The International Association for the Study of Obesity
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19 April 2012

World Health Organization
Geneva
Switzerland

Dear Sir / Madam,

RE: Comprehensive global monitoring framework for NCDs

Thank you for the opportunity to comment on the draft global framework for monitoring noncommunicable diseases (NCDs) (second WHO discussion paper, version dated 22 March 2012).

IASO is a non-governmental body in official relations with the WHO. In this document we make some general comments on the framework but focus predominantly on the obesity component where our expertise lies.

Summary

Our recommendations are similar to those made by the WHO Collaborating Centre for Obesity Prevention at Deakin University, with some additional points (shown in italics).

A. Include **'Environments'** in Table 1
B. Widen **'Health system response'** in Table 1 to **'Multi-sector response'** *We particularly wish to emphasise the need for cross-sectoral action in tackling chronic disease and obesity, with WHO taking the lead.*
C. Include a target for **'Childhood overweight and obesity'**
D. Note that the monitoring efforts by WHO and Member States will be complemented by other monitoring efforts such as those conducted by civil society

General comments

1. **Importance of the NCD monitoring framework**. This is an enormously important and long-overdue initiative and we are extremely supportive of the development of a comprehensive framework.

2. **Need to give greater prominence to overweight/obesity**. Since this framework will be in place for many years, it must have an eye on future trends in NCD prevalence. Among all NCDs and associated risk factors, overweight/obesity and its close partner, type 2 diabetes, stand out from the rest as having increasing prevalence trends in virtually all countries. They are clearly the most difficult to control (since even wealthy countries are not achieving this). Thus, they should be given particular prominence within the monitoring framework.

3. **Include environments.** Currently the framework is focused predominantly on downstream aspects (i.e. health outcomes) and some behavioural risk factors. The more upstream determinants of health are only touched on briefly, and environments are totally absent from the framework. There is almost universal agreement that environments are the biggest determinants of behaviours and thus behaviourally-related NCDs. *This is recognised and emphasised in the UN High Level Meeting Political Declaration 66/2, particularly paragraph 43, and needs to be brought into the monitoring framework document explicitly and comprehensively.* For obesity, the concept of increasingly obesogenic environments

(especially food environments) as the drivers of the rise in obesity is widely accepted [1]. The omission of environments from the framework is a major problem as it greatly diminishes their apparent importance. While there is clearly an imperative to keep the workload and complexity of the framework manageable for Member States, especially low-and middle-income countries (LMICs), the framework is meant to be comprehensive. The flip side of the axiom 'what gets measured gets done' is that if something is omitted it is not acted upon. Accordingly, the framework needs to highlight the monitoring of environmental aspects as an important component. We suggest that Table 1 is modified to include a heading '**Environments**'. This could have examples of:

- Food environments: food composition, food marketing, food labelling, food availability, and food prices
- Physical activity environments: walkability, safety, access to public transport, walking and cycling infrastructure, and recreation spaces and amenities.

It would be of great value to have environments specifically identified in this document as being part of a 'comprehensive' framework even if WHO is not recommending that Member States measure environments as part of core indicators or targets. This is because it is likely that other sectors, such as civil society, may take up this role. Indeed, the Global Strategy for Diet, Physical Activity and Health calls upon all sectors to work on reducing NCDs, and public interest civil society (including academia) have been charged by WHO with a particular responsibility for supporting monitoring and advocacy efforts [2]. In particular, the inclusion of a reference to the monitoring of environments within a 'comprehensive' WHO framework would greatly assist the work of an emerging global academic network which will be monitoring food environments (see INFORMAA below).

It is noted that the incorporation of 'environments' in Table 1 (which is just headed as 'examples') does not necessarily mean that it needs to appear in Figure 1, just as other indicators, such as morbidity, appear in Table 1 but not in Figure 1.

Broaden 'Health system response'. WHO NCD background documents refer to the need for a multi-sector, societal response to NCDs [3]. Since most of the determinants of ill health lie outside the health system, most of the solutions lie outside the health system. While indicators of health system responses may be the most accessible for WHO and health ministers in Member States, the wider government and non-government responses needed to address NCDs should be acknowledged. The footnote to Table 1 that aims to explain that the term 'health systems' is intended to be broader than just the health sector does not adequately communicate the wider multi-sector approach that WHO has consistently called for. *We believe that WHO can do more to use this monitoring framework document as an opportunity to bring other sectors into the monitoring process, and WHO can then show this activity when the UN reports on 'options for strengthening and facilitating multisectoral action' as requested from WHO in the Political Statement paragraphs 61 and 64. These paragraphs highlight the need for WHO to lead the process across the other agencies and sectors to develop policies and monitor results.*
Since Table 1 is an example of a national framework, and not binding on the content of Figure 1, we recommend that the term 'Health system response' be changed to 'Multi-sector response' and the bullet points could be:

- Government actions and capacity: infrastructure, policies and plans, access to key health-care interventions and treatments, partnerships

[1] Swinburn BA, Sacks G, Hall KD, McPherson K, Finegood DT, Moodie ML, et al. The global obesity pandemic: shaped by global drivers and local environments. Lancet 2011;378(9793):804-14
[2] World Health Organization. Global strategy on diet, physical activity and health: A framework to monitor and evaluate implementation. Geneva: World Health Organization; 2006
[3] World Health Organization. Global status report on noncommunicable diseases 2010. World Health Organization. *2008–2013 Action plan for the global strategy for the prevention and control of noncommunicable diseases*. Geneva: World Health Organization; 2008

- Private sector actions: food reformulation, food marketing, communications to consumers, employee health promotion, and not undermining public health efforts
- *Actions by regional and international governmental organisations and agencies: monitoring indicators of environments relevant to NCDs and the drivers and risk factors associated with NCDs*
- Civil society actions: monitoring, research, advocacy, workforce training

The adoption of a wider perspective on responses to NCDs would better align with the evidence, would be more concordant with previous WHO documents, and would stimulate other sectors to contribute to WHO's monitoring framework (e.g., see INFORMAA below). The experience from the monitoring approaches for HIV/AIDS suggests that having both government and civil society (including academia) involved in monitoring makes the indicators more robust [4].

4. **Terminology: Voluntary Global Targets.** Table 3 sets out the proposed global targets. These will be agreed upon (or not agreed upon) as the measures of success at a global level. The word 'voluntary' does not logically apply in this context. What is 'voluntary' is country level targets, since the absolute levels of mortality and risk factors will vary greatly by country. We suggest that the word 'voluntary' is reserved for national targets and is dropped from the descriptor for global targets.

Specific comments on overweight/obesity

We attach for your interest the targets which our organisation proposed for the UN High Level Meeting (annex 1). This did not include a specific target for obesity prevalence, and for the monitoring framework document we would like to support a target for child obesity as follows:

5. **Target for reductions in childhood overweight/obesity:** We strongly recommend that a target be set for childhood (including adolescent) overweight and obesity. We recommend that a target is set as follows:

   Sustained downward trend in the prevalence of overweight and obesity in under-5s and school-aged children (national target); reduce by *at least* 10% by 2025 (global target)

   This meets the criteria set out by WHO for target setting:

   <u>High epidemiological and public health relevance</u>
   There has been a dramatic rise in childhood (including adolescent) overweight and obesity in the past few decades, and this is likely to continue, especially in LMICs [5]. For most middle-income countries and many low-income countries, childhood overweight now exceeds childhood underweight. For some high-income countries, the prevalence appears to be plateauing [6] and in some cases reducing [7]. This means that examples of effective public health responses are emerging as benchmarks. Furthermore, divergent trends in high-income countries and LMICs will compound existing health inequalities.

   The tracking of childhood obesity into adult obesity and the adult consequences of obesity are well documented. What is less widely appreciated is the significant reductions in quality of life among obese children, especially in the social, physical and emotional domains. Reductions of approximately 5% in quality of life shown in obese children and adolescents [8] are about

[4] United Nations General Assembly Special Session on HIV/AIDS. Monitoring the Declaration of Commitment on HIV/AIDS. Guidelines on construction of core indicators, 2010 Reporting
[5] Swinburn BA, Sacks G, Hall KD, McPherson K, Finegood DT, Moodie ML, et al. The global obesity pandemic: shaped by global drivers and local environments. Lancet 2011;378(9793):804-14
[6] Olds TS, Tomkinson GR, Ferrar KE, Maher CA. Trends in the prevalence of childhood overweight and obesity in Australia between 1985 and 2008. Int J Obes 2010;34(1):57-66
[7] Nichols MS, Silva-Sanigorski A, Cleary JE, Goldfeld SR, Colahan A, Swinburn BA. Decreasing trends in overweight and obesity among an Australian population of preschool children. Int J Obes 2011;35(7):916-24
[8] Keating CL, Moodie ML, Swinburn BA. The health-related quality of life of overweight and obese adolescents--a study measuring body mass index and adolescent-reported perceptions. Int J Pediatr Obes

equivalent to those experienced by children with clinical conditions such as moderate cardiac disease, diabetes, post-treatment cancer and systemic lupus erythematosis [9].

Coherence with major strategies

All major strategy documents on reducing NCDs refer to the need to reduce overweight/obesity in children, adolescents and adults. In particular, the United Nations (UN) Political Declaration on the Prevention and Control of Non-Communicable Diseases notes with concern the rising levels of obesity and recommends multi-sectoral action to 'reverse, stop and decrease' the trends in children, youth and adult populations respectively [10]. Furthermore, the reduction of childhood obesity warrants being included as a measurable target in line with the UN Rights of the Child [11].

Availability of evidence-based effective and feasible public health interventions

The availability of evidence on effectiveness of interventions for reducing childhood overweight and obesity is escalating enormously. The latest Cochrane review [12] found sufficient studies to undertake a meta-analysis, and the findings were clear and consistent. A wide variety of interventions showed significant effectiveness for reducing unhealthy weight gain in primary school age children, and the same pattern was seen for under 5s and adolescents (although fewer studies meant these reached borderline statistical significance). Several long term (3 year) whole-of-community intervention programs in all three childhood age groups showed significant reductions in unhealthy weight gain [13], although the same approach was less successful in some populations such as Pacific Islanders.

In addition to the rapidly building empirical evidence for community-level interventions, there is mounting modelled evidence that certain obesity prevention policy interventions are likely to be highly effective and cost-effective (usually cost-saving). Analyses that we and others, such as the OECD, have undertaken have shown that policy interventions such as restrictions on unhealthy food marketing to children, traffic light food labelling, and taxes on unhealthy foods are effective and cost effective for reducing obesity [14].

Evidence of achievability at the country level (especially LMICs)

As with the achievability of the salt reduction target, most of the available evidence with respect to obesity prevention interventions is derived from high-income countries. The recent plateaus and reductions in obesity levels in high-income countries are probably occurring because of increased awareness of the problem, and some supportive programs for a healthy start in life. One very low cost program in Australia across a whole city (population 200,000) reduced overweight and obesity over 3 years in pre-schoolers by approximately 3 percentage

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2011;6(5-6):434-4. Williams J WM, Hesketh K, Maher E, Waters E. Health-related quality of life of overweight and obese children. JAMA 2005;293:70-6. Tsiros MD, Olds T, Buckley JD, Grimshaw P, Brennan L, Walkley J, et al. Health-related quality of life in obese children and adolescents. Int J Obes 2009;33(4):387-400

[9] Varni JW, Limbers CA, Burwinkle TM. Impaired health-related quality of life in children and adolescents with chronic conditions: a comparative analysis of 10 disease clusters and 33 disease categories/severities utilizing the PedsQL 4.0 Generic Core Scales. Health Qual Life Outcomes 2007;5:43

[10] United Nations. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. New York: United Nations, General Assembly; 2011

[11] United Nations, Declaration of the Rights of the Child

[12] Waters E, de Silva-Sanigorski A, Hall B, Brown T, KJ C, Gao G, et al. Interventions for preventing obesity in children, update to Cochrane Review. 2011

[13] Millar L, Kremer P, de Silva-Sanigorski A, McCabe MP, Mavoa H, Moodie M, et al. Reduction in overweight and obesity from a 3-year community-based intervention in Australia: the 'It's Your Move!' project. Obes Rev 2011;12 Suppl 2:20-8. de Silva-Sanigorski AM, Bell AC, Kremer P, Nichols M, Crellin M, Smith M, et al. Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program. Am J Clin Nutr 2010;91(4):831-40. Sanigorski AM, Bell AC, Kremer PJ, Cuttler R, Swinburn BA. Reducing unhealthy weight gain in children through community capacity-building: results of a quasi-experimental intervention program, Be Active Eat Well. Int J Obes (Lond) 2008;32(7):1060-7

[14] Magnus A, Haby MM, Carter R, Swinburn B. The cost-effectiveness of removing television advertising of high-fat and/or high-sugar food and beverages to Australian children. Int J Obes (Lond) 2009;33(10):1094-102. Sacks G, Veerman JL, Moodie M, Swinburn B. 'Traffic-light' nutrition labelling and 'junk-food' tax: a modelled comparison of cost-effectiveness for obesity prevention. Int J Obes 2011;35(7):1001-9. Sassi F. Obesity and the economics of prevention. Fit not fat. OECD 2010

points, representing approximately a 20% relative decrease [15]. Interventions as part of this program centred on policies in early childhood settings, workforce training, and the coordination of existing health promotion programs to parents and carers. A 10% relative reduction in overweight and obesity seems eminently feasible, even for LMICs, over the 15 years of the targeted period to 2025.

Unambiguous data collection instruments and potential to set baseline
Measurements of overweight and obesity are simple, accurate, readily reproducible, and inexpensive to collect. Many countries have already conducted surveys that can be used for baseline measures. In addition, many LMICs already have good early childhood growth data that is being collected with a focus on undernutrition and stunting, but which can also be used to assess overweight and obesity.

6. Links with other monitoring efforts – INFORMAA

Under WHO's Global Strategy for Diet, Physical Activity and Health [16] and the UN Political Declaration on NCDs [17], civil society has been charged with the responsibility of contributing to the monitoring efforts. The International Obesity Taskforce (IOTF) and our WHO Collaborating Centre have recently established
the International Network for Food and Obesity/NCDs Research, Monitoring and Advocacy for Action (INFORMAA). This is a global network of public-interest non-government organisations (NGOs) and researchers that aims to monitor and advocate for public and private sector actions to improve food environments and reduce obesity and NCDs. INFORMAA aims to collect and collate country-level data on public and private sector actions, and the impact of those actions on food environments (including food composition, food marketing, food labelling, food availability, and food prices) and NCD outcomes. The results will be used to inform public health advocacy efforts, particularly by supporting participating countries to use the relevant evidence to advocate for action in their country.

The monitoring conducted by INFORMAA will be highly complementary to the monitoring conducted by Member States and WHO. In particular, INFORMAA will concentrate on monitoring upstream aspects (e.g., policies, environments), which will complement the monitoring that is conducted by WHO and Member States. It would be valuable for the WHO framework to identify that it will link to, and be complemented by, other monitoring efforts such as INFORMAA.

Once again, thank you for the opportunity to comment on the draft global framework. We are highly supportive of this endeavour and look forward to assisting WHO in their efforts to address NCDs and obesity in particular.

Yours sincerely,

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Director of Policy and Programmes

On behalf of
Professor Philip James
President of the International Associaition for the Study of Obesity

[15] de Silva-Sanigorski AM, Bell AC, Kremer P, Nichols M, Crellin M, Smith M, et al. Reducing obesity in early childhood: results from Romp & Chomp, an Australian community-wide intervention program. Am J Clin Nutr 2010.

[16] World Health Organization. Global strategy on diet, physical activity and health. Geneva: World Health Organization; 2004

[17] United Nations. Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. New York: United Nations, General Assembly; 2011.

Annex 1: IASO contribution to UN High Level meeting on NCDs
OBESITY and NUTRITION OUTCOMES

The International Association for the Study of Obesity (IASO) and its International Obesity TaskForce (IOTF) request the governments attending the UN High-level Summit on NCDs on 19-20 September 2011 to commit to obesity prevention while supporting sustainable development through food and nutrition polices.

The evidence shows:

- *Good nutrition protects against NCDs caused by other risk factors such as alcohol and tobacco. Poor nutrition is a direct cause of NCDs and also promotes NCDs induced by other risk factors.*
- *A life course approach to NCD prevention ensures that policies and actions benefit people of all ages and life stages, especially the most vulnerable. Attention to nutrition early in life, during pregnancy and young childhood, will also help reduce the growing burden of NCDs.*
- *What is good for health is also good for the environment and the economy. Good nutrition from sustainable food sources can simultaneously improve household prosperity (achieving MDGs), reduce climate change and enhance economic development.*
- *Food and nutrition security, like climate change, depends on multiple cross-sectoral policies. NCDs will be reduced most effectively through a 'Health in All Policies' approach.*
- *Governments can implement policies to prevent NCDs and can ensure the provision of affordable nutrient-rich fresh foods (especially foods low in saturated and trans fats, sugars and salt) along with the skills and knowledge to help individuals make healthy choices.*

We call on governments to commit to the following tasks and targets…

Leadership	• Food and nutrition security and physical activity are cross-governmental responsibilities. **Cross-departmental strategy units** are needed to promote population health and reduce food related inequalities. *Target: year-on-year increment in the number of governments with active food and nutrition strategies.* • Meeting the MDGs and feeding 9 billion people requires **multilateral coordination of nutrition policy.** The UN Standing Committee on Nutrition (SCN) needs to identify a cross-UN set of targets to integrate health and food supply policies to promote NCD prevention, hunger reduction, sustainable food production, food security, environmental protection and farmer/producer livelihood. *Target: SCN draft proposals issued for consultation by end of 2013.* • **Partnerships**: Governments and governmental agencies need to develop and monitor healthy-weight policies without undue commercial influence, while recognising that commercial stakeholders are needed for policy implementation. NGOs can ensure effective involvement of civil society.
NCD prevention	• Governments to set **targets for food manufacturing industry** for compositional standards for salt, saturated fat, trans fat and sugar content of foods, in order to support consumption according to the WHO/FAO population guidelines. *Target: year-on-year increase in the number of governments with active targets.* • Governments to develop **tools for prevention** to include: Food-Based Dietary Guidelines; International food composition databases; Nutrient Profiling schemes, and Health Impact Assessment (HIA) criteria to ensure "Health in All Policies" (HIAP) to protect the most vulnerable. WHO to provide technical support. *Target: WHO baseline report to World Health Assembly in 2013.*

Information Research Monitoring	• Governments to develop health-related **nutrient profiling schemes** in order to identify products which may be subjected to marketing controls, taxes or subsidies, research support, market protection or producer incentives. WHO to provide technical assistance. *Target: annual increase in governments with profiling schemes.* • Governments to mandate easy-to-interpret, front-of-pack **food labelling** and restaurant menu labelling showing key nutrition information. *Target: annual increase in number of governments with active schemes.* • Governments to commission **regular surveillance** of dietary intakes and nutritional status, physical activity levels, food supply and food marketing activities and to ensure surveys include representative samples of the most vulnerable. *Target: annual increase in number of governments with active schemes.* • Governments to commission **routine surveys** of economic and physical environments for access and cost of healthy diets and amenities for physical activity, noting the social inequalities. *Target: annual increment in member state surveillance programmes.*
Children	• **Child protection:** Governments to agree to coordinated action towards an international code of marketing of foods and beverages designed to protect children from exposure to inducements to consume unhealthy products (as defined by a nutrient profiling scheme). *Target: WHO working draft of a Code or Convention submitted to World Health Assembly in 2014.* • **School standards**: Governments to ensure schools and pre-school facilities comply with standards for food service, food education and physical activity. *Target: WHO to report on nutrition-friendly schools and pre-schools actions at WHA 2014.* • Governments to extend access to **baby-friendly hospitals** to all mothers. *Target annual increment in percentage of b-f hospitals and percentage of participating nations.* • Governments to adopt the **International Code of Marketing of Breast-milk Substitutes** into national legislation. *Target: annual increase in member state enactments*.
Care and treatment	• Governments need **simple tools** to indicate excess weight, early stages of **diabetes, hypertension and high blood cholesterol**, combined with practical advice to limit progressive diseases, especially in the most vulnerable. *Target: WHO technical assistance programme operational by end of 2014.* • Governments need guidance on nutritional status and weight gain in pregnancy and infancy to meet MDGs and prevent obesity. *Target: WHO technical assistance by 2014.*
Resources	• Governments pledge to increase resources from their **development, trade, environment and health budgets** to counteract obesity and improve nutrition through food and health policies. Funding is also sought from commercial sources through a **blind trust** or **pooled levy** mechanism (to avoid conflicts of interest). • Increased resources are made available to **WHO's NCD and Nutrition sections** to provide technical assistance and secretariats for the initiatives identified above, and to the **UN Standing Committee on Nutrition** to develop cross-agency strategic plans. • Governments to use **purchasing and commissioning** activities to promote consumption of healthier foods, limit unhealthy foods and promote physical activity. *Target: annual increase in governments with purchasing policies in place and active.* • Governments to consider **taxes and levies** for specified food categories (see nutrient profiling, above), with part of the proceeds **hypothecated to health promotion** activities, including for international activities. *Target: annual increase in governments with policies for taxies and levies in place and active.*
Follow-up	• WHO to continue leading on NCDs, in collaboration with the Standing Committee on Nutrition. WHO to provide a **report on progress towards targets** (as identified above) at each World Health Assembly. *First report with baseline data 2013.*