

**Response to the consultation on the
Interim Report of the Commission on Ending Childhood Obesity
June 2015**

Submitted by Hannah Brinsden and Tim Lobstein on behalf of the World Obesity Federation. This document has received input from our advisors and experts who sit on our committees. Committee members who are also members of the Ad Hoc Working Group on Science and Evidence for Ending Childhood Obesity or the Ad Hoc Working Group on Implementation, Monitoring, and Accountability for Ending Childhood Obesity have not participated in the development of this submission.

About World Obesity

The World Obesity Federation is a not-for-profit organisation representing professional members of the scientific, medical and research communities in over 50 regional and national obesity associations. Through our membership we create a global network of organisations dedicated to solving the problems of obesity. We are officially recognized as a nongovernmental organisation by the World Health Organization. For more information, visit www.worldobesity.org.

General comments

The World Obesity Federation supports the moves by the World Health Organization to tackle childhood obesity and especially the establishment of the Commission on Ending Childhood Obesity (ECHO), and welcomes the opportunity to comment on the Commission's Interim Report. We endorse the four points raised by the NCD Alliance at the 68th Assembly¹ and add the following:

1. We would like to see a stronger emphasis placed on societal drivers of obesity rather than the developmental and biological aspects. Of course these latter factors are intrinsically important in our understanding of mechanisms for the increased susceptibility to obesity, but as we consider obesity to be a disease state which occurs as a response to adverse environments, the biological and developmental mechanisms are, in our view, subsidiary to the environmental drivers in terms of priority policies. Tackling the environmental drivers requires a comprehensive understanding of the range of trade, regulatory, media and commercial processes which have increased the obesogenicity of environments radically in developed economies and induced the rapid surge in childhood obesity in the last half-century.

¹ ncdalliance.org/sites/default/files/rfiles/Agenda%20Item%2013%203%20NCD%20Alliance%20Statement_FINAL.pdf

These changes are now transforming the environments of less developed economies and threaten even greater disease burden than is already posed by undernutrition. The sensitivity of most of the world to these societal factors, as well as recognition that more rigorous public health measures than those currently considered sufficient in affluent societies may be required, need to be more comprehensively addressed in this report.

2. It follows that we would like to see a stronger emphasis on the need to intervene in the trading, manufacturing, marketing and advertising of the products and services that increase the risk of obesogenic behaviour. We would like to see proposals for a strengthening of public health legislation so that governments are enabled and required to protect the health of children through market interventions. We would like to see stronger statements on the need to hold commercial operators to account for the health impact of their activities.

3. We are concerned that the issue of childhood obesity is treated in isolation from the issue of child growth and the problems of under-nutrition. We believe that under-nutrition and over-nutrition are closely linked, especially in maternal and child health, and a framework looking at under-consumption of healthy food products and over-consumption of unhealthy ones, and thus the need to prioritise health within food supplies at all points in the food chain, is urgently needed.

4. The epidemic of obesity, in children and in adults, is now of such extent and gravity that the WHO must use the strongest tools it has available to reverse this situation – including its treaty-making powers to protect health. For this reason, we would like to see the Commission urging WHO to develop a comprehensive framework convention on the protection and promotion of healthy diets. This should include and bind into one framework the Code of marketing of breastmilk substitutes, the Recommendations on marketing of non-alcoholic food and beverages to children, the promotion of appropriate complementary foods and feeding practices, and the relevant WHO and Codex competencies related to child nutritional health. Its implementation and monitoring and should be inspired by the framework developed for tobacco control.

5. The promotion of physical activity is equally important, requiring strong policy responses to ensure that transport systems, spatial planning, the built environment, and the sport, leisure, education and other sectors promote physically active lifestyles across all ages and population groups. There are powerful co-benefits

between the promotion of healthy food systems, the development of supportive physical activity environments, and responses to climate change. These synergies should be exploited to support healthy and sustainable development.

6. As a general comment on the Policy options in the report, we would like to see much clearer statements about who should be leading each policy, who is accountable for its delivery, what legislative inputs might be required, what resources and support is anticipated, what the targets are, and what timelines might be needed to achieve the policy goals and to be sure of meeting the general targets for no increase on 2010 prevalence levels. The policies can also be more clearly tied in to post-2015 development goals to ensure optimum dietary health, and the ICN2 priorities.

7. The document needs to consider issues of capacity – especially the need for better training of health professionals, teachers, nutritionists and upstream actors such as agricultural economists and urban planners.

8. Lastly, we would like to see greater acknowledgement of the need to protect policies from the interference of “big food” and other commercial operators who are known to exploit their economic power to undermine regulatory actions which threaten their commercial interests.²

QUESTIONS FOR CONSULTATION

1. Are there issues or strategies that have been overlooked in the Commission's interim report?

We have identified our priority concerns in our General comments, above. We are also concerned that the document expects too much from commercial operators in terms of asking for voluntary measures. There is good evidence that voluntary commitments are not adequate (e.g. the marketing restrictions offered in the various Pledge schemes) and are easily broken (especially if they do not have robust monitoring, as has been shown for the Code of marketing of breastmilk substitutes). Voluntary commitments are by their nature non-binding, are unenforceable and may be reversed if they fail to benefit the company concerned (examples of reversals can be shown from the UK Responsibility Deal and in US pledges). Health economic analyses demonstrate that voluntary measures in general are neither comprehensive nor radical enough within the time scale required. As highlighted in our general comments, above, the nature and extent of societal pressures faced by many developing economies mean there is a need for more rigorous public health

² <http://www.ploscollections.org/article/browseIssue.action?issue=info:doi/10.1371/issue.pcol.v07.i17>

measures in those countries than is sufficient in affluent societies. These differences need to be more fully explored and acknowledged in the report.

2. How can your sector/entity contribute to the proposed policy options to end childhood obesity?

We monitor obesity prevalence surveys, identify trends in food consumption and food marketing patterns, support the INFORMAS initiative to monitor food environments and food-related policies in government and private sector bodies (www.informas.org), and we undertake advocacy and training to raise awareness of the complex issues around childhood obesity, its causes, and the policies for prevention. We also support improved prevention, treatment and weight management through our scientific journals, conferences, research collaborations and web-based professional education services.

3. What are the important enablers to consider when planning the implementation of these proposed policy options?

When arguing for interventions in marketplaces, government departments responsible for promoting public health face considerable resistance from other sections of government promoting economic growth and from market-interested elements in the business sector. To strengthen government action, stronger public health legislation with coherent transparent intersectoral action commensurate with the UN Heads of Government agreements at the UN General Assembly in 2011 is needed to prevent chronic disease. These measures include actions to regulate markets. Public Health Acts need to include measures to tackle chronic disease and associated risk factors (such as the ability to regulate 'health impediments' provided in the 2008 Public Health Act of British Columbia).

In addition, governments need guidance and leadership from the World Health Organization ideally in the form of a framework convention(s) to protect and promote healthy and sustainable food supplies, diets, and physical activity environments. Such convention(s), developed without interference from commercial interest, would provide a form of external legitimacy to support and justify actions by national ministries of health. It is clear that a convention which seeks to include measures to regulate markets should be developed without being influenced by the very same interests it seeks to regulate.

4. What are the potential barriers to implementation to be considered for these proposed policy options?

Long experience in attempting to regulate the marketing of commodities which cause ill-health shows that policies to intervene in food and beverage markets will be opposed by interests that benefit from the status quo or from further de-regulation of markets (See PLoS Medicine Series on Big Food³).

Despite strong public support for effective action, governments continue to put commercial interests ahead of human health. Advocacy for measures to prevent ill-health remains a 'Cinderella' among many funders including the major medical charities and philanthropic bodies, while there are few commercial interests interested in supporting prevention. Stigma surrounding obesity, which frames it within a public and political narrative that places responsibility for obesity on the individual, further detracts from support for preventative public health measures. As a result, the capacity of civil society to support and protect public health action on obesity is severely limited and under-resourced, and needs strengthening.

5. How would your sector/entity measure success in the implementation of these proposed policy options?

Although monitoring of childhood growth has been shown to be responsive to effective public health measures, a reliance on the monitoring of long-term health outcomes may be unrealistic for most policy development and implementation cycles.

Shorter-term indicators would include reduced per-capita sales of HFSS foods / or foods recommended for low or limited consumption in national FBDGs. For additional monitoring criteria for food supplies, please see the INFORMAS accounting protocols.

In addition it should be possible to see changes on the prevalence of low birth weights, and in the prevalence of excess weight gain during pregnancy, improvements in prolonged breast feeding and exclusive breastfeeding in the first 6 months. It should also be feasible to monitor the implementation of recommended standard practices in complementary feeding, in nursery provision for healthy food as well as active play, and the establishment of rigorous controls over all media advertising (not just that supposedly confined to children's viewing time).

³ <http://www.ploscollections.org/article/browseIssue.action?issue=info:doi/10.1371/issue.pcol.v07.i17>

6. How would your sector/entity contribute to monitoring and accountability framework for these proposed options?

We support the protocols being developed by the INFORMAS group and the accountability framework described in the recent *Lancet Obesity Series II* (2015). We can provide advice and commentary on the adequacy of indicators and monitoring methods (e.g. our systematic review of the measures to restrict marketing to children – at www.ncbi.nlm.nih.gov/pubmed/23845093) and provide technical assistance through our professional membership.

ADDITIONAL COMMENTS ON THE TEXT

BACKGROUND

Paragraph 1 – This should refer to ‘infant and child nutrition’ resolutions as well as the non-communicable disease resolutions, as the childhood obesity targets cover both themes.

P2 – Obesity is not simply a risk factor but is officially recognised as a disease state in itself in WHO’s own classification of diseases (ICD).

P2 – The use of the word “novel” in this paragraph suggests current interventions don’t work, whereas it may be that they are not sufficiently implemented and/or followed-through.

INTRODUCTION

P9 – It is good to see that the health risks posed to the child are highlighted, as well as health risks when they reach adulthood.

Between P9 and P10 the issue of obesogenic environments, and the social drivers of such environments, needs to be raised. These are what act on the biological mediators in P10 to produce disease.

P10 – “later challenges such as living in obesogenic environments”. They are not ‘later’ as if they matter less. They are key to the whole life-course – i.e. obesogenic environments affect the early stages too, shaping the mother’s nutritional status prior to pregnancy, the foetal supply etc. As presented it would seem that the biological processes are the primary focus. Yet there is evidence that the nutritional and metabolic state of the mother as she conceives also plays a part so this should raise the issue of the wellbeing of girls in childhood, adolescence and then young women in their pre-pregnancy state. It would seem odd that the very analysis of biological processes does not lead one to call for even more radical public health measures particularly when one considers the prevalence of malnutrition in the world’s

population over the last four decades i.e. when the currently fertile women were born and developed in suboptimum environments.

P10 - Interventions in early life due to biology being most 'plastic' is not the only reason for focusing on children. There is usually strong political and public buy-in regarding children, their rights, their health and their protection. The age group also has some key access points such as schools, nurseries, families, midwives (in some countries), antenatal services, etc. which make children a good target for direct interventions. Also, children's experience of obesogenic environments shapes their later preferences, e.g. food tastes and physical activity behaviours, which in turn shape their risk of obesity and chronic disease in adulthood.

P12 – It is important to recognise that there is a circular argument here of targeting child, adolescent, mother, baby which could be emphasised to show the relationship and that there really need to be policies dealing with all stages.

P12 – Is the Commission arguing that interventions to reverse pathological epigenetic alterations are feasible solutions to the prevention of childhood obesity? What does this require in practice?

Page 8 BOX – We support these goals. Perhaps the earlier Paragraph 3 could state more strongly that policy recommendations are included in the role of the Commission.

WHY IS IT CRITICAL TO ADDRESS THE CHALLENGE OF CHILDHOOD OBESITY

P16 – This paragraph should note the important links between stunting and obesity, especially evidence showing the risk of high BMI is greater among stunted than non-stunted children at community, household and individual level. To us, 'of even greater concern' is the fact that poor growth sits alongside overweight/obesity, and the solution requires a comprehensive approach to child growth. Even in developed countries (e.g. the UK), in those socio-economic groups in which one finds higher levels of obese children one also finds higher levels of children with short stature.⁴

P19 – Referring to obesity as the result of an 'interplay between biological and contextual factors' significantly underplays the contextual factors and the vast amount of work that has been done on obesity-inducing systems, such as through the UK Foresight report.

P20 – This paragraph or the next really needs to acknowledge the role of trade, investment, and marketing that increases the supply and 'push' for those types of products which are not recommended for increased consumption in any FBDGs.

⁴ Lobstein T *et al.* Child and adolescent obesity: part of a bigger picture. *Lancet*. 2015 Feb 18.

P23 – Good reference to rights of children and convention of the rights of children, although perhaps this could have been more prominent earlier on.

P24 – Good reference to the central role and responsibility of governments.

Page 10 BOX – Good to reference urgency and government leadership.

OVERARCHING POLICY CONSIDERATIONS

p26 – This paragraph refers to the role of governments then to private sector engagement. Is this a place to mention the importance of professional and civil society groups?

P26 – The last sentence can say that 'constructive engagement' refers to policy *implementation* and lies outside of policy formation, which is the responsibility of government alone.

Page 12 BOX – overarching policy considerations

I. Governments are leaders not 'coordinators'. This needs to be emphasised.

II. What does the word 'consistent' mean here? Between countries or with the evidence?

V. Perhaps mention the valuable role civil society can have in supporting the monitoring role.

TOWARDS A COMPREHENSIVE STRATEGY

p30 – Are NGOs considered the same as civil society? If not, NGOs should be listed in other parts of the document where stakeholders are noted, and the difference made clear.

1: Tackle the obesogenic environments and norms

P 35 – The ordering here is important and needs to be changed. This paragraph should be moved down to follow the current P41.

P36 – "...through the use of norms and standards" – and also *regulations and multi-lateral / cross-border agreements* (as noted in the WHO Recommendations on marketing to children).

P36 – There are a wide range of issues where regulation is needed. Highlighting labelling alone does not reflect all the legislative opportunities that exist, including fiscal policies, product regulations for composition and portion size, advertising restrictions, and agricultural policies.⁵ Furthermore, in this context the use of interpretive front of pack labelling needs to be explicitly stated.

P37 – The issues related to availability, affordability, accessibility need to be expanded on. This is a good place for nutrition security to be highlighted (nutrition

⁵ http://www.mckinsey.com/insights/economic_studies/how_the_world_could_better_fight_obesity

security here includes factors which shape consumption – not just availability – including preferences and marketing influence).

P 38 – Marketing restrictions should be the number 1 recommendation in the list and thus this paragraph needs to be higher. In store promotions, price and product portion size (the size of a soda servings, for example) might also be noted here.

P38 – While voluntary efforts suggest people agree there is a problem, that does not mean it is under control. More needs to be done. The current wording almost implies marketing is sorted, while all the evidence shows it is certainly not!

P40 – We do not endorse the concept of commercial marketing of 'healthy' food to children, and believe this could be a problem for the Commission. While social marketing (not linked to any branded products) may have a place, the marketing of branded goods is a much trickier area, not only because of potential halo effects of the use of a common brand across many products, but the wider issue, in which the Commission's endorsement of marketing of branded products runs counter to moves to reduce the commercialisation of childhood, and to protect children from any form of commercial inducements to purchase goods (e.g. the Nordic and Quebec prohibitions on all commercial marketing to children).

b. reduce sedentary behaviour and promote healthy living through physical activity

P42 – The paragraph might be usefully split into three paragraphs: 1) the problem, 2) active lifestyles, 3) organised physical activity and exercise.

P42 – Should there be some kind of acknowledgement of the issue of stigma and preconceptions around physical activity? Both in terms of obese children and their participation in activity, but also around what the nature of the activity actually is – it doesn't have to be exercise as part of a sports team which might put some people off with low esteem due to their weight.

page 17 BOX policy options for strategic objective 1b (i) Sleep patterns should have been mentioned in the main text before this box.

2. Ensure the risk of obesity is reduced by addressing critical elements in the lifecourse

b. infant and young child

P50 – This is an important paragraph and needs more attention, showing the potential links between undernutrition and obesity (both through maternal undernutrition and child risk, and foetal and infant under nutrition and stunting linked to higher BMIs. These overlapping factors are critical to justifying the need for a composite, comprehensive food and nutrition policy.

c. school-age children and adolescents

page 21 BOX policy options for strategic objective 2c: These are good, but should also note the need to control marketing and sponsorship in schools and 'places

where children gather' and for item (i) add vending and canteens, and for item (ii) make it clear what this refers to – e.g. fast food outlets.

3. Treat children already affected by obesity to improve their current and future health

The treatment of children already affected by obesity is an important and under-recognised issue that will require a strong policy response if it is to be addressed appropriately, for instance through the provision of integrated health services and appropriate training of health professionals.

P58 – We suggest the inclusion of bariatric surgery for adolescents here, as an area of recognised importance but needing more coherent policy action at a national level.⁶

Add Paragraph: This section needs to state clearly the futility of treating childhood obesity if the children are then returned to an obesogenic environment. Even children who have undergone bariatric surgery are likely to maintain a high intake of fats and sugars (often in liquid form) and not eat fruit and vegetables, thanks to their continued exposure to unhealthy environments.

ISSUES AND RESPONSIBILITIES

P60 – “areas such as trade in unhealthy foods”. Generally it is trade in cheap commodities, such as fats, oils, sugars and starches. In most regions now, these commodities get turned into branded foods at local level (the exceptions being small states such as island states, and the lowest income countries, where market size does not justify local manufacture).

P61 – We welcome the reference in this paragraph to the role of NGO and civil society in monitoring and accountability, although we remain uncertain as to whether the Commission views NGOs as different to civil society or a subset (in which case, who else is in the set?)

RESEARCH GAPS

Some of the gaps identified (e.g. a, b, c, d, g, h, n) are of interest to science but not so interesting to policy-makers and policy officials trying to identify realistic steps to tackle child obesity. We suggest that, while reference can be made to the need for stronger scientific understanding of mechanisms, the purpose of this section of the Commission's report is to identify research gaps which need to be filled to support policy decision-making.

In particular, we urge more research into issues of social inequity as a causal factor in poor health outcomes,⁷ as well as the double or triple burden issue, and the

⁶ <http://onlinelibrary.wiley.com/doi/10.1111/j.1758-8111.2010.00002.x/abstract>

possible importance of moderate under-height in raising BMI and risk of chronic disease.

Some acknowledgement could be given here to the initiatives which are trying to develop indicators for gauging food environments, including ATNI and INFORMAS and the databases held by WHO on food and nutrition policies and actions.

⁷ For child obesity prevalence associated with measures of national income inequity, see <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3366624/>. For further discussion of the relationships between social and economic inequity and health outcomes, see <http://www.equalitytrust.org.uk/about-inequality/spirit-level>.