

Prevention and control of noncommunicable diseases: implementation of the global strategy

Report by the Secretariat

1. This report provides an overview of progress in implementing the action plan for the global strategy for the prevention and control of noncommunicable diseases¹ since its endorsement by the Sixty-first World Health Assembly in May 2008.²

2. The action plan aims to: (1) map the emerging epidemics of noncommunicable diseases and analyse their social, economic, behavioural and political determinants; (2) reduce the level of exposure of individuals and populations to the common modifiable risk factors; and (3) strengthen health care for people with noncommunicable diseases by developing evidence-based norms, standards and guidelines for cost-effective interventions and by orienting health systems to respond to the need for effective management of diseases of chronic nature. The plan comprises six objectives, each with two sets of proposed actions for Member States and international partners, and one set of actions for the WHO Secretariat. Its implementation is to be reviewed at the end of the first biennium.

PROGRESS BY OBJECTIVE

OBJECTIVE 1. To raise the priority accorded to noncommunicable disease in development work at global and national levels, and to integrate prevention and control of such diseases into policies across all government departments

3. Actions undertaken by the Secretariat in 2008–2009 include the following:

- An electronic discussion on noncommunicable diseases and development was held in January and February 2009, with moderation by the United Nations Department for Economic and Social Affairs and UNDP. WHO participated in the United Nations Economic and Social Council's annual ministerial review (the Regional Preparatory Meeting on Promoting Health Literacy, Beijing, 29–30 April 2009) and the Western Asia Ministerial Meeting on noncommunicable diseases and injuries (Doha, 10–11 May 2009); WHO jointly organized the latter with the Council and the United Nations Economic and Social Commission for Western

¹ See document WHA61/2008/REC/1, Annex 3.

² Resolution WHA61.14.

Asia (paragraphs 16(a) and 16(b)).¹ Participants at that Ministerial meeting adopted the Doha Declaration on Noncommunicable Diseases and Injuries, which recommended that the General Assembly may consider integrating evidence-based indicators on noncommunicable diseases into the monitoring and evaluation system for achievement of the Millennium Development Goals during its review of the Goals in 2010. Several Member States at the meeting also called for a special session of the United Nations General Assembly to consider noncommunicable diseases in low- and middle-income countries, a call echoed by some delegates at the Sixty-fourth Session of the United Nations General Assembly (paragraphs 16(a) and 16(b)).

- During the Economic and Social Council's High-Level Segment (Geneva, 6–9 July 2009), the WHO Secretariat organized a Ministerial Roundtable Breakfast meeting on noncommunicable diseases in order to review the relationship between noncommunicable diseases, poverty and development. Echoing the recommendations of the Doha Declaration on Noncommunicable Diseases and Injuries, some Member States specifically called for the Millennium Development Goals review summit in 2010 to add indicators to Millennium Development Goal 6, in order to allow evaluation of progress towards Target 6.C (Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases). A relevant indicator, for which data are immediately available in most countries, is the prevalence of tobacco use. The Ministerial Declaration adopted by Member States at the Economic and Social Council at the High-level Segment called for urgent action to implement the action plan (paragraphs 16(a) and 16(b)).
- The Secretariat organized an expert meeting on Health Equity in All Urban Policies at the WHO Centre for Health Development, Kobe, Japan, in June 2009 in order to review lessons learnt and international experiences in intersectoral action for health, with emphasis on noncommunicable conditions. The recommendations of the meeting will support Member States in their efforts to strengthen multisectoral mechanisms essential to implementing plans to prevent noncommunicable diseases (paragraphs 16(b) and 16(c)).
- The Secretariat also organized the 7th Global Conference on Health Promotion (Nairobi, 26–30 October 2009), for which it prepared, in collaboration with the Commission on Social Determinants of Health, a working paper on the theoretical foundations of intersectoral action on social determinants of health and the prevention and control of noncommunicable diseases. The outcome of the discussions will spur the finalization of a review of the links between noncommunicable diseases, development and social determinants, which is due to be published in 2010 (paragraph 16(d)).

OBJECTIVE 2. To establish and strengthen national policies and plans for the prevention and control of noncommunicable diseases

4. Secretariat actions included the following:

- preparation of a WHO manual on frameworks for country action in collaboration with international experts with the aim of guiding countries in planning, implementing, and evaluating policies, plans and programmes for prevention of noncommunicable diseases

¹ Here and subsequently, these citations refer to the actions set out in the specified paragraphs in the action plan, see document WHA61/2008/REC/1, Annex 3.

(paragraph 20, *National multisectoral framework for prevention and control of noncommunicable diseases*, (a));

- design of simplified implementation tools, including WHO/International Society of Hypertension cardiovascular risk prediction charts, for all WHO regions; these tools support the establishment of cost-effective, integrated programmes to prevent heart attacks and strokes, which can replace vertical programmes for diabetes, hypertension and raised blood lipid concentrations (paragraph 20, *Integration of prevention and control of noncommunicable diseases into the national health development plan*, (b));
- review of the diagnostic criteria for myocardial infarction and diabetes; the Secretariat has been involved in the development of evidence-based guidelines for primary and secondary prevention of cardiovascular diseases and in promoting and monitoring their implementation (paragraph 20, *Integration of prevention and control of noncommunicable diseases into the national health development plan*, (c));
- provision of support, in close collaboration with international partners, to countries in strengthening opportunities for training and capacity building with regard to public health aspects of major noncommunicable diseases. The first international seminar, designed for national managers of noncommunicable disease prevention programmes, is scheduled to be held in Lausanne, Switzerland, in November 2009. Thereafter, annual seminars are planned in collaboration with WHO collaborating centres (paragraph 20, *Integration of prevention and control of noncommunicable diseases into the national health development plan*, (d));
- formulation of strategies through cross-cluster collaboration for strengthening the health system response to noncommunicable diseases in low- and middle-income countries, in line with the recommendations of *The world health report 2008*.¹ The Secretariat is also providing technical guidance to countries in integrating a core set of effective and affordable interventions against major noncommunicable diseases into health systems in resource-constrained settings through a primary care approach (paragraph 20, *Reorientation and strengthening of health systems*, (b));
- assessment of how to expand access to a core set of essential medicines for noncommunicable diseases, including improvement of procurement, efficiency and management of medicine supplies in countries (paragraph 20, *Reorientation and strengthening of health systems*, (c)).

OBJECTIVE 3. To promote interventions to reduce the main shared modifiable risk factors for noncommunicable diseases: tobacco use, unhealthy diets, physical inactivity and harmful use of alcohol

5. At the global level, promoting interventions to reduce the main shared, modifiable risk factors needs to be guided by actions of Member States to enact or strengthen interventions to reduce risk factors, including ratifying and implementing the WHO Framework Convention on Tobacco Control, implementing the recommendations of the Global Strategy on Diet, Physical Activity and Health, the Global Strategy for Infant and Young Child Feeding, and other relevant strategies through national strategies, policies and action plans.

¹ World Health Organization. *The world health report 2008 – Primary health care: now more than ever*. Geneva, World Health Organization, 2008.

6. The Secretariat has taken the following steps to implement actions set out in the global strategy.

(a) *Tobacco control*

(i) Technical support has been provided to countries to establish or strengthen national tobacco control legislation (paragraph 25(a)), and to 15 low- and middle-income countries for implementing a package of six proven measures linked to the relevant provisions of the WHO Framework Convention (paragraph 25(d)). Four capacity assessments were conducted in low- and middle-income countries in order to identify strengths and opportunities and barriers to implementation of the evidence-based provisions of the WHO Framework Convention (paragraphs 25(a), (d) and (e)).

(ii) Support has been provided to the Convention Secretariat for the development of guidelines and protocols. A joint operational plan for the next biennium has been written.

(iii) With the Convention Secretariat a global coordination meeting has been convened (scheduled to be held in Tunis, 13–14 November 2009) in order to bring together managers of national tobacco control programmes. The expected outcome, a coordinated framework for building country capacity to implement the several provisions of the WHO Framework Convention, is intended to be the base on which to create national tobacco control planning handbooks that will include inputs from the Convention Secretariat (paragraph 25(e)).

(b) *Promoting healthy diet and physical activity*

(i) Capacity-building workshops on implementation of the Global Strategy on Diet, Physical Activity and Health have been held in the African, South-East Asia, Eastern Mediterranean and Western Pacific Regions, with, in the Eastern Mediterranean Region, a regional plan on diet and physical activity being formulated and focal points trained (paragraph 25(a)).

(ii) Networks have been set up in the Region of the Americas and the European Region in order to contribute to the reduction of salt intake at the population level, sharing of knowledge about interventions that reduce salt intake, and raising awareness of the importance of reducing salt intake for public health (paragraph 25(c)).

(iii) An updated procedural manual for the development and implementation of regional and country-specific food-based dietary guidelines is being field-tested in several countries. Technical support for the drafting of these guidelines has been provided to several Member States (paragraph 25(a)).

(iv) Several tools have been elaborated for use in the design of pilot or demonstration programmes of interventions based on the recommendations included in the Global Strategy on Diet, Physical Activity and Health (paragraph 25(b)).

(v) A set of recommendations on the marketing of foods and non-alcoholic beverages to children has been drafted (see Annex). This work has been one of the principal activities in 2008–2009.

(vi) Technical work has also included revision of the joint FAO/WHO Scientific Update on Carbohydrates in Human Nutrition (covering, for instance, matters related to dietary fibre and sugars), the WHO scientific update on *trans*-fatty acids, the joint FAO/WHO Expert Consultation on fats and fatty acids, and the systematic review of the level of total fat and obesity and diet-related noncommunicable diseases. An expert consultation on waist circumference and waist–hip ratio (Geneva, 8–11 December 2008) was convened in order to draw up international guidelines for indices and cut-off points to characterize health risks associated with fat distribution as alternative or complementary to existing WHO guidelines for assessments of obesity based on body mass index (paragraph 25(a)).

(vii) WHO has continued to monitor overweight and obesity among adult populations (collecting data in the Global Database on Body Mass Index) and children less than five years of age (the Global Database and Child Growth and Malnutrition) as well as underweight for those population groups.

(c) *Reducing the harmful use of alcohol*

(i) A global strategy has been drafted for reducing harmful use of alcohol. It is based on available evidence and existing best practices and presents relevant policy options, taking into account different national, religious and cultural contexts. The Board will consider the draft global strategy under a separate item on the provisional agenda,¹ with a view to forwarding it to the Sixty-third World Health Assembly for consideration (paragraph 25(a)).

OBJECTIVE 4. To promote research for the prevention and control of noncommunicable diseases

7. An essential element in promoting research into means to prevent and control noncommunicable diseases is the setting of a coordinated programme of research. Actions implemented by the Secretariat included the following:

- In August 2008, about 200 leading researchers, representatives of international nongovernmental organizations, donor agencies, and WHO collaborating centres were convened to discuss research priorities, mechanisms for strengthening research capacity in low- and middle-income countries and enhancing international collaboration for advancing a coordinated, and a coherent research agenda (paragraph 29(a)).
- Out of this consultation emerged a series of reviews of evidence of successful interventions for prevention and control of noncommunicable diseases and gaps in our knowledge relating to behavioural risk factors, cardiovascular diseases, cancer, diabetes, chronic respiratory disease, human genetics, primary health care and relevant health system and equity issues. The papers outlined multisectoral and transnational research that has special relevance to the development and implementation of national policies and programmes for noncommunicable disease prevention and control. A draft agenda for prioritized research, elaborated on the basis of these reviews, was examined by a group of experts in October 2009. Following further consultation, through wider dissemination of the draft agenda, the draft prioritized research agenda will be finalized in 2010 (paragraph 29(a)).

¹ See document EB126/13.

- The Secretariat is contributing material on tobacco use to a forthcoming publication on lifestyle factors in the series of IARC Monographs on the Evaluation of Carcinogenic Risk to Humans. The Secretariat will also be collaborating with IARC on a document on the effectiveness of tax and price policies for tobacco control (paragraph 29(a)).
- The Secretariat has also published jointly with the United States National Cancer Institute a monograph on the scientific basis of tobacco product regulation. A second joint monograph on the economics of tobacco control is also being finalized (paragraph 29(a)).
- Collaboration with IARC in terms of strategic planning and in specific areas such as cancer control, tobacco control and nutrition.

OBJECTIVE 5. To promote partnerships for the prevention and control of noncommunicable diseases

8. Providing effective public health responses to the global threat posed by noncommunicable diseases requires strong international partnerships. Among the actions implemented by the Secretariat are the following:

- A new WHO network to combat noncommunicable diseases (the Global Noncommunicable Disease Network) has been established in order to encourage the involvement of all relevant stakeholder groups and existing regional and global initiatives. The network was established as a voluntary collaborative arrangement. Its mission is to provide support to low- and middle-income countries in implementing the global strategy. The goals of the Network are to increase focus on prevention of noncommunicable diseases through collective advocacy; to increase the availability of resources (both financial and human); and to catalyse effective multistakeholder action at global and regional levels with an emphasis on country-level implementation thereby contributing to greater national capacity (paragraph 34(b)).
- The Global Noncommunicable Disease Network was launched at the High-level Segment of the Economic and Social Council (Geneva, 6–9 July 2009), and the first planning meeting took place in October 2009 with participants representing Member States, organizations in the United Nations system, the World Bank, international nongovernmental organizations, philanthropic bodies and the World Economic Forum. The most significant outcome of that meeting was the measurable increase in engagement of stakeholders in the Network and in supporting implementation of the action plan (paragraph 34(a) and (b)).

OBJECTIVE 6. To monitor noncommunicable diseases and their determinants and evaluate progress at the national, regional and global levels

9. Monitoring noncommunicable diseases and their determinants provides the foundation for advocacy, policy development and global action. Monitoring is not limited to tracking data on the magnitude of and trends in noncommunicable diseases, it also includes evaluating the effectiveness and impact of interventions and assessing the progress made by countries in addressing the challenge they pose.

- The Secretariat established an epidemiology reference group made up of experts in epidemiology and public health with the aim of supporting its work in designing monitoring tools and providing advice to Member States on data collection and analysis. Two technical meetings on surveillance of noncommunicable diseases were held in Geneva (in April and

August 2009) to reach consensus on the core components of a national surveillance system (risk factors and determinants, morbidity and mortality) and to agree on a set of core indicators for each of the three components (paragraph 39(a) and (b)).

- Two assessments in order to enable the Secretariat to monitor noncommunicable diseases and evaluate the effectiveness and impact of interventions are being planned. The first component (epidemiological monitoring) will assess trends in mortality and morbidity due to, and risk factors for, noncommunicable diseases. The data to support this component will be derived from existing WHO data sources. The second component (country capacity) will focus on individual countries' ability to address noncommunicable diseases in a comprehensive manner, drawing on data collected through a Global Survey on Assessment of the National Capacity for Noncommunicable Disease Surveillance, which was developed in 2009 by the Secretariat (paragraph 39(e)).
- The Secretariat has provided technical support to Member States in building capacity through training workshops in survey implementation, country data analysis and reporting for the Global School Based Student Health Survey. Other training workshops were held on planning and data collection for surveys using the WHO STEPwise approach to risk factor surveillance. Software and user materials were developed to support the use of new technology, namely hand-held computers, for data collection in household surveys using the WHO STEPwise approach (paragraph 39(c)).

Obstacles to implementation

10. The key challenges for preventing and controlling noncommunicable diseases are clearly highlighted by the Global Strategy and its Action Plan: monitoring noncommunicable diseases and their determinants through effective surveillance mechanisms built within the national health information systems; implementing interventions to reduce risk factors and determinants supported by effective mechanisms of intersectoral action; and improving health care for people with noncommunicable diseases through health system strengthening. To meet these challenges requires increased political commitment and prioritization by Member States to prevention of these diseases, and more resources for the development and implementation of national plans.

11. Despite increasing recognition of the pressing need to address the growing magnitude of noncommunicable diseases and their risk factors and the negative impact on socioeconomic development, official development assistance specifically to support low- and middle-income countries in building sustainable institutional capacity to tackle noncommunicable diseases remains insignificant.

12. If the high mortality and heavy disease burden experienced by low- and middle-income countries are to be comprehensively reduced, global development initiatives must take into account prevention of noncommunicable diseases. As the action plan states, instruments like the Millennium Development Goals provide opportunities for synergy, as do mechanisms that harmonize development and strategies for poverty reduction.

ACTION BY THE EXECUTIVE BOARD

13. The Board is invited to note the report.

ANNEX

**SET OF RECOMMENDATIONS ON THE MARKETING OF
FOODS AND NON-ALCOHOLIC BEVERAGES TO CHILDREN**

1. The Sixtieth World Health Assembly, in resolution WHA60.23 on prevention and control of noncommunicable diseases: implementation of the global strategy, requested the Director-General "... to promote responsible marketing including the development of a set of recommendations on the marketing of foods and nonalcoholic beverages to children, in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, in dialogue with all relevant stakeholders, including private-sector parties, while ensuring avoidance of potential conflict of interest".
2. The Sixty-first World Health Assembly in resolution WHA61.14 endorsed the action plan for the global strategy for the prevention and control of noncommunicable diseases. The action plan urges Member States to continue to implement the actions agreed by the Health Assembly in resolution WHA60.23. In Objective 3 (paragraph 24 *Promoting healthy diet, (e)*) the action plan identifies as a proposed key action for Member States "to prepare and put in place, as appropriate, and with all relevant stakeholders, a framework and/or mechanisms for promoting the responsible marketing of foods and non-alcoholic beverages to children, in order to reduce the impact of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt".
3. In the fulfilment of this mandate, in November 2008, the Director-General appointed members of an ad hoc expert group to provide her with technical advice on appropriate policy objectives, policy options and monitoring and evaluation mechanisms. The group was provided with an updated systematic review that confirmed previous findings that globally foods high in fat, sugar or salt were being extensively marketed to children.
4. Two meetings were held with representatives of international nongovernmental organizations, the global food and non-alcoholic beverage industries, and the advertising sector. The objectives of these meetings were to identify policy initiatives and processes and tools for monitoring and evaluation in the area of marketing of foods and non-alcoholic beverages to children.
5. The Secretariat drew on the advice from the expert group and input from the stakeholder meetings to write a working paper that provided a framework for regional consultations with Member States. These consultations elicited the views of Member States on the policy objectives, policy options, and monitoring and evaluation mechanisms presented in the working paper. By September 2009, 66 Member States had submitted a response to the consultations. Additional input on the working paper was provided through two follow-up stakeholder meetings with representatives of international nongovernmental organizations, the global food and non-alcoholic beverage industries, and the advertising sector.
6. It was clear from the consultations that Member States view marketing of foods and non-alcoholic beverages to children as an international issue and that there is a need to ensure that the private sector markets its products responsibly. The consultations also showed that policies currently in place in Member States vary in their objectives and content, approach, monitoring and evaluation practices, and the ways in which stakeholders are involved. Approaches range from statutory prohibitions on television advertising for children of predefined foods to voluntary codes by certain sections of the food and advertising industry. Several Member States indicated that they would need further support from the Secretariat in the areas of policy development, monitoring and evaluation.

7. Cross-border marketing was raised as a concern by 15 Member States. Many countries, including those with restrictions in place, are exposed to food marketing in their country from beyond their borders and the Member States indicated that the global nature of many marketing practices needs to be addressed.

8. Marketing of foods and non-alcoholic beverages to children in schools and pre-school establishments was a concern expressed by 10 Member States. The special situation of schools as a setting where children are a captive audience and the health-promoting role that schools should have were identified as factors that need also to be addressed in the recommendations.

9. The main purpose of these recommendations is to guide efforts by Member States in designing new and/or strengthening existing policies on food marketing communications to children in order to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

10. The recommendations are set out in **bold** text throughout this Annex; subsequent text sets out the context. The recommendations are structured into the following five sections: Rationale; Policy development; Policy implementation; Policy monitoring and evaluation, and Research.

EVIDENCE

11. Unhealthy diet is a risk factor for noncommunicable diseases. The risks presented by unhealthy diets start in childhood and build up throughout life. In order to reduce future risk of noncommunicable diseases children should maintain a healthy weight and consume foods that are low in saturated fat, *trans*-fatty acids, free sugars, and salt. Unhealthy diets are associated with overweight and obesity, conditions that have increased rapidly in children around the world over recent years.

12. Evidence from four systematic reviews on the extent, nature and effects of food marketing to children conclude that advertising is extensive and other forms of food¹ marketing² to children are widespread across the world.³ Most of this marketing is for foods with a high content of fat, sugar or salt. Evidence also shows that television advertising influences children's food preferences, purchase requests and consumption patterns.

13. The systematic reviews show that, although television remains an important medium, it is gradually being complemented by an increasingly multifaceted mix of marketing communications that focuses on branding and building relationships with consumers. This wide array of marketing

¹ Henceforth, the term "food" is used to refer to foods and non-alcoholic beverages.

² "Marketing" refers to any form of commercial communication or message that is designed to, or has the effect of, increasing the recognition, appeal and/or consumption of particular products and services. It comprises anything that acts to advertise or otherwise promote a product or service.

³ Hastings G et al. *Review of the research on the effects of food promotion to children*. Glasgow, University of Strathclyde, Centre for Social Marketing; 2003 (<http://www.food.gov.uk/news/newsarchive/2003/sep/promote>); Hastings G et al. *The extent, nature and effects of food promotion to children: a review of the evidence*. Geneva, World Health organization, 2006 (http://whqlibdoc.who.int/publications/2007/9789241595247_eng.pdf); McGinnis JM, Gootman JA, Kraak VI, eds. *Food marketing to children and youth: threat or opportunity?* Washington DC, Institute of Medicine, National Academies Press, 2006 (http://www.nap.edu/catalog.php?record_id=11514#toc); and Cairns G, Angus K, Hastings G. *The extent, nature and effects of food promotion to children: a review of the evidence to December 2008*. Geneva, World Health Organization, 2009 (http://www.who.int/dietphysicalactivity/Evidence_Update_2009.pdf).

techniques includes advertising, sponsorship, product placement, sales promotion, cross-promotions using celebrities, brand mascots or characters popular with children, web sites, packaging, labelling and point-of-purchase displays, e-mails and text messages, philanthropic activities tied to branding opportunities, and communication through “viral marketing” and by word-of-mouth. Food marketing to children is now a global phenomenon and tends to be pluralistic and integrated, using multiple messages in multiple channels.

RECOMMENDATIONS

Rationale

14. The reviews of evidence show a clear rationale for action to be taken by Member States in this area. The need to develop appropriate policy mechanisms was also acknowledged by various Member States during the consultation process for the development of these recommendations. These further support Health Assembly resolutions WHA60.23 and WHA61.14 on prevention and control of noncommunicable diseases and provide a solid rationale for policy development by Member States.

RECOMMENDATION 1. The policy aim should be to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

15. The effectiveness of marketing communications depends on two elements: the media in which the communication message appears and its creative content. The first element deals with the reach, frequency and impact of the message, thus influencing the *exposure* of children to the marketing message. The second element relates to the content, design and execution of the marketing message, influencing the *power* of the marketing communication. The effectiveness of marketing can thus be described as a function of both *exposure* and *power*.

RECOMMENDATION 2. Given that the effectiveness of marketing is a function of exposure and power, the overall policy objective should be to reduce both the exposure of children to, and power of, marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

POLICY DEVELOPMENT

16. Member States can take various approaches to achieve the policy aim and objective, depending on national circumstances and available resources. Member States can adopt a *comprehensive approach* to restricting all marketing to children of foods with a high content of saturated fats, *trans*-fatty acids, free sugars, or salt, which fully eliminates the exposure, and thereby also the power, of that marketing. Alternatively, Member States can start by either addressing exposure or power independently or dealing with aspects of both simultaneously in a *stepwise approach*.

17. Different policy approaches have different potential to achieve the policy aim of reducing the impact on children of marketing of foods with a high content of saturated fats, *trans*-fatty acids, free sugars, or salt. A comprehensive approach has the highest potential to achieve the desired impact.

18. When addressing *exposure*, consideration should be given to when, where, to whom and for what products marketing will, or will not, be permitted. When addressing *power*, consideration should be given to restricting the use of marketing techniques that have a particularly powerful effect. If for

example a stepwise approach is chosen, attention should be given to the marketing to which children have greatest exposure, and to the marketing messages that have greatest power.

RECOMMENDATION 3. To achieve the policy aim and objective, Member States should consider different approaches, i.e. stepwise and comprehensive, to reduce marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt, to children.

19. Effective implementation depends on clear definitions of the policy components. These definitions will determine the potential of the policy to reduce exposure and/or power, and thus impact. Important definitions include the age group for which restrictions shall apply, the communication channels, settings and marketing techniques to be covered, what constitutes marketing to children according to factors such as product, timing, viewing audience, placement and content of the marketing message, as well as what foods are to be covered by marketing restrictions.¹

RECOMMENDATION 4. Governments should set clear definitions for the key components of the policy, thereby allowing for a standard implementation process. The setting of clear definitions would facilitate uniform implementation, irrespective of the implementing body. When setting the key definitions Member States need to identify and address any specific national challenges so as to derive the maximal impact of the policy.

20. Schools, child-care and other educational establishments are privileged institutions acting *in loco parentis*, and nothing that occurs in them should prejudice a child's well-being. Therefore the nutritional well-being of children within schools should be paramount and the foundation stone for children's well being at this formative age. This is also consistent with the recommendation made in the Global Strategy on Diet, Physical Activity and Health that urges governments to adopt policies to support healthy diets in schools.

RECOMMENDATION 5. Settings where children gather should be free from all forms of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt. Such settings include, but are not limited to, nurseries, schools, school grounds and pre-school centres, playgrounds, family and child clinics and paediatric services and during any sporting and cultural activities that are held on these premises.

21. Policy on food marketing to children involves a wide range of stakeholders and cuts across several policy sectors. Governments are in the best position to set direction and overall strategy to achieve population-wide public health goals. When governments are engaging with other stakeholders care should be taken to protect the public interest and avoid conflict of interest. Regardless of the policy framework chosen, there should be widespread communication of the policy to all stakeholder groups, including the private sector, civil society, nongovernmental organizations, the media, academic researchers, parents and the wider community.

RECOMMENDATION 6. Governments should be the key stakeholders in the development of policy and provide leadership, through a multistakeholder platform, for implementation, monitoring and evaluation. In setting the national policy framework, governments may choose

¹ Member States can choose to distinguish food types in several ways, for example by using national dietary guidelines, definitions set by scientific bodies or nutrient profiling models or they can base the marketing restrictions on specific categories of foods.

to allocate defined roles to other stakeholders, while protecting the public interest and avoiding conflict of interest.

POLICY IMPLEMENTATION

22. The defined policy may be implemented through a variety of approaches. Statutory regulation is one approach through which implementation and compliance are a legal requirement. Another approach is industry-led self-regulation, which covers whole industry sectors, for example the advertising sector, and can be independent of government regulation. This approach may still be mandated by government in some form such as the setting of targets and monitoring implementation using key indicators. Other approaches include various co-regulatory mechanisms, comprising statutory, self-regulation and/or voluntary industry initiatives which either exist within the framework of a government mandate or are not formally linked. Governments or mandated bodies can also issue or implement guidelines.

23. Member States that restrict all or certain aspects of marketing of foods with a high content of saturated fats, *trans*-fatty acids, free sugars, or salt to children should ensure that restrictions at national level also apply to marketing originating from their territory and reaching other countries (out-flowing). In many countries the effects of marketing coming in from other countries (in-flowing) may be as important as the marketing originating nationally. In these situations action at national level will have to consider not only marketing originating nationally but also marketing that enters the country from beyond their borders, taking into account the international obligations of the Member State concerned. In these situations, effective international collaboration is essential to ensure significant impact of national actions.

24. Independently of any other measures taken for implementation of a national policy, private sector stakeholders should be encouraged to follow marketing practices that are consistent with the policy aim and objective set out in these recommendations and to practise them globally in order to ensure equal consideration to children everywhere and avoid undermining efforts to restrict marketing in countries that receive food marketing from beyond their borders.

25. Civil society, nongovernmental organizations and academic researchers have the potential to contribute to policy implementation through capacity building, advocacy, and technical expertise.

RECOMMENDATION 7. Considering resources, benefits and burdens of all stakeholders involved, Member States should consider the most effective approach to reduce marketing to children of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt. Any approach selected should be set within a framework developed to achieve the policy objective.

RECOMMENDATION 8. Member States should cooperate to put in place the means necessary to reduce the impact of cross-border marketing (in-flowing and out-flowing) of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt to children in order to achieve the highest possible impact of any national policy.

RECOMMENDATION 9. The policy framework should specify enforcement mechanisms and establish systems for their implementation. In this respect, the framework should include clear definitions of sanctions and could include a system for reporting complaints.

POLICY MONITORING AND EVALUATION

26. Monitoring provides a system for collecting and documenting information on whether the policy meets its objectives. Evaluation is likewise important because it measures the impact of the policy aims and objectives. Monitoring and evaluation may need different approaches to ensure effectiveness and avoidance of conflict of interest.

27. The policy framework should include a set of core process and outcome indicators, clearly defined roles and assignment of responsibility for monitoring and evaluation activities and mechanisms to parties that have no conflict of interest. Indicators need to be specific, quantitative and measurable using instruments that are valid and reliable.

28. Monitoring of the policy should use relevant indicators that measure the effect of the policy on its objective (i.e. reducing exposure and power).

29. An example of how to assess a reduction in *exposure* may be to measure the quantity of, or expenditure on, marketing communications to children of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt. This can be done through measuring the number of advertisements directed at children of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt shown on television over a 24-hour period.

30. An example of how to assess a reduction in *power* may be to measure the prevalence of specified techniques used. This can be done through measuring the prevalence of advertisements directed at children of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt using licensed characters or celebrities, or other techniques of special appeal to children, on television over a 24-hour period.

31. Information generated from monitoring can be used: (i) to support enforcement; (ii) publicly to document compliance; (iii) to guide policy refinement and improvement; and (iv) to contribute to policy evaluation.

RECOMMENDATION 10. All policy frameworks should include a monitoring system to ensure compliance with the objectives set out in the national policy, using clearly defined indicators

32. Evaluation of the policy should use specific indicators that evaluate the effect of the policy on its overall aim (that is, to reduce the impact). The indicators should also evaluate if children are directly or indirectly exposed to marketing messages intended for other audiences or media.

33. An example of how to assess a reduction in the *impact* may be to measure the changes in sales or market share for foods high in saturated fats, *trans*-fatty acids, free sugars, or salt; and measure the changes in children's consumption patterns in response to the policy.

34. Evaluation should ideally use baseline data as the benchmark, with such data being collected as a first step to establish the real policy impact.

RECOMMENDATION 11. The policy frameworks should also include a system to evaluate the impact and effectiveness of the policy on the overall aim, using clearly defined indicators.

RESEARCH

35. Global reviews have shown that most of the available evidence to date comes from high-income countries. Many Member States do not have national data and research that enable them to identify the extent, nature and effects of food marketing to children. This type of research can further inform policy implementation and its enforcement within a national context.

RECOMMENDATION 12. Member States are encouraged to identify existing information on the extent, nature and effects of food marketing to children in their country. They are also encouraged to support further research in this area, especially research focused on implementation and evaluation of policies to reduce the impact on children of marketing of foods high in saturated fats, *trans*-fatty acids, free sugars, or salt.

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