors and health outcomes such as obesity.

The results of the sensitivity analyses indicate that similar associations with obesity are obtained when using different MVPA thresholds or different definitions of obesity. We chose to use the Evenson et al. (8) MVPA threshold for our primary analysis, as a 15-s epoch may be more appropriate than a 60-s epoch to capture the sporadic nature of children’s activity, and it provides the best classification accuracy among the currently available thresholds for sedentary, light-, moderate-, and vigorous-intensity activity in children and adolescents (28). Furthermore, we chose to use the WHO BMI thresholds given that this is an international study of children from five world regions. However, the consistency of the results when using the CDC BMI thresholds is encouraging and suggests that our results may be comparable to other studies that have used the CDC thresholds.

This study has several strengths and limitations that warrant discussion. A marked strength is the large diverse sample of children from study sites from every world region, which varied in their prevalence of obesity, MVPA, VPA, and sedentary behavior. This served to increase the variability among the dependent and independent variables and increased the generalizability of the results. Hence, the results strongly indicate that the associations seen between physical activity and obesity are robust and not related to certain types of cultures, races, or geographical settings. An additional strength is the rigorous standardization of the protocol across all study sites, which included the use of the same anthropometric equipment and the same model of accelerometer to objectively monitor physical activity and sedentary behavior at all study sites. Furthermore, all data management and analysis were centrally conducted at the coordinating center, which assured consistency in data handling and interpretation.

The cross-sectional design of this study limits conclusions regarding cause-and-effect relationships and the direction of the associations observed. Furthermore, we cannot exclude the possibility that unmeasured confounding variables may explain some of the observed relationships. The results for MVPA and VPA were very consistent across the study sites, but it is not known whether lower levels of physical activity are the cause or the consequence of obesity in this sample of children. We objectively assessed physical activity and sedentary behavior using accelerometry; however, a limitation of this approach is the inability to quantify some physical activities such as cycling and swimming. It should be noted that the optimal threshold (identified as 55 min$^{-1}$ of MVPA in this study) may vary according to the method and algorithm used in classifying physical activity intensity and hence the threshold should be regarded as showing the approximate magnitude rather than an exact value. Finally, we used a threshold of 25 or less counts per 15 s to quantify time spent in sedentary behavior. Although this is commonly used threshold that is related to sitting in children during school hours (23), it does not measure “sitting” per se nor time spent in specific sedentary behaviors such as TV viewing; rather, it captures nonmovement and time spent in low-intensity movements. Further research using devices that capture postural in addition to intensity is required to better quantify sedentary behavior in children.

In conclusion, higher levels of MVPA and VPA were associated with lower odds of obesity in this multinational sample of children, independent of sedentary behavior. Attaining at least 55 min$^{-1}$ of MVPA seems to be associated with lower obesity, which supports guidelines that call for 60 min$^{-1}$ of MVPA in childhood. The implementation of a standardized protocol across countries that vary widely in economic and epidemiologic transition highlights the robustness of the relationship between physical activity and obesity in children.

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