Joint Response: WHO Draft Implementation Plan for the Recommendations to End Childhood Obesity

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This submission was prepared by the NCD Alliance, World Cancer Research Fund International and World Obesity Federation. The following organisations align themselves with this submission: 1000 Days, ACT+, Consumers International, El Poder del Consumidor, European Association for the Study of Obesity, European Public Health Alliance, European Heart Network, Healthy Caribbean Coalition, Healthy Latin America Coalition, InterAmerican Heart Federation, International Society for Physical Activity and Health, International Diabetes Federation, International Union for Health Promotion and Education, Jamie Oliver Food Foundation, Norwegian Cancer Society, UK Faculty of Public Health, UK Health Forum, Union for International Cancer Control, Vital Strategies and World Heart Federation.

The NCD Alliance, World Cancer Research Fund International, World Obesity Federation and the undersigned organisations welcome this opportunity to comment on the WHO draft implementation plan for the recommendations made by the Commission on Ending Childhood Obesity (ECHO Commission). We believe that the full implementation of the recommendations, including the establishment of a robust accountability framework, represents a real opportunity to end childhood obesity, not just in children under 5, but all school-aged children under 18 years of age.

Summary comments

We are pleased to see that the implementation plan is directly aligned with the recommendations that were made in the final report of the ECHO Commission. We strongly commend WHO for maintaining the integrity of the initial set of recommendations which highlights the need for a comprehensive package of policies to be adopted, across the life course and by different sectors of government and of society. It is clear that no one action is sufficient to address this growing epidemic, nor will one sector alone curb the issue. A piecemeal approach will achieve little and the implementation plan should make a strong case for governments to take a systems approach to ending childhood obesity.

We welcome the attention given to the role of civil society, particularly the reference made to the need for Member States to support and engage civil society. Civil society organisations around the world are supporting their governments in the development and implementation of ambitious public policies to protect and promote local, healthy and sustainable diets and physical activity. Collectively, the signatories of this response stand ready to work with WHO and Member States to end childhood obesity.

We have one major concern, which is that the tables covering the steps to be taken and the tools available are insufficiently detailed to be genuinely helpful to Member States, and should include suggestions for targets and indicators of progress. This will make the Implementation Plan very useful, but we acknowledge that it will take more time to prepare. If it cannot be done within the time available for the present Plan then we suggest that WHO proposes a second phase for the development of the Plan, namely the production of a Framework for Evaluating Progress of the Implementation Plan, as a tool for Member States. In a later section of the present consultation response we have given some examples of the types of indicators and accountability measures that could be used, but in the time available we have not been able to give this the comprehensive attention it deserves, nor have we been able to consult the many public health specialists in our networks with relevant expertise that could help create such a Framework for Evaluation. We will be happy to assist in the development of such a document in due course.

Specific comments

Below you find detailed comments on the specific components of the document which aim to highlight our concerns and proposals for improvement that which we trust the Secretariat will address in the draft

document to be presented to the WHO Executive Board in January 2017. Our recommendations focus on **three key areas**:

i) **Lack of specificity:** Many of the steps that are being recommended for Member States lack specificity. We believe that this implementation plan needs to provide more detailed, clear guidance to support Member States in the implementation and effective delivery of the recommendations made by the Commission on Ending Childhood Obesity.

ii) **Monitoring and accountability:** The lack of a robust monitoring and accountability mechanism and the lack of SMART objectives are of concern. Without a clear monitoring framework at global and national levels it will be difficult to track progress, make course corrections, and to hold Member States and other relevant stakeholders accountable.

iii) **The role of the food and beverage industry:** There is an urgent need for a greater emphasis of the need to protect policy making and policy makers from corporate influence. The Plan needs to expressly acknowledge how industry actions can prevent, delay or reverse the implementation of public policies, regulation and legislation to address childhood obesity. Adoption of voluntary measures or dependence on industry self-regulation has limited value unless there is active government involvement in setting the standards required and the time-frame for achievement, and establishing sanctions for non-compliance. This should more strongly feature in the guiding principles and underlying tone of the document[1] and translate into more nuanced guidance on how to engage with the private sector.

INTRODUCTION

Aim and Scope

- We welcome the contextualization of the aim of the implementation plan as contributing directly to the achievement the WHA nutrition targets, the WHO NCD targets, as well as several targets within the Sustainable Development Goals, including but not limited to targets 2.2, 3.4 and 3.8. In particular, we welcome the reference to the UN Decade of Action on Nutrition 2016-2025 and to the United Nations Secretary General's Global Strategy for Women's, Children's and Adolescent's Health.

Guiding principles

We support this section, and make the following comments:

- **Rights-based approach:** We welcome the emphasis on the child's right to health, but would encourage mention of the right to food as both of these are important principles which underpin work in this area. The 2016 report[2] of the UN Special Rapporteur on the Right to Food rightly points

[1] Perhaps this could be done by citing the statement made by Margaret Chan in her speech of 10 June 2013: *"Not one single country has managed to turn around its obesity epidemic in all age groups. This is not a failure of individual will-power. This is a failure of political will to take on big business. I am deeply concerned by … efforts by industry to shape the public health policies and strategies that affect their products. When industry is involved in policy-making, rest assured that the most effective control measures will be downplayed or left out entirely. This, too, is well documented, and dangerous."* http://www.who.int/dg/speeches/2013/health_promotion_20130610/en/

[2] A/71/282 Report of the United Nations Special Rapporteur on the Right to Food, Hilal Elver http://www.un.org/ga/search/view_doc.asp?symbol=A/71/282

out that children are particularly sensitive to malnutrition in all its forms. In addition, the report explains how governments and the private sector are bound by the right to food. Therefore, mentioning the right to food as a guiding principle in addition to the right to health would strengthen a rights-based approach to tackling childhood obesity.

- **Whole-of-government approach:** It would facilitate understanding of this paragraph if it were made clear that the goal is a robust governance mechanism including all of government with the aim of ensuring policy coherence, in addition to just listing examples.
- **A whole-of-society approach:** We commend the plan's acknowledgement that 'governments hold the ultimate responsibility in ensuring their citizens have a healthy start in life' (page 9) and agree that a whole-of-society approach involving parents, caregivers, civil society, academic institutions, foundations and the private sector is necessary to reverse the global epidemic of childhood obesity and NCDs.

  However, this principle should mention conflicts of interest and undue influence by the food and beverage industry which can undermine the implementation of the recommendations laid out in this plan. We remain highly concerned about the enormous interference from the food and beverage industry which delays, weakens or disrupts policy work towards effective legislation/regulation, and feel that this plan should take a stronger stance on this issue.
- **Accountability:** We strongly agree that a robust mechanism and framework is needed to monitor progress and increase accountability. We are highly concerned that in the absence of a strong monitoring and evaluation framework the plan will not deliver on its objective to halt the rise in childhood overweight and obesity.

  Additionally, commitments should not only be relevant, but specific, measurable, actionable, and time-bound (i.e. they should be SMART). See the WCRFI/NCDA brief on SMART commitments as well as the GNR SMART guidance.

  We also refer the WHO to the INFORMAS Food-Epi framework as a basis for monitoring actions in against international best practices and benchmarks[3].
- **Additional guiding principle:** We recommend adding ***comprehensiveness of policy approach*** to ensure that Member States accept that a package of policy measures is needed, in the spirit of the Commission's original set of recommendations, which involve prevention and treatment, and act on a systems, environmental, and individual level.

Action framework

- Figure 2 needs to be more specific. For example, under 'intermediate outcomes' the phrase 'healthier environments' should specify 'environments that protect and promote healthy diets and physical activity'. 'Healthier behaviours' should be included as one of the long-term outcomes and perhaps more clearly state 'healthier behaviours including less sedentary behaviour, more physical activity and healthier diets'. 'Capacity building and resources' could be included under all three columns, to match the need for monitoring and accounting all three columns.

[3] INFORMAS 2013 supplement: http://onlinelibrary.wiley.com/doi/10.1111/obr.2013.14.issue-s1/issuetoc

ACTIONS NEEDED TO END CHILDHOOD OBESITY

Provide leadership

- High-level political leadership and the involvement of parliamentarians in setting national targets and defining clear indicators to monitor progress are crucial to achieving progress on childhood obesity. Strong governance and coordination mechanisms need to be established to ensure intersectoral and multisectoral action.
- In addition member states should take leadership in capacity building, and in particular in ensuring the existence of suitable training of professionals who would be involved with implementing the recommendations on the ground. This includes specialized nutrition training for health care professionals, including doctors and nurses, encouraging interest and training in dietetics and nutritionists and encouraging these trained professionals to work in communities linked to schools and weight management activities.
- In terms of "available tools" in this section, examples of national governance mechanisms on food or NCDs could provide inspiration to Member States on how to set up a cross-ministerial group to coordinate the implementation of the ECHO recommendations. We suggest that a note here should be added to say that "Examples of government actions already taken are available in World Cancer Research Fund International's NOURISHING database." Further support for Member States on developing and enhancing mechanisms to help foster engagement across departments and sectors so as to support leadership and action could be a valuable addition to this Plan.
- It is also worth highlighting that in many cases Member States do not have a focal point to ensure implementation of Plans such as this one. As such recommending that Member States identify a focal point or person could be a valuable recommendation that underpins this Plan.
- In addition we recommend that the implementation plan refer to two additional actions on page 9, table, item b:
    - Add as a step for Member States: "Work across government ministries to remove subsidies for energy-dense, nutrient poor foods and their components and set market incentives and subsidies to ensure and promote access to healthy foods."
    - Add as a step for WHO: "Together with FAO develop technical guidance to Member States on how to remove subsidies for energy-dense, nutrient poor foods and their components and set market incentives and subsidies to ensure and promote access to healthy foods

Interventions

We welcome the range of interventions listed, and in particular that the plan has stayed true to the original recommendations made by the ECHO Commission. However, in a number of cases the steps for Member States provided are vague and a greater level of detail should be considered to ensure that Member States have the guidance needed to implement the recommendations.

Below we list our comments on this series of tables, and urge the Secretariat to include an additional column in all tables which specifies the targets and indicators which would make a clear accountability framework. As we noted in the general comment above, we appreciate that this is a larger task than there may be time for, and that a second phase of the Plan could be suggested, which produces a Framework for Evaluating Progress of the Implementation Plan.

Recommendation #	**Comments on "Steps to be taken by Member States/WHO"**	**Comments on "available tools"[4]**	***Towards an accountability framework: possible Indicators[5]***
Actions to promote the intake of healthy foods			
General comments: We propose that the nutrition actions/steps could better incorporate a foods-based approach to nutrition to encourage the protection and promotion of diverse, fresh and local diets based on minimally-processed foods. We deem such an approach preferable over an exclusive focus on reformulation of processed food products with the aim of reducing levels of saturated and trans-fats, sugar and salt. While reformulation strategies are important, especially in countries where processed foods are already readily available and regularly consumed, reformulation can be used to re-brand unhealthy processed food products as "healthy" (e.g. *Coca-Cola Life* vs classic Coca Cola), a strategy that is especially problematic in those contexts where diets are still largely constituted of minimally processed foods. To this end, we recommend that the references to foods 'high in fat, sugar and salt' should be clearly described as being ultra-processed foods. We would like to see stronger emphasis and stance on restricting promotion, marketing and advertising of energy dense, nutrient poor foods and beverages that cause harm/ increase obesity.			
1.1 Ensure that appropriate and context-specific nutrition	• Add as a step for Member States: 'Develop and implement evidence-based public	• Suggest including WHO guidance on breastfeeding.	• Knowledge on healthy eating • Sources of nutrition information

[4] * National models are available, with examples provided in the NOURISHING database.

[5] **Due to the very short timeframe of this consultation, we are not able to provide comprehensive, in-depth recommendations for indicators. The indicators provided are therefore incomplete and exemplary. We remain at the Secretariat's disposal to help develop a Framework for Evaluating Progress of the Implementation Plan.

information and guidelines for both adults and children are developed and disseminated in a simple, understandable and accessible manner to all groups in society.	education campaigns, which are appropriately funded and sustained over time'. These could be on the health harms of unhealthy diets (including sugary drinks) and/or the link between obesity in childhood to other childhood and adults illnesses and take into account stigma associated with overweight/obesity. Such campaigns should be done to empower consumers, but should not replace public policies to address the environments within which choices are made or put the blame on individuals.	• Add WHO guidance on inappropriate marketing of foods for infants and young children	• Food consumption patterns/nutritional behaviour
1.2 Implement an effective tax on sugar-sweetened beverages.	• Rephrase "sugar-sweetened beverages" to "sugary drinks" (all drinks high in sugar, intrinsic or added) throughout the document. • Consider explicitly stating that the SSB tax should be an excise tax (rather than a sales tax) and set at a minimum of 20% in order to be effective.		• Price of sugary drinks • Sales volume of sugary drinks • Consumption of sugary drinks among children
1.3 Implement the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children to reduce the exposure of children and adolescents to, and the power of, the marketing of unhealthy foods.	• Explicitly state that restrictions have to be mandatory as industry pledges and other voluntary regulation have been shown to be ineffective. • We would recommend laying out the criteria necessary to ensure that the marketing restrictions are effective: ○ Age: children should be defined as anyone below 16 at a minimum (preferably below 18); ○ Marketing channels and techniques: all marketing techniques through all	• Consider including PAHO's Recommendations from an Expert Consultation on the Marketing of Food and Non-Alcoholic Beverages to Children in the Americas as a tool.	• Presence of regulations to restrict marketing, with independent monitoring • Presence and form of enforcement of regulations • Private sector spending on food advertising to children • Number of food advertisements seen by children (e.g. per day or week) • Type of food advertisements • Presence of child-appeal internet sites showing food brands and logos

	channels should be prohibited, including social media and internet, places where children gather and spend time, sponsorship, and the use of brand equity characters and licensed characters; ○ Audience: marketing directed exclusively at children (e.g. on children's TV channels), but ALSO marketing with a specific appeal to children and marketing intended for adults but viewed by children, e.g. during sports events; ○ Food: defined as those to be banned and those to be promoted based on a nutrient profile. • Brand advertisement in schools should be prohibited (e.g. school books bearing a food company's logo).		
1.4 Develop nutrient-profiles to identify unhealthy foods and beverages. 1.6 Implement a standardized global nutrient labelling system. 1.7 Implement interpretive front-of-pack labelling, supported by public education of both adults and children for nutrition literacy.	• Labelling should include added sugar, saturated and trans-fats, and salt, in addition to those nutrients which are routinely labelled (such as protein, fat, carbohydrates). • Add as a step for Member States 'Adopt and use their regional WHO nutrient profile or where not available a model recognised by the WHO'. • In addition to being evidence-based, labelling needs to be consumer-friendly by including all the nutrients of public health concern and being easy to interpret. Labelling systems must be appropriately tested and evaluated before and after	• WHO regional offices nutrient profiles • Given the role of the Codex Alimentarius Commission in setting international standards, and the status of these standards in international trade law, Member States may wish to call for a review of the Codex Guidelines on Nutrition Labelling to align with latest WHO guidance.	• Use and compliance with national nutrient profiling and labelling requirements • Use of nutrient profiling in menu displays in chain restaurants

	implementation. Member States should be required to ensure that the labelling used is appropriate, effective and fit for purpose (this also applies to industry initiated labelling).		
1.5 Establish cooperation between Member States to reduce the impact of cross-border marketing of unhealthy foods and beverages.	• WHO Regional Committees to adopt policies and proposals for regulation of cross-border marketing. • WHO Regional Offices asked to play a coordinating role.	• WHO Regional Offices to report on measures available e.g. international health regulations, international broadcasting regulations, international sports sponsorship agreements. • WHO HQ to review national public health laws for opportunities to regulate cross-border marketing to children.	• Extent of marketing of foods on cross-border media, seen by children (includes broadcast media but also imported videos, cinema films, computer games, food-branded toys)
1.8 Require settings such as schools, child-care settings, children's sports facilities and events to create healthy food environments.	• School food standards should be applicable on a mandatory basis for both public and private elementary and secondary schools. • Consider explicitly stating that such standards should apply to both foods served in canteens, vending machines and other in-school sales outlets. • Zoning laws should prohibit establishments selling junk food around schools such as fast food restaurants, local vendors selling unhealthy food, take-aways, drive-throughs (e.g. perimeter of 400m). • Consider mentioning that school nutrition guidelines should be coupled with restrictions on food marketing in schools.		• Presence of school food standards for: - food brought into schools - food available in schools - food sold near school premises - sponsorships in schools - school fundraising activities • Number of children receiving school meals, and what type (breakfast, lunch, snacks)

1.9 Increase access to healthy foods in disadvantaged communities.	• Further details are needed here. These "steps" could include access to fruit, vegetables and milk schemes, free school meal schemes etc.
	  ○ Enable and incentivise mobile F&V vendors and supermarkets to move to disadvantaged communities (e.g. amending zoning laws; subsidies or tax breaks for supermarkets moving to disadvantaged communities).
	  ○ Social security support for low-SES population (e.g. via food stamps) combined with requirements (e.g. stamps only usable to purchase healthy foods).
	  ○ Food standards for social support programmes.
	  ○ Programmes to incentivize community food production (e.g. urban agriculture).
	• Further, a specific reference to which stakeholders should be engaged should be made. Breakfast clubs or school-food programmes funded by the food industry should be viewed critically.
			• Government spending on financial incentives for private sector
			• Government spending on social security programmes related to nutrition
			• Number of food outlets where healthy food can be purchased (by geography)
			• Types of food available in disadvantaged communities
			• Number of local food production interventions
			• Product price changes following the introduction of a new subsidy / removal of a subsidy
			• Sales of these foods
			• Barriers to healthy eating
			• Food consumption patterns/nutritional behaviour

Actions to promote physical activity			
General comments: The plan would benefit from the addition of more emphasis on health promoting environments which enable safe outdoor play, walking, cycling rather than just focusing on sport and recreational facilities. Safe environments for physical activity for transport (especially to and from school) are particularly pertinent to children who are vulnerable road users, and it is an important way for children to achieve physical activity recommendations.			
2.1 Guidance on healthy body size, physical	• Run and develop evidence–based, targeted and appropriately funded public education		

activity, sleep behaviours and appropriate use of screen-based entertainment.	campaigns on the importance of physical activity and its link to NCDs.		
2.2 Ensure that adequate facilities are available on school premises and in public spaces for physical activity during recreational time for all children (including those with disabilities), with the provision of gender-friendly spaces where appropriate.	• This currently has an accent on safe facilities for recreational physical activity. We suggest this is broadened to include safe environments for walking and cycling, and healthy urban design that enables children to be active safely in daily living. This should also make reference to safe access to green spaces and nature. • Schools should make grounds/playing fields available to communities for use outside of school hours. This is particularly important when changes to the built environment may take time.		• Number of physical activity facilities in schools • Number of safe physical activity spaces for children (e.g. parks, community sports facilities) • Barriers to physical activity • Perception of sport/reasons children exercise • Activity level of children (hours spent with physical activity /day)
Actions for preconception and pregnancy care in health care settings			
General comments: The provision of primary health care for women which includes weight guidance in pregnancy and support for breastfeeding is vital. Furthermore, there needs to be support for healthy infant growth, including maternity leave, baby-friendly hospitals, breastfeeding counselors, mother and child community facilities.			
3.1 Diagnose and manage hyper-glycaemia and gestational hyper-tension. 3.2 Monitor and manage appropriate gestational weight gain.		• WHO EURO recent report on Member State actions to protect and promote maternal and child nutrition: Good Maternal Nutrition – The best start in life • Examples for guidance on Weight gain during Pregnancy	• Presence of clinical guidelines for care pathways for managing maternal weight and weight gain in pregnancy • Inclusion of such guidelines in training course for medical professionals
3.3 Include an additional focus on appropriate nutrition in	• Guidance should expressly include healthy weight in addition to diet and PA.	• WHO EURO recent report on Member State actions	• Does medical and nurse training include nutrition as a core subject

guidance and advice for both prospective mothers and fathers before conception and during pregnancy. 3.4 Develop clear guidance and support for the promotion of good nutrition, healthy diets and physical activity, and for avoiding the use of and exposure to tobacco, alcohol, drugs and other toxins.	• Preconception and antenatal care with respect to diet, weight and PA should be part of the mandatory curriculum of health staff, e.g. in a nutrition module (nurses, doctors, community-health workers). • Action point 3.3 and 3.4 describe providing' guidance and support' but the steps only talk about guidance without describing the support (e.g. classes for new parents/pregnant women, providing coverage for antenatal care appointments to provide nutrition counseling, etc). **Note:** This is an issue throughout the document. Where it says 'guidance and support' the support related steps are often missing.	to protect and promote maternal and child nutrition: Good Maternal Nutrition – The best start in life • Examples for guidance on Weight gain during Pregnancy	• Number of hours dedicated to nutrition, weight, PA in health education • Number of suitably trained dieticians, nurses, nutritionists and other HCPs working in the field
Actions for early childhood diet and physical activity in the community			
General comments: Local governments and services need to be encouraged to take their share of the responsibility for preventing childhood obesity. This means providing health-promoting schools which offer high standards of nutrition, physical activity, health education and community involvement. In addition, this implementation plan needs a stronger focus on 'whole of school' approaches to health, physical education and physical activity - in keeping with the WHO health promoting schools model and UNESCO.			
4.1 Enforce regulatory measures such as The International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions. 4.5 Develop regulations on the marketing of complementary foods and beverages, in line with	• Regulation of marketing of breast-milk substitutes and complementary foods for infants and young children should be mandatory.		• Private sector spending on breast-milk substitutes and complimentary foods marketing • Number and type of regulation on marketing of Breastmilk substitutes and complementary foods in line with the Code of Marketing of Breast-milk Substitutes and WHA Guidance on ending the inappropriate promotion of foods for infants and young children

WHO recommendations, to limit the consumption of foods and beverages high in fat, sugar and salt by infants and young children.			
4.2 Ensure all maternity facilities fully practice the Ten Steps to Successful Breastfeeding. 4.3 Promote the benefits of breastfeeding for both mother and child through broad-based education to parents and the community at large. 4.4 Support mothers to breastfeed, through regulatory measures such as maternity leave, facilities and time for breastfeeding in the work place.	• Train lactation consultants to support women in the community (e.g. community-health workers, respected women in the community, nurses). • Breastfeeding and appropriate complimentary feeding should be part of the mandatory curriculum of health staff, e.g. within a nutrition module (nurses, doctors, community-health workers).		• Number of lactation consultants trained • Number of hours dedicated to breastfeeding and complimentary feeding in health education • Number of women breastfeeding (duration, partial or exclusively)
4.6 Provide clear guidance and support to caregivers to avoid specific categories of foods (e.g. sugar-sweetened milks and fruit juices or energy-dense, nutrient-poor foods) for the prevention of excess weight gain. 4.7 Provide clear guidance and support to caregivers to encourage the consumption of a wide variety of healthy foods.	• Train community-health workers or women respected in the community on appropriate complementary feeding.		• Number of community-health workers trained • Knowledge on appropriate complimentary feeding

4.8 Provide guidance to caregivers on appropriate nutrition, diet and portion size for this age group.			
Actions for health, nutrition and physical activity in child care and school settings			
4.9 Ensure only healthy foods, beverages and snacks are served in formal child care settings or institutions. 5.1 Establish standards for meals provided in schools, or foods and beverages sold in schools, that meet healthy nutrition guidelines. 5.2 Eliminate the provision or sale of unhealthy foods, such as sugar-sweetened beverages and energy-dense, nutrient-poor foods, in the school environment. 5.3 Ensure access to potable water in schools and sports facilities.	• See comments above on intervention 1.8.		
4.10 Ensure food education and understanding are incorporated into the curriculum in formal child-care settings or institutions. 5.4 Require inclusion of nutrition and health education within the	• Consider expressly including that nutrition and health education in schools should contain practical skills, i.e. teaching cooking skills and knowledge about foods available in the local context, in particular fruits, vegetables and grains. • Nutrition and health education should be		• Number of schools offering nutrition and health classes • Knowledge on healthy eating • Number of trained professionals who can deliver such education in schools • Number of schools with nurses/suitably trained healthcare professional

core curriculum of schools. 5.5 Improve the nutrition literacy and skills of parents and caregivers. 5.6 Make food preparation classes available to children, their parents and caregivers.	mandatory, not optional, components of the school curriculum.		
4.13 Engage whole-of community support for caregivers and child care settings to promote healthy lifestyles for young children.	• Consider mentioning that a community approach requires that citizens are able to exercise their political and civil rights.		
4.11 Ensure physical activity is incorporated into the daily routine and curriculum in formal child care settings or institutions. 5.7 Include Quality Physical Education in the school curriculum and provide adequate and appropriate staffing and facilities to support this.	• Physical activity should be part of the mandatory, not optional, school curriculum. • To support children in meeting the WHO recommendations for physical activity as a minimum requirement, at least 60 minutes per school day should be incorporated.		
Actions for weight management			
General comments: We would like to raise the issue of weight stigma in healthcare (and also in the community, politics, media and other arenas). People with obesity suffer from stigmatization, and this includes the stigmatization by professionals. Stigmatization is included in the most severe complications of obesity. Efforts are needed to educate professionals and to inform the public about obesity, in particular that obesity is someone's 'own responsibility', is not at the same as obesity is one's own fault.			
6.1 Develop and support appropriate weight management services for children and	• Where primary care is not accessible, consider training community-health workers in childhood weight management.	It could be helpful to point to some examples of where this approach has been	• Number of children enrolled in clinical weight management • Number of clinics offering clinical weight

adolescents who are overweight or obese that are family-based, multicomponent (including nutrition, physical activity and psychosocial support) and delivered by multi-professional teams with appropriate training and resources, as part of Universal Health Coverage.	• Health services need to improve the delivery of weight management and treatment services to ensure access for every person who needs them. This will require appropriate care pathways for children with weight difficulties, including family based interventions. It will involve establishing multidisciplinary teams of trained and specialist health care professionals at community level, covering nutrition, physical activity, psychosocial factors	successful. E.g. see this paper for a description of the interventions done at the WATCH clinic at UCSF: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921937/	management • Number of community-health workers trained • Average weight lost in clinical weight management

Monitoring and Accountability

As we have noted before we are concerned that the steps presented in relation to monitoring and accountability of this implementation are not specific enough, lacking targets and indicators. There is a risk that without accountability, implementation will not follow. Further development of indicators and an accountability framework is essential for the effective delivery of this implementation plan, showing what successful implementation would look like and how it can be measured. It is also unclear which elements of the existing monitoring frameworks mentioned are relevant here.

We encourage the Secretariat to develop a more robust monitoring and accountability process for this Plan or to acknowledge the need for a second phase which would produce a Framework for Evaluation. For the nutrition actions, this could be based on the INFORMAS food-epi, as this framework has been developed based on international best practices[6]. At a minimum the addition of targets relating to a time line for the immediate, medium and long term to the present plan would better guide the proposed development of the framework which defines baseline, indicators and responsible sectors.

This should include:

- Indicators for each recommendation;
- Indicators relating to government resources supporting each recommendation.

It is important to highlight that a comprehensive monitoring framework would require resources, and that Member States will need to allocate appropriate funds as part of their programme for tackling NCDs.

A number of detailed implementation plans exist for other strategies and action plans. It would be worthwhile using these as a basis for the development of a comprehensive monitoring and accountability framework for this Implementation Plan. Examples include:

- PAHO Plan of Action for the Prevention of Obesity in Children and Adolescents
- CARPHA Plan of Action for Promoting Healthy Weights in the Caribbean: Prevention and Control of Childhood Obesity (2014 - 2019)
- WHO's Implementation of Marketing restrictions
- Monitoring & Evaluation of WHO Strategy on Diet, Physical Activity and Health

Figure 3 logic model

We also have a number of comments on the Figure 3 logic model. There does not appear to be a rationale for which actions/steps are emphasized within this model or why some actions have been left out, despite the recognition for a comprehensive package of measures. For instance, why are fiscal measures such as taxes, levies and subsidies not included? It is important that any logic model supporting this implementation plan is comprehensive and cover the items mentioned elsewhere in the document, as appropriate. We are concerned that an incomplete logic model may be more misleading than the absence of a logic model.

Figure 4: policy and action planning matrix

The policy and action planning matrix is a useful tool for assigning responsibility and process within relevant departments. However, it does not go far enough to be useful for Member States. This implementation plan would be significantly enhanced if more guidance on each of the steps and the questions posed was provided to Member States in order to guide them appropriately and ensure actions taken are sufficient to

[6] INFORMAS 2013 supplement: http://onlinelibrary.wiley.com/doi/10.1111/obr.2013.14.issue-s1/issuetoc

reach the desired goal. It could be a follow-up action for WHO to develop technical advice on tools for monitoring and accountability, as part of the suggested development of a Framework for Evaluating Progress of the Implementation Plan. Furthermore, specific examples of the roles of different sectors/ministries in supporting a whole of government response to NCDs should be provided. This also creates greater accountability outside of the health sector and provides health with a tool to approach sectors for leadership in the implementation of various elements in the plan.

KEY ELEMENTS FOR SUCCESSFUL IMPLEMENTATION

Awareness, communication and education

This short section speaks about communication and could include explicit mention of mass media, social media or social marketing, which play an important role in health education and literacy. Evidence-based mass media campaigns based on social marketing theory, and implemented with sufficient weight and frequency should be developed and implemented to justify and gain support for a wider programme of action. Such approaches have been shown to play an important role in changing perceptions, attitudes and intentions, as well as promoting community discussion about obesity, physical inactivity and healthy diets. Such campaigns and programs can also be targeted, for example at parents and care-givers. Member States should be provided with examples of effective and affordable campaigns to support them in this area and to ensure efficacy of their actions.

Responsibilities

World Health Organization:

- Action 1b needs to be removed as no longer relevant.
- Action f): "to report on progress made on ending childhood obesity" is vague. Please see our comments under monitoring and accountability. Currently to "contribute to the development and implementation of a monitoring and accountability mechanism" is only listed as an action for civil society. Additional responsibility needs to be taken by the WHO for this, and be acted on in future iterations of this implementation plan.
- Action c) ii: Add" ...including through the establishment of multisectoral committees/task forces etc. to support the implementation of the recommendations of the Commission".

Civil society:

- Civil society not only has a responsibility to "contribute to the development and implementation of a monitoring and accountability mechanism", but also to independently carry out activities which hold relevant actors to account.
- Civil society should seek to be active members on national commissions tasked with addressing childhood obesity whether through National NCD Commissions or specific multisectoral groups/ task forces/committees established to address childhood obesity.

The Private sector:

- To strengthen this section, it would be useful to reframe it in terms of the contribution that the private sector can make to the implementation of policy, rather than speaking in generic terms about "engagement" and "private sector initiatives". The role of the private sector in this context should be primarily framed around implementation of government-determined and government-led policies. This is not to per se discredit industry initiatives, but to emphasize that governments must provide a clear policy framework for private sector companies to operate in. It would be useful to

explicitly state somewhere in the document that “Adoption of voluntary measures or dependence on industry self-regulation has limited value unless there is active government involvement in setting the standards required and the time-frame for achievement, and establishing sanctions for non-compliance”.

- We recommend adding to this section that multinational companies should apply coherent standards across their entire global portfolios based on global WHO guidance when it comes to labelling, marketing etc. to ensure that actions are global and do not differ between countries.
- The WHO Report on "addressing and managing conflicts of interest in the planning and delivery of nutrition programmers at country level[7]" could be mentioned in this section as a tool for supporting Member States in managing conflicts of interest.
- We have also noted that the private sector entities referred to in this paragraph are limited to the food and beverage industry. Therefore, “facilitating access to, and participation in, physical activity” should not be listed as a responsibility as it is not part of the core business of these organisations. Promotion of physical activity in fact is often used to distract from the impact of unhealthy diets. We recommend that WHO list the responsibilities of other sections of the private sector corresponding to their core business (e.g. relating to companies whose core business is physical activity, infrastructure etc).

Philanthropic foundations:

- A core function of civil society is to hold actors to account, however such activities are rarely funded. The recommendation for philanthropic organisations to “Mobilize funds to support research, capacity-building and service delivery” should be extended to include the funding of mechanisms to hold actors to account and leverage action.

[7] http://www.who.int/nutrition/events/2015_conflictsofinterest_nut_programmes/en/

Signatories: