Technical Consultation on Identifying Approaches to Control Obesity

11 to 13 April 2011
Melbourne, Australia
REPORT

TECHNICAL CONSULTATIONS ON IDENTIFYING APPROACHES TO CONTROL OBESITY

Convened by:

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NOTE

The views expressed in this report are those of the participants at the Technical Consultation on Identifying Approaches to Control Obesity in the Western Pacific Region and do not necessarily reflect the policies of the World Health Organization.

This report has been prepared by the WHO Collaborating Centre for Obesity Prevention at Deakin University on behalf of the World Health Organization Regional Office for the Western Pacific and participants of the Technical Consultation on Identifying Approaches to Control Obesity in the Western Pacific Region, which was held in Melbourne, Australia, from 11 to 13 April 2011.
The World Health Organization (WHO) Regional Office for the Western Pacific Region in collaboration with Deakin University (WHO Collaborating Centre for Obesity Prevention), Melbourne, Australia, organized a Technical Consultation on Identifying Approaches to Control Obesity in the Western Pacific Region. The meeting was held in Melbourne, Australia from 11 to 13 April 2021. It was attended by technical advisors from 11 countries in the Region. The objectives of the consultation were:

1. to review and discuss the current best practices for reducing overweight and obesity in relation to enabling environments, policies, health service responses and cross-cutting actions; and
2. to identify priority approaches and formulate operational guidance for programmes for control of overweight and obesity for countries and areas in the Region.

The proceedings included presentations, panel discussions, participatory exercises and group work. The burden of overweight and obesity and current global and regional responses were presented. Highlights in obesity prevention and control from the Western Pacific Region were shared by participants in a marketplace activity. Frameworks and essential domains for obesity prevention were presented. Participants applied priority setting tools for identifying potential actions.

At the end of the meeting, it was recommended that: Member States should strengthen and promote obesity prevention as part of an overall NCD prevention and control strategy, obesity prevention can be addressed through the five domains as discussed, priority interventions should be identified by engaging all key stakeholders, the prioritization tools have to be field tested and adapted, WHO collaborating centers and professional organizations should facilitate information exchange and work collectively towards capacity building, and WHO to continually provide its technical support.
# CONTENTS

## SUMMARY

<table>
<thead>
<tr>
<th>1. INTRODUCTION</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Background</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Objectives</td>
<td>1</td>
</tr>
<tr>
<td>1.3 Participants</td>
<td>1</td>
</tr>
<tr>
<td>1.4 Opening remarks</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. PROCEEDINGS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Burden of Overweight and Obesity and Current Responses</td>
<td>2</td>
</tr>
<tr>
<td>2.2 Highlights from the Region – Marketplace</td>
<td>4</td>
</tr>
<tr>
<td>2.3 Framework for obesity prevention</td>
<td>8</td>
</tr>
<tr>
<td>2.4 Domains and interventions</td>
<td>8</td>
</tr>
<tr>
<td>2.5 Identifying potential actions</td>
<td>10</td>
</tr>
</tbody>
</table>

| 3. CONCLUSIONS AND RECOMMENDATIONS | 16 |

## ANNEXES:

- ANNEX 1 - LIST OF TEMPORARY ADVISERS, RESOURCE PERSONS, OBSERVERS AND SECRETARIAT
- ANNEX 2 - PROVISIONAL PROGRAMME
- ANNEX 3 - OPENING REMARKS BY REGIONAL DIRECTOR
- ANNEX 4 - CHARACTERISTICS OF FOUR PRIORITY-SETTING APPROACHES
- ANNEX 5 - GROUP OUTPUTS
- ANNEX 6 - PROCESS AND TOOLS

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**Key words**

Obesity-Prevention and Control/Overweight-Prevention and Control/Noncommunicable diseases
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE</td>
<td>Assessing Cost-Effectiveness</td>
</tr>
<tr>
<td>ANGELO</td>
<td>Analysis Grid for Elements Linked to Obesity</td>
</tr>
<tr>
<td>BMI</td>
<td>Body Mass Index</td>
</tr>
<tr>
<td>DALY</td>
<td>Disability-adjusted life-years</td>
</tr>
<tr>
<td>DPAS</td>
<td>Global Strategy on Diet and Physical Activity and Health</td>
</tr>
<tr>
<td>ECOSOC</td>
<td>Economic and Social Council</td>
</tr>
<tr>
<td>mPAST</td>
<td>Modified Problem and Solution Tree</td>
</tr>
<tr>
<td>NCD</td>
<td>Non-communicable disease</td>
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<td>NGO</td>
<td>Non Government Organization</td>
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<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<tr>
<td>TROPIC</td>
<td>Translational Research for Obesity Prevention in the Pacific</td>
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<td>WHA</td>
<td>World Health Assembly</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
1. INTRODUCTION

1.1 Background

Globally, 44% of the diabetes burden, 23% of the ischaemic heart disease burden and 7%–41% of certain cancer burdens are attributable to overweight and obesity. It is estimated that overweight and obesity are responsible for 410 000 deaths in the Western Pacific Region annually.

Overweight and obesity are public health problems in all Member States of the Western Pacific Region. While initiatives have been taken in high-income countries, there is an urgent need to support low- and middle-income countries to identify approaches for preventing overweight and obesity.

1.2 Objectives

(1) to review and discuss the current best practices for reducing overweight and obesity in relation to enabling environments, policies, health service responses and cross-cutting actions; and
(2) to identify priority approaches and formulate operational guidance for programmes for control of overweight and obesity for countries and areas in the Region.

1.3 Participants

The meeting brought together 13 technical advisers from 11 countries in the Western Pacific Region: Fiji, Japan, the Republic of Korea, Malaysia, Mongolia, New Zealand, China, Hong Kong (China), the Philippines, Samoa, Singapore and Viet Nam. Representatives from the Malaysian Health Promotion Board (MHPB), Korea Centers for Disease Control and Prevention, Food Standards Australia and New Zealand (FSANZ), the Secretariat of the Pacific Community (SPC) also attended. The Secretariat comprised representatives from the WHO Regional Office of the Western Pacific and Headquarters.

The programme and a list of participants are provided in Annex 1 and Annex 2, respectively.

1.4 Opening remarks

Professor Lee Asthiemer, Deputy Vice-Chancellor (Research) at Deakin University, opened the technical consultation, welcoming the distinguished guests and participants.

Dr Shin Young-soo, Regional Director, WHO Western Pacific Region, gave the opening remarks. Dr Shin noted that communicable diseases receive greater attention than noncommunicable diseases (NCD), stating that it was critical that NCD receive equal attention. It was emphasized that a whole-of-government and whole-of-society approach that engages all sectors is required to address obesity. Dr Shin’s remarks are in Annex 3.

Dr Jim Bishop AO, Chief Medical Officer, Australian Government Department of Health and Ageing, gave the opening address. Dr Bishop began with reporting that NCD are responsible for 60% of deaths globally, of which 25% are premature (occur before 60 years old)
and are preventable. He highlighted the burden of disease attributable to various NCD, emphasizing that the key to prevention is the control of risk factors, including tobacco, blood pressure, overweight and obesity, physical inactivity and blood cholesterol.

Dr Bishop outlined tobacco control initiatives in Australia, reporting that there are decreasing rates of tobacco use in the country. In contrast, obesity rates in Australia are increasing in almost all age groups. Dr Bishop outlined a series of Australian initiatives, including the National Partnership Agreement on Preventive Health and the National Preventative Healthy Agency, plans for a comprehensive Australian Health Survey (between 2011 and 2013) and the Measure Up and Swap It social marketing campaigns.

2 PROCEEDINGS

2.1 Burden of Overweight and Obesity and Current Responses

Dr Han Tieru, Director of the Division of Building Healthy Communities and Populations, WHO Regional Office for the Western Pacific, outlined the prevalence of NCD, deaths due to NCD and the prevalence of selected NCD risk factors in the Region. Dr Tieru presented the regional response to NCD over the last decade. Responses include the Regional Diabetes Declaration and Plan of Action between 2000 and 2005 and between 2006 and 2010, the Regional Tobacco Action Plan, the Regional NCD STEP surveys, Healthy Cities Initiatives, NCD & Poverty: Pro-Poor Strategy 2006, the Regional Action Plan for NCD, the Regional Strategy to Reduce Alcohol-related Harm and the Saitama call to action on multi-sectoral intervention for NCD prevention. Dr Tieru outlined a comprehensive strategic approach to NCD prevention and control, focusing on three domains:

1. Social determinants – poverty reduction and placing NCD on the development agenda; adopting a whole-of-government and whole-of-society approach;
2. Risk factor control (tobacco, unhealthy diet, physical inactivity, harmful use of alcohol) – achieved via multisectoral action (ministries of health working in partnership with other sectors such trade, agriculture, industry, education and local government) leading to the formulation of public policies, legislation, regulations and fiscal measures;
3. Health systems – primary health care-focused health system strengthening. An affordable and cost-effective integrated NCD service package is essential for NCD management; and
4. NCD prevention programmes should be supported by advocacy efforts, research, surveillance and monitoring.

Dr Cherian Varghese, Technical Officer, NCD, WHO Regional Office for the Western Pacific, outlined the burden of obesity, the current response in the region and objectives of the consultation. In 2004, overweight and obesity was the fifth highest leading risk factor for global mortality and the tenth highest cause of attributable burden of disease.

Dr Varghese reported a large variation in obesity prevalence in the Region, highlighting the complex relationship between obesity and associated risk factors. Examples of current country-specific initiatives were presented, including the National Obesity Taskforce and subsequent plans to address overweight and obesity in Australia; community-based interventions with sustained funding in China; healthy public policies and diet and physical activity programmes in Brunei Darussalam; the National Strategic Plan in NCD 2010-2014 in Malaysia;
national diet and physical activity programmes in Mongolia; the Healthier You food labelling programme in the Philippines; a settings approach targeting schools, workplaces, health care institutions and communities in Singapore; and many programmes in the Pacific island countries.

Dr Timothy Armstrong, Coordinator, Surveillance and Population-based Prevention Unit, Department of Chronic Diseases and Health Promotion, WHO (Geneva), presented the current global responses to obesity. Dr Armstrong reported that NCD are the single largest cause of deaths globally, with 90% of global premature deaths occurring in low-to-middle-income countries.

Dr Armstrong described the relationship between NCD and poverty. The global response in the last decade was presented. Responses outlined included the World Health Assembly session in 2000 which provided a vision on how to address NCD and the session in 2008 which provided a roadmap for NCD management; the announcement of the First Global Ministerial Conference on NCD by the Russian Federation at the 2009 Economic and Social Council (ECOSOC) High-level Segment; in 2010, Resolution 64/265 (Prevention and Control of NCD) and Resolution 65/238 (Scope, modalities, format and organization of the high-level meeting of the United Nations General Assembly on the prevention and control of NCD) were adopted by the General Assembly; and the United Nations Secretary-General’s report on NCD (New York, May 2011) and the General Assembly high-level meeting on the Prevention and Control of NCD (New York, 19 to 20 September 2011).

He emphasized the current unique opportunity to raise the priority of NCD on the agendas of international leaders. Dr Armstrong reported WHO’s role in preparation for the United Nations high-level meeting, which includes regional consultations for Member States; informal dialogues with nongovernmental organizations (NGOs), the private sector and United Nations agencies; reports (the report by the WHO Director-General, the report by the United Nations Secretary-General, the WHO Global Status Report on NCD); informal interactive hearings with NGOs, civil society organizations and the private sector; and global consultations. Dr Armstrong also outlined the WHO response to addressing childhood obesity, emphasizing that it is one of the most serious public health challenges of the 21st century. The various tools developed by WHO on diet and physical activity were presented.

Dr Tommaso Cavalli-Sforza, Regional Adviser in Nutrition, WHO Regional Office for the Western Pacific, gave a presentation on measuring obesity in children (preschool 0-5 years old; school age 5-19 years old) and in adults. Dr Cavalli-Sforza emphasized that the multiple definitions of overweight and obesity complicate advances in relation to obesity and, therefore, there is a need to use standardized definitions across studies and populations. An anthropometric indicator, a reference population in which to compare and cut-offs which identify populations and individuals at risk, are required in order to classify weight.

The preferred indicator for classifying weight from birth to 19 years old is body-mass-index (BMI)-for age. The recommended reference population is the WHO standards of 0-5 years old and WHO reference 5-19 years old (to be used at both a population and individual level). For adults, the commonly used indicator to assess overweight and obesity is BMI. A WHO consultation in 2002 addressed the issue of whether population-specific cut-off points for BMI are necessary. It was concluded that the WHO cut-off points were not an adequate basis on which to assess risk in Asian populations. However, the available data was inconclusive regarding clear BMI cut-offs for assessing risk in the Asian population. Attempts to define cut-offs for specific populations was therefore not made and WHO BMI cut-off points were retained as the accepted international classification. However, some additional public health action points
along the BMI continuum were identified. It is important to recognize that increased risk is a continuum with increasing BMI.

*The presentation and comments by Dr. Eric Finkelstein were not included in this report due to conflict of interest.*

Dr Rhonda Galbally AO, interim Chief Executive Officer of the Australian National Preventive Health Agency, presented highlights of obesity prevention in Australia and outlined the strategic goals of the National Preventive Health Agency. The agency is a statutory body established by the Australian government to assist with preventing chronic disease and the lifestyle-related risk factors of tobacco use and the excessive consumption of alcohol and obesity.

### 2.2 Highlights from the Region – Marketplace

Participants were given the opportunity to demonstrate or showcase country progress in obesity prevention and control through a marketplace activity. Each participant had five minutes to present or “sell” up to three key obesity prevention programmes or interventions in their country. Fellow participants were asked to assess and “buy” the initiatives to address obesity in their own countries.

#### 2.2.1 Singapore

Ms Seah Peik Ching, Manager Nutrition Department, Adult Health Division, Health Promotion Board, presented the multisectoral healthier food commitment in Singapore, outlining:

1. **Healthier Choice Symbol programme**: Working with food manufacturers and retailers to produce and sell more food products that meets the Healthier Choice Symbol standards (lower in fat, saturated fat, sugar and salt; higher in whole-grains and calcium).

2. **Working with food service providers to offer and actively promote lower calorie healthier meals.**

3. **Hawker Centre initiatives**: Hawkers are encouraged to use healthier ingredients (e.g. brown rice, whole-grain noodles) and sell meals at a lower price; calorie labeling on menu boards and a list showing the calorie content of commonly eaten hawker centre foods appears on notice boards (allowing consumers to compare products); working with community leaders to generate demand for healthier products; gaining the support of local politicians.

First prize: Singapore’s initiatives were awarded the “best-buy” in the marketplace.

#### 2.2.2 Malaysia

Dr Feisul Mustapha, Public Health Specialist, Ministry of Health, presented “NCD Prevention 1 Malaysia”, a roadmap of the planned response to NCD in Malaysia. The steps are:

1. Establish NCD teams at the state and federal levels.
2. Produce document and tools to support implementation.
3. Identify specific sources for funding.
4. Conduct advocacy campaigns at the local level.
5. Identify interested stakeholders in an appropriate setting.
(6) Form a working group.
(7) Train implementers.
(8) Conduct soft launching (support of political leaders).
(9) Undertake implementation.
(10) Conduct monitoring and evaluation.

Malaysia’s initiative was awarded the second “best-buy” in the market place.

2.2.3 Hong Kong

Dr (Gemma) Gao Yang, School of Public Health and Primary Care, The Chinese University of Hong Kong

Dr Yang presented the “colourful and bright fruit and vegetables project”, an ecological model for obesity prevention in Hong Kong. The aim of the project was to help primary school children eat enough fruit and vegetables by creating a supportive eating environment. An integrated approach based on a healthy school framework was used and included the following strategies: improved school eating policies and eating; training of teachers and parents; involvement of family and community; a comprehensive nutritional education programme; and the active participation of students.

Outcomes:

(1) Increase in fruit and vegetable consumption by 25.5% and 44.2%, respectively, for students (8.5% and 4.1% in parents).
(2) Decrease in percentage of high fat, sugar snacks and sugar drinks.
(3) Increased nutritional knowledge (students and parents).
(4) The mean weight of vegetables supplied at lunchtime increased by 23.6%.
(5) Strengthened monitoring of school lunch supply and snack shop.

Dr Yang reported that the factors which contributed to the success of the programme included an integrated approach, a collaborative approach, comprehensive needs assessment, adequate orientation and training, high quality education resources, a strong link with community resources, improvement in school health policies and environment, strong leadership and genuine commitment, coordination of schools, interactive approach and the active involvement of students.

More than 3000 students in 10 schools participated over 18 months. The model has been adopted by the Hong Kong Department of Health to become the blueprint for the eatsmart@school.hk campaign (www.eatsmart.gov.hk).

Hong Kong’s initiative was awarded the third “best-buy” in the marketplace.

2.2.4 The Philippines

Ms Frances Cuevas, Chief Health Programme Officer, Department of Health

Ms Cuevas presented the “Healthier Options for Filipinos: the ‘Healthier You’ certification programme”, in which processed food products and fast food outlet menu items are given a “Healthier You” seal if established fat, sugar, sodium and fibre standards are met.
The three objectives of the programme are:

(1) Establish standards for healthy food products.
(2) Establish guidelines and a mechanism to certify healthy food products.
(3) Monitor and evaluate the effectiveness of the programme.

2.2.5 Mongolia

Dr Jamiyan Batjargal, Director, Nutrition Research Centre, Public Health Institute

Dr Batjargal highlighted the current policies relating to NCD, obesity and risk factor control, including:

(1) National NCD Prevention and Control Programme (adopted in 2005);
(2) Multi-sectoral National Strategy for Diet and Physical Activity (approved in 2009); and

Dr Batjargal highlighted the need for a range of behaviour change interventions for the prevention of overweight and obesity, the implementation of setting specific policies on healthy diet and physical activity and policy actions which support primary health care settings.

2.2.6 Viet Nam

Dr Le Bach Mai, Deputy Director, National Institute of Nutrition

Dr Mai reported that 16% of adults (25-64 years old) in Viet Nam in 2009 had a BMI $\geq 23$ kg/m$^2$. Dr Mai presented the following three initiatives:

(1) National survey on adult overweight and obesity in Viet Nam (2005);
(2) Study on lipid nutrition disorder (2010) and the Study on Metabolic Syndrome; and
(3) National Nutrition Strategy 2011-2020. Control of overweight and obesity is one of the objectives.

Dr Mai reported that Viet Nam needed interventions to decrease fat and salt consumption and increase vegetable and fruit consumption.

2.2.7 China

Professor Fu Hua, Deputy Dean and Professor, School of Public Health, Fudan University

Professor Hua presented the “workplaces for promoting physical activity” initiative, which involves:

(1) promoting less use of the lifts at work;
(2) short exercises during working time (exercises which come up on computer); and
(3) special exercise clubs.

Professor Hua reported that >5000 workers had joined the programme.

2.2.8 Samoa

Dr Satupaitea Viali, Specialist Physician and Cardiologist

Dr Viali reported that 70% of Samoans >25 years old had a BMI ≥ 30 kg/m² in 2010, compared with 57% in 2002, and that NCD prevalence is increasing. However, Samoans are living longer. Dr Viali reported they have an NCD policy and are trying to adopt a healthy island, healthy village approach. The initiatives presented were:

(1) Visiting villages (started in 2010): Multidisciplinary health care team visits to the villages to conduct “healthy checks” in conjunction with providing health promotion messages (e.g. two and five fruit and vegetables and exercises). Dr Viali reported checks had been conducted on 4000 people and so far, the initiative is encouraging.

(2) Sports grounds: The availability of sports grounds promotes exercise (although they are mostly in towns rather than in rural areas).

Dr Viali also mentioned the effect of the 2009 tsunami on the economic status of Samoa, commenting that injected funds helped in the short term to resuscitate the economy.

2.2.9 Fiji

Dr Wendy Snowdon, C-POND Coordinator

Dr Snowdon presented the evidence-based approach occurring in Fiji, which includes:

(1) Surveys: National Nutrition Survey; NCD STEPS survey and Pacific Obesity Prevention in Communities project (focus on adolescents);

(2) Strategies and policies: NCD strategy; Fiji Food and Nutrition Policy;

(3) Guidelines: Food and health guidelines for Fiji (with implementation training and support mechanisms); and

(4) Other: Policy; social marketing campaigns (focusing on fruit and vegetable intake and physical activity e.g. “5 & 30” campaign).

2.2.9 Japan

Dr Nobuo Nishi, Chief, Center for Collaboration and Partnership and Project Leader of the National Health and Nutrition Survey, National Institute of Health and Nutrition

Dr Nishi reported that about 30% of men and 20% of women have a BMI ≥ 25 kg/m² (however, he also acknowledged underweight is a problem, especially in younger women in urban areas). Dr Nishi highlighted the “Healthy Japan 21” strategy that started in 2001. The three factors, which assist with maintaining healthy weight in Japan, are:

(1) Japanese diet (less meat, greater consumption of fish and rice);
(2) Public transport – good subway system, which helps to promote walking; and

(3) Annual health checkups, including a metabolic syndrome screening system, started in 2008, with health guidance given if waist circumference exceeds healthy limits.

2.3 Framework for obesity prevention

Dr Gary Sacks, Research Fellow in the WHO Collaborating Centre for Obesity Prevention at Deakin University, presented the Obesity Prevention Policy Framework, adapted from the WHO Global Strategy on Diet and Physical Activity and Health (DPAS) implementation framework. The Obesity Prevention Policy Framework identifies multiple instruments that can be used to achieve policy objectives, including government spending and taxing, laws and regulations, service and programme delivery and advocacy. Three approaches are considered in the framework:

(1) Socio-ecological (upstream) approach: Considers policies that aim to influence the underlying determinants of population health and the food and physical activity environments. Interventions using this approach occur in sectors such as finance, commerce and trade, education, food marketing, retail, transport or sport and recreation.

(2) Lifestyle (midstream) approach: Considers policies which aim directly to influence diet and physical activity behaviour by targeting individuals within a particular setting (e.g. households, schools).

(3) Health services (downstream) approach: Considers policies that support health services and medical interventions (e.g. targeting primary, secondary or tertiary care or therapeutic goods).

The framework acknowledges the importance of monitoring, evaluation, surveillance, research and advocacy.

A series of analysis grids were presented as a means of systematically and comprehensively identifying policy intervention areas across relevant sectors and settings. The grids consider the sector (for socio-ecological and upstream approaches) or setting (for midstream and downstream approaches) in which particular policies apply and the level of governance (local, state, national, international and regional and private sector and nongovernment sector) that is responsible for administering that policy.

2.4 Domains and interventions

Professor Boyd Swinburn gave an overview of the five domains for obesity prevention:

(1) Advocacy and leadership

It was acknowledged that the culture and political system of certain countries might place constraints on advocacy efforts. Visible and external advocacy often comes from NGOs but internal advocacy is also possible (e.g. from bureaucrats within government). Professor Swinburn acknowledged that funding advocacy groups is a challenge, commenting that Health Promotion Foundation funding can be an excellent source of money. Advocacy groups need to be both reactive and proactive. Several factors were outlined with regard to leadership: the need to recognize
political cycles, the powerful and growing influence of the private sector on public policy and the challenge of getting political leadership.

(2) Policies and environments (including marketing to children)

Policy drives environmental (physical, economic and sociocultural) change. Setting priorities (moving from a long list of possible options to a shorter list of feasible options) is a challenge. However, tools are available to assist with prioritizing options. Professor Swinburn made reference to the Obesity Policy Coalition in Australia and its top priorities for action.

(3) Health promotion programmes

The distinction was made between Generation 1 studies or interventions (short-term, single setting, modest outcomes), Generation 2, or whole-of-community studies (longer-term, multiple setting, some promising results) and Generation 3 studies (systems-oriented, untested currently but theoretically sound). Professor Swinburn outlined the results of several whole-of-community programmes, including Romp & Chomp, It’s Your Move, Be Active Eat Well (Barwon-South West region of Victoria Australia) and the Obesity Prevention in the Pacific (OPIC) study (Australia/Tonga/New Zealand/Fiji).

(4) Health services

The role of the health care system was outlined, including diagnosis and treatment, primary prevention, extending the individual focus to include family and communities and providing leadership.

(5) Cross-cutting actions and structural interventions (health promotion foundations, monitoring, research, capacity-building)

Actions in this domain include intelligence systems (monitoring, evaluation and research); leadership; governance and coordination; healthy public policies; workforce development; partnerships and organizational relationships; financing; policy implementation support systems; and communications (including social marketing).

Professor Swinburn’s presentation was followed by a panel discussion. The participants included Dr Timothy Armstrong (WHO, Geneva); Dr Tommaso Cavalli-Sforza (WHO, Western Pacific Regional Office); Mr Godfrey Xuereb (WHO, Geneva); Ms Jane Martin (Senior Policy Officer, Obesity Policy Coalition, Melbourne, Australia); and Professor Boyd Swinburn (Deakin University). The key issues that emerged from the discussion were:

(1) What to do when there is inadequate evidence: Aim to achieve best-practice; consider taking on a broader definition of “evidence”.

(2) How to best frame and communicate the importance of obesity prevention when competing with other priorities. Public health needs to become more strategic.

(3) It is critical to consider country-specific factors. Interventions often are tested and implemented in high-income countries and are not transferrable to low- and middle-income countries. The lack of resources in low- and middle-income countries needs to be considered as well as country-specific socio-cultural factors.
How to influence and change political will; the experiences of some of the participants were shared.

2.5 Identifying potential actions

Mr Godfrey Xuereb, Team Leader, Surveillance and Population-based Prevention Unit, WHO (Geneva), gave a presentation on tools for priority setting. Priority-setting tools assist stakeholders in conducting a systematic, evidence-informed approach to effectively identify priority areas for action. There are four common steps in the priority-setting process:

1. problem identification and needs analysis;
2. identification of potential solutions;
3. assessment and prioritization of potential solutions; and
4. strategy development.

The key criteria used in the priority-setting process includes population impact or effectiveness; costs (affordability); cost-effectiveness; feasibility; relevance; strength of the evidence base; effects on equity; sustainability; acceptability to stakeholders and other side-effects (positive or negative) of the intervention.

The characteristics of four different approaches that can be used for priority-setting (WHO STEPwise Framework for Preventing Chronic Disease; Modified Problem and Solution Tree (mPAST) process; and the ANGELO process and the Assessing Cost-Effectiveness (ACE) process) were outlined considering purpose and outcomes, key criteria used, stakeholders, level of financial resources required, level of human resources required (taking into account time and technical expertise) and the level of data required. A table outlining the main characteristics of each approach is provided in Annex 4.

2.5.1 Tools for priority-setting

2.5.1.1 STEPwise framework for preventing chronic disease

Dr Temo Waqanivalu, Technical Officer, Nutrition and Physical Activity, WHO Representative Office in the South Pacific, outlined the STEPwise framework for surveillance and STEPwise framework for preventing chronic disease. The WHO STEPwise framework for surveillance distinguishes between three "step" levels: core, expanded and optional, and three levels of risk-factor assessment: questionnaires, physical measurements and biomedical measurements.

The STEPwise framework for preventing chronic disease incorporates three levels of intervention: national (macro), subnational and community (Micro) and individual (clinical interventions). It also includes three levels of priority: core -- top priority interventions which are feasible to implement within a two-year timeframe with current resources; expanded -- slightly lower priority and feasible to implement within two to five years; and optimal and desirable -- less urgent interventions which require resources beyond the current levels (five years). The Tonga NCD plan 2004 was used as an example.
2.5.1.2 ANGELO process

Professor Boyd Swinburn gave a presentation on the Analysis Grid for Elements Linked to Obesity (ANGELO) process. The ANGELO process is a practical tool for formulating community action plans (but they can be adapted for use at the subnational and national levels). The process engages stakeholders and uses literature and stakeholder knowledge as the evidence base. It involves background work followed by a two-day workshop with stakeholders. The ANGELO process involves the following steps:

1. Situational analysis: Taking into account the size of the problem; the nature of the problem (who, when, where, why); existing activities, organizations and champions.

2. Scan: Identify potential behaviours to change; potential knowledge and skill gaps to fill; and potential environmental barriers to overcome in relevant settings (e.g. homes, schools, day care, churches, and neighbourhoods).

3. Prioritize: Each option is scored considering its importance (incorporating relevance and impact) and feasibility. Individual scoring and group means result in top priorities for each of the three areas.

4. Merge: Present results in a list of potential targets for the action plan.

5. Formulate an action plan: Comprehensive, multi-strategy, multi-setting, evaluable (objectives should be SMART: Specific, Measurable, Achievable, Relevant, Time-bound) and capacity building.

2.5.1.3 Modified Problem and Solution Tree (mPAST) process

Dr Wendy Snowdon, Coordinator of C-POND (Pacific Research Centre for the Prevention of Obesity and Noncommunicable Diseases), outlined the modified Problem and Solution Tree (mPAST) process, a slightly modified version of the standard problem and solution tree approach which assists in determining the root causes of a problem and possible solutions. The process involves engaging all relevant stakeholders in a workshop setting. Best available evidence and data are used to inform the process.

The mPAST process begins with the identification of a starting problem and, in the next level up, possible factors associated with the problem e.g. “cost”, “supply” and “preference”. From this, stakeholders are asked to consider why the situation is occurring. The question of “why” continues until lines cannot be further progressed or until the point at which solutions become apparent. For each problem area, one or more possible solutions are then identified. Once solutions have been identified using the mPAST process, a prioritization process can be applied.

2.5.1.4 ACE process

Associate Professor Marj Moodie, Senior Research Fellow, Deakin Health Economics, Deakin University, outlined the Assessing Cost-Effectiveness (ACE) process which has been used in six projects to date, including ACE-Obesity and ACE-Prevention. The key features of the process include a clear rationale and process for selecting interventions; standardized evaluation methods; evaluations are conducted as part of priority-setting; the process is evidence-based; information is assembled by an independent research team; the process involves stakeholders (to achieve “due process”); and benefit is measured using a two-stage process.
(technical analysis of cost-effectiveness followed by a second stage or implementation filter analysis). An overview of the process was given:

1. research the question;
2. create a working group of stakeholders;
3. select interventions;
4. confirm evaluation methods (technical analysis (US$ cost per disability-adjusted life-years (DALY); second stage filters, e.g. equity, strength of evidence, feasibility, acceptability, sustainability, side-effects);
5. undertake technical analysis and second stage filter analysis; and
6. agree on findings and disseminate.

Associate Professor Moodie outlined the ACE-Obesity project, which assessed the most cost-effective options for preventing unhealthy weight gain in Australia (particularly children, adolescents) using a societal perspective.

2.5.2 Group session 1: Identifying potential actions

Participants were divided into three groups for group activities. Each group had two facilitators to assist with group activities. Group 1 had representatives from Viet Nam, China, Malaysia, Mongolia and the Philippines. Group 2 had representatives from Japan, the Republic of Korea, Singapore and Hong Kong (China). Group 3 had representatives from Fiji, New Zealand, Samoa, Australia and New Caledonia. After the session, a group member reported on group outputs.

In Group Session 1, potential actions were identified using the Modified Problem and Solution Tree (mPAST) process. The aim of using the mPAST process was for participants to experience application of the process. Each group selected two diet and one physical activity problem (chosen from a list of potential starting problems based on behaviours, knowledge and skills). A specific population group or cohort could also be specified e.g. children 6-12 years old. Each group began with a starting problem and completed the mPAST process using “cost”, “availability” and “preference” as the starting layer (see below diagram). The group outputs are provided in Annex 5.
2.5.3 Making operational the Modified Problem and Solution Tree process

Dr Wendy Snowdon, C-POND Coordinator, gave a presentation about putting into operation the mPAST process. The aim was to give participants a greater understanding of factors such as the timeframes involved and the stakeholders required. The mPAST process and subsequent prioritization process involves the following tasks and timeframes:

Based on the successful use of the processes in the Pacific Islands, background data searches and the organisation of workshops can be completed in approximately one month. Some of the required background data may already have been collated, therefore the time required will be reduced. These tasks could be completed by a student (e.g., of health or nutrition) or a project worker.

Stakeholders participate in workshops spread over a two to three month period, amounting to a total of five days (maximum) cumulated time. The stakeholder group should ideally include representatives from all Ministries as well as representatives from civil society and the private sector, for example, food manufacturers. The addition of modelling to the prioritisation process would increase the time and work required.
2.5.4 Setting priorities

2.5.4.1 Group session 2: Setting priorities

In Group Session 2, groups applied the ANGELO prioritization process (ranking by importance and changeability) on at least one of the problems identified using the mPAST process in group session 1.

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Score (range 1-5)*</th>
<th>Rank</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Importance</td>
<td>Changeability</td>
<td>I x C</td>
</tr>
<tr>
<td>Action 1</td>
<td>2</td>
<td>4</td>
<td>8</td>
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<td>3</td>
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<tr>
<td>Action 3</td>
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<td>4</td>
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<td>Action 4</td>
<td>4</td>
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<td>Action 5</td>
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</tr>
<tr>
<td>Action 7</td>
<td>5</td>
<td>2</td>
<td>10</td>
</tr>
</tbody>
</table>

*Where:

I= Importance (what is the relevance and impact of this in our situation?) 1 = not important at all; 2 = a little important; 3 = somewhat important; 4 = very important; 5 = extremely important.

C=Changeability (how easy or hard is this to change?) 1 = very hard to change; 2 = hard to change; 3 = possible to change; 4 = easy to change; 5 = very easy to change.

The aim of using the ANGELO process was for participants to experience the application of the process. The group outputs are provided in Annex 5.

2.5.5 Beyond priority setting

Dr Helen Mavoa, Senior Research Fellow in the WHO Collaborating Centre for Obesity Prevention at Deakin University, gave a presentation on the TROPIC (Translational Research for Obesity Prevention in the Pacific) project. Dr Mavoa outlined experiences in the successful translation of data and evidence into policy in Fiji, a process facilitated by the use of a knowledge broker. The aims of the TROPIC project are:

1. To increase the uptake of evidence in policy-making to improve eating and physical activity environments (by building capacity for evidence-informed decision-making and to provide user-friendly research evidence that is relevant, timely and accessible).

2. To increase the awareness of evidence sources.

3. To build research capacity.
The process has involved engaging stakeholders (government and NGOs) for 15 months, running workshops to up-skill stakeholders in evidence-informed decision-making, supporting the development of policy briefs and evaluating the outcomes and process. To date, it has resulted in two endorsed policy briefs (and a further five submitted and 14 in progress).

Professor Boyd Swinburn gave a presentation on the recommended actions for obesity prevention, outlining two types of actions:

1. **Specific actions:** Targeted policy and programmes that could be expected directly to influence BMI. Professor Swinburn reported the following interventions were modeled by the OECD/WHO in seven countries and have been recommended as priority actions in the lead-up to the United Nations General Assembly high-level meeting. Other actions are mass media campaigns, food labeling, fiscal measures (taxes and subsidies) and food advertising regulation.

2. **Structural actions:** Cross-cutting actions to support the targeted policies and programmes as well as community and individual effects to reduce BMI. These include leadership; monitoring; workforce development; intelligence systems (monitoring, evaluation, research); leadership, governance and coordination; healthy public policies; partnerships and organizational relationships; financing; and policy implementation support systems and communications.

2.5.6 Next steps

2.5.6.1 Group session 3: Next steps

In the final group session, participants were asked to consider the short- and long-term next steps for Member States, WHO, collaborating centres and academia and civil society. The specific group outputs are provided in Annex 5.

2.5.6.2 Closing session

Dr Han Tieru closed the technical consultation, stating that the agenda had been completed and a positive outcome had been achieved. Dr Han Tieru thanked the Secretariat and technical advisers for their contributions and Professor Boyd Swinburn and Deakin University for hosting the consultation.

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3. CONCLUSIONS AND RECOMMENDATIONS

The Technical consultation on Identifying Approaches to Control Obesity, organized by the WHO Western Pacific Region in collaboration with Deakin University, Melbourne, Australia brought together technical advisers from 11 countries in the Region. The objectives of the consultation were to review the current best practices in the Region. The proceedings included presentations, panel discussions, participatory exercises and group work and the objectives of the consultation were met.

The following recommendations were made;

(1) Member States should strengthen and promote obesity prevention as part of an overall NCD prevention and control strategy.

(2) Obesity prevention can be addressed through five domains; advocacy and leadership, policies and environments, health promotion programmes, health services and cross cutting and structural interventions.

(3) Priority interventions should be identified through a process which engages all key stakeholders in the formulation of an action plan with due consideration being given to the different roles and contributions of those stakeholders while protecting the public interest and avoiding conflict of interest

(4) Prioritization tools have to be field tested and adapted to the local and national context. A draft process for identification of priorities is provided in Annexe 6.

(5) WHO collaborating centers and professional organizations should facilitate information exchange and work collectively towards capacity building. Civil society should be engaged as a key stakeholder in the obesity prevention programme.

(6) WHO will continue to provide technical support in monitoring and surveillance, priority setting and facilitate linkage between obesity prevention and other relevant programmes.
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Telephone: +41 22 791 26 17. Facsimile: +41 22 791 1581.E-mail: xuerebg@who.int
### Day 1 (11 April, Monday)

#### Opening session

<table>
<thead>
<tr>
<th>Time</th>
<th>M.C.</th>
<th>Chair</th>
</tr>
</thead>
</table>
| 09:00-09:15 | Welcome address  
09:15-09:30 | Opening remarks  
09:30-09:45 | Opening address  
09:45-10:00 | Introduction of participants | Professor John Catford  
DVC Academic Professor  
Professor Lee Asthiemer  
DVC Research Professor  
Dr Shin Young-soo, Regional Director  
WHO Western Pacific Region  
Dr Jim Bishop AO, Chief Medical Officer  
Department of Health and Ageing  
Self-introduction |
| 10:00-10:30 | Group Photo and coffee break | Dr Hai-Rim Shin |

#### Session 1: Burden of overweight and obesity, and current responses

<table>
<thead>
<tr>
<th>Time</th>
<th>Topic</th>
<th>Chair</th>
</tr>
</thead>
</table>
| 10:30-10:45 | NCD in Western Pacific Region - Regional  
situation and strategic response | Dr Han Tieru |
| 10:45-11:05 | Burden of obesity, current response and objectives of the consultation | Dr Cherian Varghese |
| 11:05-11:20 | Current responses - Global | Dr Tim Armstrong |
| 11:20-11:35 | Measuring obesity | Dr Tommaso Cavalli-Sforza |
| 11:35-11:55 | Economic impact of obesity | Dr Eric Finkelstein |
| 11:55-12:15 | Highlights of obesity prevention in Australia | Dr Rhonda Galbally AO |
| 12:15-12:30 | Discussion and questions | Dr Hai-Rim Shin |
Annex 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>12:30-1:30</td>
<td>Lunch</td>
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**Session 2: Highlights from the Region – Marketplace**

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<th>Time</th>
<th>Session</th>
<th>Details</th>
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<tbody>
<tr>
<td>1:30-3:00</td>
<td>Display of programmes from the region and brief presentation and discussion</td>
<td>Facilitator: Dr Temo Waqanivalu</td>
</tr>
<tr>
<td>3:00-3:30</td>
<td>Mobility break</td>
<td></td>
</tr>
<tr>
<td>3:30-4:00</td>
<td>Framework for obesity prevention (adapted from WHO DPAS implementation framework)</td>
<td>Dr Gary Sacks</td>
</tr>
<tr>
<td>4:00-4:30</td>
<td>Day 1 - Summary - How these 5 areas will be used days 2 &amp; 3</td>
<td>Dr Cherian Varghese and Professor Boyd Swinburn</td>
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**Reception**
The Colonial Tramcar Restaurant departs from and returns to Tramstop # 125 Normanby Road, near the corner of Clarendon Street, South Melbourne. Located diagonally across the road from Crown Casino and adjacent to the Melbourne Exhibition Centre (1.5km walk from Deakin Prime).

**Day 2 (12 April, Tuesday)**

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<th>Session</th>
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<tr>
<td>09:00-09:15</td>
<td>Welcome to day 2</td>
<td>Dr Cherian Varghese and Professor Boyd Swinburn</td>
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</table>

**Session 3: Domains and interventions**

<table>
<thead>
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<th>Session</th>
<th>Details</th>
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<tbody>
<tr>
<td>09:15-09:35</td>
<td>Co-Chairs: Five domains for obesity interventions - overview</td>
<td>Professor Steve Allender/ Dr. T. Cavalli-Sforza</td>
</tr>
<tr>
<td></td>
<td>1. Advocacy and leadership</td>
<td>Professor Boyd Swinburn</td>
</tr>
<tr>
<td></td>
<td>2. Policies and environments (including marketing to children)</td>
<td>Discussants: Dr T. Cavalli-Sforza, Ms Jane Martin, Dr Tim Armstrong, Mr Godfrey Xuereb, Professor Boyd Swinburn</td>
</tr>
<tr>
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<td>3. Health promotion programmes</td>
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<td></td>
<td>4. Health services</td>
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<td></td>
<td>5. Cross-cutting actions (HP foundations, monitoring, research, capacity-building)</td>
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<tr>
<td>09:35-10:45</td>
<td>Panel discussion</td>
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**Mobility break**

**Session 4: Identifying potential actions**

<table>
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<tr>
<th>Time</th>
<th>Session</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>11:05-11:30</td>
<td>Tools for priority-setting</td>
<td>Mr Godfrey Xuereb</td>
</tr>
<tr>
<td></td>
<td>WHO STEPwise ANGELO Problem &amp; Solution Trees</td>
<td>Dr Temo Waqanivalu, Professor Boyd Swinburn, Dr Wendy Snowdon, Associate Professor Marj Moodie</td>
</tr>
<tr>
<td>11:30-12:30</td>
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<td></td>
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</table>
### Session 4: Identifying potential actions (continued)

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Group Facilitator</th>
<th>Facilitators</th>
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<tr>
<td>12:30-1:30</td>
<td>Lunch</td>
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<tr>
<td>1:30-3:00</td>
<td>Group Facilitator: Mr Chad Foulkes</td>
<td>Group 1</td>
<td>- Professor Boyd Swinburn/Dr Cherian Varghese/Dr Godfrey Xuereb</td>
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<tr>
<td></td>
<td></td>
<td>Group 2</td>
<td>- Mr Chad Foulkes/Dr Tim Armstrong/Dr Hai-Rim Shin</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Group 3</td>
<td>- Dr Temo Waqanivalu/Dr T. Cavalli-Sforza/Associate Professor Marj Moodie</td>
</tr>
<tr>
<td>3:00-3:30</td>
<td>Mobility break</td>
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<tr>
<td>3:30-4:30</td>
<td>Group Facilitator: Mr Chad Foulkes</td>
<td>Group 1</td>
<td>- Professor Boyd Swinburn/Dr Cherian Varghese/Dr Godfrey Xuereb</td>
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<tr>
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<td>Group 2</td>
<td>- Mr Chad Foulkes/Dr Tim Armstrong/Dr Hai-Rim Shin</td>
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<td></td>
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<td>Group 3</td>
<td>- Dr Temo Waqanivalu/Dr T. Cavalli-Sforza/Associate Professor Marj Moodie</td>
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<tr>
<td>4:30-5:00</td>
<td>Group Facilitator: Mr Chad Foulkes</td>
<td>Group 1</td>
<td>- Professor Boyd Swinburn/Dr Cherian Varghese/Dr Godfrey Xuereb</td>
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<td>Group 2</td>
<td>- Mr Chad Foulkes/Dr Tim Armstrong/Dr Hai-Rim Shin</td>
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<td>Group 3</td>
<td>- Dr Temo Waqanivalu/Dr T. Cavalli-Sforza/Associate Professor Marj Moodie</td>
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### Day 3 (13 April, Wednesday)

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<th>Group 2</th>
<th>Group 3</th>
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<tr>
<td>09:00-09:10</td>
<td>Welcome to day 3</td>
<td>Dr Cherian Varghese</td>
<td>Professor Boyd Swinburn</td>
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<tr>
<td>09:10-10:10</td>
<td>Session 5: Setting priorities</td>
<td>Group 1</td>
<td>Group 2</td>
<td>Group 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Professor Boyd Swinburn/Dr Cherian Varghese/Dr Godfrey Xuereb</td>
<td>Mr Chad Foulkes/Dr Tim Armstrong/Dr Hai-Rim Shin</td>
<td>Dr Temo Waqanivalu/Dr T. Cavalli-Sforza/Associate Professor Marj Moodie</td>
</tr>
<tr>
<td>10:10-10:40</td>
<td>Mobility break</td>
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<tr>
<td>10:40-11:30</td>
<td>Group Facilitator: Mr Chad Foulkes</td>
<td>Group 1</td>
<td>Group 2</td>
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<tr>
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<td></td>
<td>Professor Boyd Swinburn/Dr Cherian Varghese/Dr Godfrey Xuereb</td>
<td>Mr Chad Foulkes/Dr Tim Armstrong/Dr Hai-Rim Shin</td>
<td>Dr Temo Waqanivalu/Dr T. Cavalli-Sforza</td>
</tr>
<tr>
<td>Time</td>
<td>Session 5: Report back</td>
<td>Session 6: Next steps</td>
<td>Session 6: Report back</td>
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<tr>
<td>11:30-12:00</td>
<td><strong>Co-Chairs:</strong> Group 1 Group 2 Group 3</td>
<td><strong>Group Facilitator:</strong> Mr Chad Foulkes Group 1 Group 2 Group 3</td>
<td><strong>Co-Chairs:</strong> Group 1 Group 2 Group 3</td>
<td><strong>Facilitators</strong> Professor Boyd Swinburn/ Dr Cherian Varghese/Dr Godfrey Xuereb Mr Chad Foulkes /Dr Tim Armstrong/ Dr Hai-Rim Shin Dr Temo Waqanivalu /Dr T. Cavalli-Sforza</td>
</tr>
<tr>
<td></td>
<td>Dr Han Tieru/ Professor Boyd Swinburn</td>
<td><strong>Group Facilitator:</strong> Mr Chad Foulkes Group 1 Group 2 Group 3</td>
<td><strong>Co-Chairs:</strong> Group 1 Group 2 Group 3</td>
<td><strong>Facilitators</strong> Professor Boyd Swinburn/ Dr Cherian Varghese/Dr Godfrey Xuereb Mr Chad Foulkes /Dr Tim Armstrong/ Dr Hai-Rim Shin Dr Temo Waqanivalu /Dr T. Cavalli-Sforza</td>
</tr>
<tr>
<td>12:00-1:00</td>
<td><strong>Lunch</strong></td>
<td></td>
<td><strong>Closing session</strong></td>
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<tr>
<td>1:00-2:30</td>
<td><strong>Group Facilitator:</strong> Mr Chad Foulkes</td>
<td><strong>Facilitators</strong> Professor Boyd Swinburn/ Dr Cherian Varghese/Dr Godfrey Xuereb Mr Chad Foulkes /Dr Tim Armstrong/ Dr Hai-Rim Shin Dr Temo Waqanivalu /Dr T. Cavalli-Sforza</td>
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<td>2:30-3:15</td>
<td><strong>Co-Chairs:</strong> Group 1 Group 2 Group 3</td>
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<td><strong>Closing remarks</strong></td>
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<td></td>
<td>Dr Hai-Rim Shin and Professor Boyd Swinburn</td>
<td></td>
<td><strong>Closing remarks</strong></td>
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<tr>
<td>3:15-3:45</td>
<td><strong>Closing remarks</strong></td>
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<td><strong>Closing remarks</strong></td>
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<tr>
<td></td>
<td>Professor Boyd Swinburn Dr Han Tieru</td>
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<td><strong>Closing remarks</strong></td>
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<tr>
<td></td>
<td><strong>Coffee</strong></td>
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<td><strong>Coffee</strong></td>
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</table>
OPENING REMARKS BY DR SHIN YOUNG-SOO, REGIONAL DIRECTOR
WHO WESTERN PACIFIC REGION

Professor John Catford, Academic Professor, Deakin University, Dr Jim Bishop, Chief Medical Officer Department of Health and Ageing, Australia, Professor Boyd Swinburn, Director of the WHO Collaborating Centre for Obesity Prevention, experts in the field of obesity prevention, partner agencies, ladies and gentlemen.

It's a pleasure to join you this morning for this consultation on Identifying Approaches to Control Obesity. I would like to thank both Australia's Department of Health and Ageing and the WHO Collaborating Centre for Obesity Prevention at the Deakin University School of Health Sciences for their support for this meeting. There are 174 WHO collaborating centres in the Western Pacific Region, providing WHO with access to the resources and technical expertise of top medical and scientific research centres. The excellent work being undertaken on obesity control at the collaborating centre here at Deakin University shows just how valuable this cooperation can be.

It is usually communicable diseases, such as pandemic influenza, HIV/AIDS and tuberculosis, that make headlines around the world. But for every health story that makes the morning papers or the evening news, there are many equally critical public health issues —obesity and noncommunicable diseases for example — that don’t grab the spotlight.

In the 37 countries and areas that make up the WHO Western Pacific Region, four out of every five deaths can be attributed to noncommunicable diseases. These are diseases which can and should be prevented. Certainly, tobacco and the harmful use of alcohol play a role in this rising tide of noncommunicable diseases. But two other significant factors — unhealthy diets and increasingly sedentary lifestyles — also are chief contributors. And that's why we are meeting here today—to look at the best approaches to control the risk factors that lead to overweight and obesity. WHO data paint a grim picture. More than 1 billion people worldwide are overweight and another 300 million people are obese. And the number of overweight people is expected to increase by 50% by the year 2015. Overweight and obesity are responsible for 44% of all diabetes cases globally, according to WHO data. And physical inactivity is estimated to cause between 15% and 25% of breast and colon cancers, and is responsible for 30% of the worldwide heart disease burden. While the number of overweight and obese people, based on body mass index, is highest in the Americas, the Eastern Mediterranean and Europe, overweight and obesity have become increasingly worrisome problems in our Region, particularly in many of the Pacific island countries.

Throughout history, changes in the ways we live, the foods we eat and the work we do have evolved slowly, allowing our bodies to adapt. But changes over the past few decades — particularly rising urbanization, an increasingly sedentary lifestyle, and the aggressive marketing of foods unnaturally high in fat, salt and sugar — have occurred so rapidly that the human organism has not had time to adapt. In fact, not so long ago, obesity was considered as a sign of affluence and wealth. Today, it can be a death warrant.
Annex 3

Think back to when you were young. Perhaps you walked to school or rode your bicycle. Once classes were over, maybe you helped with chores at home, or if you were lucky you rushed out to the park to play with friends. But today, the environments in which we work, study and play are increasingly sedentary. More and more of us rely on individual motorized transport. And how many of us have had to pry our children or grandchildren away from the computer and encourage them to play outside?

Of course, the health costs of unhealthy lifestyle choices – and the obesity and other noncommunicable diseases that often accompany them – have been enormous. Unlike communicable diseases, which tend to affect people quickly, noncommunicable diseases generally progress much more slowly, creating complex health needs that are expensive to treat and can overwhelm already stressed health systems. Globally, deaths due to cardiovascular disease – with poor diets and sedentary lifestyles as key risk factors – are expected to rise more than 70% in the first 30 years of this century. Childhood obesity is a particular concern, especially among the poor who often eat unhealthy foods because they are cheaper. We often see street children in our cities who seem to subsist on sugar-laden soft drinks and snacks.

As public health officials we have a responsibility to protect the next generation from unhealthy diets and lifestyle choices that will only shorten their lives. If we don't take action now, an even bigger wave of noncommunicable diseases will be upon us. These diseases are claiming victims at increasingly younger ages, depriving many of our citizens of their most productive years. These premature deaths not only devastate families by claiming the lives of primary wage earners, but they weaken communities and national economies, making it more difficult to achieve equitable and sustainable development. To the uninitiated, obesity control sounds like a "health issue" that should be solved by the health sector.

But as public health specialists, we know that by the time people enter the health system with obesity-related diseases, it's often too late to offer much help. The battle really needs to begin at a much earlier stage. If we want to win the battle against obesity and noncommunicable diseases, the health sector must join hands with other sectors – agriculture, education, the environment, the food industry, trade, transportation and others. We need a "whole-of-government" and "whole-of-society" approach that engages all these sectors. The private sector – those involved in producing, marketing and trading food – can take important steps to make our food healthier, while still enjoying healthy profits. Actions can be taken by city planners and transportation officials to create urban environments that promote healthier and more active lifestyles. Since eating habits are ingrained early in life, parents and family members can help children develop healthier dietary habits. Our goal should be to make it easier for all of our people to make healthier choices. That’s why WHO has developed a Global Strategy on Diet, Physical Activity and Health, approved by the World Health Assembly in 2004. Since then much additional evidence has been found for interventions that can improve health and survival by reducing risk factors, many of which are related to diet and physical activity. Now, the challenge for Member States is to implement the strategy in their local communities.

The approaches you help identify at this consultation can help us meet that challenge. Of course, the approaches you recommend to fight obesity must take into account local customs and contexts. We need solutions that can be tailored to meet the needs of our diverse Region. What works in Australia or Singapore might not be the best fit for Cambodia and the Lao People's Democratic Republic. While the general principles remain the same, we have to calibrate our approaches to local realities. And we need to speak with one voice. Those of us in public health, in partner agencies working in development, in nongovernmental organizations and in government, need to better align our programmes for obesity prevention. We all know that with adequate resources, commitment and
sustained effort, health behaviours can be changed – with dramatic results. You have quite a bit of work before you these next three days. I look forward to hearing the outcome of your discussions and your recommendations, as due our Member States. Thank you.
## ANNEX 4

### Characteristics of four priority-setting approaches

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>WHO Stepwise framework</th>
<th>mPAST process</th>
<th>ANGELO process</th>
<th>ACE process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>For Ministries of Health to develop a unifying course of action</td>
<td>For identifying solutions and barriers to action</td>
<td>For developing community action plans</td>
<td>To assess cost-effectiveness of potential solutions</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Action plan or strategy with specific activities and timelines</td>
<td>List of problems and solutions</td>
<td>Community action plan with agreed objectives and strategies</td>
<td>Specified interventions with modelled data on costs, effectiveness, cost effectiveness. Statement on implementation considerations</td>
</tr>
<tr>
<td><strong>Key criteria used</strong></td>
<td>Feasibility; Impact; Affordability; Area of Impact</td>
<td>Feasibility; Effectiveness; Relevance; Acceptability; Costs</td>
<td>Feasibility; Importance (relevance, impact)</td>
<td>Cost-effectiveness; Effectiveness; Several ‘Implementation filters’</td>
</tr>
<tr>
<td><strong>Level of financial resources required</strong></td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td><strong>Level of technical expertise required</strong></td>
<td>Some expertise in running similar processes</td>
<td>Some expertise in running specific process</td>
<td>Some expertise in running specific process</td>
<td>High expertise (including academic)</td>
</tr>
<tr>
<td><strong>Level of data required</strong></td>
<td>Low</td>
<td>Low - medium</td>
<td>Low</td>
<td>High (best available)</td>
</tr>
<tr>
<td><strong>Timeline</strong></td>
<td>&lt;3 months 2 workshops</td>
<td>&lt;3 months 2-3 workshops</td>
<td>&lt;3 months 2 day workshop</td>
<td>2-3 years</td>
</tr>
</tbody>
</table>

ANNEX 5

GROUP OUTPUTS

Group session 1 and 2: Identifying potential actions using the mPAST process and setting priorities using the ANGELO prioritization process

Group 1

Group 1 completed problem trees on three starting problems:

1. Not enough vegetables eaten by children
2. Sedentary behaviours linked to small screen viewing
3. High intake of fast foods by children (considering international franchises only, excluding local franchises)

The solution tree component was completed on only one problem: ‘High intake of fast foods by children’. Possible solutions identified were: Junk food tax; Restrict opening hours; Create advocacy groups; Traffic light menu labels; Government accreditation of healthier choices; Social marketing with clear messages; Restrict zoning around schools; Monitor exposure to marketing; Ban all marketing of fast foods to children; Remove tax (GST/VAT) from healthy food products; Industry self regulation; Restaurant partnerships and advocacy for healthier choices; Nutrient information labelling; Monitor food composition.

The ANGELO process was applied as a group using the starting problem of ‘High intake of fast foods’. The top five prioritised solutions were:

1. Create advocacy groups;
2. Social marketing with clear messages;
3. Restrict zoning around schools;
4. Monitor exposure to marketing;
5. Ban all marketing of fast foods to children.

Group 2

The mPAST process was completed as a group considering two problems:

1. Not enough vegetables eaten by school children aged 6-12 months

Possible solutions identified were: Guidelines/standards in schools; Training for vendors (cooking); Education of vendors; New cooking methods; Free vegetables in schools; Guidelines for children’s menus; Social marketing campaign; Improved storage for vegetables; Broad tax/subsidy; Subsidise transport; Urban/local vegetable production; Research and Development funding for innovative farming methods; Education for parents; Free carrots; Free vegetable dishes at restaurants.
Annex 5

The ANGELO prioritisation step was conducted on each problem by individual participants. The top five prioritised solutions were:


Hong Kong: 1. Marketing new healthy menus for children at point of sale; 2. Incentives to children who eat all vegetables in their lunchbox; 3. Continue to use Healthy School Award system to encourage schools to adopt/maintain healthy eating policies/environments; 4. Continue to train vendors in offering tasty food with enough vegetables; 5. Continue to educate school teachers, parents and children on healthy food.


2. Sedentary behaviours linked to excessive television and video games in children

Possible solutions identified were: High tax on television; Rewards system for schools; Healthy cities approach (schools, workplaces); Health-in-All policies; Physical activity and education in schools (directives); Make games more active; Tax exemption for working parents and babysitting; Active afterschool programme; Sport injury insurance; Marketing of physical activity (as opposed to sports); Better supervised active activities (to promote safety); Role models for physical activity; Parents restrict time spent gaming/watching television; Tax on gaming.

The ANGELO prioritisation step was conducted by individual participants. The top five prioritised solutions were:


Korea: 1. More fun/exciting and active games for children; 2. Making role models to lower popularity of television/games; 3. Marketing of physical activity (as opposed to sports); 4. Increase tax exemption for having more children (so children have siblings to play with); 5. Introduce a tax exemption for both working parents for babysitting.

Hong Kong: 1. Set up rewards system for school in terms of physical activity levels of students; 2. Sports Injury insurance; 3. Continue to educate parents, students and school teachers; 4. Marketing of playing actively (e.g., role modelling, advertisements, stars); 5. Guidelines for schools.

Annex 5

Group 3

The mPAST process was completed for three problems:

1. Sedentary behaviours linked to excessive television viewing
   Possible solutions identified were: No programming at meal times; Walking bus; Get people moving while watching television; Rules for television watching; Role models (television, community); Have more boring repeated advertisements; Encourage active transport; Address community security; Five minute recaps to avoid watching entire programme; Ban televisions in bedroom; Improve urban planning; Increase cost of channel access; Increase cost of television; Limit number of televisions; Recommended television viewing guidelines.

2. High intake of sugar-sweetened drinks (high intake cordials, carbonated drinks)
   Possible solutions identified were: Tax companies/ingredients/packaging materials; Increase availability of water (product, taps, water foundations); Provide filtered clean water especially public areas; Education; Regulation of advertising/marketing; Work with water industry to improve marketing; Social marketing campaign to promote water

3. High-fat meals
   Possible solutions identified were: Increase local meat production to meet supply; Import quality stock (including low fat); Support for backyard and commercial farmers; Support for fish farming; Subsidise local fishing; Work with food industry to reduce unhealthy ingredients (gradual decrease in fat); Increase import tax on fatty foods; Price control on healthy foods; Regulate the number of fast-food outlets; Quality controls on meat; Guidelines for catering/canteens (frying); Social marketing on saturated fat; Social marketing on disease link; Voluntary controls for caterers on serving size; Compulsory controls for catering on serving size; Compulsory controls for schools on serving size.

The ANGELO prioritisation process was completed for only one starting problem: ‘high-fat meals’. The top five possible solutions prioritised by each participant were:


Annex 5

Group session 3: Next Steps

Group 1

Member States:

Assess policy buy-in for obesity prevention and control; Promote prevention of obesity as part of overall NCD prevention and control; Consider use of tools in priority-setting; Apply tools at National/Sub-national levels; Look at existing strategies in which the tools can be used

Group 2:

Member States:

Long term – Monitoring and surveillance

Temporary Advisors:

Short term – Participants take learning’s back to Ministries; Share current practices/experiences with others; Develop a consistent framework for helping position arguments

Long term – Continue to collaborate/network with other participants

WHO:

Short term – Distinguish which tools are most appropriate for particular countries, under what circumstances and when; Ongoing monitoring

Long term – Review evidence of existing interventions; Develop a regional framework for Member States to prioritize actions

Collaborating Centres/Academics:

Long term – Provide evidence of effectiveness of different tools; Provide data/evidence to inform the way in which public health frame the arguments; Provide evidence on effectiveness of interventions; Support low-income countries in developing and implementing sustainable programmes (knowledge sharing); Develop indicators of environment factors

Civil Society:

Short/long term – Help frame/position arguments; Advocate; Monitor action of the private sector and policies

Private Sector:

Short term – Share data on market research, sales and food consumption; Provide funding

Group 3:
Annex 5

Member States:

Short term – Run priority-setting processes within the next 12 months; Present outcomes of priority-setting process at Ministers meeting in 2013; Engage civil society in priority-setting and policy-making process

Long term – Evaluate priority-setting, implementation and impact (Evaluate the priority process → Implement → Evaluate impact → Revise or consolidate actions); Implement Health Promotion Foundations

WHO:

Short term – Add hard examples into draft priority-setting document and add evidence-informed policy development TROPIC Fiji; Link with 2-1-22 strategy to ensure the recommendations from the WHO Technical Consultation in Melbourne are translated into action

Long term – Facilitate scale-up of demonstration projects, priority-setting and best-practice; Ongoing dissemination of best-practice projects

Collaborating centres/Academia:

Short/long term – Add hard examples to WHO meeting document; Update research findings to appropriate agencies (timely, relevant, language appropriate); Capacity building to working with students and health promotion professional from the WPRO region; Provide workshops to WPRO area on request; Work collaboratively with governments, NGOs and civil societies to develop projects for knowledge exchange to develop obesity-prevention policies and advocacy statements

Civil society: Be actively engaged in priority setting; Support advocacy around
Process and tools

The domains and interventions which need to be considered in the prevention of obesity include advocacy and leadership; policies and environments; health promotion programmes; health services; and crosscutting and structural actions.

For each of these domains, long lists of possible actions can be created, but resources never are able to implement them all. Ideally, a short list of concrete, agreed, promising, evidence-informed, feasible actions is needed. Going from the long list to the short list requires a process of prioritization and it is important to note that the process of taking key stakeholders along the priority-setting journey is just as important as the outcome of the eventual short list.

The cross-cutting or structural actions needed, such as monitoring, workforce development, leadership and governance are less amenable to the tools described for priority-setting, although the same processes as described in the recommendations would still apply.

A general step-by-step process is outlined below (all steps apply due process by working with all relevant stakeholders throughout the prioritization process).

In selecting the most appropriate approach, it is recognized that regardless of the approach chosen as the best fit, it will be necessary to adapt the chosen approach to the specific needs of the country, region or area to which it is being applied.

Figure 1. Steps for identifying and prioritizing potential actions for obesity prevention
Annex 6

The standard steps for identifying and prioritizing potential actions for obesity prevention have been expanded to show where the available tools can be used in the process:

(5) Needs assessment (what is the current overall problem and its determinants?)

(a) Check available data (STEPS, National Nutrition Surveys, other health surveys).
   (i) disease burden (e.g. diabetes, cardiovascular diseases) related to high BMI;
   (ii) prevalence of overweight and obesity (in specific population groups e.g. sex, age group, income group, ethnicity) using WHO criteria;
   (iii) prevalence of under nutrition (e.g. low birth weight, stunting) in children;
   (iv) trends in overweight, obesity and underweight in adults and children;
   (v) prevalence of behavioural and environmental determinants;

(b) Identify key socio-cultural and political barriers and facilitators which will need to be considered.

(1) Examine various options

(a) Scientific literature;
(b) Knowledge from local experts; and
(c) WHO publications.
   (i) what works?;
   (ii) the Global Strategy on Diet, Physical Activity and Health (DPAS);
   (iii) fruit and vegetables for health (WHO/Food and Agricultural Organization (FAO);
   (iv) school policy framework;
   (v) set of recommendations on the marketing of foods and non-alcoholic beverages to children;
   (vi) population-based prevention strategies for childhood obesity;
   (vii) global recommendations on physical activity for health;
(viii) a framework to monitor and evaluate implementation;

(d) Expansion and modification of existing programmes and resources which currently exist in the community or region.

(3) Identify specific problems and specify potential actions.

(a) Modified Problem and Solution Tree (mPAST) process

(i) identify specific problems; and

(ii) create a list of possible specific actions.

(b) Other processes can also be used to identify potential options, including:

(i) ANGELO (Analysis Grid for Elements Linked to Obesity) process;
   - situational analysis and scanning tasks to identify target behaviours, skills and knowledge gaps and environmental barriers;

(ii) STEPwise framework for preventing chronic disease; and
   - planning steps

(iii) ACE (Assessing cost-effectiveness) process.

(c) All processes involve due process by working with multiple stakeholders throughout.

(d) Create the ‘long list’ of potential actions.

(4) Prioritize potential actions

(a) ANGELO process

(i) Originally developed for use in formulating community action plans. But it can be adapted for use at the national and subnational levels.
Annex 6

(b) Several processes can also be used to identify prioritize options, including:

(i) STEPwise framework for preventing chronic disease;
   ▪ to develop a unifying course of action, for example, NCD strategy or plan of action

(ii) ACE process;
   ▪ to assess cost-effectiveness of potential solutions

(iii) Other prioritization processes such as the approach presented in the Modified Problem and Solution Tree section of the document titled “Prioritizing areas for action in the field of population-based prevention of childhood obesity” can also be used to prioritize solutions.

(6) Strategy and specific action plan development
(7) Implementation of the plan
(8) Evaluation of the plan

Items 5-7 were not part of this technical consultation.

(viii) a framework to monitor and evaluate implementation;

(d) Expansion and modification of existing programmes and resources which currently exist in the community or region.

(3) Identify specific problems and specify potential actions.

(a) Modified Problem and Solution Tree (mPAST) process

(i) identify specific problems; and

(ii) create a list of possible specific actions.

(b) Other processes can also be used to identify potential options, including:

(i) ANGELo (Analysis Grid for Elements Linked to Obesity) process;
   ▪ situational analysis and scanning tasks to identify target behaviours, skills and knowledge gaps and environmental barriers;
(ii) STEPwise framework for preventing chronic disease; and

- planning steps

(iii) ACE (Assessing cost-effectiveness) process.

(c) All processes involve due process by working with multiple stakeholders throughout.

(d) Create the ‘long list’ of potential actions.

(4) Prioritize potential actions

(a) ANGELO process

(i) Originally developed for use in formulating community action plans. But it can be adapted for use at the national and subnational levels.

(b) Several processes can also be used to identify prioritize options, including:

(i) STEPwise framework for preventing chronic disease;

- to develop a unifying course of action, for example, NCD strategy or plan of action

(ii) ACE process;

- to assess cost-effectiveness of potential solutions

(iii) Other prioritization processes such as the approach presented in the Modified Problem and Solution Tree section of the document titled “Prioritizing areas for action in the field of population-based prevention of childhood obesity” can also be used to prioritize solutions.

(9) Strategy and specific action plan development

(10) Implementation of the plan

(11) Evaluation of the plan

Items 5-7 were not part of this technical consultation.