



Feidhmeannacht na Seirbhíse Sláinte  
Health Service Executive



# HSE Framework for Action on Obesity 2008 - 2012



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## Foreword

### **Obesity is one of the most serious health issues facing Irish people.**

We know that overweight and obesity in childhood and adolescence is likely to continue into adulthood. In 2007, 19% of boys and 17% of girls in the 13-17 year age group were overweight or obese. That year, 38% of the population was overweight and 23% obese.

We also know that obesity is a precursor of many chronic illnesses and the increasing numbers of Irish people who are overweight or obese has led to the dramatic rise in type 2 diabetes. Approximately 80% of GP consultations and 60% of hospital bed days are related to chronic illnesses and their complications.

This Framework was developed by the HSE National Working Group on Obesity to translate the recommendations of the National Taskforce on Obesity into tangible actions to address this serious public health issue.

The Framework has five key strategic priorities each of which are supported by a series of specific actions. The strategic priorities are:

- To enhance effectiveness in surveillance, research, monitoring and evaluation of obesity.
- To develop a quality uniform approach to the detection and management of obesity.
- To develop our capacity in preventing overweight and obesity to promote health.
- To communicate our messages on obesity effectively.
- To proactively engage and support the work of other sectors in addressing the determinants of obesity and the obesogenic<sup>1</sup> environment.

While the HSE can implement the actions outlined in this Framework by seeking to address the determinants of obesity and reduce health inequalities, it alone cannot stem the growing tide of obesity. It is essential that other sectors are involved. These include Government departments, educators, producers, suppliers and food advertisers. Sectors responsible for physical environment and social and community sectors also have very important roles to play. The HSE will continue to work and support these and other relevant sectors, at strategic and operational levels, to implement the recommendations of the National Taskforce Report that are outside the remit of the health sector.

Finally, I would like to thank members of the National Working Group on Obesity for their work in preparing this Framework under the chairmanship of Ms. Maria Lordan Dunphy.



Professor Brendan Drumm  
CEO



Dr Patrick Doorley  
National Director of Population Health

<sup>1</sup> A very significant determinant of obesity is the environment in which we live which often makes the unhealthy choices more accessible. This environment was termed obesogenic by the World Health Organisation in 1998. Food commercialism, technology, urban and socioeconomic development are contributing to the creation of this obesogenic environment which nurtures over-eating and inactive lifestyles.

## **Membership of the National Working Group on Obesity**

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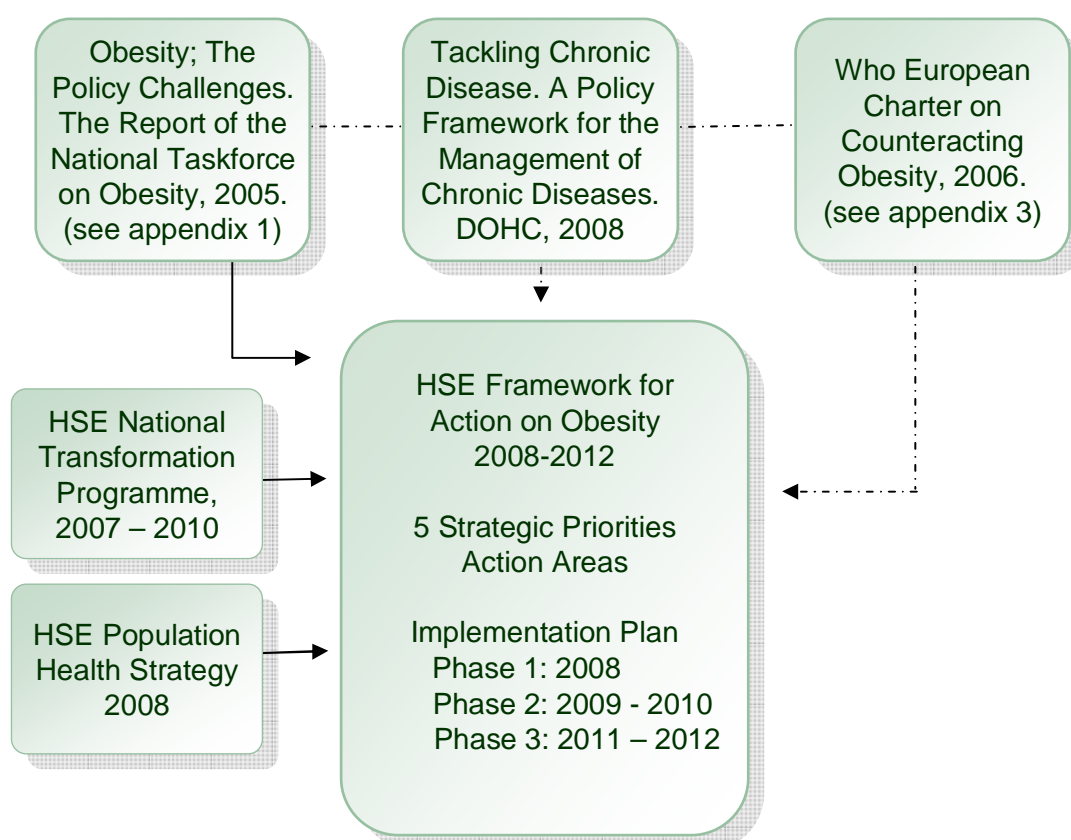
Ms. Miriam Stack, Communications Health Promotion Campaigns HSE.

## **SECTION 1:**

### **> Introduction**

Obesity is now emerging as one of Ireland's most serious health problems. In 2005, Obesity The Policy Challenges – The Report of the National Taskforce on Obesity was published. It includes recommendations, over eighty in all, relating to actions across six broad sectors including high-level government, education, social and community, health, food commodities, production and supply, and physical environment (See Appendix 1 for list of recommendations relevant to the Health Sector).

The Health Services Executive in its commitment to tackling the growing problem of obesity established a national working group in 2006 to implement the recommendations of the Task Force on Obesity relevant to the HSE. Obesity has also been included as a priority for the HSE within its Transformation Programme 2007-2010, which incorporates the Population Health Strategy, whose aim is to enable people to live healthier and more fulfilled lives. The national working group adopts an integrated, multidisciplinary approach working at strategic, policy, governmental, community and individual levels. The group has developed a framework for action for the HSE. See figure 1 for the context of framework development and implementation.



*Figure 1: Context for Framework development and implementation*

The national and international documents that informed this framework are outlined in Appendix 2.

The HSE acknowledges the need for an inter-departmental and multi-sectoral approach to addressing obesity and is committed to supporting this work. Indeed, the Department of Health and Children in its publication "Tackling Chronic Disease: A Policy Framework for the Management of Chronic Diseases" (2008) states that " *A whole government approach is essential in promoting health and reducing the burden of chronic disease in the population*". Agreement has been reached at government level to establish a high level inter-departmental group to address the determinants of chronic illness. Obesity has been highlighted as one of the priorities of this group. The HSE will provide the necessary support to progress the work of this group.

Emerging statistics demand immediate action through integrated, multidisciplinary working at strategic, policy, governmental, community and individual levels. A total of 23% of Irish adults are reported to be obese, with 38% overweight according to the SLAN 2007 survey. The figure for overweight adults has remained the same since the Irish University Nutrition Alliance (IUNA) study in 2001, but the incidence of obesity has risen by 5% in the intervening period. The prevalence of overweight and obesity among Irish children is also considerable. In 2005 the National Children's Survey measured weight and height in 5-12 year olds and found the prevalence of overweight to be 11 % in Irish boys and 12 % in Irish girls; the prevalence of obesity was 9% in boys and 13% in girls (IUNA, 2005). A study of 450 teenagers, 13 -17 year olds in Irish secondary schools found that since 1990, the prevalence of overweight and obesity has increased from 6% to 19% in boys and from 15% to 17% in girls (IUNA, 2007).

The Irish Health Behaviour in School-Aged Children (HBSC) Study 2006 found that across all age groups (10 -18 years), rates of fruit consumption in girls (23%) continue to be higher than for boys (16%), with a slight increase among girls only, between 2002 and 2006. Moreover the proportion of girls (20%) reporting vegetable consumption more frequently than daily is greater than the proportion of boys (16%), and this is the case across each age category. There is some evidence of a social class effect especially among girls, with those from higher social classes being more likely to report frequent vegetable consumption. Children from the higher social classes were also less likely to report frequent consumption of soft drinks (HBSC 2007).

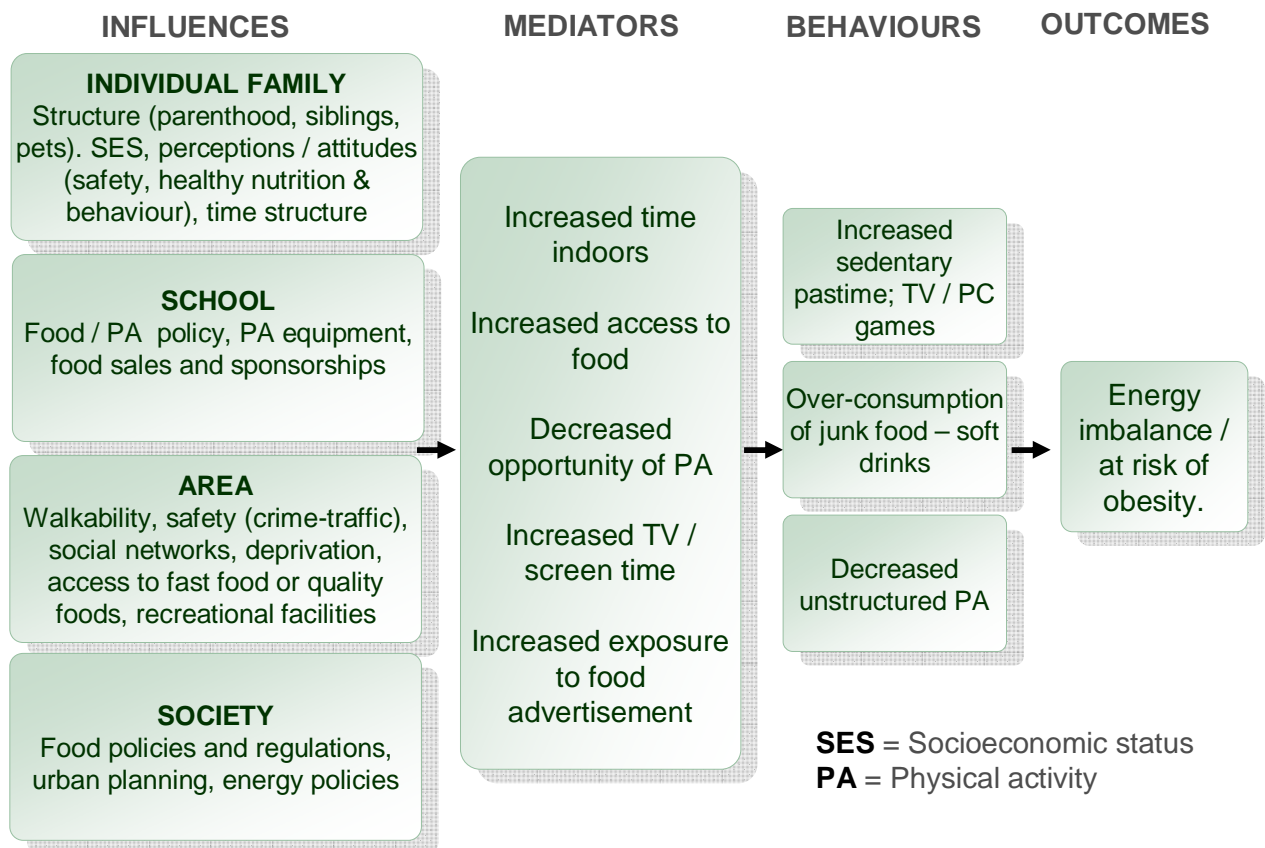
In the same study there has been little change in reported frequency of participation in physical activity, with 53% of children exercising 4 or more times a week (48% in 2002). Gender differences are evident with 63% of boys and 43% of girls exercising 4 or more times per week. Exercise participation decreases with age. This is particularly noticeable among girls (dropping from 58% of 10 -11year olds to 28% of 15 -17 year olds). These age and gender patterns are unchanged from 2002 (HBSC 2007).

In the SLAN 2007 survey of Irish adults 18 years and over, two thirds (65%) of respondents were consuming the recommended 5 daily portions of fruit and vegetables. However the majority (86%) consumed more than 3 daily servings of foods, high in fat, sugar and salt from the top shelf of the Food Pyramid. Almost half (48%) snacked between meals, most commonly on biscuits and cakes. There was little evidence of a change of physical activity from SLAN 1998 to 2002 to 2007. The percentage reporting moderate and/or strenuous exercise 3 or more times per week for at least 20 minutes each time were similar across the

three surveys: 38% (1998), 40% (2002) and 41% (2007). Over one-fifth (22%) reported being physically inactive. The most common response for men and women across all social classes and most age groups was having “no time” (41%). The only exception was among those aged 65 and over, a high percentage of whom gave “injury/disability/medical condition” as the main reason for physical inactivity. Other reasons cited included ill-health (18%), lack of interest (14%) and interested but unwilling to commit the time (14%). A few respondents (3%) mentioned lack of access to facilities as a barrier to physical activity (SLAN 2007).

Being overweight or obese contributes significantly to the impairment of health, reduction in the quality of life and increased health care costs.

Our living and working environments often make unhealthy choices very accessible, resulting in a high intake of energy dense foods and in decreased physical activity. The determinants of physical activity that have been identified as contributing to an increasingly sedentary population include social factors such as age, gender, socio-economic status and social support, and environmental determinants such as availability, safety and distance from destination/venue. The determinants of poor dietary behaviour have been identified as multifactorial, including lack of knowledge of diet and health and inadequate means to provide a healthy diet. See Figure 2



**Figure 2:** Simplified multi-level approach to the study of environmental influences on obesity

**Source:** Figure 1 pg 38 Maziak W, Ward K.D. , Stockton M.B. Childhood obesity: are we missing the big picture? Obesity reviews 2008. 9, 35-42.

The prevalence of obesity in Irish society is not a consequence of the effect of single determinants, but an outcome of the relationship between multiple determinants, such as social, environmental, economic and cultural factors, or due to individual/lifestyle behaviours and genetic make-up. Indeed it is argued that the clinical approach to obesity is also confusing the public health agenda by placing the healthcare system as the first line of response to the obesity epidemic (Mello et al 2006).

While it is recognized that a clinical solution cannot solely address the complex issue of obesity, treatment services for established moderate and severe obesity will continue to be required into the future and must be developed. These services will address established clinical need and help support and inform promotional and preventative interventions. Promotion and prevention of childhood overweight and obesity is critical and must be prioritised. Resources need to be balanced to ensure effective population health approaches are adopted, while providing relevant needs based services.

The scale of obesity in most countries has already surpassed the ability of any healthcare system to cope with it from the clinical perspective (Kumanyila et al 2003). Single-strategy or single-setting interventions are therefore also unlikely to impact adequately upon the obesity issue but a multiple strategy approach that is mindful of educational, policy, environmental and social inputs, is required to be integrated into multiple settings (i.e. work, schools, community).

While nutrition and physical activity based programmes can be effective as treatments, affecting the population distribution of energy imbalance will require a different level of intervention, targeting elements of the obesogenic environment rather than personal behaviours (Maziak et al 2008). Opportunities are required at governmental, societal and individual levels for specific measures that may help diminish the driving forces that promote weight gain.

A population health approach\* has been adopted in the drafting of this framework for action which will be accompanied by a detailed implementation plan with targets, timeframes, a process for monitoring and evaluating progress and responsibility assigned for achieving required outputs and outcomes. The progress and achievements to date of the HSE in promoting health and addressing obesity are outlined in Appendix 4 of this document.

\* A population health approach focuses on improving the health status of the population. Action is directed at the health of an entire population, or sub-population, rather than individuals. This necessitates the reduction of inequalities in health status between population groups. An underlying assumption of the approach is that reductions in health inequalities require reductions in material and social inequalities. The outcomes or benefits therefore extend beyond improved population health outcomes to include a sustainable and integrated health system, increased national growth and productivity, and strengthened social cohesion and citizen engagement. (Ref Health Service Executive 2008 HSE Population Health Vision ... to optimise the health and quality of life of the people of Ireland.)

In essence optimal solutions should not impinge on people's freedoms but rather render unhealthy choices costly to individuals, corporations and government officials alike (Maziak et al, 2008).

### **Resource Implications**

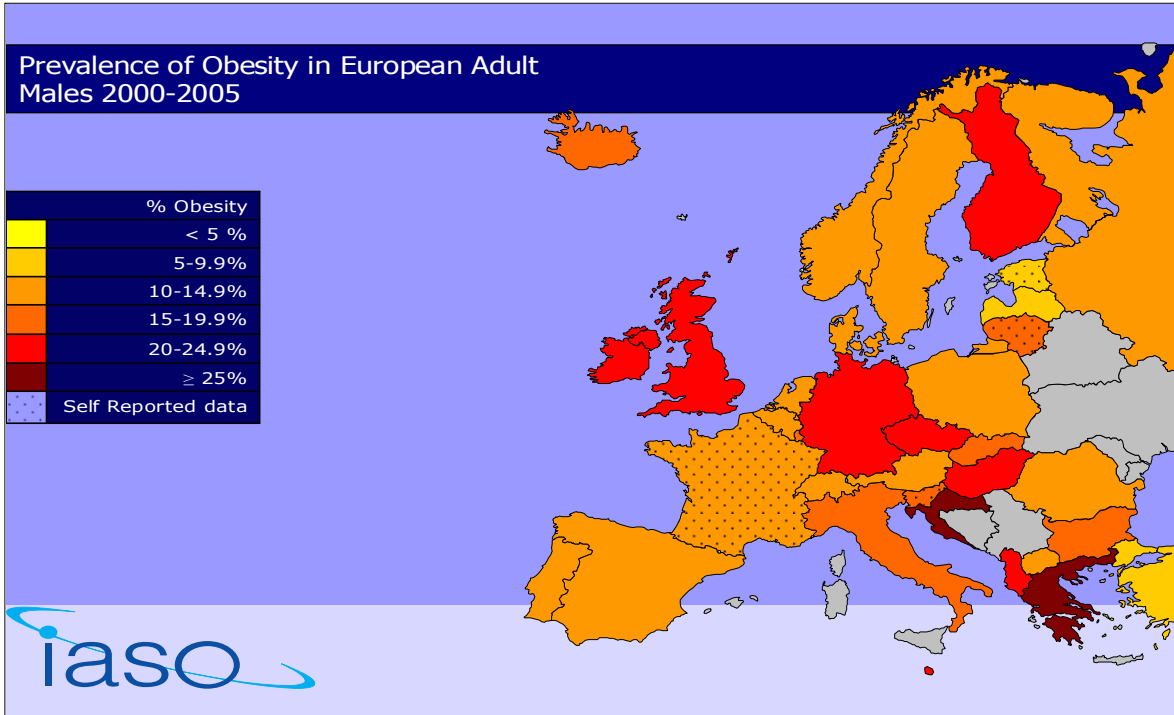
This framework contains high-level actions, whose elements will be translated into three phases. Phase 1 of implementation seeks to maximise use of existing available resources with a view to carrying out a needs assessment for phases 2 and 3.

### **Prevalence of Obesity**

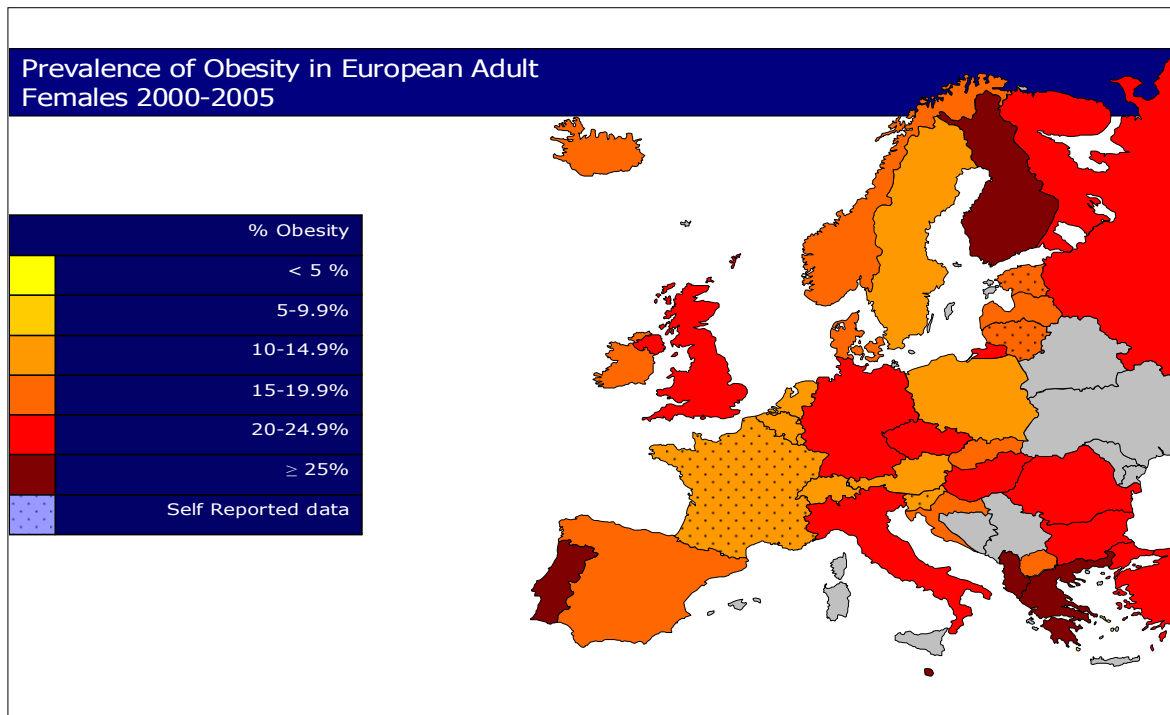
Obesity is viewed simply as an excess of body fat, which has accumulated to the extent that health is adversely affected (WHO, 1998). While the key causes of obesity are linked to food habits and physical activity, its manifestations are more complex and obesity has many other determinants. These include, among others, physiological adjustment to energy imbalance, behavioural factors, socio-economic factors, age, gender and educational status.

The prevalence of overweight (BMI  $\geq$  25kg/m<sup>2</sup>) and obesity (BMI  $\geq$  30kg/m<sup>2</sup>) has been receiving considerable attention in the past decade and is now recognized as one of the leading public health problems facing our society. According to the World Health Organization, there are over 1.6 billion people overweight globally, and at least 400 million of them are clinically obese. Europe has an average BMI of 26.5 – one of the highest of all WHO regions (WHO, 2002).

As figures 3 and 4 (overleaf) illustrate significant differences exist between countries, however rates are rising in virtually all regions of Europe (James, 2008). In Europe it is estimated that 6% of all health costs are attributed to obesity and this excludes the indirect costs of loss of income and productivity and the social costs incurred (WHO, 2006). The Report of the National Taskforce on Obesity, states that "39% of Irish adults are overweight and 18% are obese, (23% SLAN 2007) and even more concerning is that this trend is increasing by at least 1% every year". In 2005, it was estimated that about 2,000 premature deaths in Ireland were attributed to obesity and that these deaths could be costing the state around €4 billion a year (DOH&C, 2005).

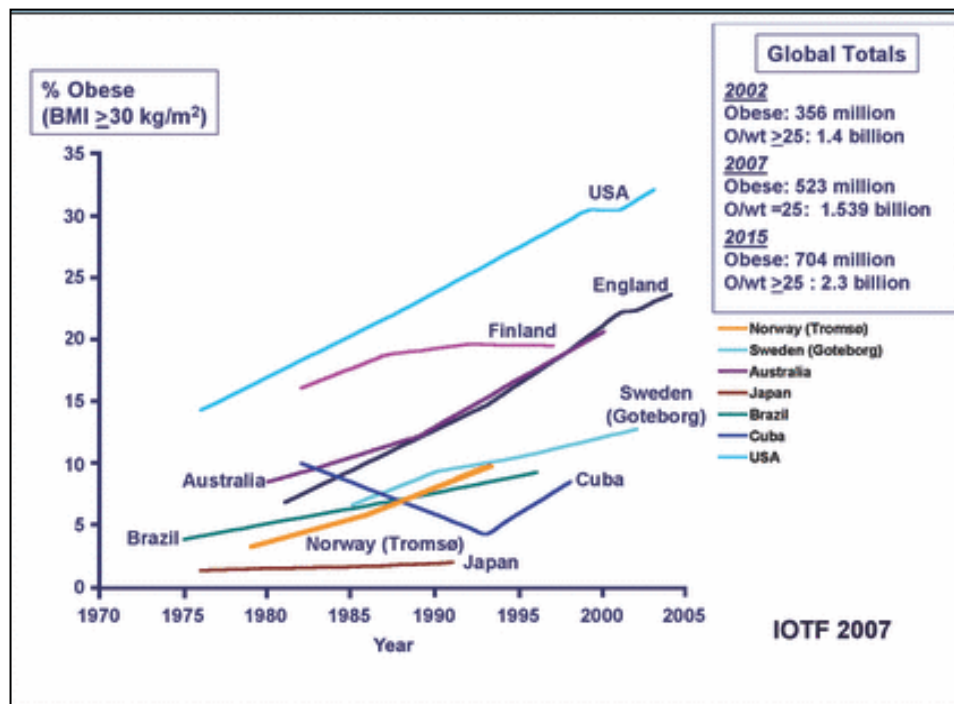


**Figure 3:** Prevalence of Obesity in European Adult Males



**Figure 4:** Prevalence of Obesity in European Adult Females

**Source:** International Association for the study of obesity, an umbrella organisation for national obesity associations which comprises 52 member associations, representing 56 countries



**Figure 5:** Current analyses of the escalating obesity rates in different countries

**Source:** James, W. P. T. *The epidemiology of obesity: the size of the problem.* *Journal of Internal Medicine* 2008; 263 (4):, 336-352

**NOTE:**

Only Cuba during the financial and food crisis showed a decrease in obesity. However Finland is doing better than other countries in modifying the problem.

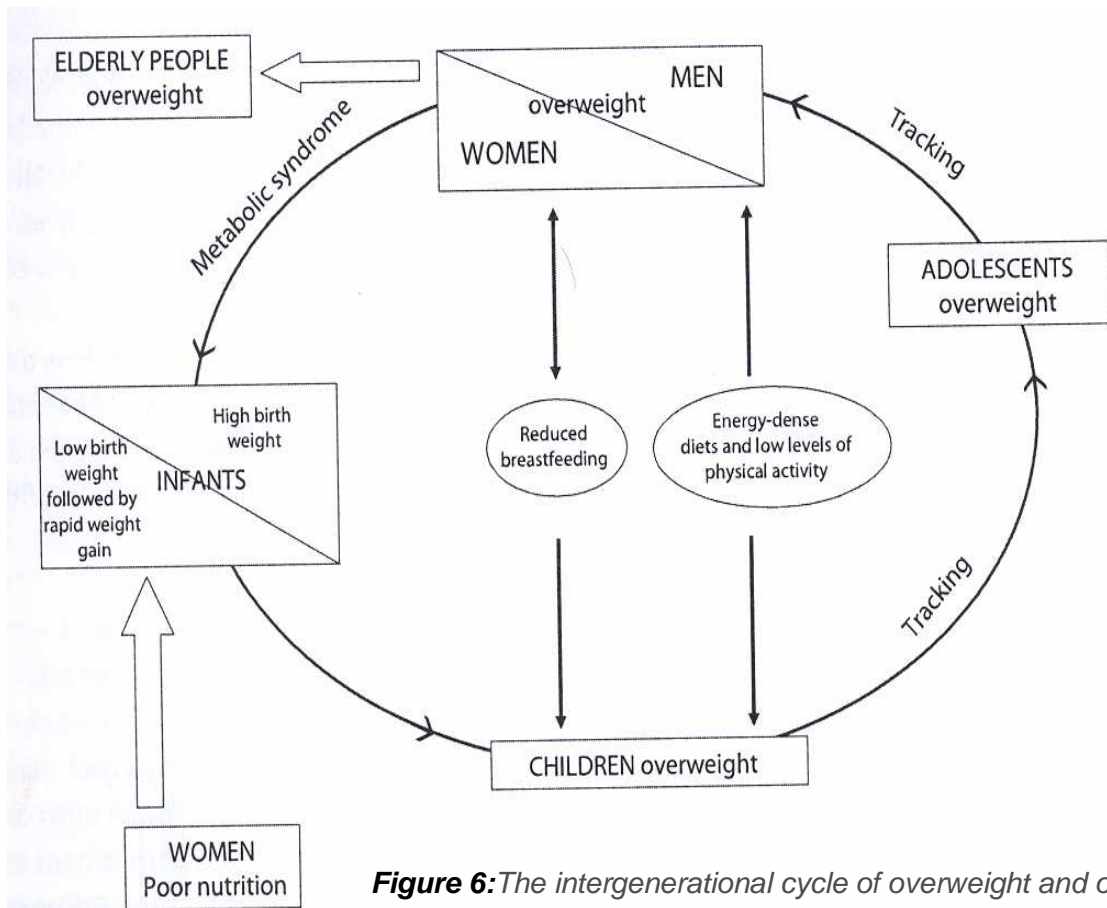
Strategies which were adopted in Finland to increase fruit and vegetable intake whilst simultaneously reducing total fat and salt intakes not only helped to reduce the average blood pressure, but also probably contributed substantially to limiting the rise in obesity rates which were beginning to rise rapidly before the fat intake dropped below 35% of energy and the average vegetable intake trebled (James, 2008).

**Why have the rates of overweight and obesity increased?**

A very significant determinant of obesity is the environment in which we live, which was termed obesogenic by the WHO in 1998. Obesogenic environment means the extent to which neighbourhood safety, poverty, advertising and socially constructed desires, along with the poor quality of available foods, high costs of natural and organically grown foods and similar components impact obesity (Whitehead, 2007). Food commercialism, technology, urban and socio-economic development are contributing to the creation of these obesogenic environments which nurture over-eating and inactive lifestyles (Maziak et al 2008).

## Consequences of overweight and obesity

Obesity not only harms the health and wellbeing of a large proportion of the adult population, it also has a striking and unacceptable impact on children. The increasing tendency for obesity to persist as children grow older (a feature known as tracking) implies that public health initiatives need to be undertaken at each stage of the life cycle (WHO, 2006). These effects can be depicted in an intergenerational cycle that creates a vicious circle involving all age groups. See Figure 6



**Figure 6:** The intergenerational cycle of overweight and obesity

**Source:** WHO Europe The challenge of obesity in the WHO European Region and the strategies for response summary 2006.

A significant correlation exists between childhood and adolescent BMI and adult overweight and obesity (HSE, 2006). See Table 1 (overleaf).

**Table 1:** Risk of childhood obesity tracking into adulthood

Age in Years	Risk for boys	Risk for girls
< 8 years	1 in 5	1 in 3
8 – 13 years	1 in 3	> 1 in 2
> 13 years	1 in 2	2 in 3

**Source:** Guo SS, Wu W, Chumlea WC. Predicting overweight and obesity in adulthood from body mass index values in childhood and adolescence. *American Journal of Clinical Nutrition* 2002; 76: 653-658

Effective prevention needs responses from all parts of society to encourage more active living and healthy eating, starting at the very beginning of life with breast feeding (Commonwealth of Australia, 2008). More recent studies suggest that breast feeding genuinely protects (Arenz et al, 2004), and this may, in part, be explained by the fact that mothers have little understanding of how much energy their child is getting from breast milk as the amount taken is highly dependent on the child's own neural control of appetite. This mechanism, may therefore be fine tuned during the early months of life when breast feeding allows the controls to be established on an individual basis and in keeping with the child's own lean tissue mass, differential organ size and energetic efficiency. Bottle-feeding, may unwittingly lead to a readjustment in these controls which allow greater weight gain as the child may inadvertently be overfed by an anxious mother seeking to satisfy her new baby (James 2008).

Indeed, the prevention of childhood obesity begins prior to conception. Many factors such as a healthy maternal diet and lifestyle during pregnancy and the choice to breastfeed, depend on parental knowledge, skills and choices about food and physical activity for themselves and their families. Maternal obesity at the point of conception is associated with a 4-fold greater risk of childhood obesity by the age of four (Whitaker, 2004). Childhood is a critical period for developing obesity as well as an opportune time to prevent or intervene on it, as eating and activity patterns develop during this period (Harper, 2006).

It is important to treat overweight and obesity in childhood as obesity has a worse prognosis in adult life (Gunnell et al. 1998) with increased risk of metabolic syndrome (56 v 16) (Vanhala et al. 1998) and increased morbidity and mortality if overweight in adolescence even if extra weight is lost in adulthood (Must et al. 1992).

There is also a higher rate of delivery by emergency Caesarean section among obese mothers. A study, which looked at 5,162 women, (39% first time mothers) who delivered between 2001 and 2002 at University Hospital Galway, measured BMI and cross-referenced it against method of delivery. The BMI statistics found that 2.6% of women were underweight, 49.2% were normal weight, 22.8% overweight, 19.8% obese and 5.6% were morbidly obese. For the women in their first pregnancy who were of normal weight, the normal delivery rate was 83.1% but fell to 55.3% for obese women. The authors recommended that obese women in their first pregnancy should be "clearly counselled" about the 30% risk of emergency Caesarean section in delivering their baby. (Morrison & Lynch 2008)

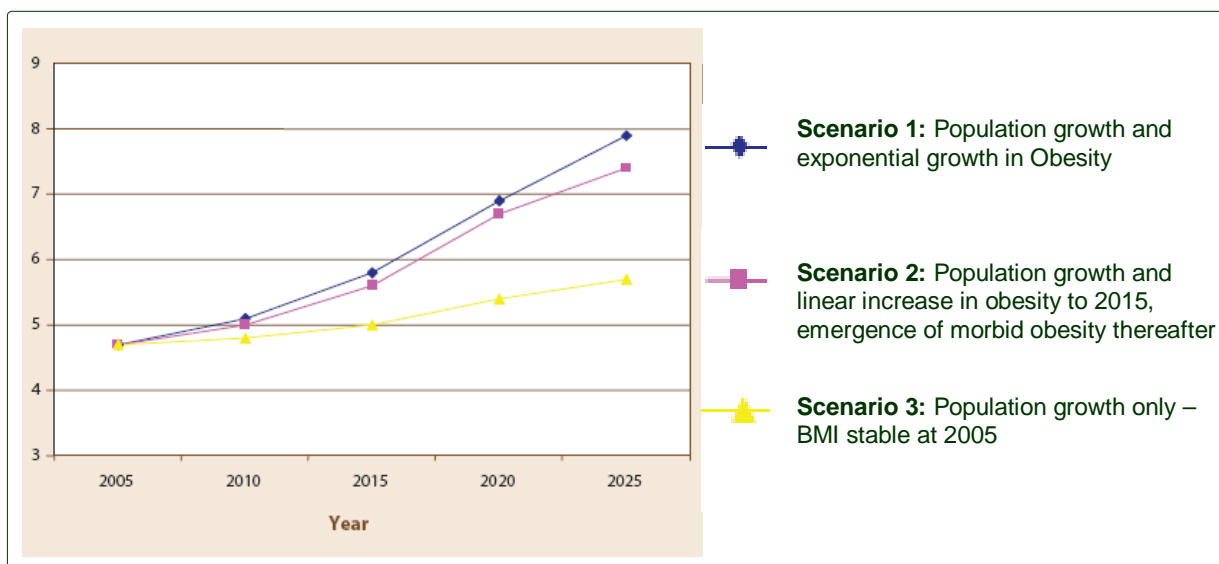
## Economic considerations

Obesity accounts for up to 6% of Ireland's total health care costs. Each year, roughly 2,000 premature deaths are attributed to obesity resulting in an estimated cost of €4 billion to the state. It is linked to many serious illnesses including type 2 diabetes, heart disease, stroke, high blood pressure, respiratory disease and certain types of cancer. The rise in obesity has been linked to the dramatic rise in type 2 diabetes (DOH&C, 2007). It is predicted that the prevalence of diabetes will increase by 15% over the next 20 years as a direct consequence (WHO, 2002).

A study was carried out to collect all discharges (using The Hospital In-Patient Enquiry (HIPE) data base) for all children from 6 -18 years and all adults from all acute hospitals in the Republic of Ireland from 1997 – 2004, with a principal or secondary diagnostic code for obesity (Vellinga et al, 2008). A discharge frequency was calculated by dividing obesity related discharges by the total number of diagnoses (principle and secondary) for each year. The hospital costs related to obesity was calculated based on the total number of days care.

The discharge frequency increased from 1.14% in 1997 to 1.49% in 2004 for adults and from 0.81% to 1.37% for children. The relative length of stay (number of days in care per 1000 days of hospital care given) increased from 1.47 in 1997 to 4.16 in 2004 for children and from 3.68 in 1997 to 6.74 in 2004 for adults. Based on 2001 figures for cost per inpatient bed day, the annual hospital cost was calculated to be €4.4 million in 1997, increasing to €13.3 million in 2004. At a 20% variable hospital cost the cost ranges from €0.9 million in 1997 to €2.7 million in 2004; a 200% increase.

Disease modeling carried out by the Institute of Public Health (see Figure 7) shows the relationship between increase in obesity and rise in diabetes. This has implications for our health system (DOH&C, 2008).



**Figure 7:** Forecasts of population prevalence of diabetes (adults only) from 2005 to 2025 under three scenarios

**Source:** Taken from pg 13 "Tackling Chronic Disease, A Policy Framework for the Management of Chronic Diseases". Department of Health and Children 2008.

Approximately 80% of GP consultations and 60% of hospital bed days are related to chronic diseases and their complications. Chronic diseases make up two thirds of emergency medical admissions to hospitals. The UK estimates that 8 of the top 11 causes of hospital admissions are due to chronic diseases and that 5% of inpatients with a long-term condition consume 42% of all acute bed days (DOH&C, 2008).

Bariatric surgery, considered the last management option for the morbidly obese, is estimated to cost approximately €30,200 per gastric bypass procedure and €20 - €22,000 for gastric banding in 2008. Patients deemed suitable for surgery require extensive pre and post operative multidisciplinary support, especially psychological support. They also require long term monitoring by medical staff and Dieticians and in the case of gastric bypass, accompanying nutrient supplement drug treatment.

## **SECTION 2:**

### **➤ Purpose of the Framework for Action against Obesity**

This framework for action sets out how the HSE will work proactively and constructively with other sectors to facilitate the full implementation of the recommendations contained in the National Taskforce on Obesity report. It is also a practical action plan, which the HSE will use to implement those recommendations directed towards the health sector.

The framework examines the national and international documents and what these broadly mean for the HSE.

The framework has a number of purposes:

- It translates the recommendations from the national document on obesity into core areas of action so that there is a practical application of the recommendations
- It builds on existing practice and services
- It broadly outlines the areas where action will be undertaken
- It outlines the structures including roles and responsibilities necessary to drive the recommendations forward
- It outlines how the HSE plans to work with other sectors.

### **Within the framework for action on obesity there are five key priority areas:**

- To enhance effectiveness in surveillance, research, monitoring and evaluation of obesity.
- To develop a quality uniform approach to the detection and management of obesity.
- To develop our capacity in preventing overweight and obesity and to promote health
- To communicate our messages on obesity effectively.
- To proactively engage and support the work of other sectors in addressing the determinants of obesity and the obesogenic environment.

### **The overall approach**

This framework was developed by the national working group responsible for advising and directing the activities of the HSE on obesity. This group looked at the recommendations within the Taskforce Report and developed an action plan designed to deliver, in the shortest time possible, real and effective programmes of work for HSE staff.

The HSE is committed to developing a national unified approach to evidence-based service delivery. The knowledge base around obesity is limited at present but is growing. In this framework for action the importance of ongoing research and dissemination of good practice is highlighted.

The priorities and action areas in this document will be implemented using a well structured project management approach linked to the Transformation Programme of the HSE. It will also cross reference and complement other projects within Programme 4 all of which are affected by, or help to prevent obesity:

- Health inequalities framework
- Chronic illness framework
- Population health strategy
- Cardiovascular health strategy
- Tobacco control framework
- Breastfeeding 5 year strategy

The priorities outlined in this framework for action will be translated into full project implementation plans broken down into three phases. Completion dates for these phases are indicated within the framework. The development of these implementation plans will require broader consultation and engagement with key stakeholders within the HSE and with key external stakeholders.

### **What does the HSE hope to achieve?**

Through the implementation of this framework for action, the HSE will

- be a national leader in promoting and improving health in the population and addressing chronic illness
- will through its work with other sectors, advocate for environments and settings that are more conducive to the provision of healthier choices
- take integrated actions to address the determinants of obesity
- provide comprehensive information and education on healthy lifestyles
- advocate for and support the development of healthy public policy to improve health and to prevent obesity
- develop national surveillance systems and research capacity and processes for monitoring and evaluation
- ensure that staff are confident and competent in the management of overweight and obesity
- offer a range of treatment options for overweight and obesity

## The relationship between obesity and chronic illness

Obesity in itself represents a major chronic illness but is also a major contributor to other chronic illness's such as heart disease and type 2 diabetes and to decreased ability to function normally and independently. Table 2 illustrates how overweight and obesity contribute to other illness's.

Greatly increased (relative risk > 3)	Moderately increased (relative risk 2-3)	Slightly increased (relative risk 1-2)
Type 2 diabetes	Coronary heart disease	Cancer <sup>b</sup>
Gallbladder disease	Hypertension	Reproductive hormone abnormalities
Dyslipidemia	Osteoarthritis (knees)	Polycystic ovary syndrome
Insulin resistance	Hyperuricemia & gout	Impaired fertility
Breathlessness		Low back pain
Sleep apnea		Anesthesia complications
		Foetal defects

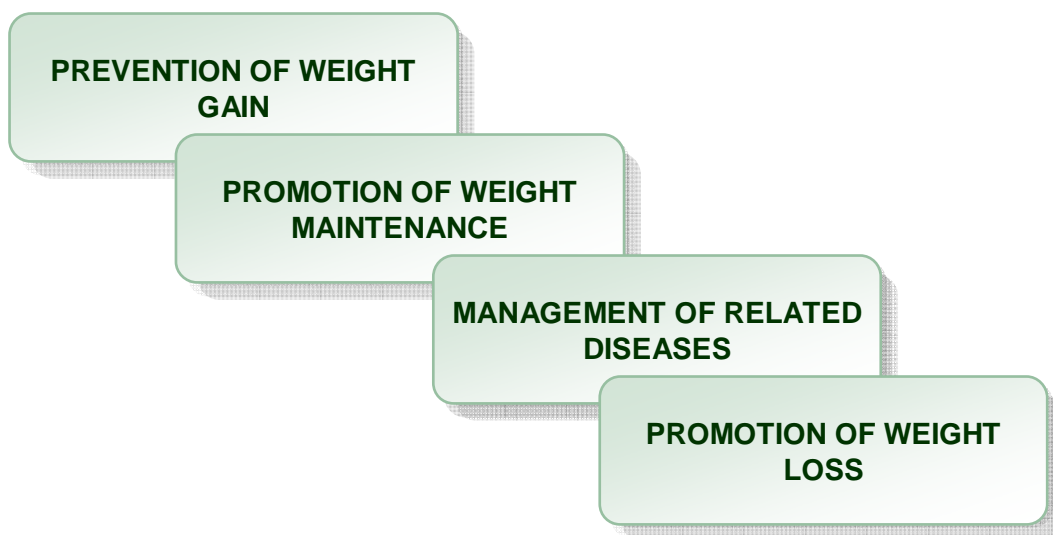
**Table 2:** Relative risk of health problems associated with obesity<sup>a</sup>

<sup>a</sup> All relative risk values are approximate

<sup>b</sup> Breast cancer in postmenopausal women, endometrial cancer, colon cancer  
Source: World Health Organization, 2000; Table 4.1, page 43.

(Ref: World Health Organization 2000. Obesity: Preventing and managing the global epidemic. WHO Technical report series 894. Geneva.)

HSE staff have a unique role in the prevention of obesity. Not only does the national report make specific recommendations for the health sector, it also outlines the role of the HSE in enabling other sectors play their part in the prevention of obesity. Staff may play a role at different points as shown in Figure 8.



**Figure 8 :** Management of obesity

*Source: Based on WHO model which shows the broad range of overlapping activities that are involved in prevention and treatment of obesity*

### **What are the root causes of obesity?**

There is no one single cause: many factors come together to contribute to obesity.

These include:

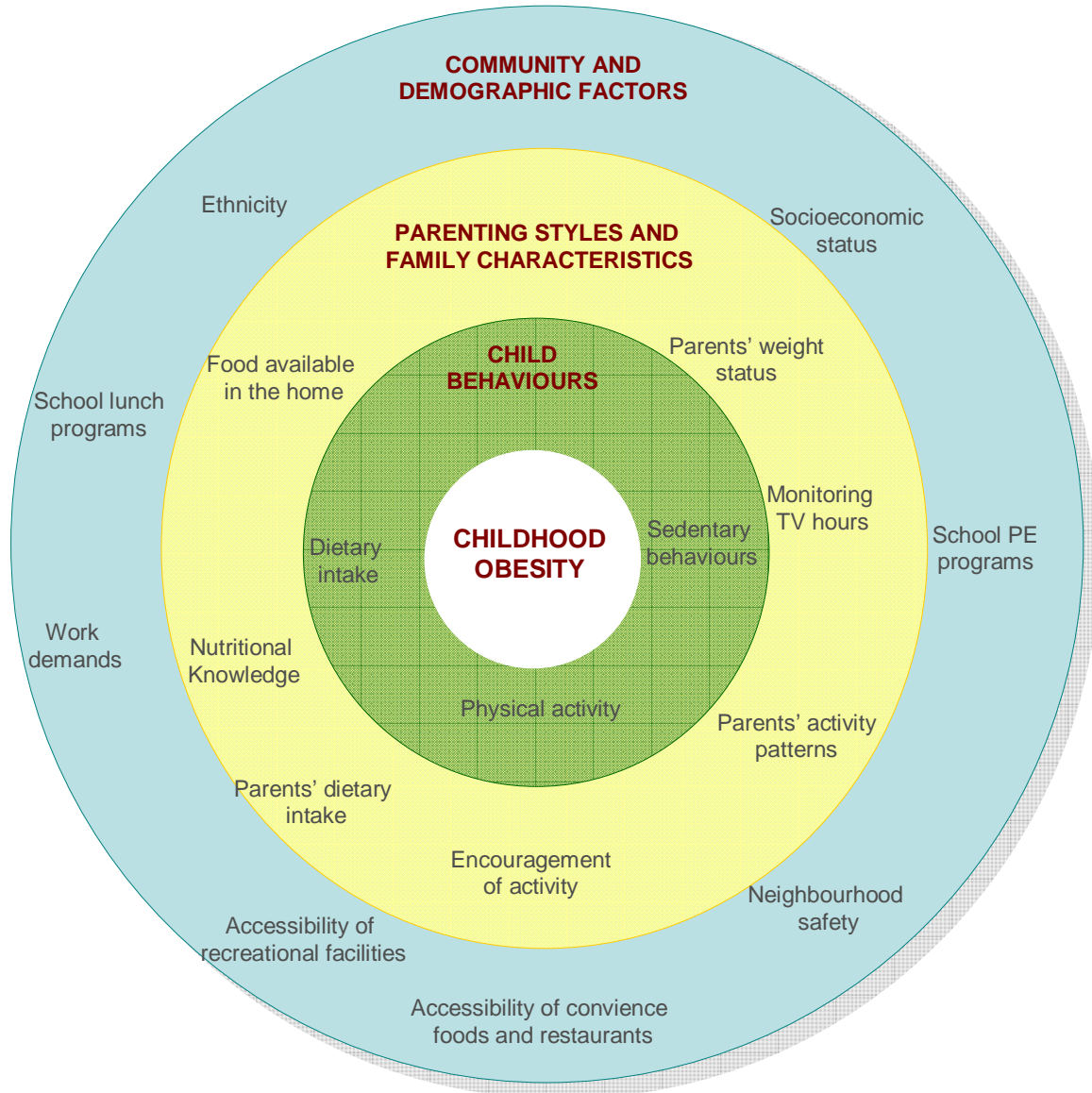
**Individual/behavioural determinants:** diet and physical inactivity. There is general agreement that regular physical activity and a healthy diet, high in fibre and low in energy-dense foods protect against weight gain and obesity.

**Environmental determinants:** the context for individual behaviour. It is generally recognized that the current epidemic of obesity is largely related to an environment that, in multiple ways, promotes excessive food intake and discourages physical activity.

**Social determinants:** socio-economic status/poverty. While this is an emerging area of knowledge, we know that obesity is more common among low income and less well- educated groups. There is evidence to suggest that behaviour patterns of people living in poverty are more likely to promote obesity than those of their higher-income counterparts. In a US study, nearly one-third of the mothers of the 8494 low income children enrolled in the Special Supplement Nutrition Program for Women, Infants and Children (WIC) in Ohio, were already obese when they conceived, and one in four of all

children born to these mothers were obese by 4 years of age (Whitaker, 2004).

The National Taskforce on Obesity document illustrates the different sectors that play a role in the prevention of obesity.



**Figure 9:** Contextual influences on the development of childhood obesity

**Source:** Davison and Birch (2001) *Obesity Reviews* 2, 159-171

## **SECTION 3:**

### **➤ What works?**

A key element of the HSE approach is the use of evidence to guide its response and interventions concerning overweight and obesity. The HSE will continue to improve capacity to build evidence around how best to prevent and manage obesity. Secondary preventative strategies with effective long-term multidisciplinary treatments are cost-effective and achieve the best results when applied early in childhood or adolescence. The treatment of established adult obesity tends to have a poor outcome. Treatment of adult obesity is often disappointing with poor weight loss maintenance, with regain of 30-35% weight loss in year 1 (Brownell et al. 1991). Children are more successful in maintaining weight loss (Epstein et al. 1995, Nuutinen et al. 1992 and Braet et al. 2000).

### **A brief summary of the evidence on social marketing is outlined below**

*Social marketing including media interventions:*

- Can increase awareness of what constitutes a healthy diet (Hastings et al, 2003).
- Can improve knowledge, attitudes and awareness of physical activity (Hastings et al, 2003)
- Can have an effect on children's food preferences, purchase behaviour and consumption (Goldberg et al, 1978a, 1978b, Stoneman et al 1981, Kaufman et al, 1983).

Books, magazines and television programmes are an important source of information (Spungin, 2003).

### **The home**

Parents and guardians are important role models. Interventions that involve parents in a significant way, may be particularly effective and can improve parental engagement in active play with children and in their children's dietary intake (McGarvey et al, 2004).

The evidence is weaker on the effectiveness of interventions among lower socio-economic groups and what works best with children and young people. There is a body of evidence that suggests that food promotion can have an effect on children's food preferences, purchase behaviour and consumption (Gorn, 1980b, Gorn et al,1982). Family-based interventions that target improved weight maintenance in children and adults, focusing on diet and activity, can be effective, at least for the duration of the intervention (Hopper, 1996).

### **Health Service**

Sustained health professional-led interventions in primary care or community settings, focusing on diet and physical activity, or general health counselling, can support maintenance of a healthy weight (Simkin et al, 2003). There is some evidence that primary care staff may hold negative views on the ability of patients to change behaviours, and on their own ability to encourage change (Fuller et al, 2003). Interventions, which provide support and advice on physical activity and diet are more likely to be effective for weight outcomes than interventions which focus on physical activity alone. Interventions with a

greater number of components are more likely to be effective.

Behavioural/educational interventions to increase physical activity can be moderately effective, particularly for walking and non-facility-based activities, although increases may not be sustained over time (Harland et al, 1999).

There is a body of evidence that creation of, or enhanced access to, space for physical activity (such as walking or cycling routes), combined with supportive information/promotion, is effective in increasing physical activity levels (Brownson et al, 2004).

Moderate or high-intensity dietary interventions such as those provided by Dietitians most commonly report clinically significant reductions in fat intake and an increase in fruit and vegetable intake (Havas et al, 2003).

Brief interventions, such as brief counselling/dietary advice by GPs or other health professionals, can be effective in improving dietary intake but tend to result in smaller changes than intensive interventions (Steptoe et al, 2003). There is a need to develop integrated care pathways to support longer-term interventions.

### **Schools**

School-based multi-component interventions addressing various aspects of diet and/or activity in the school, including the school environment, are effective in improving physical activity and dietary behaviour, at least while the intervention is in place, but there is a need to work with and engage schools to implement programmes (Caballero et al, 2003).

### **Workplaces**

Worksite behaviour modification programmes such as health screening followed by counselling and, sometimes, environmental changes, can lead to improvements in nutrition and physical activity while the intervention is in place (Glanz et al, 1996), but again there is a need for strong involvement of workplaces to invest in these programmes. The HSE can play a role in enabling this.

### **What are the challenges?**

The evidence base shows that public communication campaigns can be effective in changing behaviour but they must be planned and implemented based on best available evidence. The evidence also shows that not all health service staff are convinced of the need for the health care sector to lead the drive against overweight and obesity (Williams et al, 2004).

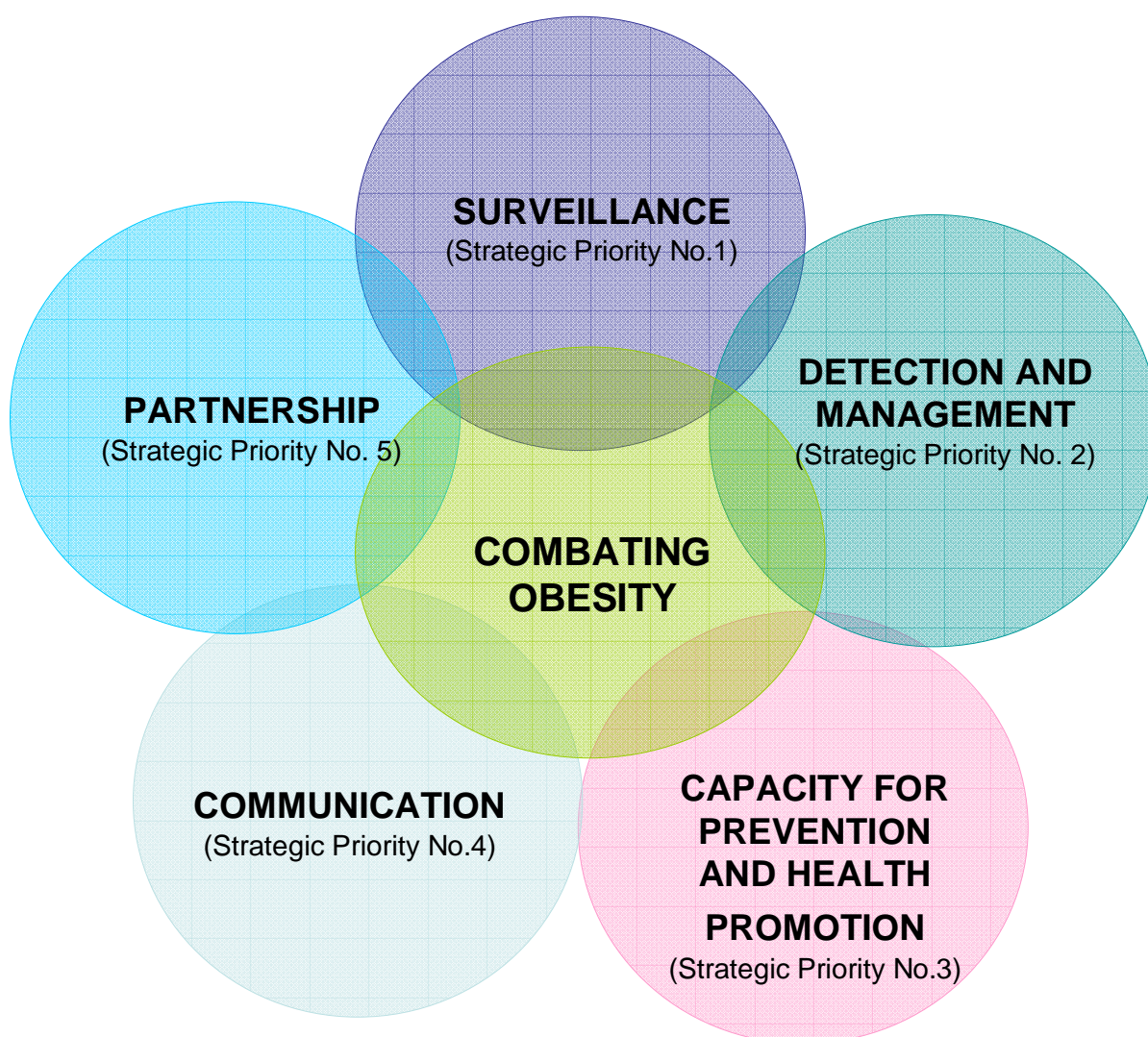
The National Taskforce on Obesity names a number of other sectors and delivers a series of recommendations towards education, environment and social and community as well as the food sector and national governmental leadership. The HSE will play a role in working with these sectors to advocate for the development of multi-agency responses to obesity.

At present obesity prevention and treatment programmes are provided unevenly throughout the country depending on services available in each area. The HSE will standardise practice to ensure that all clients, whether normal weight or overweight/obese, receive advice, information and support on eating a healthy diet and including sufficient physical activity to achieve or maintain a healthy weight.

## **SECTION 4:**

### **➤ Priority Action Areas for the HSE**

The National HSE Working Group on Obesity has identified five key priority areas for implementation of the recommendations relevant to the HSE. This framework for action will be accompanied by a detailed implementation plan with targets, timeframes and processes for monitoring and evaluation. The five priority action areas are depicted in Figure 10.



**Figure 10:** Strategic Priorities for Combating Obesity

## **STRATEGIC PRIORITY NUMBER 1:**

### **➤ To enhance effectiveness in surveillance, research, monitoring and evaluation of obesity**

The National Taskforce Report points to the need for effective surveillance, research, monitoring and evaluation of obesity. It recommends that a national database of growth measurements for children and adults be developed by the Population Health Directorate to monitor trends in growth overweight and obesity. Taking a population health approach, the HSE will progress research on overweight and obesity as well as evaluating and monitoring progress on key priority areas. Population health surveillance of obesity in children and adults is essential to provide a clear indicator of whether our actions are effective.

#### ***Strategic Objectives:***

To develop robust surveillance, monitoring and evaluation systems to inform service provision and lead to improved outcomes.

To establish systems to demonstrate cost effectiveness and return on investment.

RESPONSIBLE	<b>P</b>	<b>NHO</b>	<b>PCCC</b>	<b>PH</b>	<b>C</b>
DIRECTORATE	Procurement	National Hospitals Office	Primary, Community, & Continuing Care	Population Health	Communications

### **Action Areas**

#### **1.1 Surveillance**

- 1.1.1** Undertake a review of best practice on the surveillance of obesity in children and adults. **(PH)**
- 1.1.2** Carry out a critical appraisal of existing surveillance systems in Ireland to exploit their potential for integration into a national surveillance system for children and adults. **(PH)**
- 1.1.3** Hold a surveillance symposium in association with the proposed North/South Obesity conference involving key stakeholders and international experts. Use the findings from the above pieces of work to agree the optimum way forward in an all island context. **(PH)**
- 1.1.4** Develop a national database of height and weight BMI and additional variables as appropriate. **(PH)**
- 1.1.5** Develop links to other data sources i.e. client index, patient records and child health records. **(PH, PCCC)**
- 1.1.6** Utilise the child health record to raise awareness on height, weight, waist, circumference and BMI. **(PH, PCCC)**

- 1.1.7 Continue to work with the National Surveillance Centre to progress key areas of work for the HSE (See Appendix 6 for Work plan of NNSC 2007-2008). **(PH)**
- 1.1.8 Monitor mortality trends in obesity associated conditions. **(PH)**
- 1.1.9 Monitor costs of hospital admissions for obesity associated conditions. **(PH, NHO)**
- 1.1.10 Utilise HIPE and Heartwatch data to monitor morbidity from obesity associated conditions. **(PH, PCCC, NHO)**

## **1.2 Research**

- 1.2.1 Participate in WHO European Childhood Surveillance initiative as an initial step in the development of a national database. **(PH, PCCC)**
- 1.2.2 Develop a database of existing research available in the Irish context. Identify research priorities and agree a mechanism for funding of these priorities for the next five years. **(PH)**
- 1.2.3 Develop linkages with 'Growing Up in Ireland' the National Longitudinal Study of Children. **(PH)**
- 1.2.4 Use the experience of 'Measuring Height And Weight In Schoolchildren As A Public Health Indicator' (Glacken, et al. 2006) to develop the potential of using school health surveillance services for measuring BMI in children. **(PH, PCCC)**
- 1.2.5 Participate in SLAN, HBSC and other relevant surveys and utilise the findings for monitoring prevalence and spatial and social diffusion factors. **(PH)**
- 1.2.6 Identify key findings from national and international research relating to obesity, and the interrelationship between obesity, physical activity and nutrition and other determinants; review outcomes and implement as appropriate in an Irish context. **(PH)**
- 1.2.7 Develop mechanisms for dissemination of results of significant pieces of research to all key stakeholders in the HSE, i.e. SLAN, HBSC, IUNA, Lifeways intergenerational study (partly funded by HSE) including significant pieces of health services research carried out by HSE. **(PH)**
- 1.2.8 Critically appraise findings of SLAN and HBSC by HSE area to utilise patterns of variation for action. **(PH)**
- 1.2.9 Further develop links with academic institutions, universities and IT colleges. **(PH)**

## **1.3 Monitoring & Evaluation**

- 1.3.1 Develop an evaluation framework for implementation of HSE priorities on overweight and obesity. **(PH)**
- 1.3.2 Ensure equipment used to measure and record height and weight is in line with best international practice and regularly reviewed. **(PH)**
- 1.3.3 Ensure all staff involved in surveillance measurement receive appropriate training and retraining. **(PH)**

## **STRATEGIC PRIORITY NUMBER 2:**

### **➤ To develop a quality uniform approach to the detection and management of obesity**

The core task for the HSE will be to develop a uniform integrated national approach to the management of overweight and obesity. This work will require significant support to ensure the development of a national quality assured, evidence-based service, capable of measuring outcomes. A centre of excellence for tertiary referral of the severely obese with academic background and international collaborations is needed. Such a resource can aid development of best practice, be a resource for local centres and provide training for staff to work in other areas.

#### ***Strategic objectives:***

To review existing services, identify gaps and develop appropriate services based on identified requirements.

To enhance the capacity of HSE staff in the management of overweight and obesity and to develop a framework for training on obesity so that a standard quality of service can be provided across all services.

To provide national quality assured services for the detection and management of overweight.

### **Action Areas**

#### **2.1 Review Services**

- 2.1.1** Engage with the Expert Groups on Children, Diabetes and Cardio Vascular Disease to ensure an integrated approach to the prevention and management of obesity. **(PH, PCCC, NHO)**
- 2.1.2** Convene an advisory group to review existing evidence for the provision of services to manage obesity in adults and children in PCCC and NHO and advise on options for the development of quality treatment services. **(PH)**
- 2.1.3** Undertake a review of existing Child Health Services that contribute to the prevention of overweight and obesity. **(PH)**

## **2.2 Enhance capacity of staff**

- 2.2.1** Plan, develop and implement a training plan to provide a tiered training programme for staff in PCCC and NHO appropriate to the levels of intervention and expertise of staff. **(PH, PCCC, NHO)**
- 2.2.2** Develop National guidelines for community based practitioners for PCCC on the prevention and management of overweight and obesity in adults and vulnerable groups. **(PH, PCCC)**
- 2.2.3** Implement the National Guidelines in PCCC for Community Based Practitioners on Prevention and Management of Childhood Overweight and Obesity. **(PCCC, NHO, PH)**
- 2.2.4** Develop family based integrated approaches between NHO and PCCC for the management of overweight and obesity. **(NHO)**
- 2.2.5** Work with the ICGP to facilitate training of General Practitioners and other primary care staff in the management of obesity based on existing guidelines for children and young people and those being developed for adults. **(PH, PCCC)**

## **2.3 Quality Assured Services**

- 2.3.1** Develop integrated care pathways between PCCC and NHO on services for overweight and obesity. **(PCCC, NHO)**
- 2.3.2** Implement the National GP Exercise Referral Programme through Primary Care Teams and Networks. **(PCCC, PH)**
- 2.3.3** Provide nutrition health promotion and clinical nutrition services in PCCC and NHO and identify gaps in service delivery for adults and children. **(PCCC, NHO)**
- 2.3.4** Provide tertiary hospital services for the management of overweight and obesity for children, young people and adults. **(NHO)**
- 2.3.5** Develop primary care teams and networks which include the prevention, management and treatment of overweight and obesity as part of their core service. **(PCCC)**

## **STRATEGIC PRIORITY NUMBER 3:**

### **➤ To develop our capacity in preventing overweight and obesity and to promote health**

The National Taskforce Report refers to the importance of the Health Sector providing clear and consistent advice on the prevention and management of obesity. The HSE can play a major role in improving the health of the population and preventing overweight and obesity.

#### ***Strategic objectives:***

To agree and implement evidence-based approaches to improving health through a settings approach targeted at the whole population with emphasis on reducing health inequalities.

To further develop health promotion services using an integrated population health approach that shifts the balance from hospital to primary care and health promotion.

To develop and implement guidelines and policies that support the prevention of overweight and obesity.

To address health inequalities through implementation of the HSE Framework on Health Inequalities.

### **Action Areas**

#### **3.1 Settings**

- 3.1.1** Provide training on optimal foetal and maternal nutrition to staff in antenatal settings through provision of information and training. **(PH, NHO, PCCC)**
- 3.1.2** Promote breastfeeding as a prevention strategy through implementation of “Breastfeeding in Ireland: A Five Year Strategic Action Plan” 2005. **(PH, PCCC, NHO)**
- 3.1.3** Provide evidence based nutrition/physical activity programmes in pre-school settings. **(PH)**
- 3.1.4** Support implementation of the Social Personal Health Education (SPHE programme). **(PH)**
- 3.1.5** Implement the Health Promoting Schools Model. **(PH)**
- 3.1.6** Provide health promotion programmes in communities targeting lower socio-economic groups. **(PH)**
- 3.1.7** Partner the public and private sector in developing workplace health promotion. **(PH)**

- 3.1.8 Progress the development of the Health Promoting Hospitals Network and progress development of health promotion approaches in hospitals. **(PH, NHO, PCCC)**
- 3.1.9 Develop guidelines for health promotion and prevention of overweight and obesity in Residential adult and Child Care Settings provided by the HSE or voluntary organizations providing community based institutional services on the HSE's behalf. **(PH)**
- 3.1.10 Support work with the prison services as required on Health Promoting Prisons e.g. menu planning. **(PH)**
- 3.1.11 Develop health promotion capacity specifically in nutrition and physical activity through provision of training and support to HSE staff community groups, teachers, health professionals, prison staff etc. **(PH)**
- 3.1.12 Work with key stakeholders to progress WHO Healthy Cities/Communities through provision of health promotion programmes and initiatives. **(PH)**
- 3.1.13 Partner the national governing bodies of sports organisations in developing health promotion policies and programmes. **(PH)**

### **3.2 Guidelines and Policies**

- 3.2.1 Establish a National expert physical activity steering group with representation from HSE and key national organisations and universities. **(PH)**
- 3.2.2 Develop National Physical Activity Guidelines and an accompanying action plan with all key stakeholders. **(PH)**
- 3.2.3 Implement the National Guidelines for Community Based Practitioners in PCCC on Prevention and Management of Childhood Overweight and Obesity. **(PH, PCCC)**
- 3.2.4 Implement, on completion, the National Nutrition Policy in PCCC, NHO, Population Health and Procurement. **(PH, PCCC, NHO, Procurement)**
- 3.2.5 Support the development of National Healthy Eating Guidelines with key Stakeholders. **(PH)**
- 3.2.6 Implement the national Healthy Catering Guidelines for Staff and Visitors in Healthcare Facilities in NHO and PCCC. **(NHO, PCCC)**
- 3.2.7 Develop and implement an HSE Healthy Procurement Policy to lead by example in the procurement of healthy food. **(PH, Procurement)**
- 3.2.8 Develop and implement a Corporate Catering Policy for the HSE. **(PH)**

### **3.3 Health Inequalities**

- 3.3.1 Further develop capacity in Health Impact Assessment. **(PH)**
- 3.3.2 Further develop food poverty projects and provision of nutrition programmes (Healthy Food Made Easy and Cook It) in partnership with key stakeholders in lower socio-economic groups. **(PH, PCCC)**

## **STRATEGIC PRIORITY NUMBER 4:**

### **➤ To communicate our message on obesity effectively**

Tackling obesity effectively is a challenge for the HSE. As part of this work, the HSE will need to develop evidence-based messages on the determinants of overweight and obesity to raise awareness among the population on improving health and maintaining a healthy weight. There is also a need to develop effective communication processes with all stakeholders to ensure implementation of this framework for action. Acknowledgement of excess weight and an understanding of its health consequences are essential first steps to tackling obesity (DOH&C, 2005). It is a priority that this is communicated both internally and externally, using social marketing approaches, as people have difficulty in identifying themselves and their children as obese or at risk of obesity (IUNA 2001). Social marketing attempts to use commercial marketing methods for socially beneficial purposes: this in its fuller form includes a range of methods for changing cultural norms and targeting opinion makers, legislators and commercial operators who set those norms (European Heart Network 2006).

#### ***Strategic objectives:***

To identify gaps in health promotion resources provided by the HSE on the prevention and management of overweight and obesity and to develop new resources where required.

To engage the public by progressing the development and implementation of health promotion campaigns to address physical activity and nutrition.

To develop a communication plan to inform and engage with all directorates, staff and external stakeholders on this action plan.

### **Action Areas**

#### **4.1 Health Information Resources:**

- 4.1.1** Review current Irish resources in relation to overweight and obesity and identify where the gaps are. **(PH)**
- 4.1.2** Develop, through the National Health Promotion Information Project, health information materials on nutrition, physical activity and maintaining healthy weight for adults and children. **(PH)**
- 4.1.3** Manage the storage, distribution and dissemination of health promotion materials on overweight and obesity nationally to ensure that relevant information is readily available to the public and other key stakeholders. **(PH)**

## **4.2 Health Promotion and Health Awareness Campaigns:**

- 4.2.1 Implement an annual health promotion campaign, taking an all island approach to address physical activity and nutrition in partnership with key stakeholders i.e. Safefood and the Health Promotion Agency of Northern Ireland. **(PH)**
- 4.2.2 Identify opportunities and work with media to raise awareness on healthy lifestyles through TV, radio and print media to gain support in the implementation of this framework. **(PH, C)**

## **4.3 HSE Communication Plan:**

- 4.3.1 Hold an annual North/South Conference to communicate with key stakeholders in order to share best practice with partners. **(PH)**
- 4.3.2 Relevant actions of this framework to be included in annual business plans and performance monitoring throughout the HSE. **(PH, NHO, Procurement, PCCC)**
- 4.3.3 Identify opportunities to advocate for and communicate with external stakeholders to promote adequate labeling of food and to address the marketing of unhealthy foods to children. **(PH, C)**

## **STRATEGIC PRIORITY NUMBER 5:**

### **➤ To proactively engage and support the work of other sectors addressing the determinants of obesity and the obesogenic environment**

The Taskforce Report identified the key role of other sectors in implementing its recommendations. These include:

- Government departments and interdepartmental offices and groups
- Sectors responsible for physical environments
- The producers, suppliers and advertisers of food
- Social and community sectors
- Education sector

The HSE will continue to work and support these and other relevant sectors, at strategic and operational levels, to implement the recommendations of the National Taskforce Report that are outside the remit of the health sector.

#### ***Strategic objectives:***

To strengthen the advocacy role of the HSE to support the recommendations of the National Taskforce Report.

To develop new and existing partnerships to address the recommendation set out in the national document.

## **Action Areas**

### **5.1 Interdepartmental**

- 5.1.1** Work through the Government proposed Interdepartmental Group to advocate for and ensure action on obesity receives a high priority within all relevant government departments. **(PH)**

### **5.2 Physical environment**

- 5.2.1** Work with Local Authorities and other strategic partners to advocate for and undertake Health Impact Assessments (HIAs). **(PH, PCCC)**
- 5.2.2** Support implementation of the recommendations from the National Heart Alliance report 'Physical Activity and the Physical Environment'. **(PH)**

### **5.3 Physical Activity**

- 5.3.1 Develop National Physical Activity Guidelines with key stakeholders. **(PH)**
- 5.3.2 Work with the Irish Sports Council to provide funding to support Local Sports Partnerships. **(PH)**
- 5.3.3 Work with Local Authorities and Sports Partnerships to implement physical activity programmes at community level. **(PH)**

### **5.4 Food**

- 5.4.1 Work with the Irish Heart Foundation to carry out research on the marketing of food to children. **(PH)**
- 5.4.2 Work with other sectors to address the marketing of unhealthy food to children. **(PH)**
- 5.4.3 Work with the Combat Poverty Agency in supporting the expansion of “Healthy Food for All”, a multi-agency all-island initiative which promotes access, availability and affordability of healthy food for low-income groups. **(PH)**
- 5.4.4 Support development of National Healthy Eating Guidelines in association with the Food Safety Authority of Ireland and other agencies. **(PH)**
- 5.4.5 Partner Safefood and the Health Promotion Agency Northern Ireland (HPANI) in an all Island obesity media campaign. **(PH)**

### **5.5 Education**

- 5.5.1 Carry out the first national childhood growth surveillance initiative among school going children in partnership with the Department of Education and Science. **(PH)**
- 5.5.2 Support the implementation of the SPHE and Health Promoting Schools Programme. **(PH)**
- 5.5.3 Continue support of the Young Social Innovators to raise awareness among young people on the prevention of overweight and obesity. **(PH)**
- 5.5.4 Complete research into the determinants of overweight and obesity (IUNA). **(PH)**
- 5.5.5 Complete research into surveillance of overweight and obesity (NNSC). **(PH)**
- 5.5.6 Complete research into obesity prevention – getting health promotion evidence into practice (NUIG). **(PH)**

### **5.6 Other sectors**

**In addition to the collaborative work with other sectors outlined above, further progress existing strategic partnerships.**

- 5.6.1 Develop a strategic framework and guidelines for working with other sectors including the private sector, in the prevention of obesity. **(PH)**
- 5.6.2 Support implementation of nutrition, physical activity and other health promoting programmes in out of school settings through the National Youth Health Programme. **(PH)**

- 5.6.3 Work with the National Heart Alliance on advocacy issues relevant to obesity. **(PH)**
- 5.6.4 Work with the Institute of Public Health in progressing Health Impact Assessments (HIAs). **(PH)**
- 5.6.5 Progress work with the voluntary sector to raise awareness of the links between lifestyle choice and obesity e.g. Diabetes Federation. **(PH)**

## **SECTION 5:**

### **➤ Structures to support implementation**

There are a number of requirements essential to the implementation of the framework for action against obesity.

These are:

- Clarity on roles and function
- Clear leadership
- Engagement across HSE directorates to implement the framework for action against obesity
- A need to develop implementation structures at area level which initially concentrate on developing and building capacity on the ground, followed by an implementation phase.

#### **Existing resources:**

Prior to 2007 a large number of staff were already working on initiatives in most priority areas identified throughout this document. This work will continue and the HSE will maximise the use of available resources to implement this framework for action. However resources and staff will be required to implement all of the recommendations of the Task Force Report and the actions in this document. These requirements will become clearer as actions become more focused, partnerships and intersectoral working is advanced and the evidence base of effective interventions becomes available. The implementation plan will be costed on a yearly basis and submitted as part of the estimates process.

#### **Proposed structures to support implementation:**

The framework for action on obesity proposes a number of structures to support the implementation of the framework for action on obesity.

The following are proposed:

1. National inter-departmental group
2. National implementation steering group
3. North – South communication
4. Area representation to support implementation of key priorities
5. Obesity support staff

Proposed roles and responsibilities for each level are outlined in Table 3.

**Table 3:** Proposed structures to support the implementation of the framework for action on overweight and obesity

Level	Title	Description and responsibilities	Membership
<b>Government</b>	<b>Inter-Departmental &amp; multisectoral forum on obesity</b>	Responsibility for implementation of the National Task Force recommendations on obesity across all sectors	All Government Depts.& other sectors with HSE Input.
<b>National</b>	<b>National Implementation steering group</b>	Develop strategic process to support implementation <ul style="list-style-type: none"> <li>- This group reports to the National Directors and communicates with inter departmental group through agreed mechanisms</li> <li>- Advocates for management and funding support</li> <li>- Senior HSE representation</li> <li>- Oversees implementation of framework for Action</li> <li>- Communicates with all stakeholders</li> <li>- Develops annual estimates</li> </ul>	Undertake a stakeholder analysis on completion of framework for action to agree membership going forward.
<b>North-South communication</b>	<b>North/South Health Fora</b>	<ul style="list-style-type: none"> <li>- Regular updates at quarterly DoHC/DHSS/HSE/HPANI meetings</li> <li>- All-Island Obesity Conference</li> </ul> <p>A forum to facilitate sharing of good practice and communication of progress from an all island group perspective. Provide update to internal and external stakeholders on progress on framework for action.</p>	<p>Senior officials from relevant Govt Depts and agencies</p> <p>Representation of Key stakeholders From North and South.</p>
<b>Evaluation staff</b>		<ul style="list-style-type: none"> <li>- Identify staff to support evaluation at national level.</li> </ul>	

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## **APPENDICES**

### **Appendix 1**

#### **➤ Recommendations from The Report of the National Taskforce on Obesity**

<b>Recommendation</b>
<b>4.1</b> The Health Services, in their strategic planning and delivery, should advocate and lead an emphasis from the primary and individual responsibility to environments that support healthy food choices and regular physical activity.
<b>4.2</b> Supporting the population in healthy eating and active living, in the prevention of overweight and obesity, should be a key goal of health services and health care providers.
<b>4.3</b> The health services should recognise maintenance of a healthy weight as an important health issue, and measurement of height, weight, waist circumference and calculation of BMI should be part of routine clinical healthcare practice in primary care and in hospitals.
<b>4.4</b> An individual's interaction with health care services should be an opportunity to develop life-skills and foster self-efficacy in support of healthy eating, active living and positive self-image.
<b>4.5</b> A national database of growth measurements (height, weight, waist circumference, BMI) for children and adults should be developed by the Population Health Directorate to monitor prevalence trends of growth, overweight and obesity. This database could be achieved by developing the surveillance systems that are already established and expanding these systems to collect the required data e.g. the national health and lifestyle surveys, established longitudinal research projects and the school health surveillance system.
<b>4.6</b> Individuals who have a BMI over 25kg/m <sup>2</sup> and who choose to manage their weight, can do so in partnership with their health care Provider using the Treatment Algorithm. Individuals with a BMI in the Normal range should be enabled to monitor their progress with follow-up measurements every 3 years.
<b>4.7</b> An education and training programme for health professionals in the appropriate and sensitive management of overweight and obesity should be developed and implemented. Programmes should include training in developing life skills for healthy eating and active living, counselling,

<p>readiness to change / brief intervention, and standardised measuring techniques. Primary Care Teams should be the focus of the initial education drive.</p>
<p><b>4.8</b> A practical framework for implementation of the training programme, which would address the constraints of current Primary Care workload and practices, should be established. Incentives such as additional study leave, bonus CME accreditation and payment may have to be considered.</p>
<p><b>4.9</b> Detection, prevention and treatment programs should be evaluated to ensure they are being implemented as planned and are effective. This must include stakeholder input at all stages to ensure programs are being tailored to meet the needs of target population.</p>
<p><b>4.10</b> The curriculum for undergraduates and postgraduates in relevant health sciences should provide training in appropriate and sensitive obesity prevention and management</p>
<p><b>4.11</b> Individuals at risk of developing an eating disorder should be assessed proactively with the aid of a simple screening tool developed by relevant support groups and appropriate experts.</p>
<p><b>4.12</b> A north/south communication and public awareness programme on overweight and obesity should be developed in conjunction with and regularly evaluated by the HSE in partnership with the Northern Ireland Department of Health, appropriate food agencies, government representatives, non-governmental agencies, consumers and appropriate industries. Consistent, clear medial messages should be sensitive and appropriate to culture, age and gender.</p>
<p><b>4.13</b> The guidelines for physical activity, and for food and nutrition required for good health should be reviewed by the Population Health Directorate, in partnership with the appropriate food agencies, consumer and community groups, relevant government bodies and NGOs, and industry, to include the prevention and management of overweight and obesity.</p>
<p><b>4.14</b> All guidelines for physical activity, food and nutrition should be developed according to age and gender and should be independently proofed by the relevant authorities to ensure that they are appropriate.</p>
<p><b>4.15</b> To ensure best practice, consistency and safety of the population, all overweight and obesity prevention and management strategies should be coordinated and regularly reviewed by the Population Health Directorate, of the HSE.</p>
<p><b>4.16</b> Individuals should be facilitated in choosing to manage their health and weight effectively by establishing their needs and possible risks. This should be achieved through partnership with their healthcare provider.</p>

<p><b>4.17</b> Antenatal visits are an opportunity to empower parents and their families to develop life skills, which support healthy eating and active living. This should encompass family goals, such as healthy weights, which are regularly discussed.</p>
<p><b>4.18</b> The choice of a mother to breastfeed and the skills required to breastfeed exclusively for the recommended six months should be supported antenatal and postpartum.</p>
<p><b>4.19</b> The postpartum check presents a further opportunity for the public health nurse, parents and their families to discuss and facilitate health choices. To support the family in maintaining healthy weights, key measurements, such as child's weight/length and the mother's BMI, should be recorded to enable self management.</p>
<p><b>4.20</b> The primary care vaccination visits and public health nurse visits carried out during the first three years of a child's life is another opportunity to engage with families, working in partnership with parents to assess and monitor changes in the BMI of the parents and height/length of child and to identify skills to overcome barriers for change.</p>
<p><b>4.21</b> All children and parents have the opportunity through the school health services to develop self-capacity in relation to healthy eating and active living and this should include the opportunity to have a growth assessment for overweight or under- weight. Assessments should be carried out on school entry (4-5 years) and then at regular intervals (e.g.9-11 years and 14-16) throughout the child's development. Children and their families should be enabled to make appropriate changes by working in partnership with relevant professionals, in particular the primary care team and dietary and physical activity professionals.</p>
<p><b>4.22</b> Individuals' capacities in choosing to manage their health and well-being are strengthened with the knowledge of their height, weight, waist circumference and BMI. This can be achieved in partnership with their GP and health care providers in the primary care team.</p>
<p><b>4.23</b> Individuals should be facilitated in the management of their health in the Community setting by the provision of opportunistic standardised height/weight measurement in leisure centres, sports clubs and recreational facilities. This should be developed in partnership with the relevant health services.</p>
<p><b>4.24</b> Formative research should be carried out to ensure programs are being implemented as planned. This must include stakeholder input at development; implementation and evaluation stages to ensure programs are being tailored to meet the needs of target population.</p>

## **Appendix 2**

### **➤ Documents that informed the Framework for Action on Obesity**

Obesity; The policy challenges.  
The report of the National Taskforce  
on Obesity, 2005

*This is the national policy context.*

WHO European Charter on  
counteracting obesity, 2006

*This charter was adopted by the Ministers and delegates attending the WHO European Ministerial Conference on Counteracting Obesity (Istanbul, Turkey, 15–17 November 2006), in the presence of the European Commissioner for Health and Consumer Protection.*

National Institute for Health and  
Clinical Excellence (NICE) Obesity:  
the prevention, identification,  
assessment and management of  
overweight and obesity in adults and  
children

*The NICE clinical guideline on the prevention, identification, assessment and management of overweight and obesity in adults and children covers clinical advice on the prevention and treatment of obesity, particularly in a primary care setting.*

HSE National Transformation  
programme, 2007-2010

*This is the national Transformation Programme for the HSE for the period, 2007-2010. It is available on [www.hse.ie](http://www.hse.ie).*

Recommendations for the clinical  
management of overweight and  
obesity in adults and children

*Department of Health and Children, 2005. Clinical guidance.*

National guidelines for community  
based practitioners on prevention  
and management of childhood  
overweight and obesity, 2006

*Evidence review with recommendations for good practice. Developed by Children and Young people team, population health directorate*

Proposed Second WHO European  
Action Plan for Food and Nutrition  
Policy 2007-2012

*Proposed New European Action Plan on Nutrition*

Tackling Chronic Disease

*A Policy Framework for the Management of Chronic Diseases. Department of Health and Children, 2008*

WHO guidelines on  
Nutrition/Physical  
Activity 2007

*Review of evidence on best practice in physical/ activity nutrition*

## **Appendix 3**

### **➤ European Charter on Counteracting Obesity**

Taken from World Health Organization 2007. WHO European Ministerial Conference on Counteracting Obesity Conference Report. Available at <http://www.euro.who.int/document/E90143.pdf>.

To address the growing challenge posed by the epidemic of obesity to health, economies and development, we, the Ministers and delegates attending the WHO European Ministerial Conference on Counteracting Obesity (Istanbul, Turkey, 15–17 November 2006), together with the WHO Regional Director for Europe, in the presence of the European Commissioner for Health and Consumer Protection, hereby adopt the following European Charter on Counteracting Obesity. The process of developing the present Charter has involved different government sectors, international organizations, experts, civil society and the private sector through dialogue and consultations.

We declare our commitment to strengthen action on counteracting obesity in line with this Charter and to place this issue high on the political agenda of our governments. We also call on all partners and stakeholders to take stronger action against obesity.

Sufficient evidence exists for immediate action; at the same time, the search for innovation, adjustments to local circumstances and new research on certain aspects can improve the effectiveness of policies.

Obesity is a global public health problem; we acknowledge the role that European action can play in setting an example and thereby mobilizing global efforts.

#### **1. THE CHALLENGE**

We acknowledge that:

**1.1** The epidemic of obesity poses one of the most serious public health challenges in the WHO European Region. The prevalence of obesity has risen up to three-fold in the last two decades. Half of all adults and one in five children in the WHO European Region are overweight. Of these, one third are already obese and numbers are increasing fast. Overweight and obesity contribute to a large proportion of non-communicable diseases, shortening life expectancy and adversely affecting the quality of life. More than one million deaths in the Region annually are due to diseases related to excess body weight.

**1.2** The trend is particularly alarming in children and adolescents, thus passing the epidemic into adulthood and creating a growing health burden for the next generation. The annual rate of increase in the prevalence of childhood obesity has been rising steadily and is currently up to ten times higher than it was in 1970.

**1.3** Obesity also strongly affects economic and social development. Adult obesity and overweight are responsible for up to 6% of health care expenditure in the European Region; in addition, they impose indirect costs (due to the loss of lives, productivity and related income) that is at least two times higher. Overweight and obesity most affect people in lower

socioeconomic groups, and this in turn contributes to a widening of health and other inequalities.

**1.4** The epidemic has built up in recent decades as a result of the changing social, economic, cultural and physical environment. An energy imbalance in the population has been triggered by a dramatic reduction of physical activity and changing dietary patterns, including increased consumption of energy-dense nutrient-poor food and beverages (containing high proportions of saturated as well as total fat, salt and sugars) in combination with insufficient consumption of fruit and vegetables. According to available data two thirds of the adult population in most countries in the WHO European Region are not physically active enough to secure and maintain health gains, and only in a few countries does the consumption of fruit and vegetables achieve the recommended levels. Genetic predisposition alone cannot explain the epidemic of obesity without such changes in the social, economic, cultural and physical environment.

**1.5** International action is essential to support national policies. Obesity is no longer a syndrome of wealthy societies; it is becoming just as dominant in developing countries and countries with economies in transition, particularly in the context of globalization. Taking intersectoral action remains a challenge and no country has yet effectively managed to bring the epidemic under control. Establishing strong internationally coordinated action to counteract obesity is both a challenge and an opportunity, as many key measures are cross-border both in character and in their implications.

## **2. WHAT CAN BE DONE: the goals, principles and framework for action**

**2.1** The obesity epidemic is reversible. We believe that it is possible to reverse the trend and bring the epidemic under control. This can only be done by comprehensive action, since the root of the problem lies in the rapidly changing social, economic and environmental determinants of people's lifestyles. The vision is to shape societies where healthy lifestyles related to diet and physical activity are the norm, where health goals are aligned with those related to the economy, society and culture and where healthy choices are made easy for individuals.

**2.2** Curbing the epidemic and reversing the trend is the ultimate goal of action in the Region. Visible progress, especially relating to children and adolescents, should be achievable in most countries in the next 4–5 years and it should be possible to reverse the trend by 2015 at the latest.

### **2.3 The following principles need to guide action in the WHO European Region:**

**2.3.1** High-level political will and leadership and whole-government commitment are required to achieve mobilization and synergies across different sectors.

**2.3.2** Action against obesity should be linked to overall strategies to address non-communicable diseases and health promotion activities [as well as to the broader context of sustainable development]. Improved diet and physical activity will have a substantial and often rapid impact on public health, beyond the benefits related to reducing overweight and obesity.

**2.3.3** A balance must be struck between the responsibility of individuals and that of

government and society. Holding individuals alone accountable for their obesity should not be acceptable.

**2.3.4** It is essential to set the action taken within the cultural context of each country or region and to acknowledge the pleasure afforded by a healthy diet and physical activity.

**2.3.5** It will be essential to build partnerships between all stakeholders such as government, civil society, the private sector, professional networks, the media and international organizations, across all levels (national, sub-national and local).

**2.3.6** Policy measures should be coordinated in the different parts of the Region, in particular to avoid shifting the market pressure for energy-dense food and beverages to countries with less regulated environments. WHO can play a role in facilitating and supporting intergovernmental coordination.

**2.3.7** Special attention needs to be focused on vulnerable groups such as children and adolescents, whose credulity should not be exploited by commercial activities.

**2.3.8** It is also a high priority to support lower socioeconomic population groups, who face more constraints and limitations on making healthy choices. Increasing the access to and affordability of healthy choices should therefore be a key objective.

**2.3.9** Impact on public health objectives should have priority consideration when developing economic policy, as well as policies in the areas of trade, agriculture, transport and urban planning.

**2.4** A framework, linking the main actors, policy tools and settings, is needed to translate these principles into action.

**2.4.1** All relevant government sectors and levels should play a role. Appropriate institutional mechanisms need to be in place to enable this collaboration.

- Health ministries should play a leading role by advocating, inspiring and guiding multisectoral action. They should set the example when facilitating healthy choices among employees in the health sector and health service users. The role of the health system is also important when dealing with people at high risk and those already overweight and obese, by designing and promoting prevention measures and by providing diagnosis, screening and treatment.

- Ministries and agencies such as those for agriculture, food, finance, trade and economy, transport, urban planning, education and research, social welfare, labour, sport, culture and tourism have an essential role to play in developing health promoting policies and actions. This will also lead to benefits in their own domain.

- Local authorities have great potential and a major role to play in creating the environment and opportunities for physical activity, active living and a healthy diet, and they should be supported in doing this.

**2.4.2** Civil society can support the policy response. The active involvement of civil society is important, to foster the public's awareness and demand for action and as a source of

innovative approaches. Nongovernmental organizations can support strategies to counteract obesity. Employers', consumers', parents', youth, sport and other associations and trade unions can each play a specific role. Health professionals' organizations should ensure that their members are fully engaged in preventive action.

**2.4.3** The private sector should play an important role and have responsibility in building a healthier environment, as well as for promoting healthy choices in their own workplace. This includes enterprises in the entire food chain from primary producers to retailers. Action should be focused on the main domain of their activities, such as manufacturing, marketing and product information, while consumer education could also play a role, under guidance from public health authorities. There is also an important role for sectors such as sports clubs, leisure and construction companies, advertisers, public transportation, active tourism, etc. The private sector could be involved in win-win solutions by highlighting the economic opportunities of investing in healthier options.

**2.4.4** The media have an important responsibility to provide information and education, raise awareness and support public health policies in this area.

**2.4.5** Intersectoral collaboration is essential not only at national but also at international level. WHO should inspire, coordinate and lead the international action. International organizations such as the United Nations Food and Agriculture Organization (FAO), the United Nations Children's Fund (UNICEF), the World Bank, the Council of Europe, the International Labour Organization (ILO), and the Organisation for Economic Co-operation and Development (OECD) can create effective partnerships and thus stimulate multisectoral collaboration at national and international levels. The European Union (EU) has a principal role to play through EU legislation, public health policy and programmes, research and activities such as the European Platform for Action on Diet, Physical Activity and Health.

Existing international commitments such as the Global Strategy on Diet, Physical Activity and Health, the European Food and Nutrition Action Plan and the European Strategy for the Prevention and Control of Noncommunicable Diseases should be used for guidance and to create synergies. In addition, policy commitments such as the Children's Environment and Health Action Programme for Europe (CEHAPE), the Transport, Health and Environment Pan-European Programme (THE PEP), and the Codex Alimentarius within the limits of its remit, can be used to achieve coherence and consistency in international action and to maximize efficient use of resources.

**2.4.6** Policy tools range from legislation to public/private partnerships, with particular importance attached to regulatory measures. Government should ensure consistency and sustainability through regulatory action, including legislation. Other important tools include policy reformulation, fiscal and public investment policies, health impact assessment, campaigns to raise awareness and provide consumer information, capacity-building and partnership, research, planning and monitoring. Public/private partnerships with a public health rationale and shared specified public health objectives should be encouraged. Specific regulatory measures should include: the adoption of regulations to substantially reduce the extent and impact of commercial promotion of energy-dense foods and beverages, particularly to children, with the development of international approaches, such as a code on marketing to children in this area; and the adoption of regulations for safer roads to promote cycling and walking.

**2.4.7** Action should be taken at both micro and macro levels, and in different settings. Particular importance is attached to settings such as the home and families, communities, kindergartens, schools, workplaces, means of transport, the urban environment, housing, health and social services, and leisure facilities. Action should also cover the local, country and international levels. Through this, individuals should be supported and encouraged to take responsibility by actively using the possibilities offered.

**2.4.8** Action should be aimed at ensuring an optimal energy balance by stimulating a healthier diet and physical activity. While information and education will remain important, the focus should shift to a portfolio of interventions designed to change the social, economic and physical environment.

**2.4.9** A package of essential preventive action should be promoted as key; countries may further prioritize interventions from this package, depending on their national circumstances and the level of policy development. The package of essential action would include: reduction of marketing pressure, particularly to children; promotion of breastfeeding; improvement of supply of healthier food, including fruit and vegetables; economic measures that facilitate healthier food choices; offers of affordable recreational/exercise facilities, including support for socially disadvantaged groups; reduction of fat, free (particularly added) sugars and salt in manufactured products; promotion of cycling and walking by better urban design and transport policies; creation of opportunities in local environments that motivate people to engage in leisure time physical activity; provision of healthier foods, opportunities for daily physical activity, and nutrition and physical education in schools; facilitating and motivating people to adopt better diets and physical activity in the workplace; developing/improving national food-based dietary guidelines and guidelines for physical activity; and individually adapted health behaviour change.

**2.4.10** Attention should also continue to be focused on preventing obesity in people who are already overweight and thus at high risk, and on treating the disease of obesity. Specific actions in this area would include: introducing routine anthropometric measurements and counseling in primary health care system; providing training for health professionals in the prevention of obesity; and issuing clinical recommendations for screening and treatment.

**2.4.11** When designing and implementing policies, successful interventions with demonstrated effectiveness need to be used. They include projects with proven impact on the consumption of healthier foods and levels of physical activity such as: schemes to offer people free fruit at school and work; affordable pricing for healthier foods; increasing access to healthier foods in areas of socioeconomic deprivation; establishing bicycle priority routes; encouraging children to walk to school; improving street lighting; promoting stair use; and reducing television viewing. There is also evidence that many interventions against obesity, such as school programmes and active transport, are highly cost-effective. The WHO Regional Office for Europe will provide decision-makers with examples of good practice and case studies.

### **3. PROGRESS AND MONITORING**

**3.1** The present Charter aims to strengthen action against obesity throughout the WHO European Region. It will stimulate and influence national policies, regulatory action including legislation and action plans. A European action plan, covering nutrition and physical activity, will translate the principles and framework provided by the Charter into specific action packages and monitoring mechanisms.

**3.2** A process needs to be put together to develop internationally comparable core indicators for inclusion in national health surveillance systems. These data could then be used for advocacy, policy-making and monitoring purposes. This would also allow for regular evaluation and review of policies and actions and for the dissemination of findings to a wide audience.

**3.3** Monitoring progress on a long-term basis is essential, as the outcomes in terms of reduced obesity and the related disease burden will take time to manifest themselves. Three-year progress reports should be prepared at the WHO European level, with the first due in 2010.

## **Appendix 4**

### **Progress to-date - working with internal and external stakeholders**

#### **National Steering Group established**

- Allocated funding of €1.4 million to fund obesity prevention projects in 2007.
- Implementation of Task Force report recommendations included as a Transformation priority for Programme 4.
- Funded new projects in nutrition i.e. Healthy Food Made Easy Community Nutrition Programmes, Community Food Co-ops, Pre school nutrition programmes.
- Action Plan developed for HSE.
- The first WHO European Childhood Growth Surveillance Initiative, measuring weight, height, and waist circumference in a national sample of 7 year old school going children, has been completed. This will support development of national database of height and weight. 2425 children (1263 boys & 1373 girls), from 163 schools were measured.

#### **Primary Care Setting**

- Procurement process completed for purchase of equipment for height and weight measurement for Primary Care Practitioners.
- Provision of training to health professionals.
- Development of an obesity management programme for overweight children (ACE) in HSE Dublin Mid Leinster.
- Development of a programme to manage morbidly obese clients in the Primary Care setting in HSE Dublin North East.

#### **Clinical Services**

- Funded clinical services in Loughlinstown, Cork, Crumlin and Galway.
- Provision of clinical dietetic services across all areas.
- Review completed of best practice in provision of surgery for morbidly obese clients. It addresses best practice, safety issues and current service provision. A review of obesity management services will also be undertaken.

#### **Development of Strategic Alliances**

- WHO - Benchmarking against progress of Bangkok Charter
- European Network of Health Promotion (Move Europe) - Engaging workplaces in Workplace health promotion
- Health Promotion Policy Unit - Advocated for and supported the Dept in progressing the development of an Inter-sectoral Group on Obesity to progress the recommendations of the Task Force Report that are outside the remit of the HSE.
- Dept of Education & Science - Joint Management of SPHE and Health Promoting Schools.
- Irish Sports Council - Joint strategic planning on physical activity, input into participation strategy, funding of and input into physical activity programmes with Local Sports Partnerships

- Community Games (CG) - Health Promotion strategic priority in CG strategic plan. Healthy Catering developed, 200 free places provided at Mosney May Week-end for disadvantaged children to encourage participation in physical activity. Healthy catering policy being developed for all CG events. Substance use policy developed. Guidelines for Healthy Events developed and disseminated throughout Community Games Organisation.
- National Youth Council - Funding development of healthy youth organisations for out of school youth
- Irish Heart Foundation - Physical Activity programme development in schools, Workplace physical activity programmes and nutrition programmes - happy heart at Work and Healthy Eat Out, Physical Activity campaign
- National Universities - Analysis of the National Children's Survey to inform the national media campaign
- Food Safety Promotion Board - Joint campaign development, shared funding of nutrition research
- National Heart Alliance - Development of advocacy report on Physical Activity and the Built Environment
- Diabetes Federation of Ireland - Funding provided to Diabetes Federation to raise awareness on prevention of diabetes and health promotion projects in workplaces, community and schools.
- Crosscare - Funding of Food Poverty Project

**Research Commissioned on:**

- Marketing of foods to children
- Evidence-practice on health promotion
- Determinants of childhood obesity IUNA
- "Obesity Prevention: Getting Health Promotion Evidence Into Practice" NUIG
- NNSC Surveillance Projects
  - Investigation of grey literature on existing data of growth monitoring of children in Ireland
  - Review of the National Guidelines for Community Based Practitioners on the Prevention & Management of Childhood Overweight & Obesity
  - Qualitative Exploration of the Acceptability of Obesity Surveillance among Children, Parents & Teachers
  - Primary Care RCT examining interventions at micro and meso level to promote healthy eating in babies & their mothers
  - NNSC Position Paper on the national Taskforce on Obesity – Where is Ireland at?
  - Lifeways three generational study
- Provided health promotion technical support to SLAN survey

## **Breastfeeding**

National implementation committee on breastfeeding established

- Annual breastfeeding campaign to coincide with National Breastfeeding Awareness Week.
- Annual conference run during National Breastfeeding Awareness Week.
- New breastfeeding resources developed and disseminated.
- Survey of breastfeeding rates carried out.
- -

## **Guidelines**

- Development of National Guidelines on Prevention and Management of childhood overweight and obesity
- Development of nutrition guidelines for chronic disease management

## **Obesity Conference and surveillance symposium**

- The North South obesity conference and surveillance Symposium took place in Belfast on November 13<sup>th</sup> & 14<sup>th</sup> 2008. It provided an update on international best practice and addressed partnership approaches to the prevention of obesity and the development of a national database of height and weight. The Multisectoral Conference “Obesity : Weighing up the Evidence” attracted an audience of 260 and was organised in partnership with the Health Promotion Agency of Northern Ireland.

## **Obesity Campaign**

- “ Little Steps Go A Long Way” media campaign was launched in June 2008. It was developed by the HSE and Safefood in collaboration with the Health Promotion Agency of Northern Ireland. The partnership approach was adopted to provide one voice and a clear message to the public in the island of Ireland of how little steps can lead to a healthier future. It’s emphasis is on the crucial impact of parents and guardians as role models for their children. Phase 2 of the campaign commenced on August 25<sup>th</sup> 2008 to coincide with the start of the new school year. It will continue into 2009 as part of a 3 year campaign.
- Developing a 5year social marketing plan for prevention of obesity
- Developed a DVD on obesity prevention for submission to the Broadcasting Commission to develop a 10 series programme on obesity prevention.

## **Provision of information/Resources**

- Funded re-printing of a significant number of physical activity /nutrition resources.
- Provided an information/resources service on physical activity/nutrition to schools, workplaces, community organizations, Health Centres, GPs etc via Health Promotion Departments and central ordering service on [www.healthpromotion.ie](http://www.healthpromotion.ie)

## Appendix 5

### ➤ Priority developments for 2009 (Phase 2)

- Secure sign off and progress implementation of this action plan
- Initiate the development of a National Preschool Programme, to include physical activity and nutrition in pre school settings, in partnership with members from the pre-school inspection teams and childcare committees
- Partner the public and private sector in developing workplace health promotion in line with the Move Europe model, which focuses on smoking prevention, healthy eating, promotion of exercise and mental health (stress) initiatives. To date 12 Irish companies have come through the initial stages of the process with Workplace Health Promotion Officers assisting with site visits.
- Complete the national physical activity guidelines in early 2009 and develop an accompanying action plan to move forward in consultation with key stakeholders.
- Support the development of National Healthy Eating Guidelines with key stakeholders – FSAI, HSE, DOHC, INDI and the academic sector.
- Represent the HSE on the Intersectoral Group on Obesity, chaired by Ms. Mary Wallace T.D., Minister of State for Health Promotion and Food Safety. The implementation of the recommendations of the National Task Force on Obesity is the focus of this group.
- Work with other sectors to address the marketing of unhealthy foods to children.
- Progress the development of a national database of growth monitoring and commit to participation in the WHO – European Childhood Growth Surveillance Project.
- Roll out national physical activity programmes with the Irish sports council and local sports partnerships.
- Progress the “ Little Steps” campaign and add in a physical activity component.
- Work with other government departments and sectors to progress implementation of the recommendations contained in “ Physical Activity and the Built Environment” (Heart Alliance).
- Work with the other government departments to include Health Impact Assessments (HIAs) as part of the planning process to address the obesogenic environment.
- Participate in the All Island Obesity Forum.

**N.B.** These key initiatives are included in a list of 63 actions assigned to phase 2. This list also contains a number of actions, which are ongoing, being implemented on a rolling basis spanning all three phases of implementation



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# HSE Framework for Action on Obesity 2008 - 2012





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