Working together to tackle obesity:

An advocacy toolkit for IASO members
The International Association for the Study of Obesity (IASO) is a not-for-profit organisation linking over 50 regional and national associations with over 30,000 professional members in scientific, medical and research organisations. It is an umbrella organisation for 53 national obesity associations, representing 55 countries.

Over the last decade, IASO has established itself as a dynamic, professionally managed organisation which has become a ‘nerve centre’ for everyone from governments, professionals and media wanting the latest information on prevalence data and new developments in scientific research into the prevention and management of obesity.
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Part 1: The global burden of obesity

Part 1 gives a brief introduction and overview to the global burden of obesity and introduces the purpose of this toolkit

Obesity is one the most challenging public health problems that we face today, with prevalence rising at an alarming rate around the world. Obesity imposes a significant burden at an individual and societal level, both from a health and from an economic perspective.

There are around 475 million obese adults worldwide and over 1 billion adults who are considered to be overweight (1). Over 200 million school-age children are overweight, making this generation the first predicted to have a shorter lifespan than their parents (2). Whilst traditionally seen as a “disease of the developed world”, significant increases in prevalence can be seen in many African and Latin American and Asian countries and it is increasingly common to see obesity alongside under-nutrition within the same country, community, household or even individual. This “double burden” can have serious consequences on the local economy and development prospects.

Worldwide, high body mass is the 6th leading disease burden (based on Disability-Adjusted Life Years DALYs) (3), with more than 3million deaths in 2010 attributed directly to it, independent of any further deaths associated with co-morbidities (4). Combined, overweight and obesity and physical inactivity are estimated to cause more than 6.5million deaths per year, more than that of tobacco smoking (4).

Furthermore, obesity increases the -of developing many other chronic diseases, accounting for approximately 60% of type 2 diabetes, over 20% of hypertension and coronary-heart disease, and between 10% and 30% of various cancers (2). Other co-morbidities include gall-bladder disease, fatty liver, sleep apnoea and osteoarthritis. Childhood obesity increases the risk of co-morbidities in later in life (5). There are also a multitude of adverse social and psychological conditions affecting mental and physical health, quality of life and workforce efficiency as well as putting a strain on health services.

Multiple causes of obesity

Obesity is caused by a complex interaction between environmental, social and genetic factors. We have evolved to store fat in times of plenty, to help prepare us for times of food shortage. For many people in the 21st Century however, those periods of shortage never come and weight gradually increases.

At an individual level, genetic and psychological factors are important determinants of obesity, providing some explanation for similarities within families as well as differences between individuals who have similar life experiences (6). However, they are not the only contributing factors and social and environmental situations affect an individual’s likelihood of becoming overweight, whether due to accessibility and/or affordability to certain types of food, having a sedentary lifestyle and/or job, attitudes of peers or exposure to certain marketing.

Furthermore, genetics are also not sufficient explanations in themselves for the marked rise in obesity that has occurred over the past three decades at a population level. A change in the environment that we live in is the leading causal factor of the obesity epidemic. In particular, an increase in the consumption of energy dense foods such as ultra-processed, convenience foods which are high in fat, sugar and salt, coupled with a reduction in energy expenditure as communities become more reliant on public transport and active labour is replaced by machinery and desk based jobs. Ten out of 20 of the leading causes of disease in the world are due to dietary
patterns (3). Importantly, these factors are largely preventable and therefore offer us an opportunity to help tackle the rising obesity epidemic.

**Tackling obesity**

There is growing concern surrounding the prevalence of obesity and increasing efforts to prevent any further increase. The World Health Organisation has issued a number of statements regarding obesity, and activities can be seen at international, regional, national and local levels within Governments, academia, civil society and the private sector. As obesity is a complex issue, there is a need to mobilise all relevant interests, whether based in academia, health professionals or from other areas such as social science, psychology and education. By working together we can challenge the social and commercial causes of obesity so as to try and tackle the obesity epidemic itself.

![The 'causal web; or factors leading to obesity](image)

**Figure1:** The ‘causal web; or factors leading to obesity (7)

**1.1 WHO Global Framework targets**

In May 2013 the World Health Assembly adopted an omnibus resolution on reducing preventable non-communicable diseases (NCDs) such as diabetes, cancer and cardiovascular diseases. This resolution includes an endorsement of a World Health Organisation action plan to reduce premature mortality from NCDs by 25% by 2025, the adoption of 9 global targets with 25 indicators to reduce NCDs and a commitment to publish a global coordination mechanism by the end of 2013. One of the 9 targets is to “halt the rise in (diabetes and) obesity by 2025” (8).
This resolution, and in particular the targets, were the product of a vast amount of advocacy action by a number of organisations and individuals around the world. The task ahead is now to engage governments at regional, national and local level to achieve these targets by 2025. As members of IASO you can play a role in initiating discussions and commitments within your own governments to implement the policies needed to tackle obesity.

**Box 1: WHO Global Target Framework: Obesity & overweight target (8)**

Target: “Halt the rise in diabetes and obesity by 2025”

Indicators of progress to include:
- Age-standardized prevalence of overweight and obesity in adults aged 18+ years (defined as body mass index greater than 25 kg/m2 for overweight or 30 kg/m2 for obesity)
- Age-standardized prevalence of overweight and obesity in adolescents (defined according to the WHO Growth Reference, overweight—one standard deviation BMI for age and sex and obese—two standard deviations BMI for age and sex)
- Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply as appropriate within the national context and national programmes
- Policies to reduce the impact on children of marketing on foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt

**1.2 What is the purpose of this toolkit?**

The purpose of this toolkit is to
- Offer support and advice to IASO members on how to advocate
- Provide key facts and figures that may help with advocacy work on obesity
- Promote an integrated approach to tackling obesity

**1.3 Who is this toolkit for?**

This toolkit aims to provide the necessary background information, resources and key messages to allow us to move forward together to help combat obesity. It is designed to help support your work, allowing you to take into account the context and resources in your country.

Whether you are an academic, a medical doctor, a health care professional, a policy director or a civil society advocate you can play a role in advocating for improved food environments to improve health. Advocates can be individuals or work within community groups, expert groups or organisations with an issue close to their heart.
Part 2: An introduction to Advocacy

Part 2 aims to provide you with an overview of advocacy, including an outline of the different types of advocacy and some tips to get you started.

The aim of advocacy is to influence decision makers on a specific issue, putting forward a strong case for action.

Specifically in relation to obesity it can be defined as activities aimed at “Improving global health by promoting the understanding of obesity and weight-related diseases through scientific research and dialogue, whilst encouraging the development of effective policies for their prevention and management”.

Often advocacy work is done in collaboration with other like-minded stakeholders. Depending on the specific goal, advocacy work can target politicians, government departments, the industry, members of the public and/or other stakeholders. The following toolkit aims to provide insight and ideas about how we can collectively and individually ensure that the obesity agenda is taken seriously by Governments and the private sector alike all around the world.

The most effective advocacy and campaigning involves consistent messages and calls for actions. IASO and its global membership are in a unique position to push forward the obesity agenda together, working from the same key positions.

2.1 Why is advocacy important?

Evidence-based or evidence-informed policy is considered an important part of policy making, where problems are identified and measured along with policy options and solutions such as efficacy and potential consequences, in order to evaluate the benefit of a particular policy solution. In theory this means your job as an advocate is to present policymakers with the appropriate evidence in support of the policy in question. In reality the power of different interest groups is imbalanced, with some organisations having stronger influence than others. The diagram below shows this power conflict in the case of marketing food to children.

By working together we can help to increase the influence of those working in the public rather than market interest.

Figure 2: stakeholders with different interests do not have equal influence on policies. Adapted from Lobstein & Polmark Consortium, 2010 (9)
Advocacy and obesity

The WHO global targets framework provides us with the global political leverage to make a difference in our own regions and countries. This will involve
- Addressing the complex interacting factors in order to prevent/halt the trend of rising obesity, with environmental and social shifts towards a less obesogenic promoting environment.
- Increasing understanding, support and treatment of those who are obese to reduce individual risk of comorbidities

Whether you want to increase bariatric care, educate people about the health effects of obesity or improve the food system, there will be policies and processes in place which you need to influence in order to reach (or get closer) to your goals. The steps to be taken are:

- Know the issue
- Understand the policy process
- Establish goals
- Develop key messages
- Build relationships with stakeholders
- Engage with politicians
- Communicate effectively
- Use the media
- Keep up to date
- Monitor your progress

2.2 Types of advocacy

Advocacy covers a number of different activities all of which can be valuable in different contexts. They may be used independently of one another, although they are best used together. It is important to consider how you frame the problem and also to take advantage of political opportunity wherever possible. This is when working in collaboration with others can be beneficial as it allows everyone involved to play to their strengths.

Direct advocacy, that is advocacy directed at the policy makers, is most suitable when an issue has already gained some political backing– for instance if you are in support of/against a particular bill, a consultation is in process or a high-profile meeting is upcoming. This kind of advocacy usually involves
a. Holding meetings with and/or writing to politicians expressing concern/alerting them to the issue
b. Responding to consultations put out by the Government
c. Issuing a report and/or press release which provides evidence in support of your cause

Indirect advocacy

Often advocacy has a broader remit, with the aim of raising awareness amongst the public and initiating debate on the topic area. Indirect advocacy can be useful prior to targeting policymakers directly, or simultaneously with direct advocacy with the aim of adding weight to your view with public support.

a. Meeting and collaborating with non-governmental groups, charities and research groups
b. Organising consumer awareness activities such as local events, public calls for action, petitions, advertisements
c. Holding an event/conference/meeting with stakeholders to get support, apply political pressure, discuss actions can be a valuable tool for advocacy
d. Carrying out research with the specific aim to get media coverage, most often survey work
e. Writing reports or briefing documents which serve to highlight the problem and/or the solutions
f. Producing regular newsletters to engage stakeholders and keep them up to date with developments in the area
g. Using social media to get message widely heard

Three key components of effective advocacy are 1) taking advantage of political opportunity 2) framing messages so as to generate the maximum interest possible and 3) mobilizing resources to increase your power and to allow you to advocate effectively.
2.3 Before you start

a) Getting to know the issue

Understanding the problem and the causes

1. Gather information on obesity prevalence, co-morbidities, trends, forecasts for your country.
   - If your country isn’t there but you have the details send them to IASO and we will include them in the prevalence data and maps that we provide

Consider the solutions

2. Gather information on policies and initiatives already in place in your country or region e.g. marketing pledges, healthy eating schemes, taxes, sports schemes.
   - Help keep IASO informed of policy work in your area. It may help us create good practice guides for others to use [http://www.iaso.org/publications/trackingobesity/submitpolicyinformation/](http://www.iaso.org/publications/trackingobesity/submitpolicyinformation/)

3. Be sensitive to other issues, such as financial restraints, as well as any potential negative effects that could occur

4. Identify both short and long term “wins” – short term is good for getting issues higher on the agenda, while longer term is more likely to make a sustained difference.

b) Understand your legal and political systems

The political situation and legal context is different in every country so it is important that you are aware of these processes in your own country. This will, in many cases, inform how you advocate on obesity issues in your area. This toolkit aims to aid your work while giving you flexibility to do what is right for you.

You also need to be aware of the different activities and policies at international, national, regional and local, level. The processes involved with be different and you’ll need to familiarise yourself with the opportunities that lie within each government level.
2.4 Establish your goals and messages

a) Goals
Your overall policy goals should be consistent with the WHO recommendation to halt the rise in obesity by 2025.

Two of the WHO indicators of progress include the adoption of policies that reduce saturated fat in food and policies that reduce marketing exposure for children. Setting goals related to these will help you to progress the policy programmes in your area whilst also working towards the WHO overall goal.

Other goals could be on issues such as:
- Physical activity
- School meals
- Sugar reformulation
- In-store promotions
- Labelling
- Junk food taxes
- Childhood obesity
- Bariatric surgery
- Education of health care professionals
- Transport/town planning issues

You should try to fit in to, and be sympathetic towards, established campaigns run by other organisations and priorities of your government in order to achieve wider objectives. e.g. economy, health, social issues, sustainability, education. Agree priority actions to achieve your goals.

b) Framing the problem with key messages
Making sure that you frame your problem (and the solution) around clear messages will be important in initiating concern. Having clear messages in relation to your goals will help improve the clarity and effectiveness of your activity. Clearly identifying the problem is the first step, making sure that you communicate it in the right way to the right people.

Also important is being clear about what action you are calling for and what the desired solutions are. In particular make sure you address any practical issues e.g. the cost implications which will be important to the decision maker.

There are lots of different components to advocacy and it is important to work out what will work for you. It is likely that a combination of activities will be most effective. For instance fundamental changes occur slowly, with activity based on negotiations and compromise in meetings, letters and consultations. “Easy” wins and “controversial” issues may get a better response via campaigning and media work.

Your messages should:
- Be simple, focused, relevant, meaningful and suitable for the culture you are dealing with. Stick to the point.
- Keep to the facts - Be shocking and stir imagination/provoke emotion whilst remaining credible and appealing.
- Be tactical – be persistent and realistic, accept and expect small wins (while keeping your eye on the main target) and be willing to compromise (but aim high)
- Emphasise the huge burden, particularly economic burden, of obesity which policy makers have the power to change

c) Get the timing right
Timing is a crucial feature of successful advocacy efforts, as political cycles and agendas can be fairly rigid. By identifying points in the calendar that will be useful and/or present opportunity for change you can maximise the likelihood that your message gets heard. For instance, be aware of political party debates, WHO meetings, consultations and elections (local and national).

The exception to this is in a time of “crisis”, when an event happens which is viewed as sufficiently important or urgent enough to require immediate action. In such opportunities events may happen rapidly and it is important
that you are available to respond and advocate as required. For this reason it is important to have clearly established positions and goals, ready to be used when required.

### 2.5 Partnership building

Working together is vital to initiate change and is an invaluable resource. Drawing on expertise from researchers, health professionals, campaigners and policy experts provides you with a strong evidence base for taking forward an issue to Government. By working in collaboration you are acknowledging that you don’t have skills or knowledge in everything. Building up a relationship with politicians and policymakers can also be useful in getting your message heard.

When starting to consider your advocacy work it will be useful if you identify

a. Who is active in the area already e.g. academics, charities, community groups, local governments
b. Who are the key parliamentary figures, e.g. the MP who focuses on health, wellbeing, school food

In both cases it is useful to note who is on your side and who is opposed to your cause, both within and outside of government. You may identify a number of stakeholders who are opposed to your view, either explicitly or implicitly through their own campaigns. While it may not be useful to collaborate with them, keeping an eye on their activities will prove valuable to ensure that your work is not undermined.

<table>
<thead>
<tr>
<th></th>
<th>Supporters</th>
<th>Opposition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Very important</strong></td>
<td>Mobilise their interest, enthusiasm, keep them informed and involved</td>
<td>Develop strategies to manage or reduce their antagonism</td>
</tr>
<tr>
<td><strong>Important</strong></td>
<td>Keep them onside and ensure they remain supportive</td>
<td>Monitor their position to be ready to respond</td>
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</tbody>
</table>

### Policymaker collaboration

Identifying and building rapport with politicians who are sympathetic to your cause can help give weight to your activity. Furthermore, identifying other non-governmental organisations (NGO) or academics that hold similar views can help to strengthen the messages you put out. Building partnerships, particularly with those who have access to complementary resources or expertise will be of particular value to you.

### Stakeholder Collaboration

Working in collaboration with other like-minded groups and individuals can help strengthen messages, share knowledge and experience and broaden resources available. Relationships can vary from informal information sharing, to coalitions producing co-signed letters and consultation responses. It is more likely that you will have a positive response if it is apparent that your view is widely held.

Potential stakeholders who may be of value to you when advocating on obesity issues include

<table>
<thead>
<tr>
<th></th>
<th>Industry</th>
<th>Experts</th>
<th>Government departments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nutrition</strong></td>
<td>Agriculture, manufacturers, retailers, trade bodies</td>
<td>Caterers, teachers, health experts, academics</td>
<td>Health, environment, education</td>
</tr>
<tr>
<td><strong>Physical activity</strong></td>
<td>Sports clubs, gyms, equipment specialists</td>
<td>Health experts, teachers, community groups, academics</td>
<td>Transport, town planning, education</td>
</tr>
<tr>
<td><strong>Health care</strong></td>
<td>Pharmaceutical companies, surgical equipment</td>
<td>Community groups, health professionals and unions, academics</td>
<td>Health, social welfare</td>
</tr>
</tbody>
</table>
Conflicts from collaboration

When collaborating with others it is important to be mindful of potential conflicts of interest that may arise directly or indirectly from collaborating. Collaborations can cause conflicts where agendas are too different or conflicting and while compromise is often possible it should not be at the expense of reaching your goal. See Appendix 3 for more information.

2.6 Keep up to date

Research and policies that effect obesity agendas can be fast paced so it is important to keep up to date with the latest developments to ensure your activities remain relevant. Google alerts, newsletters, e-bulletins, twitter, LinkedIn, Facebook and RSS feeds can all be useful in keeping up to date with activities, progress, publications and events about obesity.

IASO offers a weekly news bulletin service (Sign up here: http://www.iaso.org/news/) which summarises the latest research and news related to obesity as well as a monthly newsletter with updates of our work. IASO also has a LinkedIn group and Twitter account which provide regular news updates and the opportunity for discussion of current obesity related issues.

Useful key words for Google alerts include: obesity; overweight; bariatric; junk food; marketing; advertising; food industry; weight-loss; BMI

2.7 Monitor your progress

Policy change doesn’t happen overnight, nor does it happen in one go. Slow progress is to be expected, with many small progressive steps made over time. Often it requires a look back in time to fully appreciate where progress has (or hasn’t) been made.

Monitoring progress is important to allow you to assess where you are and where you need to go in order to meet your goals. Monitoring can be done both directly on your work, but also looking at the wider issues which may have altered for a number of reasons (e.g. prevalence of obesity).

Process indicators:
- media hits
- social media interactions
- networks
- meeting numbers with officials
- letters sent
- supporter/membership numbers

Progress indicators:
- reduction in obesity
- Increase in activity
- reduction in calorie consumption
- adoption of a policy
Part 3: Advocacy activities and resources

Part 3 suggests some key activities you may consider as part of your advocacy programme. A lot of the information in this section is supported by material in the appendix 5 and 6.

There are a wide range of activities and resources that are useful in advocacy, ranging from large scale campaigns, events/conferences and reports, to smaller scale activities such as presenting research findings, responding to consultations, issuing press releases and using social media. Depending on your resources you may work ‘behind the scenes’, dealing direct with politicians and focusing on ensuring scientific accuracy, or you may involve yourself in a large campaign which also functions to raise consumer awareness, engages a wider number of stakeholders and lends itself to more debate on this issue.

Some examples of activities include:

- Holding meetings with politicians, other stakeholders
- Writing letters to politicians, stakeholders expressing concern/alerting them to the issue
- Forming coalitions with like-minded stakeholders
- Responding to consultations put out by the Government
- Writing reports/ briefings/position statements which serve to highlight the problem and/or the solutions
- Producing regular newsletters to engage stakeholders and keep them up to date with the developments in the area
- Putting out press releases about a new campaign, new research or expressing a point of view
- Use of a website to promote activity, viewpoint, developments
- Use of social media e.g. Twitter/LinkedIn/Facebook to disseminate your message

For advice on what may be most suitable for your causes see Appendix 5 and 6.

3.1 Media

The media is considered a powerful tool for spreading a particular message to a large number of people. The media can be used to help shape public discussion and debate as well as offering the opportunity to address misconceptions related to a particular issue. The media can be used passively (e.g. responding to media enquiries) or in a more active way (e.g. issuing press statements, writing blogs and letters). Regular use of the media allows you to build up a relationship with journalists and engage them in the messages that you want to spread.

- **Print media** e.g. newspapers and magazines - *See appendix 7 for an example press release and some tips for writing your own*
- **TV, radio** – Either an exclusive TV programme or as part of media coverage from a press release. Can also be used as a platform for a debate or discussion with other stakeholders.
- **Social media** – e.g twitter, Linkedin and Facebook as a platform for getting your message out to a wide audience. *See appendix 4 for some advice on using social media*
- **Website** - to promote activity, viewpoint, developments

3.2 Direct communication with politicians and policymakers

Building a relationship with decision-makers and policy advisors can be a good way to get your voice heard and to make your presence and interest on an issue known. Holding meetings with, or writing to, politicians to express
concern and raise awareness to an issue is a low cost way to try and stimulate action. Minutes and responses from meetings can be documented making this form of advocacy easy to monitor and evaluate. Government departments often put out tenders for particular research to be conducted which may provide you with an opportunity to work closely with them.

Planning: Before going to a meeting make sure you plan what you are going to say; think of it as a sales pitch. First and foremost try to engage them with the issue and the implications (cost and health in particular) of the problem and your findings. Have a simple ‘ask’ – i.e. a clear request for action that you want them to undertake

3.2 Consultation responses

Governments regularly conduct public consultations on issues which require stakeholder feedback. Usually anyone can respond to these, so keep an eye out for consultations in your area of interest. It is often worth liaising with other stakeholders if there are specific points you wish to reinforce and emphasise. This can be done on an informal basis (e.g. sharing responses) or more formally via a joint response. Bear in mind that stakeholders with a vested interest, e.g. the food or pharmaceutical industry, may also be responding, so where possible preempt what they may say and address this in your response. See appendix 9 for an example.

3.4 Reports & data collection

Collecting data and evidence and presenting it in the form of reports, updates and/or press releases can be a powerful tool and evidence base to support your campaign and useful for presenting your case to relevant stakeholders, such as policymakers or industry representatives. Examples include
- Literature research on the problem and solutions
- The state of environments (e.g. locality of fast food outlets, prices of fruit and vegetables, availability of cycle lanes)
- Existing policies (e.g. school food, marketing, bariatric surgery access)
- Progress made towards targets (e.g. meeting voluntary commitments, health outcomes)
- Good practice examples; naming and shaming; case studies; benchmarking
- cost-effectiveness

3.5 Briefings and guidelines

Briefing papers summarise the situation, present new ideas and offer suggestions for future activities. They can be distributed to different stakeholders to emphasise the problem that you are concerned with and ensure you keep a consistent message. Position statements can be written in context of wider debates/policy and clearly state your position on an issue and what your goals.

You could also consider developing your own guidelines which you want to be adopted to solve a particular issue. Developing your own guidelines provides your target audience with clear guidance on how you think it should move forward

3.6 Coalitions

Demonstrating to policy makers that you have widespread support for your positions and proposals can help validate what you are advocating. By forming coalitions and collaborating with others, ideally from a wide range of disciplines, and demonstrating a united front on an issue you can increase your credibility in the field you are working in.
A coalition usually involves a position statement which is co-signed by a number of organisations and individuals who feel strongly about the issue.

### 3.7 Expert advisory role

If you are an expert in your field you may have the opportunity to be part of an expert panel, meeting or to take on an advisory role. If you do, this is an opportunity to ensure that the policymakers are presented with all the information necessary for them to make a judgment which is first or foremost made with the public interest in mind.

### 3.8 Events

Holding an event, conference or roundtable meeting with stakeholders can be a valuable advocacy tool in order to increase support, apply political pressure or to discuss future actions. When organising an event there are a number of considerations depending on the intended purpose of the event and the audience. These include:

- Consider the choice of venue, audience and time
- Have a realistic budget, agenda and timetable
- Be media friendly
- Plan materials
- Know your audience and pitch topic/content appropriately
- Stay on point with speakers selected and themes
- Take note of lessons learnt
- Consider the event’s output and how this may be used for future activities

### 3.9 Consumer awareness activities

Any change, whether policy based or at an individual level, requires engagement with and the support of members of the public. Consumer focused campaigns can be useful tools, particularly when aiming to raise awareness on an issue or to get support from a large number of people. They are typically based on a key goal which may be independent of, or feed into other advocacy work.

Engagement can be undertaken in a variety of ways, including local/community events, public calls for action, petitions or advertisements.

### 3.10 Disseminating research

There is a growing and highly important need for more inter- and multi-disciplinary work in the field of public health and obesity. If you are an academic conducting cellular, mechanistic or clinical trials, consider how your findings may be useful for public health policy and make sure you alert the relevant people to your work. By linking up the different fields of research and working in a collaborative way we will advance our understanding and knowledge in the area and be more likely to make a significant difference to the health of individuals and populations.

IASO publishes four leading obesity journals. If you’re active in research why not submit a paper to one of our journals to help get your message communicated to the rest of the field? Even if you aren’t in a position to advocate yourself, your research findings may be a valuable addition to an advocate’s evidence base and may help them get their message heard.
Presenting your work at conferences is another good way to get your message heard. In particular, you can apply the findings to a policy context which supports (or refutes) calls to actions, provides further evidence ahead of an upcoming consultation or decision, or stimulates action in your area. Data slides can be found on the IASO website which may help you put your findings in context of the obesity problem in the population groups relevant to your research.

References

Appendices - Advocacy resources

The following sections aim to build on the previous information to give you some further material, background, resources and advice to help you advocate for measures to reduce the impact of obesity.
# Appendix 1 – Global obesity facts & figures

<table>
<thead>
<tr>
<th>Key Message</th>
<th>Important Facts</th>
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| **Obesity is a growing global health problem around the world** | - Since 1980 obesity prevalence has more than doubled worldwide  
- Obesity is now recognized as one of the most important public health problems facing the world today (1).  
- In 2008, around 1 in 4 adults were overweight (1.5 billion adults).  
  - Of these over 200 million men and nearly 300 million women were obese (2).  
- Figures suggest that in 2010 more than 3.37 million deaths occurred worldwide due to high BMI, an increase from 1.96 million in 1990 (3).  
  - The combined total of deaths from high BMI and physical inactivity was 6.56 million in 2010, more than that from tobacco (3).  
- 65% of the world’s population live in countries where overweight causes more deaths than being underweight (3). |
| **Childhood obesity is increasing and is associated with an increase in disease risk factors** | - Childhood obesity is becoming increasingly common, especially in westernized countries.  
- Over 200 million school-age children and more than 40 million children under the age of five were overweight in 2010 (2).  
- This generation of children is the first predicted to have a shorter lifespan than their parents (4).  
- Obese children have been found to have increased risk of type 2 diabetes, hypertension, raised blood cholesterol, metabolic syndrome and fatty liver disease (5,6).  
- Obesity in childhood and adolescence continues into adulthood; it has been predicted 77% obese children are obese adults (7).  
- Becoming obese earlier in life also amplifies certain health risks later in life, particularly for type 2 diabetes. |
| **Obesity is a major cause of morbidity, disability and premature death** | - Obesity increases the risk for a wide range of chronic diseases  
  - BMI is thought to account for  
    - 60% of the risk of developing type 2 diabetes;  
    - 20% of hypertension and coronary-heart disease;  
    - 10 to 30% of various cancers.  
  - Other co-morbidities include raised cholesterol, gall-bladder disease, fatty liver disease, sleep apnoea, heartburn, osteoarthritis and depression.  
  - The global disease burden attributable to obesity has been calculated at over 93 million disability-adjusted life years (DALYs), almost doubling since 1990 (51.5 million) (8).  
    - Due primarily to ischaemic heart disease and type 2 diabetes.  
  - Middle-aged women suffer more ill-health from obesity than from any other cause (3). |
| **Many low- and middle-income countries are now facing a "double burden" of disease.** | There is increasing evidence that when economic conditions improve, obesity and diet-related non-communicable diseases may escalate in countries with high levels of under-nutrition (9).  
- There is evidence to indicate that under-nutrition in utero and early childhood may predispose individuals to greater susceptibility to some chronic diseases.  
- Many low and middle income countries continue to face problems of infectious disease and under-nutrition and are now experiencing a rapid increase in non-communicable disease risk factors such as obesity and overweight.  
  - It is not uncommon to find under-nutrition and obesity existing side-by-side within the same country, community, household or even individual.  
  - Populations are increasingly exposed to high-fat, high-sugar, high-salt, energy-dense, micronutrient-poor foods, resulting in sharp increases in childhood obesity while under-nutrition issues remain unsolved.  
  - Research has suggested that early life nutritional stunting, which is usually caused by chronic under nutrition, is positively associated with raised body fatness later in life (10). |
**Obesity has substantial direct and indirect costs that put a strain on healthcare and social resources.**

- Obesity presents a significant cost burden to individuals, health services and the economy, both directly and indirectly.
- It has been estimated that the average obese person spent 36% more on medical care than normal weight people (11).
- Direct medical costs include the preventative, diagnostic and treatment services related to overweight and associated co-morbidities.
- Indirect costs are often much higher and include income lost from decreased productivity, reduced opportunities and restricted activity, illness, absenteeism and premature death.
- The cost of obesity is rising in OECD countries – The proportion of total healthcare spend rose from 5% in 1970 to 9% in 2003; the highest figure is in USA at 16% (12).
- In the USA, the annual combined direct and indirect cost is 126 billion euros in 2000, a rise from 72 billion in 1995 (13).
- In the UK, the healthcare costs attributable to overweight and obesity are projected to double to £10 billion per year by 2050. The wider costs to society and business are estimated to reach £49.9 billion per year (at today’s prices) (14).
- High costs are also associated with infrastructure changes required to cope with the rising obesity, such as reinforced beds, operating tables and wheelchairs; enlarged turnstiles and seats in sports-grounds and modifications to transport safety standards.

**Maternal obesity during pregnancy poses risks for both foetus and mother pre- and post-pregnancy**

- Global figures suggest there are more than 100 million obese women of child bearing age, with a further 250 million who are overweight (2).
- Obese women are 3 times more likely to present with infertility compared with women of normal BMI, with the infertility rate increasing by 4% per BMI unit in obese women (15).
- Obesity in pregnancy is associated with an increased risk of a number of adverse outcomes including miscarriage, gestational diabetes (16), hypertension, pre-eclampsia (17), high risk labour (18), haemorrhage (16) and maternal death.
- Maternal obesity can increase the risk of foetal distress, still birth (19) and a ‘large for gestational age’ birth which can increase the likelihood of labour and birth complications.
- High gestational weight gain can increase BMI of an infant later in life.
- In an obese mother, high levels of inflammatory cytokines, insulin resistance, glucose levels and hyperlipidaemia (20) can be seen which can result in the foetus having a higher insulin resistance and higher percentage body fat (21).

**At an individual level some links between genes and obesity can be seen but are not sufficient explanations for the rapidly rising rates of obesity**

- There is a direct link between genes and obesity in conditions such as Bardet-Biedl syndrome and Prader-Willi syndrome.
- According to the ‘thrifty gene hypothesis’, the same genes that helped our ancestors survive are the same genes that are causing obesity.
- Many obesity genes are only expressed in the presence of obesity-promoting behaviours such as sedentary behaviour and/or high energy intake.
- Whilst genes are an important determinant of obesity in some individuals, they are not a sufficient explanation of the rapid rise in obesity over the past couple of decades.

**Poor nutrition, in particular an increase in energy dense processed food which is high in fat, sugar and salt, is contributing to obesity globally**

- Eleven out of 20 of the leading causes of disease in the world can be attributable, at least in part, to poor nutrition. These are high blood pressure, low fruit, high BMI, childhood under-nutrition, high sodium, low nuts and seeds, iron deficiency, high total cholesterol, low whole grains, low vegetables and low omega-3 (3). A major driver of obesity is excess energy consumption in relation to energy expenditure.
- FAO figures indicate that total energy availability per person per day has increased by 450 kcal/day in developed and more than 600 kcal in developing countries (between the mid 60’s and early 90’s) (22).
- There has been a dietary shift away from fresh, minimally processed, grain based foods towards ultra-processed foods (23).
  - These are often high in fat, salt and sugars but low in vitamins, minerals and other micronutrients.
- In the USA the proportion of food eaten away from home has increased by approximately 40% (24) and by 25-30% in Australia and UK (25, 26).
Changing cultures, an increase in technology and an increasing reliance on motor vehicles is resulting in more sedentary lifestyles which, without compensatory reduction in energy intake, increases the risk of obesity.

- Adult energy expenditure was predicted to have fallen by up to 800kcal between 1970 and 1990 (27), and although in part compensated for by a suppression of intake, still leaves a positive energy balance which gradually results in weight gain.
- There is evidence for a close association between obesity and hours spent watching TV and the number of cars per household (28).
- Changes to mode of travel have occurred – in the USA, use of own vehicles increased from 7% to 88% between 1970 and 2000 while walking as sole mode decreased from 7.4 to 2.9% and use of public transportation decreased from, 8.9%-4.7% in the same period (29).
- There has also been a decline in active work (30) as machinery and technology replace human labour.

The food industry has an important role to play in reducing obesity

The World Organization says that the food industry can play a significant role in promoting healthy diets (31)
- Reducing the fat, sugar and salt content of processed foods;
- Portion control;
- Nutrition labelling (front and back)
- Ensuring that healthy and nutritious choices are available and affordable to all consumers;
- Practicing responsible marketing, particularly to children;
- Supporting regular physical activity practice in the workplace.

There is increasing support for restrictions of food marketing to children

- Advertising restrictions are increasingly recognised as an important way in which to reduce exposure to unhealthy food marketing
- In early 2012 the World Health Organization issued a set of guidelines to assist member states in the development of national marketing controls(33)
- There have been a range of responses globally, including some voluntary, some industry-led and some mandatory guidelines
  - Industry-led schemes include USA CFBAI guidelines and EU pledge
  - Mandatory include UK OfCom
  - Voluntary - Danish Forum Code
- A 2011 monitoring report from the EU indicated an overall decline in marketing impacts of 29% between 2005 and 2011 (3.6bn to 2.5bn impacts) across seven EU countries, however some countries had significant increases, including Slovenia (up 26%) and the Netherlands (up 38%) (34).
- There are a number of issues that need to be addressed, in particular the effectiveness of voluntary vs. mandatory schemes, the age definition of a child, the media forms covered by schemes and the use of branding.

Support at a societal level is vital for individual change

At the individual level, people can:
- limit energy intake from total fats;
- increase consumption of fruit and vegetables, as well as legumes, whole grains and nuts;
- limit intake of sugars;
- engage in regular physical activity;

Individual responsibility can only have its full effect where people have access to a healthy lifestyle. Therefore, at the societal level it is important to:
- Ensure that the healthier options are the default and easiest options;
- Support individuals, through sustained political commitment and the collaboration of many public and private stakeholders;
- Make regular physical activity and healthier dietary patterns affordable and easily accessible to all - especially the poorest individuals;
- Create environments which promote healthier lives, active travel and reduced car usage.
| Health practitioners need to be able to identify obesity and make appropriate recommendations for weight loss | • Body mass index (weight (kg)/height(m^2)) is the standard method used for determining overweight and obesity – a BMI ≥25kg/m^2 is overweight, ≥30 is obese kg/m^2, ≥35 severely obese kg/m^2 and ≥40 morbidly obese kg/m^2
• When losing weight, aim to lose between 500g and 1kg per week.
• Weight loss of 10%- can bring about improvements in co-morbidities.
• Very low calorie diets (VLCD) (less than 800kcal/day) can achieve rapid weight loss, but sustained weight loss and maintenance is low. |
| --- | --- |
| Behaviour change is an important method of weight loss and should always be tried in the first instance | Behaviour change involves both increasing physical activity and changing diet.
• It is important to set realistic and specific goals;
• Diet diaries, exercise logs and pedometers can all be used to help maintain motivation;
• Commercial weight loss programmes can help by offering supportive networks to keep people motivated. Individuals should discuss with their GP what is most appropriate for them; |
| Pharmacological treatment can be used to ‘kick-start’ weight loss when coupled with behaviour change | • Drugs to promote weight loss are typically targeted in one of three ways (42) - reduce hunger/food intake, stimulate energy expenditure or inhibit absorption of dietary fats.
• Such drugs are advised as part of lifestyle change in patients with a BMI >30 (or >27kgm2 if co-morbidities are also present).
• The main drug used today is Orlistat (reduces fat absorption) which- found to achieve 10% weight loss after a year in a third of cases (43).
– Often all weight is put back on when the drug is withdrawn. |
| Bariatric surgery is the most cost effective treatment for severe-morbid obesity | • Bariatric surgery is considered the most cost-effective treatment for morbid obesity (35), leading to loss of excess weight by 45-70% (36).
• Bariatric surgery can significantly reduce type 2 diabetes, with more than 75% of cases being resolved completely (37), eliminate sleep apnoea in 60-70% of subjects as well as reducing other risk factors such as hypertension and lipidaemia (38,39).
• In 2008, 344221 bariatric surgery operations were performed, 220000 of which were in USA (based on a survey of international federations for the surgery of obesity and metabolic disorders) (40).
• The most common procedures are laparoscopic gastric banding (42.3%) and laparascopic gastric bypass (39.7%). Almost all procedures increased in frequency the period 2003-2008 (40).
• Gastric bypass surgery can be performed in adolescents, resulting in significant weight reduction (between 28 and 45% 1–6 years after surgery) (41). |
| The WHO has set a global target to “Halt the rise in obesity by 2025” | The WHO NCD Global Action Framework has set a target on obesity, to halt the rise in obesity by 2025 (31) Indicators of progress will include:
• Age-standardized prevalence of overweight and obesity in adults aged 18+ years (defined as body mass index greater than 25 kg/m2 for overweight or 30 kg/m2 for obesity);
• Age-standardized prevalence of overweight and obesity in adolescents (defined according to the WHO Growth Reference, overweight-one standard deviation BMI for age and sex and obese-two standard deviations BMI for age and sex);
Related progress indicators include:
• Adoption of national policies that limit saturated fatty acids and virtually eliminate partially hydrogenated vegetable oils in the food supply as appropriate within the national context and national programmes;
• Policies to reduce the impact on children of marketing on foods and non-alcoholic beverages high in saturated fats, trans fatty acids, free sugars, or salt; |

References


(10) Pepkin BM, Richards MK, Montiero CA. (1996) Stunting is associated with overweight in children of four nations that are undergoing the nutrition transition. J Nutr, 26:3009–16.


(23) Monteiro C (2011) Commentary. The big issue is ultra-processing. There is no such thing as a healthy ultra-processed products. World Nutrition. 2 (7) 333-349


### Appendix 2 – Regional statistics for obesity and co-morbidities


<table>
<thead>
<tr>
<th>Region</th>
<th>Overweight and obesity (1):</th>
<th>Overweight and obesity (1):</th>
<th>Overweight and obesity (1):</th>
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</table>
| **Europe**                      | 248million people in the European region are classified as overweight, with a further 141million who are obese. This represents 1 in 3 people being overweight (34%) and 1 in 5 (19%) being obese.  
   - In the European Union 27 member states, approximately 60% of adults and 20% of school-age children are overweight or obese.  
   - Diabetes (2): More than 55 million (8.4%) people in the Europe Region have diabetes, with the highest incidence found in Russia (12 million). In 2012 diabetes caused 622,000 deaths and cost almost EUR 140billion.  
   - CVD (3): Every year there are 4,584,000 deaths due to cardiovascular disease in the region.  |
| **Middle Eastern Regions (incl. North Africa)** | Approximately 84 million people in the region are classified as overweight (21%), with 50million obese (13%). Overall 1 in 3 (34%) people are either obese or overweight. Kuwait has one of the highest global obesity rates with a prevalence of 36% in men and 48% in women.  
   - Diabetes (2): more than 34million (11%) diabetes have diabetes, the highest prevalence globally. Diabetes is responsible for over 350,000 deaths every year and cost USD 12billion in 2012. Egypt has the highest number of people living with diabetes, with 7.5million, followed by Pakistan with 6.6million.  
   - CVD (3): Every year there are 1,195,000 deaths due to cardiovascular disease in the region.  |
| **African Region**              | 123 million people (27%) in the African region are classified as being overweight or obese. Broken down, this represents 1 in 5 being overweight (19%) overweight, 8% who are obese. Although the prevalence is not the lowest globally, the African region has the lowest number of individuals who are obese or overweight.  
   - Diabetes (2): 14million (4.3%) have diabetes in the region, resulting in over 400,000 deaths every year. In 2012 2.5billion was spent on treating diabetes. The African region has the higher percentage of undiagnosed diabetes in the world (81%).  
   - CVD (3): Every year there are 1,254,000 deaths due to cardiovascular disease in the region.  |
| **North America and Caribbean** | 220 million people are overweight, with a further 159million obese in the North American and Caribbean region. This equates to 1 in 3 (31%) people being overweight and almost 1 in 4 (23%) being obese – more than half (54%) of the population are either overweight or obese. The region has the highest proportion of overweight or obese individuals globally.  
   - Diabetes (2): 38.4million people in the region have diabetes (11%) diabetes, 24.1million of which are in US and 10.6million in Mexico. In 2012, USD 227.2billion was spent on treating diabetes in the region. Diabetes was responsible for almost 300,000 deaths in 2012.  
   - CVD (3): Every year there are 1,944,000 deaths due to cardiovascular disease in the region.  |
| **Western Pacific**             | In the WHO Western Pacific region there are currently 279 million overweight people and 63million who are obese. Overall 1 in 4 (24%) are either overweight or obese. The region has the highest number of overweight individuals, although it does not have the highest prevalence.  
   - Large variations exist between the countries within the region. In Australia for instance, 42% of men are overweight and 26% are obese (31% and 2% for women) while in Cambodia, Fiji, Hong King, Vietnam the figures are significantly less, with obesity rates at under 10%.  
   - Diabetes (2): 132.2million people have diabetes (8%). In 2012 this cost USD 72.2billion and resulted in 1.7million deaths. More people live with diabetes in the Western Pacific region than any other region, the largest proportion of which are in China (92.3million).  
   - CVD (3): Every year there are 4,735,000 deaths due to cardiovascular disease in the region.  |
| **South East Asia**             | The WHO Region for South East Asia had the lowest proportion of obesity and overweight - overall 1 in 10 people are overweight and just 2% are obese.  
   - Due to the population of the region however this equates to 131million people who are overweight and 30million who are obese, which represents a significant health and cost burden to the region.  
   - Diabetes (2): More than 70.3million people are living with diabetes (8.7%) in the region, with the highest levels found in India (approximately 63million). In 2012, diabetes cost USD 46billion and caused 1.1 million deaths.  
   - CVD (3): Every year there are 3,616,000 deaths due to cardiovascular disease in the region.  |

### References

Appendix 3 – Managing conflicts of interest

There is increasing concern and debate surrounding issues of conflicts of interest and potential risks that may arise from engaging with corporate entities. Whilst financial support from the corporate sector may be appealing, questions need to be asked about how accepting such support may influence your decisions, priorities, credibility and independence from business.

Non-governmental organisations (NGOs), governments and academics are under increasing scrutiny regarding their financial situation and sponsors. IASO has been working to develop its own “terms of engagement” which allows members of the steering committee to do a risk analysis on whether or not it would be acceptable and in line with IASO’s aims, to accept support or funding from a particular organisation.

To support your work in advocacy we recommend that you follow our terms of engagement as much as possible so as to support and guide your own funding decisions. The development of terms of engagement guidelines allow you to identify and manage potentially conflicting interests. This is important to ensure your aims and objectives are not affected, that potential reputational risks are managed and to enable you to defend any engagement that you do allow.

**Key terms**

“Risk” = Anything that could potentially cause reputational damage and/or prevent you working towards your goals in your capacity as an independent charitable organisation or research group.

Conflict of interests = This relates to the potential for an NGO’s links to commercial concerns to inhibit the NGO’s actions in pursuing their core public interest, health-promoting and health policy advocacy work – for example inhibiting their willingness to criticise commercial organisations or to propose policy measures which affect commercial markets (e.g. taxation, controls on advertising).

Sources of funding = ‘Funding’ includes income for its core operational activities, income for special programme and project activities, income obtained from conferences, publications and services and income obtained from the investment of funds. It also includes gifts and donations and sponsorship of staff (or the training of staff) or accommodation or equipment for an NGO.

Relations, partnerships and co-sponsorships = This relates to an NGO’s relations with commercial organisations in the pursuit of the NGO’s normal activities, such as the development of policies and consultation responses, the co-delivery of outputs including services and the co-sponsorship of third parties.

Governance processes = This relates to the structures and processes for decision-making within the NGO and the potential for commercially-interested parties to participate in these structures and processes.

Co-branding and public facing activities = This relates to a collection of additional activities which may bring an NGO into potentially conflicting positions.

**Terms of engagement**

There are four key elements of good practice that you should consider when engaging with the corporate sector

1. Presence of a risk assessment
2. Transparency
3. Protection of reputation
4. Avoidance of dependency
1. Presence of a risk management process
This should be transparent and can be inspected by observers, and can be used by governing bodies as an objective tool for decision-making.

<table>
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<tr>
<th>Key components of a risk assessment</th>
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<tbody>
<tr>
<td>(a) division of activities into categories of higher risk (e.g. core funding), medium risk (e.g. educational grants, project co-sponsorship) and lower risk (e.g. contracts with suppliers, advertisers in journals);</td>
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<td>(b) division of commercial sector into three tiers: (a) high risk / unacceptable; (b) medium risk / further information, (c) low risk / generally acceptable;</td>
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<tr>
<td>(c) construction of a matrix which sets the activity categories against the commercial categories, thereby defining instances where no further risk assessment is required (due to immediate exclusion or to immediate acceptability);</td>
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<tr>
<td>(d) a detailed risk assessment for those instances where further assessment is required: this should involve an ethical committee or similar body considering a check-list of questions about potential reputational damage from association with a specified commercial organisation, for a particular proposed activity or range of activities;</td>
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<tr>
<td>(e) the use of a set of mitigation processes to further reduce and manage potential risks.</td>
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</table>

2. Transparency
You need to ensure that there is transparency of any engagement you may have with corporations, namely that all funding sources, relationships, governance and other activities are openly declared and available for inspection.

3. Protection of reputation
The governing body’s duties include the protection of the reputation of the organisation. The activities described under the four issues here should not damage the NGO’s image and reputation or allow the NGO’s name to be used in a potentially damaging manner.

4. Avoidance of dependency and bias
Avoidance of dependency to ensure that the NGO remains capable of acting within its own remit, rather than co-optation with corporate interests is important.

An NGO should strive to avoid dependence on commercial sources of income and avoid bias due to commercial influence in governance. Reliance on commercial funding, and the presence of commercial influence on the governing bodies, may not only damage the NGO’s reputation but may inhibit its ability to criticise commercial actors (especially those with which it has a funding or governance relationship) or to propose policies which include market-restricting measures (e.g. taxes on products, controls on advertising).

Actions which can mitigate dependency and bias include:
- Restricting the proportion of core funding from commercial sources to a specified limit;
- Increasing the spread of sources of funding, so that no industry sector provides the majority of the commercial funds;
- Requiring that all trustees maintain up-to-date conflicts of interest statements, and that trustees deemed to have a conflict of interest are always a minority of the total, both in general and in any specific meeting, and cannot hold the position of Chair;
- Requiring commercially-linked trustees to be absent from discussions of general policy and NGO policy directions;
Social media gives you a platform for making your messages more accessible and for networking with wider audiences nationally and internationally. It is becoming an increasingly popular tool in advocacy as it is free and easy to use. It can be useful for:

- Raising awareness
- Getting messages out to large numbers of people
- Networking
- Promoting activities and events
- Getting support for a specific call to action/petition
- Directly targeting politicians
- Reaching consumers and organisations alike
- Keeping up to date with others activities

**Twitter**

Twitter is one of the most commonly used social media platforms in advocacy. Tweets can be best described as short ‘snippets’ of information with a 140 character limit (including any links) and can be used to share links, give top tips and statistics as well as promote news stories and campaign updates.

**Twitter jargon**

- **#hashtags** – These are key words in a tweet preceding a ‘#’ which helps to improve search ability and group your tweet with others using the same hashtag.
- **RT (Retweets)** – You can retweet someone else’s tweet if you like what they are saying (MT = modified tweet)
- **Replies** – You can send a reply to a tweet, in answer to a question or to comment on what someone else has said
- **@Username (Mentions)** – You can send a tweet to someone, or mention them in a tweet by using the ‘@’ symbol followed by their twitter name

### Suggestions of people to follow

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Suggestions of hashtags to use or search

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**WHO**
#NCDs
#post2015
#MDG
#GlobalHealth
#WHOGlobalTarget
#publichealth
#prevention

LinkedIn
You can get involved with IASO discussions and find out more about events through the IASO LinkedIn page. You can also set up your own page to promote activities and work to your own members.

Facebook
Facebook is particularly good if you have a lot of individual members or wish to advocate on consumer issues. You can initiate debate, share updates or post general information about the aspect of obesity you are interested in.
### Appendix 5 – Examples of advocacy activities by different stakeholders

<table>
<thead>
<tr>
<th>Activity</th>
<th>Stakeholder type</th>
<th>Example</th>
<th>Description</th>
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<tbody>
<tr>
<td>Data collection</td>
<td>Assessment of Government policies</td>
<td>NGO (obesity)</td>
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<td>Monitoring corporation action</td>
<td>Academic group (policy)</td>
<td>Cereal Facts (Rudd)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Academic (policy)</td>
<td>25 global food companies (City)</td>
</tr>
<tr>
<td>Assessing the food environment</td>
<td>NGO (consumer)</td>
<td>Check outs checked out (Sustain)</td>
<td>Survey of junk food availability at checkouts in a sample of UK supermarkets. Calls for the removal of unhealthy foods marketed at checkouts and replaced by healthy or non-food products</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Health Professionals</td>
<td>Measuring up: The medical professions prescription to the nation’s obesity crisis (AoMRC)</td>
</tr>
<tr>
<td>Consumer Engagement/advocacy</td>
<td>NGO</td>
<td>STAR Programme OAC</td>
<td>The purpose of the STAR Program is to support and communicate the mission and goals of the OAC before the state legislature and regulatory agencies. The STAR Program seeks individuals who are interested in volunteering their time and wish to make a strong impact in state advocacy initiatives.</td>
</tr>
<tr>
<td></td>
<td>NGO</td>
<td>The Parents’ Jury</td>
<td>A campaign based around parents becoming community champions on issues that are important to them, such as marketing and school meals.</td>
</tr>
<tr>
<td>Legislation</td>
<td>NGO</td>
<td>Centre for Science in the Public Interest</td>
<td>CSPI litigation project works in the public interest to monitor and hold companies to account for actions. They file lawsuits (or threaten to do so) When they believe companies are making unacceptable claims on their products and/or the use of certain ingredients</td>
</tr>
</tbody>
</table>

4. [http://www.which.co.uk/documents/pdf/a-taste-for-change---which-briefing---responsibility-deal-305379.pdf](http://www.which.co.uk/documents/pdf/a-taste-for-change---which-briefing---responsibility-deal-305379.pdf)
5. [http://www.sustainweb.org/publications/?id=212](http://www.sustainweb.org/publications/?id=212)
8. [http://www.obesityaction.org/advocacy/star-program](http://www.obesityaction.org/advocacy/star-program)
<table>
<thead>
<tr>
<th>Events</th>
<th>Scientific</th>
<th>NGO (obesity)</th>
<th>ICO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parliamentary</td>
<td>NGO/ academic</td>
<td>CASH/WASH¹¹</td>
<td>An annual event held at the House Of Commons, bringing together MPs, Peers, Food Industry and other stakeholders to discuss issues relating to salt and health and to call for further Industry and Government action to reformulate processed foods</td>
</tr>
<tr>
<td>Launch</td>
<td>Academic &amp; NGO (NCDs)</td>
<td>Lancet</td>
<td>The Lancet runs a special edition on NCDs every 2-3 years. A 2 day event was held to launch the edition and initiate debate on the issues covered and how to move forward.</td>
</tr>
<tr>
<td>Use of media</td>
<td>Social media</td>
<td>NGO (health)</td>
<td>#RDUK (Dietitians)¹²</td>
</tr>
<tr>
<td>Name and shame awards</td>
<td>NGO</td>
<td>Parents’ Jury²³</td>
<td>Aim to raise awareness of the techniques that advertisers use to promote unhealthy foods and drinks to children, and to recognise the advertisements that promote healthy food to children in a fun and appealing way.</td>
</tr>
<tr>
<td>Petition</td>
<td>NGO (consumer)</td>
<td>Save our school food standards (Sustain)¹⁴</td>
<td>Petition to get individuals to feed into school food plan and/or write to MP to get them to support school food. Suggested text offered in both cases, but it is possible to amend.</td>
</tr>
<tr>
<td>Stakeholder coalitions</td>
<td>NGO (health)</td>
<td>Conflicts of Interest coalition¹⁵</td>
<td>A group of interested parties around the world have signed a joint statement of concern to be given to WHO regarding conflicts of interest in the policy making process. By demonstrating the widespread view that conflicts of interest need to be managed careful, the stakeholders involved hope that the WHO will take on the groups recommendations</td>
</tr>
<tr>
<td></td>
<td>NGO (cycling), academics</td>
<td>Scientists for cycling¹⁶</td>
<td>The ‘scientists for cycling’ network was established to bridge the gap between research and scientists, professionals and volunteers who work on cycling or cycling-related issues. Through the coalition can work on and support research, policies and infrastructure changes to promote cycling</td>
</tr>
<tr>
<td></td>
<td>NGO (health)</td>
<td>NCD Alliance¹⁷</td>
<td>The mission of the NCD Alliance is to combat the NCD epidemic by putting health at the centre of all policies. It is made up of four international NGO federations working across more than 170 countries. Together they issue consultation responses and position statements in response to WHO. The idea being that unified messages are stronger than individual messages which may or may not have inconsistencies</td>
</tr>
</tbody>
</table>

¹¹ http://www.actiononsalt.org.uk/awareness/awareness/House%20of%20Commons%20Reception/41837.html
¹² http://www.thefoodcoachltd.com/rduk/
¹⁴ http://www.sustainweb.org/sos/
¹⁵ http://coicoalition.blogspot.co.uk/
¹⁶ http://www.ecf.com/projects/scientists-for-cycling/
¹⁷ http://www.ncdalliance.org/who-we-are
Appendix 6 – Which advocacy method should you use?

Are you concerned about an issue that isn’t already part of a political debate?

- Identify the most appropriate governmental department
- Write to & setup meetings with them
- Conduct a literature based review of the problem, write up a report and disseminate via media routes
- Once you have the attention of policymakers you can move on

Are you concerned about an existing political debate?

- Identify other stakeholders who are already active in this area
- Set up meetings with stakeholders and policy makers in this area
- Consider coalition work e.g. producing a position statement
- Keep on top of consultations and respond accordingly
- Conduct research to support further work and publish using media

Are you concerned about behaviour change at the consumer level?

- Produce consumer friendly campaigns
- Hold a consumer event, day or week
- Use lay language media such as facebook and twitter

Do you want industry practices/policies to change?

- Hold meetings with the relevant organisations to discuss with them directly
- Identify like-minded stakeholders, form coalitions
- Conduct surveys, benchmark and publish report – publicise these in the media

Do you want government policies to change?

- Hold meetings with relevant MPs
- Identify like-minded stakeholders, form coalitions
- Conduct surveys, find case studies, produce best practice guides and report – publicise these in the media
- Feed into appropriate consultations
- Generate consumer support/raise awareness, petition, lobby

Do you want a change to be made within your own organisation?

- Identify the most appropriate person to speak to, hold meetings
- Carry out a survey on the issue you are interested in, petition with like-minded colleagues
- Gather evidence and present a report on problems and solutions
Which advocacy methods should you use?

**Target**

- **Policy maker**
  - Introduce a new policy
  - Policy amendment
  - Influence a policy being discussed
  - Advocacy options:
    - Best practice guidelines
    - Form a coalition
    - Information sharing
    - Letters/meetings
    - Policy briefings / position statements / draft guidelines
    - Generate wider support e.g. voters
    - Academic research / evidence base
    - Hold a conference / meeting
    - Advisory role
  - Monitor activities
  - Consultation response

- **Corporation**
  - Change practice
  - Introduce policy
  - Align with guidelines
  - Advocacy options:
    - Surveys/benchmarking
    - Targeted media
    - Naming & shaming
    - Letters / meetings
    - Social media e.g. twitter, FB, YouTube
    - Conference
    - Monitor activities

- **Consumer**
  - Change behaviour
  - Raise awareness / educate
  - Encourage lobby for change
  - Advocacy options:
    - Social media e.g. twitter, FB, YouTube
    - Community events, open meetings
    - Press release with “shocking” headlines
    - Newsletters / website
    - Campaign / awareness activities
  - Lay language resources
  - Petition
Appendix 7 - Writing a press release

Before you start

- Have a legitimate news angle (announcing something new and/or timely)
- Know your numbers. Is what you’ve done relevant?
- Is there a date in particular that is needed e.g. launch of campaign? Think ahead and make sure you send it the press with sufficient time
- Know your audience – e.g. newspaper, radio, magazine

Date and embargo Remember to date your press release, particularly if it is not for immediate release. Include an embargo data and time clearly in red at the top of the release, and remember to indicate time zones, particularly for international press releases.

Catchy headline A strong headline (and email subject line when you send out the prelease) will attract journalists seeking good stories. Your headline should be as engaging as it is accurate.

Summary Emphasise the key points that you want included in any news stories. Get the message of your press release out quickly. Every important point should be addressed in the first few sentences. The subsequent paragraphs should be for supporting information. Use the introductory paragraph to sum up the story in 50-100 words – it could be all that gets read! Stick to the facts. Explain who you are, what you’re announcing, where it is taking place, when it’s happening, plus possibly why and how. These questions communicate the gist of your story. “who, what, where, when, why”

Empirical evidence Leave the artistry to the journalist - your press release should be filled with hard numbers that support the significance of your research or other announcement. If you’re claiming a trend, you need proof to back it up. Quantify your argument and it will become much more compelling.

Include a quote by a person who conducted research or is an expert in the area. This adds a human element to the press release, as well as being a source of information in its own right. Remember to make sure that the quoted person is available for further interviews if required.

Length: keep it short and sweet, about 1-2 sides of A4. Also include graphics for extra information which may be useful to the journalist, and will also serve to grab their attention.

Background information Make sure that the journalist can get in contact with you should they have any queries or require further information. It is also good to provide them with some information about your organisation or project, as well as any links to relevant information which they may find useful.
Junk food advertising to kids: Self-regulation is failing across Europe

London, 27 September 2012:

Advertising of junk food continues to undermine children’s health despite the food industry’s promises that they would restrict their marketing activities, according to a new report *A Junk-Free Childhood 2012: Marketing foods and beverages to children in Europe* published today by the International Association for the Study of Obesity (IASO).

The review of advertising in Europe undertaken by IASO, a not-for-profit organisation, found that the industry’s own figures show that children’s exposure to advertisements for fatty and sugary foods had fallen by barely a quarter over the last six years.

The report’s author, Dr Tim Lobstein, said “The food and beverage companies were told in 2004 by the then European Health Commissioner Markos Kyprianou that they must cut their advertising to children or face regulation. The figures show that self-regulation achieved only a 29% fall in children’s exposure, which is deeply disappointing. Exposure is now creeping up again in some countries.”

“The problem is made worse because the companies are allowed to set their own standards for what they consider ‘junk food’ and they set the bar too low,” said Dr Lobstein. “Our report found over 30 fatty and sugary foods which are classified as unhealthy in government-approved schemes across Europe and the USA but which are considered healthy by the manufacturers and which they allow themselves to advertise.”

He said “Each company came up with its own definitions of what and how it will advertise, which it uses to its own advantage. No-one understands all the definitions and no-one can monitor them effectively. This anarchy might suit the companies, but it means that children remain exposed to advertising which encourages them to eat a junk food diet. Self-regulation simply does not work in a highly competitive marketplace,” said Dr Lobstein. “Asking the companies to restrict their own marketing is like asking a burglar to fix the locks on your front door. They will say you are protected, but you are not.”

Proposals being debated in Norway this month suggest that all advertising of junk food which targets anyone under age 18 should be restricted by law. “Children have a champion in Norway,” said Dr Lobstein. “We want this high level of protection applied across Europe.”

Contact: The International Association for the Study of Obesity, 12 Roger Street, London WC1N 2JU
Notes


Children’s reduced exposure to advertisements for EU Pledge non-compliant products (specified by the manufacturer)

Number of impacts (in millions) and percentage change from first quarter 2005 to first quarter 2011, for children’s exposure during all programming.

Source: *EU Pledge 2011 Monitoring Report*. http://www.eu-pledge.eu/content/annual-reports

<table>
<thead>
<tr>
<th>Country</th>
<th>2005 Q1</th>
<th>2011 Q1</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>1,031</td>
<td>673</td>
<td>- 35 %</td>
</tr>
<tr>
<td>Ireland</td>
<td>58</td>
<td>32</td>
<td>- 45 %</td>
</tr>
<tr>
<td>Netherlands</td>
<td>111</td>
<td>153</td>
<td>+ 38 %</td>
</tr>
<tr>
<td>Poland</td>
<td>1,618</td>
<td>1,018</td>
<td>- 37 %</td>
</tr>
<tr>
<td>Portugal</td>
<td>264</td>
<td>199</td>
<td>- 25 %</td>
</tr>
<tr>
<td>Romania</td>
<td>462</td>
<td>434</td>
<td>- 6 %</td>
</tr>
<tr>
<td>Slovenia</td>
<td>23</td>
<td>29</td>
<td>+ 26 %</td>
</tr>
<tr>
<td><strong>All countries reported</strong></td>
<td><strong>3,567</strong></td>
<td><strong>2,538</strong></td>
<td><strong>- 29 %</strong></td>
</tr>
</tbody>
</table>

2. The report is part of the StanMark Project which aims to promote responsible standards for marketing food and beverages to children. Further details of the StanMark project is available at http://www.iaso.org/policy/euprojects/stanmarkproject/


4. The food and beverage companies’ European pledges are at http://www.eu-pledge.eu/.

5. The Norwegian government’s proposals for restricting marketing of foods and beverages to children are at www.regjeringen.no/nb/dep/hod/dok/hoeringer/hoeringsdok/2012/horing---forslag-tilny- regulating-av-ma.html. An unofficial English summary is at www.iaso.org/resources/library/721/

6. The World Health Organization’s 2010 *Recommendations on marketing foods and beverages to children* can be found at www.who.int/dietphysicalactivity/marketing-food-to-children/en/index.html

7. The International Association for the Study of Obesity is a not-for-profit organisation with over 10,000 professional members in 54 national and regional associations, based in London UK. See www.iaso.org.
DATE
XXX
XXX

Dear XXX

Re: Brazil as a world leader in policy actions to prevent obesity,

The rising prevalence of obesity in most countries is creating enormous pressures on health care systems which are straining under the escalating costs of chronic diseases like type 2 diabetes burden, overtaking smoking in some high income countries and undernutrition in many low and middle income countries. At the recent International Congress on Obesity in Stockholm, Sweden, the International Obesity Taskforce (IOTF) reviewed the progress countries were making in instituting effective, sustainable policies for the prevention of obesity. Based on the evidence presented at the conference and the feedback from our network of experts, two countries were clearly taking the lead in obesity prevention – Brazil and England. IOTF would like to highly commend Brazil on its excellent progress on this very challenging societal problem. In particular, IOTF was impressed with the following initiatives:

1. Regulating food marketing: Resolution 24/2010 from ANVISA on the regulation of advertisements of food products with excessive salt, sugar, saturated fats or trans fats is a major advance internationally. In particular, the clear, pre-determined health warnings on any advertisement of these unhealthy products on television, print media and the internet will be a valuable strategy. While this will come under strong attack from the food industry and the commercial media sector, such measures are an essential part of reducing the rising health burden associated with unhealthy diets.

2. School meals: The federal law approved by the Congress and signed by the President, requiring that a minimum of 30% of the resources of the National School Meal Program (more than 1 billion US dollars per year) be used to buy fresh foods grown by local family farmers is very important for health and local economies. This builds on a previous resolution required that 0% of foods offered to children were basic, minimally processed foods. The School Meal Program is an excellent exemplar for other countries with similar programs to follow. There was much interest in the program when it was presented at the recent International Congress on Obesity in Stockholm.

3. Monitoring of obesity trends: The existence of a solid national system which monitors obesity prevalence and its immediate determinants (diet and physical activity patterns) through periodic national household surveys is another exemplar that even many wealthy countries would wish to have. It is based on high quality, international standards and covers both adults and children.

4. Obesity management: The incorporation of actions aiming at the prevention and management of obesity and other chronic diseases in the national Family Health Program is another important strategy in a comprehensive plan.

5. Breastfeeding: The successful comprehensive national breastfeeding program has been a remarkable success (and again the envy of many countries) by increasing the median duration of total breast feeding from 3 months in the 1970s to 12 months in 2008. The inclusion of a strong code which regulates the marketing of infant formula is an essential strategy to protect mothers from the unethical marketing practices of some infant formula companies.

Minister, this is an impressive suite of policies and programmes and if other countries were following Brazil’s lead, we would have much more positive news to present to obesity conferences on positive evidence of progress in obesity prevention. The progress in Brazil since the International Congress on Obesity was held in Sao Paulo in 2002 has been extremely positive. IOTF recognises that the journey to turn the tide of obesity will be a long one with many challenges, especially from commercial vested interests, along the way. In any complex and contested endeavour to improve societal outcomes, a combination of government policies, community programmes, capacity building and individual actions will be needed but it is often the vision and commitment of the political leaders that really makes a difference between progress and no progress.
IOTF would like to highly commend you and your government for making a difference for the population of Brazil, especially the children and adolescents to whom society has a special responsibility. In addition, we would like to acknowledge the international leadership that Brazil is providing for other countries. This is critically important for obesity, which is a global epidemic with no easy or short term answers. If IOTF can assist your government in any way to build on this excellent base, we would be happy to do so.

Yours sincerely

Prof. Boyd Swinburn; Prof. Shiriki Kumanyika, Joint Chair IOTF

In addition all the international members of the IOTF Scientific Advisory Council are co-signatories to the letter as listed below:-

Prof. Narendra Arora, India
Prof. Simon Barquera, Mexico
Prof. Louise Baur, Australia
Prof. Kelly Brownell, USA
Prof. Johannes Brug, The Netherlands
Prof. Martin Caraher, UK
Prof. Narendra Arora, India
Prof. Simon Barquera, Mexico
Prof. Louise Baur, Australia
Prof. Kelly Brownell, USA
Prof. Johannes Brug, The Netherlands
Prof. Martin Caraher, UK
Prof. Walmir Coutinho, Brazil
A/Prof. Tim Gill, Australia
Prof. Lei Zhenglong, China

Dr. Corinna Hawkes, France
Prof. Susan Jebb, UK
Prof. Jiang Jingxiong, China
Prof. Albert Lee, China Hong Kong
Dr. Tim Lobstein, UK
Prof. Carlos Monteiro, Brazil
Prof. Barry Popkin, USA
Dr. Mike Rayner, UK
Prof. Barbara Riley, Canada
Dr. Aileen Robertson, Denmark
Prof. Thomas Robinson, USA
Prof. Jaap Seidell, The Netherlands
Prof. Marc Suhrcke, UK
Prof. Ricardo Uauy, Chile
Prof. Emorn Wasantwisut, Thailand

Copies of this letter have also been sent to the following:

Dirceu Raposo de Mello – Diretor Presidente da ANVISA
Francisco Batista Junior - Presidente do Conselho Nacional de Saúde
Ana Beatriz Vasconcellos- Diretora da Coordenação Geral da Política de Alimentação e Nutrição (CGPAN)
baneide Peixinho- Coordenadora Geral do Programa Nacional de Alimentação Escolar (PNAE)

Response to WHO consultation
About IASO
The International Association for the Study of Obesity (IASO) is a not-for-profit organisation linking over 50 regional and national associations with over 10,000 professional members in scientific, medical and research organisations. It is an umbrella organisation for 53 national obesity associations, representing 56 countries, along with a policy analysis body, the International Obesity TaskForce (IOTF). The headquarters are in London, UK.

IASO is officially recognised as a non-governmental organisation by the WHO. Our mission statement is "To improve global health by promoting the understanding of obesity and weight-related diseases through scientific research and dialogue, whilst encouraging the development of effective policies for their prevention and management."
For further information see www.iaso.org and www.iotf.org

General comments on the updated Global Action Plan
IASO welcomes the opportunity to contribute to this consultation exercise on the Global Action Plan for NCDs 2013-20. We support the proposed objectives in the action plan, and we endorse the amendments and suggestions proposed by World Cancer Research Fund International and the UK National Heart Forum in their detailed responses.

However, we are disappointed that reference to obesity is limited to two sentences on page 21, with no clear policy options specifically aimed at reducing and preventing excess bodyweight. This is a serious omission, given the importance of excess body weight in a wide range of chronic diseases – for example bodyweight has a greater impact on hypertension than does dietary sodium, and bodyweight has a greater impact on liver disease than alcohol consumption.

We also draw attention to the recent analytical document on best buys and cost-effectiveness in public health circulated at the WHO EURO Regional Assembly 2012 (see http://www.euro.who.int/__data/assets/pdf_file/0009/171819/The-Economic-Case-for-Public-Health-Action.pdf) which includes reductions of child exposure to food and beverage marketing as a cost effective intervention, an intervention which appears to have fallen off the list of best buys in recent WHO documentation. Lastly, we urge WHO to develop a more coherent set of actions to improve nutrition in terms of upstream drivers of the diet, including food availability, food affordability and food acceptability to comprehensively reduce risk, and to support the development of goals and monitoring mechanisms to assist the control and governance of these drivers.

Answers to specific questions
Part 1: Accelerate national responses
Which recommended actions for Member States would generate a national political commitment on how to contribute to a global target of a 25% reduction in premature mortality from NCDs by 2025?
• Advocacy and Communication: strengthen and sustain advocacy through the construction of a searchable database of public health interventions being attempted by member states and by authorities within member states, aimed at improving nutrition and preventing obesity.

Which recommended actions for Member States would strengthen the development and implementation of national multisectoral plans for the prevention and control of NCDs? (including national targets and indicators, and actions to strengthen surveillance and monitoring systems).
• Increased surveillance of the drivers of health behaviour and the shapers of environments that affect health, including the role of commercial operators and the development of food and beverage markets.

Which recommended actions for the WHO Secretariat could be included in the 2013 to 2020 Action Plan to strengthen the capacity of Member States in mobilizing a whole-of-government response to NCDs?
Member states need to establish coordinating authorities able to propose interventions and monitor their effects. WHO should strengthen its capacity to provide technical support to such authorities.

Which recommended actions for Member States would increase and prioritize budgetary allocations for addressing NCDs? (including through an increase in taxation on tobacco and alcohol)

- This is an opportunity to warn member states to be extremely cautious in their development of public-private partnerships, and to have clear mechanisms for dealing with potential conflicts of interest. WHO has some experience in this and could provide technical support.

Which recommended actions for international partners would increase the provision of adequate, predictable and sustained resources through bilateral and multilateral channels to support national NCD efforts?

- Again, the appropriate warnings and mechanisms are needed to manage the potential conflicts of interest.

Part 2: Roles and responsibilities of civil society and the private sector?

What are the recommended actions for NGOs and civil society that can contribute to the achievement of a 25% global reduction in premature mortality from NCDs by 2025?

- NGOs have a key role to play in policy development and in providing a counterweight to the influence of commercial sponsors. NGOs need to be encouraged to monitor and evaluate the actions of the various stakeholders, and to develop their role as ‘critical friends’ of public authorities and multilateral agencies.

Achievement of a 25% global reduction in premature mortality from NCDs by 2025, in particular with regards to:

- In the case of products which are likely to increase the risk of diet-related ill-health, the private sector should be held to have a duty of care to reduce the exposure of its customers to these products. This includes restricting their marketing communications, reformulating their products and providing clear labelling guidance.

Part 3: Partnerships

What functions should global and national partnerships for the prevention and control of NCDs include, in addition to the five identified in paragraph 18 of WHA paper A65/7?

- Clear procedural transparency is needed to reduce the risks inherent in partnerships having, or appearing to have, conflicted interests.

How does the WHO Secretariat ensure synergies between the recommended actions to promote partnerships to be included in the 2013 to 2020 Action Plan and the outcomes of discussions at the UN General Assembly before the end of 2012 in relation to WHO’s inputs into the report of the UN Secretary-General on options for strengthening multi-sectoral action for the prevention and control of NCDs through effective partnership?

- WHO needs to lead a coordinating body across the UN agencies, which answers to member states through the usual channels and which specifically receives input from a range of stake-holding organisations, including those with academic expertise and those with advocacy and policy development experience. Input from commercial operators needs to be carefully handled using open and transparent processes for managing potential conflicting interests.

Part 4: Monitoring

Which recommended actions for the WHO Secretariat should be given priority in the 2013 to 2020 Action Plan to monitor the implementation of the 2013 to 2020 Action Plan and evaluate its results?

- We trust that monitoring will include the monitoring of policy development and implementation, and the monitoring of market developments and market influence that shape health behaviours.

Part 5: Post-2015 UN development agenda

Which recommended actions for Member States, international partners and the WHO Secretariat should the 2013 to 2020 Action Plan include in order to ensure that NCDs continue to be included in the discussions on the post-2015 UN development agenda?

- As others have indicated, the WHO needs to be bold in its development and coordination of health policies through other UN agencies. It will have strong support for these moves from many of the health-related NGOs.
Appendix 10 – Example statement of concern

(In response to Draft Agenda, Committee A, point 13.1, first bullet point.)

Thank you. My name is Modi Mwatsama, and I am here today representing the International Association for the Study of Obesity with the International Obesity Task Force, and a number of organisations concerned with nutrition including the National Heart Forum, World Cancer Research Fund International, World Action on Salt and Health, World Public Health Nutrition Association and Consumers International. I wish to contribute the following short statement to this Assembly debate.

Statement to the 65th World Health Assembly
We welcome the Political Declaration from UN High Level Meeting on non-communicable diseases, and note that paragraphs 61 and 64 highlight the need for the World Health Organization to lead cross-sectoral action to tackle NCDs.

Food and nutrition are the most important drivers of the recent rise in NCDs and the worldwide pandemic of obesity. We therefore welcome the inclusion of nutrition goals in the draft Global Monitoring Framework and Voluntary Targets for the Prevention and Control of Non-communicable diseases. We strongly endorse the target to reduce salt intake to 5g per day, particularly as this is extremely cost-effective. We urge member states to reinstate and strengthen the targets on obesity, alcohol and trans fats, and to keep the indicators on cholesterol and marketing to children.

Secondly, we urge this Assembly to mandate the WHO to seize the challenge from the UN High Level Meeting on NCDs, and to proceed immediately to develop global governance structures and comprehensive food policies which integrate the prevention of NCDs with the reduction of hunger and the promotion of nutrition security for all. We call on WHO to work with agencies including the Food and Agriculture Organization to support the call for sustainable food production and nutrition security being made at the “Rio plus-20” conference next month.

Thirdly, we welcome the WHO’s new publication that provides a framework for member states to develop policies on the marketing of food and beverages to children and adolescents, and we urge this Assembly to mandate the WHO to draft an international code to strengthen controls on cross-border marketing and to protect children where national controls are not implemented.

Lastly we urge Member States and this Assembly, to increase actions to monitor and regulate food and nutrition environments including food production and trade, food composition, food marketing, food labelling, food availability, food prices and the activities of the associated commercial sectors. We urge member states to provide support to public interest non-governmental organisations engaged in such monitoring activities. We also urge the WHO to keep food and nutrition policy free from the undue influence of vested interests and to develop an ethical framework to guide interactions with the commercial sector.

Thank you.
Appendix 11 – Useful links

Regional obesity associations
Europe (EASO) http://www.easo.org/
America (TOS) http://www.obesity.org/
Asia & Oceania (AOASO) http://www.aoaso.org/
South America (FLASO) http://www.flaso.net/
Full IASO members list (includes national associations): http://www.iaso.org/about-iaso/membership/

IASO Resources & publications
SCOPE http://www.iaso.org/scope/
Journals http://www.iaso.org/publications/
Events List http://www.iaso.org/events/
Policy & Advocacy tools http://www.iaso.org/resources/
Child BMI cut off criteria http://www.iaso.org/resources/aboutobesity/newchildcutoffs/

WHO Regional offices
Africa: http://www.afro.who.int/
South East Asia http://www.searo.who.int/en/
Europe: http://www.euro.who.int/en/home
Eastern Mediterranean http://www.emro.who.int/
Western Pacific http://www.wpro.who.int/en/

WHO publications & websites
Framework on NCDs: http://www.who.int/nmh/events/2013/revised_draft_ncd_action_plan.pdf
Population approaches to child obesity prevention http://www.who.int/dietphysicalactivity/childhood/en/
UN NCD meeting information http://www.who.int/nmh/events/un_ncd_summit2011/en/index.html
PAHO Carmen (NCD Prevention group) http://new.paho.org/carmen/