A FITTER FUTURE FOR ALL

Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012-2022

CONTENTS

MINISTERIAL FOREWORD

Obesity continues to be one of the most important public health challenges facing Northern Ireland. Its impact is wide-ranging throughout society and across all life courses. Obesity can contribute to, and increase the risk of, life threatening diseases. Its cost can extend far beyond the public sector and affect individuals, families, communities, the economy, and society as a whole. Up until recently, the number of people within Northern Ireland who are overweight or obese has been rising year-on-year. Recent figures have shown that since the publishing of Fit Futures this rising trend seems to have leveled out and now we must make sure that obesity is effectively dealt with on a permanent basis.

Fit Futures was developed to tackle the issue of obesity in children and young people; however, through monitoring the implementation of this strategy it was realised that to be effective obesity needed to be tackled on a life course basis. It is not enough to inform and encourage children and young people to make healthier food and nutrition choices and increase their participation in physical activity; we need to ensure that their families are also participating in healthier lifestyle choices. These choices would then be instilled within future generations and would be an effective investment into the future health of the entire population.

The life course stages through which this Framework has directed its outcomes are:

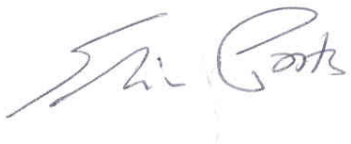
- Pre-conception, Antenatal, Maternal and Early Years;
- Children and Young People; and
- Adults and General Population.

The biggest challenge we face, concerning obesity, is to change attitudes and behaviours. We must encourage people to choose to eat healthier food and to participate more in physical activity, but we must also be mindful that it should be an individual's choice to do so. People must retain responsibility for maintaining their own health and wellbeing.

It is the responsibility of all Departments however, through cross-Departmental working and collaboration, to ensure that people are given opportunities, and are supported, to access

and participate in a healthier lifestyle, which will benefit their long-term health and wellbeing. However, existing barriers can make choices more restricted and therefore we must also consider the importance and the influence of the 'obesogenic environment'. This Framework emphasizes the importance of all the inter-connected and related factors involved and aims to address the issue of overweight and obesity through a coordinated, integrated and cross-sectoral approach. This issue requires commitment through the public, voluntary and community, and the private sectors if it is to be tackled effectively. I am seeking commitment and buy-in across Northern Ireland to take this Framework forward; it is everyone's responsibility and no single Department or organisation can make progress in isolation.

It is important to acknowledge that change will not come overnight, but by working together and recognising the impact this will have on future generations, we can and will make a difference. We have therefore set ourselves a challenging target, over the next ten years we are aiming to reduce the level of obesity - not just halt its rise.
I would like thank the members of the Obesity Prevention Steering Group, the Advisory Groups, and those who took part in any of the consultation process for their input, commitment and dedication to addressing this issue. This Framework highlights what can be achieved by working in partnership.



Edwin Poots MLA
Minister for Health, Social Services, and Public Safety

SUMMARY

Background

The prevalence of people who are overweight and obese has been steadily rising in Northern Ireland, and in the western world, over the last few decades. It has been described as an "obesity time-bomb"[1]; given the impact that obesity can have on physical and mental health and wellbeing. Throughout the Framework reference is made to obesity – it should be noted that this term is used to refer to both those overweight and obese.

Evidence has shown that, while weight gain is the result of a relatively simple energy imbalance, the causes that underpin changes to energy intake and expenditure are very complex and cover issues such as social and individual psychology, physiology, food production and consumption, individual activity, and the built environment. These factors, known as the "obesogenic environment"[2], need cross-sectoral and cross-Government action to change effectively. In addition, many wider determinants of poor health such as health inequalities, poverty, mental health, deprivation, and structural barriers also play an important role.

Approach to date

Prior to 2006, the main approach to addressing this issue was through actions that promoted participation in physical activity and maintaining a healthy diet. However, based on growing research on the need for an integrated approach Fit Futures was published in 2006[3] and used this approach in addressing childhood obesity. Further emerging evidence, particularly from the Foresight Report in 2007[4], highlighted the importance of effectively intervening throughout an individual's life. The Department of Health, Social Services and Public Safety (DHSSPS) therefore led the development of a cross-sectoral, integrated life course framework to prevent and address obesity within Northern Ireland over the next 10 years.

Obesity Prevention Framework

Aim

This Framework aims to *"empower the population of Northern Ireland to make healthy choices, reduce the risk of overweight and obesity related diseases and improve health and wellbeing, by creating an environment that supports and promotes a physically active lifestyle and a healthy diet"*.

Target

In addition, the following overarching targets have been set:

Adults

- To reduce the level of obesity by 4% and overweight and obesity by 3% by 2022.

Children

- A 3% reduction of obesity and 2% reduction of overweight and obesity by 2022

The target is in two parts; the proportion that are obese and the proportion that are overweight and obese.

Objectives

Prevention is typically taken forward through action to address two main areas – improving diet and nutrition, and increasing participation in physical activity. Acknowledging this, two overarching objectives for the Framework have been set: *to increase the percentage of people eating a healthy, nutritionally balanced diet;* and *to increase the percentage of the population meeting the CMO guidelines on physical activity.*

Outcomes

Chapter 5 sets out a range of short, medium, and long-term outcomes that delivery partners will seek to deliver in relation to obesity. These outcomes have been structured by life course stages, and have been developed using a logic model approach.

Implementation

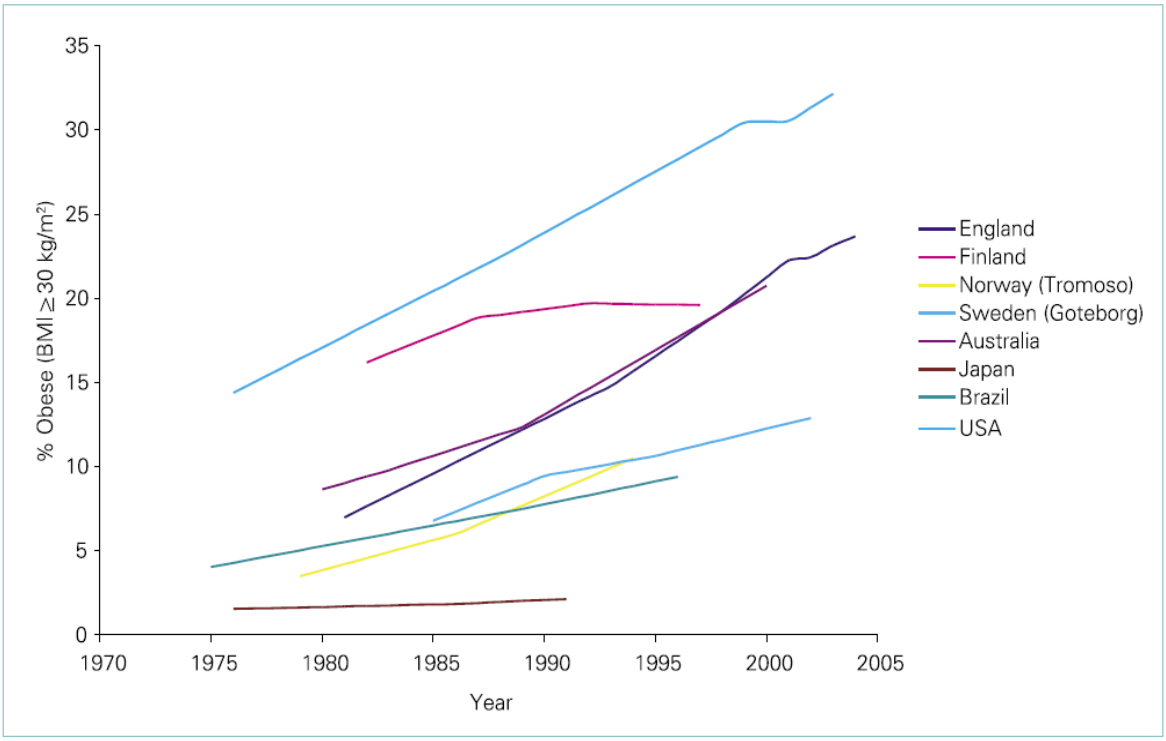
An overarching steering group will be established to monitor progress and cross-Departmental action. Underpinning this, the Public Health Agency will establish a group to drive forward the implementation and delivery.

CHAPTER 1 – INTRODUCTION

Background

1.1 The prevalence of overweight and obesity has increased dramatically over the past few decades throughout the UK and across many other Western countries (see Figure 1). In 1998, the World Health Organisation (WHO) highlighted that obesity was becoming one of the most important factors contributing to ill health with global increases in prevalence[5].

Figure 1 - Trends in adult prevalence of obesity – percentage of the adult population assessed as obese in a selection of countries around the world.

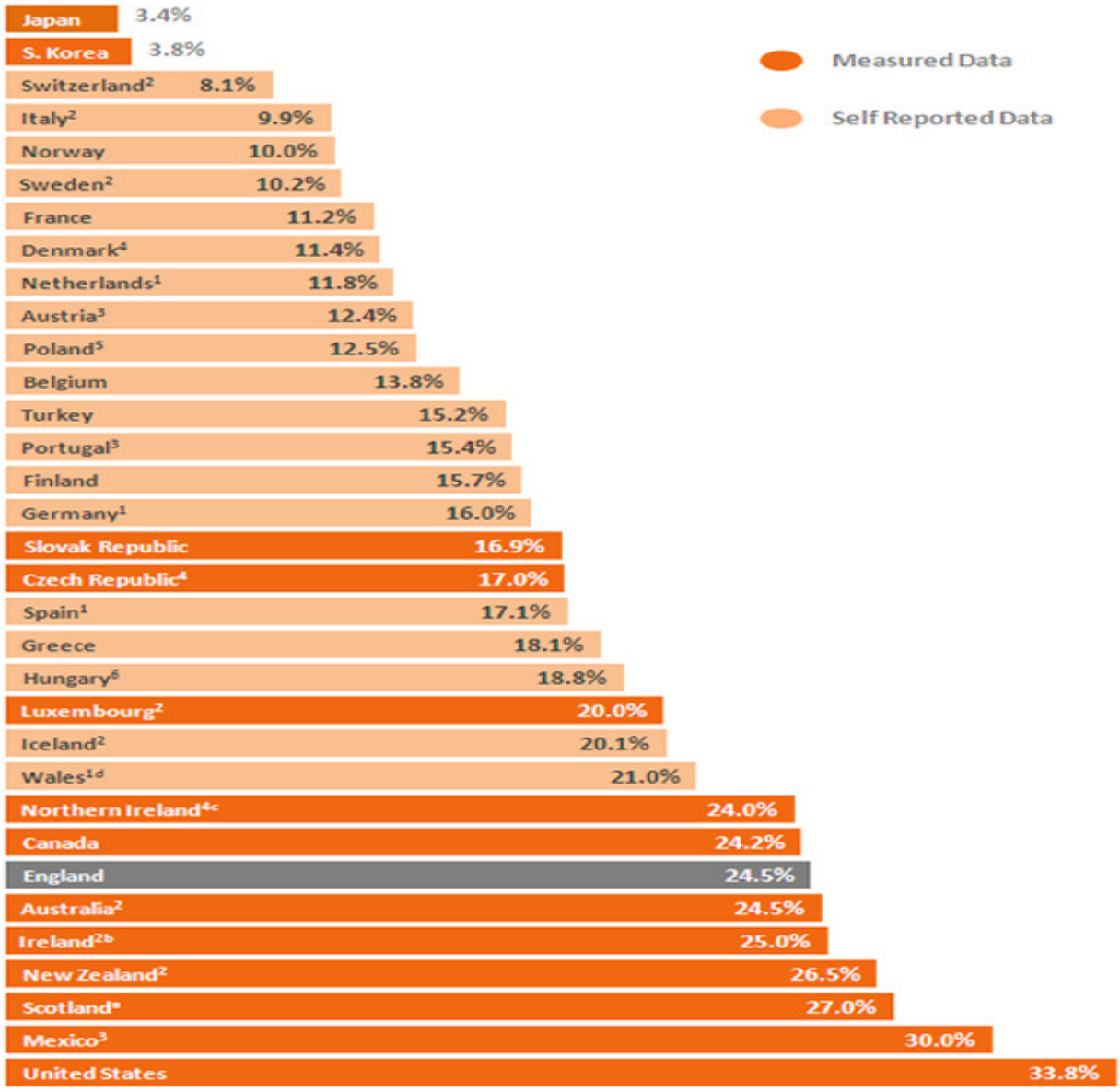


Source Foresight – Tackling Obesities: Future Choices – Project Report

Page 24. Lobstein, T and Jackson Leech, R 2007. *International Comparisons of Obesity Trends, Determinants and Responses*. Evidence Review[6].

1.2 The diagram below (Figure 2) also sets out the prevalence of obesity in a range of countries across the world.

Figure 2: Adult obesity prevalence, latest available data [7]



Source: National Obesity Observatory
http://www.noo.org.uk/uploads/doc/vid_9111_International_prevalence_adult_obesity_revised%20251110.xls
based on: Metadata for OECD Health Data 2008 can be found at: www.ecosante.org/oecd.htm Obese defined as BMI ≥ 30kg/m2. Source: OECD Health Data 2010 - Version: June 10

1.3 Obesity has been described as a "time-bomb", and it has the potential to severely affect the health and wellbeing of the population. It also impacts upon wider society

through the increased cost of health care (including increased pressure on the system) and lost productivity.

1.4 In fact, overweight and obesity are now so common among the world's population that they are beginning to replace malnutrition and infectious diseases as the most significant contributors to ill health. Maintaining a healthy weight, eating a balanced diet and keeping physically active can improve health and reduce the risk of diseases associated with being overweight, such as coronary heart disease, osteoporosis, type-two diabetes and certain cancers.

1.5 The obesity-related conditions outlined above can reduce life expectancy, impact on mental health, undermine quality of life, and impose huge burdens on families, carers and health services. Investing resources in preventing and addressing obesity should provide value for money, and if levels of obesity continue to rise unabated, it is very likely that the related costs will grow significantly over the next few decades.

1.6 It should be noted that throughout this report the term 'obesity' is used to refer to both those overweight and obese.

Defining overweight and obesity

1.7 Obesity is a condition where weight gain has got to the point that it poses a serious threat to health. Obesity is usually measured by Body Mass Index (BMI) and is defined as the weight in kilograms divided by the square of the height in metres (kg/m^2).

1.8 According to the World Health Organisation (WHO),[8] adults who have a BMI of 25-29.9 are classified as being pre-obese and those having a BMI over 30 are classified as obese. WHO states that there is also evidence that risk of chronic disease in populations increases progressively from a BMI of 21. For adults over 20 years old BMI is categorised as follows:

Table 1: BMI Status

BMI	Status
Below 18.5	Underweight
18.5 - 24.9	Healthy Weight
25.0 - 29.9	Pre-Obesity (referred to in this Framework as overweight)
30.0 - 34.9	Obesity Class One
35.0 - 39.9	Obesity Class Two
Above 40	Obesity Class Three

Source: World Health Organisation (WHO) : http://www.euro.who.int/en/what-we-do/health-topics/disease-prevention/nutrition/a-healthy-lifestyle/body-mass-index-bmi

1.9 However, BMI should only be considered as an approximate guide to categorising overweight and obesity for individuals. Differences in distribution of fat around the body, higher or lower than average amounts of muscle, and ethnic differences may mean that people with the same BMI have different levels of fat, and this may affect the associated health risks.

1.10 There have been some concerns about the validity of using BMI to measure obesity among individuals, and there are other potential measures such as waist circumference measurements. However, at the population level, BMI is generally accepted as a good measure of overweight and obesity, and it will therefore be used throughout this Framework.

1.11 The situation for children is much more complex because a child's BMI varies with age and gender. Whilst there is not a generally agreed definition of childhood obesity there are two widely used indicators;

- UK reference curves have been established based on a nationally representative sample of children. Children who exceed the 85th centile are considered to be overweight and those who exceed the 95th centile are classified as being obese.
- An international classification of overweight and obesity in children has been proposed to help calculate internationally comparable prevalence rates of overweight and obesity in children and adolescents. The definition interprets

overweight and obesity in terms of reference cut-off points for BMI by age and sex, in relation to a reference population based on pooled international data, and is linked to the adult overweight cut-off point of 25 kg/m^2 and the adult obesity cut-off point of 30 kg/m^2.

1.12 The levels of obesity in children and young people in Northern Ireland that have been included in this report have been determined using the International Classification.

Health Impacts

1.13 Epidemiological research has indicated that being obese can increase the risk of a range of health conditions including:

- heart disease and stroke;
- type II diabetes;
- some cancers, including post menopausal breast cancer;
- hypertension;
- metabolic syndrome;
- gall bladder disease;
- osteoarthritis;
- sleep apnoea;
- breathing problems;
- liver dysfunction;
- mental health issues such as depression;
- lower back pain; and
- complications in pregnancy.

1.14 In addition, evidence indicates that being obese can reduce life expectancy by up to 9 years, and can affect emotional/psychological wellbeing and self-esteem. Globally it has been estimated that overweight and obesity is the fifth most significant risk factor for mortality and a significant risk factor for disease[9].

Obesity and Mental Health

1.15 Depression, anxiety and other forms of mental illness can be more common in obese individuals than in the general population. Obesity may trigger psychological issues such as eating disorders, distorted body image, and low self-esteem. Other mental health effects of obesity include social discrimination – people can often judge and mistreat those who are overweight. Depression may also lead to reduced physical activity and increased appetite including binge eating. Limitation in activity due to obesity or related chronic illnesses may also increase the risk of depression by reducing involvement in physically beneficial activities.

Obesity and Disabilities

1.16 The prevalence of both obesity and disability is increasing globally and there is growing evidence to suggest that these two health priorities might be linked. The impact of obesity on the four most prevalent disabling conditions in the UK (arthritis, mental health disorders, learning disabilities and back ailments) has been examined through data analysis of the 2001 Health Survey for England and UK Back Exercise and Manipulation trial data. Together these strongly suggest that whether the cause or result of disability, obesity is associated with disability, thus presenting a serious public health issue[10].

1.17 People with disabilities can find it more difficult to eat healthily, be more physically active and control their weight. This might be due to:

- a lack of healthy food choices;
- difficulty with chewing or swallowing food, or its taste or texture;
- Medications that can contribute to weight gain, weight loss, and changes in appetite;
- physical limitations that can reduce a person's ability to exercise, including pain;
- a lack of energy;
- a lack of accessible environments (for example, pavements, parks, and exercise equipment) that can enable exercise; and
- a lack of resources (for example, money, transportation, and social support from family, friends, neighbours, and community members).

1.18 It is therefore important that the specific needs of people with disabilities are considered when implementing programmes addressing overweight and obesity.

Obesity and young people

1.19 Obesity can affect a child's growth and development. Children and young people who are overweight or obese are also at increased risk of developing negative health factors that contribute to heart disease and include raised blood pressure, blood cholesterol and blood sugar. Obesity in childhood can also be linked to many other factors including social and psychological bullying, low self-esteem, and depression. In fact, the immediate consequence of being overweight, as perceived by children themselves, is social discrimination and low self-esteem. These can have a significant impact upon their future health and wellbeing, especially in relation to mental health.

1.20 A child who is overweight or obese is more likely to take this into adulthood. The health conditions associated with overweight and obesity will be carried into adulthood and increase the likelihood of developing disease where obesity is a contributing factor. Not only that, but it is likely that the manifestations of these diseases are more likely to occur at a younger age than if the adult did not have existing overweight or obesity issues. Adults who have been obese since childhood are at a greater risk of suffering weight-related ill health and have a higher risk of facing an early death than those who may have only become obese later in adulthood.

Obesity and pregnancy

1.21 The Centre for Maternal and Child Enquiries (CMACE)[11] identified obesity as a risk factor for maternal death in pregnancy and stated that almost one in five pregnant women in the UK are obese with complication rates amongst pregnant women being higher that amongst non-pregnant women.

1.22 Furthermore obesity during pregnancy can lead to increased chances of complications including:

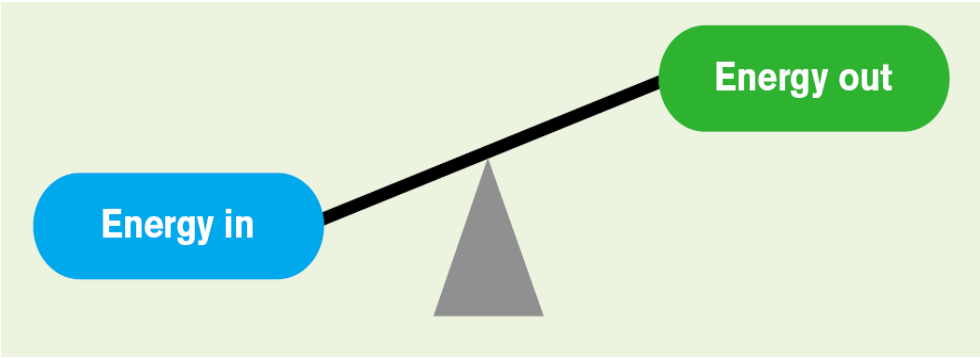
- miscarriage;
- fetal abnormality;

- blood pressure problems;
- diabetes;
- thrombosis;
- difficulty in delivery leading to higher caesarean rates; and
- infection following delivery.

Causes of Obesity

1.23 With the rise in obesity levels in recent years, more attention has been placed on assessing those factors that have led to this position. It is generally accepted that obesity occurs when an energy imbalance is created by an individual taking in more energy through the food and drink they consume than they expend (see Figure 3). The direct cause of obesity is, therefore, an energy imbalance. However, it does not take much to tip the balance. It has been estimated that an average adult whose daily energy intake is just 60 calories more than their energy output will become obese within ten years[12]. It is less clear, however, which factors contribute most to tipping the energy balance, and some have put forward the argument that certain individuals are genetically predisposed to put on weight more easily than others.

Figure 3: Energy Balance diagram (Energy Equation)



Source: Investing for Health Update 2004 - http://www.dhsspsni.gov.uk/ifh-update-2004.pdf[13]

1.24 In terms of energy intake, current diets contain greater amounts of fat and sugar than has historically been the case. Eating high fat, energy dense foods can create an overeating effect and contribute to obesity. It is also recognised that evolving eating patterns have a key role to play; for example, there is more snacking and greater dependence on processed and prepared foods.

1.25 In relation to energy use, many people today are less active than previous generations. The National Audit Office has previously estimated that the extra physical activity involved in daily living 50 years ago, compared with today was equivalent to running a marathon a week[14].

Obesogenic Environment

1.26 However, whilst understanding the nature of the 'energy balance', historically obesity prevalence rates were low and relatively unchanging until about 20–30 years ago. In countries where regular monitoring of population heights and weights have been in place for several decades, a fairly consistent upward trend has been seen in the prevalence of obesity from the early 1980s in children and adults.

1.27 Attention has therefore been drawn to what factors may have led to this rise, typically described as the 'obesity epidemic', and the impact of what is termed the 'obesogenic environment'. The 'obesogenic environment' relates to the influences that contribute towards obesity, such as our surroundings, opportunities or life conditions. These 'influences' include:

- Environment
- Planning
- Design
- Transport
- Physical Activity
- Food
- Policy
- Culture

1.28 Therefore, attention is drawn towards how the obesogenic environment has affected the levels and prevalence of obesity and this can be seen by again looking at the energy equation and looking at what changes have taken place over the past 20-30 years.

1.29 On the intake side of the energy equation (how much energy is consumed compared with how much is expended), there are several (not mutually exclusive) hypotheses to explain what might have changed in the past few decades:

- The energy density of food has increased, and this 'short-circuits' normal satiety mechanisms.
- Food, especially high in fat and sugar, is cheaper and more available, so people have more opportunity to eat, and this overcomes the normal balance of appetite and satiety.
- There has been an increase in the range and number of 'fast food' outlets. Food of this type is therefore more readily available for consumption instead of, or in addition to, meals cooked at home.
- Food has become more varied, so a wider range of flavours and sensory experiences is likely to lead to greater food intake. Furthermore, the sensory stimuli from salt and sugar contribute to the mechanisms that control appetite; in other words, they make food more palatable and therefore people eat more.
- People are eating more processed food and are eating out more, and hence are less aware of their nutrient intake. Processed food and food in restaurants may often have higher fat and sugar content than that prepared in the home.
- Processed food is often low in protein and it is thought that the body may regulate protein intake more precisely than fat and carbohydrate. In attempting to increase protein intake, excess carbohydrate and fat is taken in as a side effect. Protein is recognised to induce a greater sense of satiety than fat or carbohydrate, and therefore a diet low in protein may lead to a person consuming more in order to achieve satiety.
- Portion sizes have increased.

- Home life has changed, and there is some evidence that working parents/carers are less likely to cook more traditional, balanced meals. One reason for this is that many people, especially women, are under greater time constraints than they used to be. Additionally, there has been a loss of cooking skills.
- Energy-dense foods are heavily advertised and marketed, especially to children.

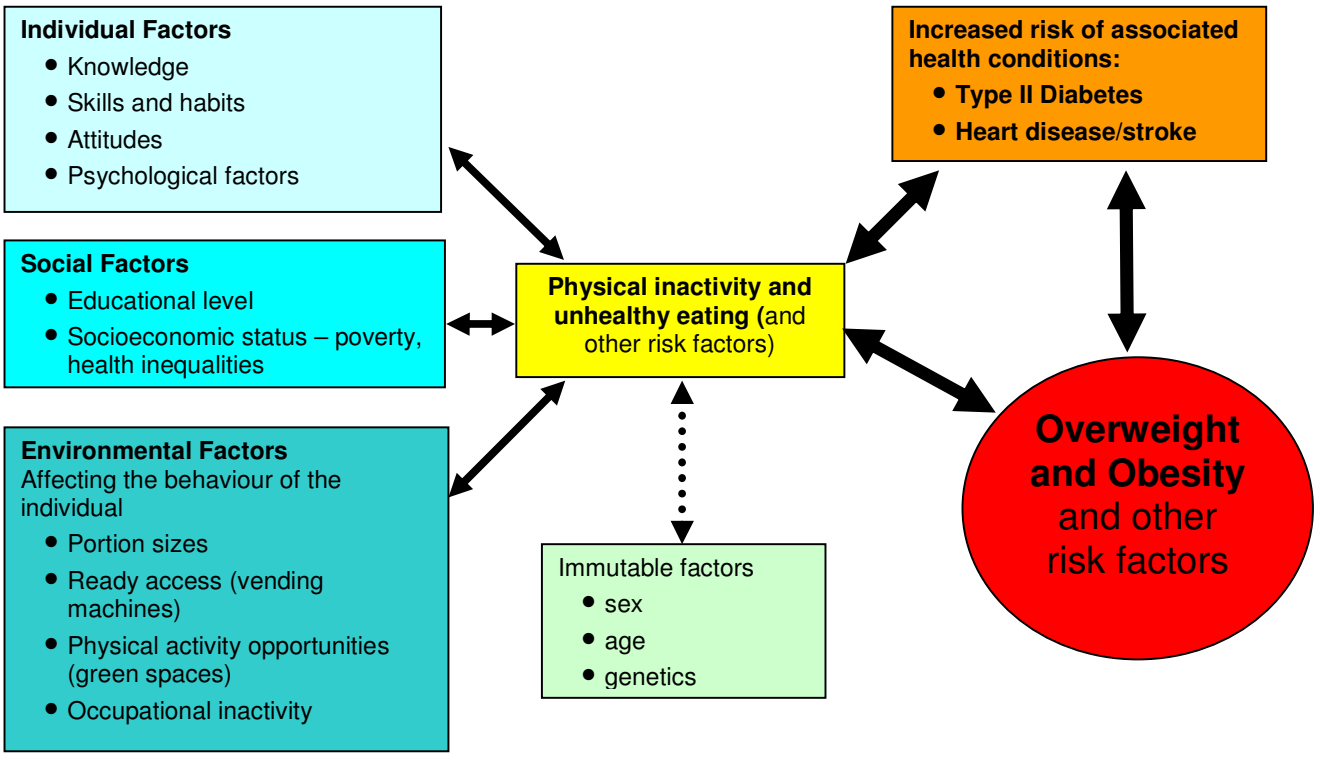
1.30 On the expenditure side of the equation there are similarly several factors that contribute to this 'obesogenic environment' - these are less conducive to energy expenditure:

- Patterns and modes of transport have changed, for example, from foot or bicycle to car or other forms of motorised transport. Many planning decisions have resulted in increased use of private vehicles and increased distances from homes to schools, shops, leisure facilities and workplaces, making it difficult to walk or cycle.
- Manual labour has largely been replaced by sedentary jobs and by mechanisation.
- Parental concerns about the safety of children have led to reductions in outdoor play and walking or cycling to school.
- Public and private buildings often include more lifts, moving walkways and escalators.
- Labour-saving devices in the home have reduced energy expenditure.
- Improved central heating encourages people to be less active in the home and may mean that people expend less energy keeping warm.
- Television, computers and other forms of sedentary entertainment have largely replaced active play among children and teenagers.

1.31 Therefore, while responsibility for consumption of food and physical activity lies with the individual, it also important to consider the responsibility of the statutory, private and community/voluntary sectors. The Government is also responsible for developing opportunities where people are empowered to make healthier decisions in relation to their food choices and their participation in physical activity.

1.32 The 'obesogenic environment' and the array of factors and 'influencers' within it provide the context for any integrated prevention approach. This has been at the heart of this Obesity Prevention Framework. The interrelatedness of all the factors associated with obesity is shown in Figure 4.

Figure 4: Interrelated factors associated with obesity.



Inequalities and obesity

1.33 Alongside the recognition that there are factors that are associated with both overweight and obesity, and the recent rise in their levels, has also come the acknowledgement that there are clear links between obesity and inequalities. Rates of obesity tend to rise in association with increasing social disadvantage in developed countries, although the pattern is considerably more marked among women than men. For example, in women rates of overweight and obesity in England show a consistent rise with increasing social disadvantage, from 19% in the 'managerial and professional' group to 29% in the 'routine and semi-routine' group. For men, the differences in the rates of obesity between different groups are less marked[15].

1.34 Those with lower socio-economic status tend to have lower participation in formal leisure-time physical activity. Nevertheless, on average, people in these groups engage in more domestic and work-related physical activity, and in childhood they are more physically active in everyday activities such as walking to school and unstructured play, so that total physical activity levels may differ less across social groups. Barriers which prevent these individuals from making healthier choices include:

- low income and debt;
- inaccessibility of affordable, healthy foods;
- time restrictions;
- limited education, skills or information;
- combined poor urban environments, limited safe play facilities and a lack of community safety; and
- sedentary lifestyle.

1.35 This has an obvious resonance with the whole issue of health inequalities and the social determinants of health and wellbeing, and the recent Marmot report[16] refocused attention on this issue. The Northern Ireland Public Health Strategy, Investing for Health[17], also places particular emphasis on addressing health inequalities. Therefore, this is recognised and acknowledged in this Obesity Prevention Framework. The Framework also reinforces the importance of understanding the interrelatedness, not only of the issues impacting on and involved with obesity, but of those policies and strategies which affects those issues.

Importance of the built environment and food environment

1.36 Within the 'obesogenic environment' specific reference is made to the impact and importance of the built environment. There is also an argument that there is a particular relationship between the built environment and health inequalities. In respect of obesity it has been argued that[18]:

- Physical activity through the presence of green space not only reduces the risk of heart disease (by up to 50%), but also has a positive impact on stress, obesity and a general sense of wellbeing. It also cuts the risk of premature death (by 20-30%).
- Green spaces link directly to levels of physical activity. Children with more green space are less likely to be over-weight. Children in greener neighbourhoods have lower Body Mass Index.
- 'Walkable' neighbourhoods help because they are by definition more compact and traffic tamed. Many walkable destinations such as shops, schools etc encourage exercise through cycle routes, parks, and foot paths which are a prerequisite for 'active travel' and healthier life styles.

1.37 This therefore highlights the importance of urban design and planning in delivering green infrastructure, play areas and active travel routes. This is an issue which any Obesity Prevention Framework should address.

1.38 It is also important to consider how food production and the whole "food environment" impacts on our society. This covers issues such as production, distribution, marketing, advertising, sales, catering, restaurants, supermarkets, etc. and these have all changed the food landscape dramatically in recent years.

Challenges, opportunities, leadership and responsibilities

1.39 Individuals have a key responsibility to be engaged in, and take control of, their own health and well-being and lifestyle behaviours. However, while individuals have responsibility for their own actions and choices, there are powerful constraints on choice, imposed by the environment in which people live.

1.40 Because of the many factors and influences involved in the 'obesogenic environment', there is no single 'magic bullet' to reduce obesity, and effective strategies are likely to incorporate many small changes implemented over a long time period by many stakeholders. Clearly many parties need to take some responsibility for responding in a coordinated manner to the problem of obesity and to support individuals to

overcome barriers and constraints and make healthier choices. These include central and local Government, institutions such as schools and employers, charities and the community/voluntary sector, the private sector, as well as families and individual citizens.

1.41 The interactions between individuals and their environment are such that the Government increasingly acts as a facilitator of choices. For example, urban planning policies may encourage or discourage walking or cycling, and regulations imposed on food and drinks industries might influence the availability of foods with different nutritional profiles. However, while Government policies establish the 'playing field', it is argued that the responsibilities of the food and drink industries involved in producing, marketing and selling products should go further than simply complying with mandatory regulations.

1.42 Therefore, Government (and in the case of this Framework DHSSPS and the Health and Social Care Sector) should take a leadership role in co-ordinating action and taking this work forward**,** and where appropriate acting as champions.

CHAPTER 2 – OBESITY IN NORTHERN IRELAND

Introduction

2.1 As set out in Chapter 1, the World Health Organisation (WHO) has defined overweight and obesity as "abnormal or excessive fat accumulation that presents a risk to health". The WHO uses Body Mass Index (BMI) as an indicator of population overweight and obesity. BMI is calculated as a person's weight (in kilograms) divided by the square of his or her height (in metres).

Adults

2.2 Height and weight measurements were collected through the Northern Ireland Health and Social Wellbeing Survey in 2005/06. To allow for comparisons, the Health and Social Wellbeing Survey (HSWB) results are routinely presented using the International approach. It should be noted that the Health and Social Wellbeing Survey (HSWB) has now been replaced with the new Health Survey for Northern Ireland, which will report on an annual basis.

2.3 The 2005/06 HSWB found that overall 59% of all adults (aged 16 years and over) measured were either overweight (35%) or obese (24%). A similar proportion of men (25%) and women (23%) were identified as having a BMI of 30 or over and therefore classified as obese. Relevant figures are set out by age and gender in the graphs below.

Figure 5

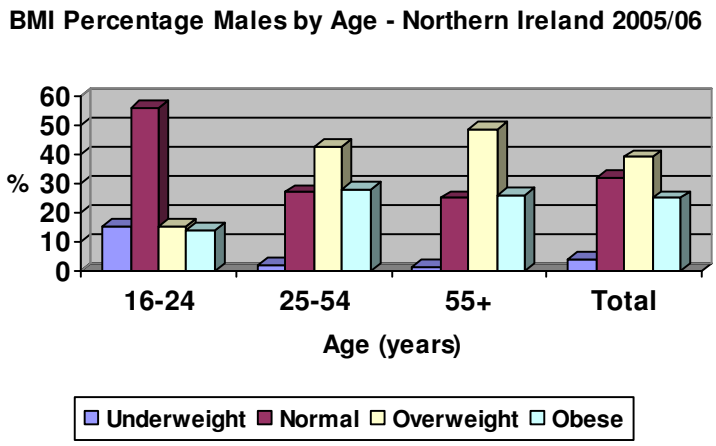
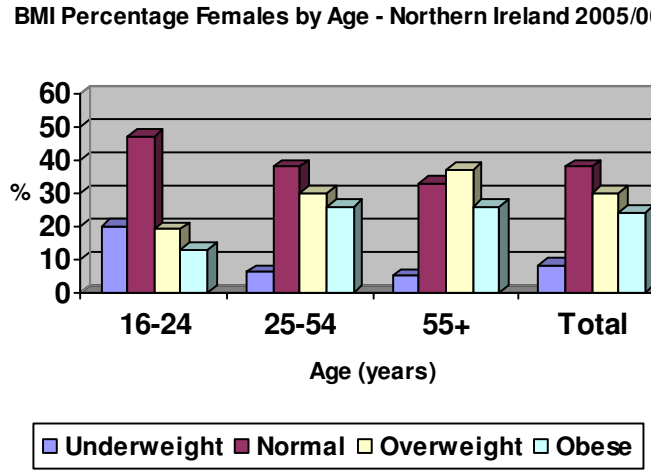


Figure 6



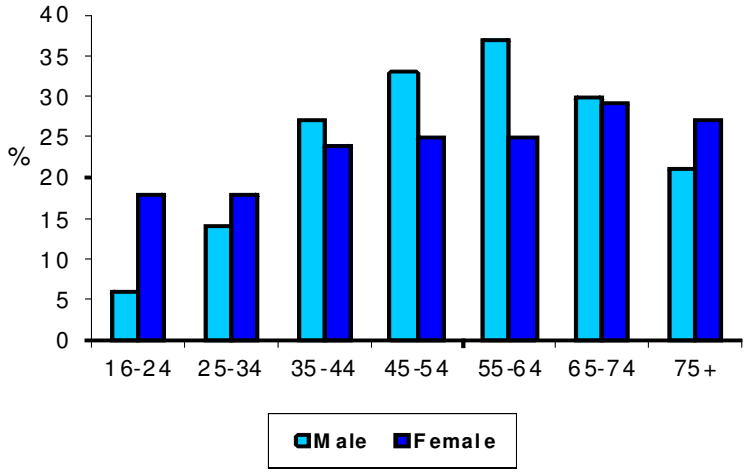
NB: the above figures are survey estimates and are therefore subject to confidence intervals

Source: Information & Analysis Directorate - Northern Ireland Health and Social Wellbeing Survey 2005/06

2.4 The new Health Survey for Northern Ireland 2010/11, which has led on from the HSWB, released its first report in November 2011[19]. This showed that overall, 59% of adults measured were either overweight (36%) or obese (23%). A similar proportion of males and females were obese (23%) however males were more likely to be overweight (44%) than females (30%). These figures are broadly in line with the last survey results.

2.5 Obesity was more prominent amongst the middle and older age-groups than the younger age-groups. A quarter of those aged 35-44 were classified as obese and around 30% of those in the 45-54, 55-64 and 65-74 age-groups were obese compared with 12% of 16-24 year olds and 16% of 25-34 year olds

Figure 7: Obesity levels by age and sex



Health Survey for Northern Ireland 2010/2011

Further Breakdown

2.6 Through analysis of the 2005/06 HSWB Survey, it was also possible to look at overweight and obesity rates broken down by several different population groups. It should be noted that these figures were subject to confidence intervals. Unfortunately, it is not possible to breakdown these figures by dependants, sexual orientation or political opinion; a race breakdown is possible, but not feasible as 99.4% of survey respondents are of 'white' ethnic background.

2.7 In the 2005/06 HSWB survey there was no significant difference in levels of obesity between various religious groups (Catholic 26%, Protestant 23%, Other 18%, None/refused/missing 24%). In terms of marital status, those who were single were

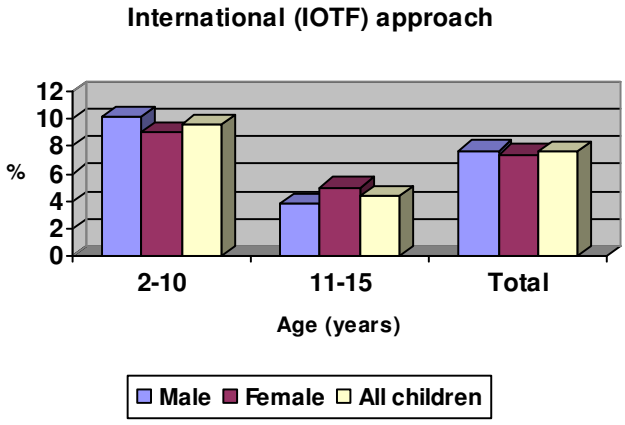
less likely to be obese (17%) compared to those who are married (27%), separated (30%), divorced (31%) or widowed (28%).

2.8 Those who had a long standing illness, disability or infirmity had higher rates of obesity (33%) than those who did not (19%), however levels of overweight were similar (36% compared to 34%). This meant this group may need to be targeted within the various outcomes.

Children

2.9 The HSWB Survey 2005/06 also collected height and weight measurements for children aged 2-15 years. This survey indicated that using the International Approach 8% of these children were recorded as obese (8% of boys and 7% of girls). Relevant figures are set out by age and gender in the graph below.

Figure 8: Percentage of Northern Ireland children



NB: the above figures are survey estimates and are therefore subject to confidence intervals

Source: Information & Analysis Directorate - Northern Ireland Health and Social Wellbeing Survey 2005/06

2.10 The Health Survey for Northern Ireland 2010/11 reported that, using the guidelines put forward by the International Obesity Task Force, 8% of children were assessed as obese, with similar results for boys (8%) and girls (9%). Around a quarter (27%) was assessed as either overweight or obese.

2.11 Information on the weight and height of children is also collected through the Child Health System. This indicated that in 1997/98, based on measurements carried out during the primary one health appraisal approximately 4% of children aged around 5 were found to be obese with 17% classified as being overweight or obese. In 2008/2009, more than 5% of children were obese with 22.5% classified as being overweight or obese. Using the data it had been projected that without significant intervention just over 7% of children aged around five will be obese and almost 27% would be overweight or obese by 2010.

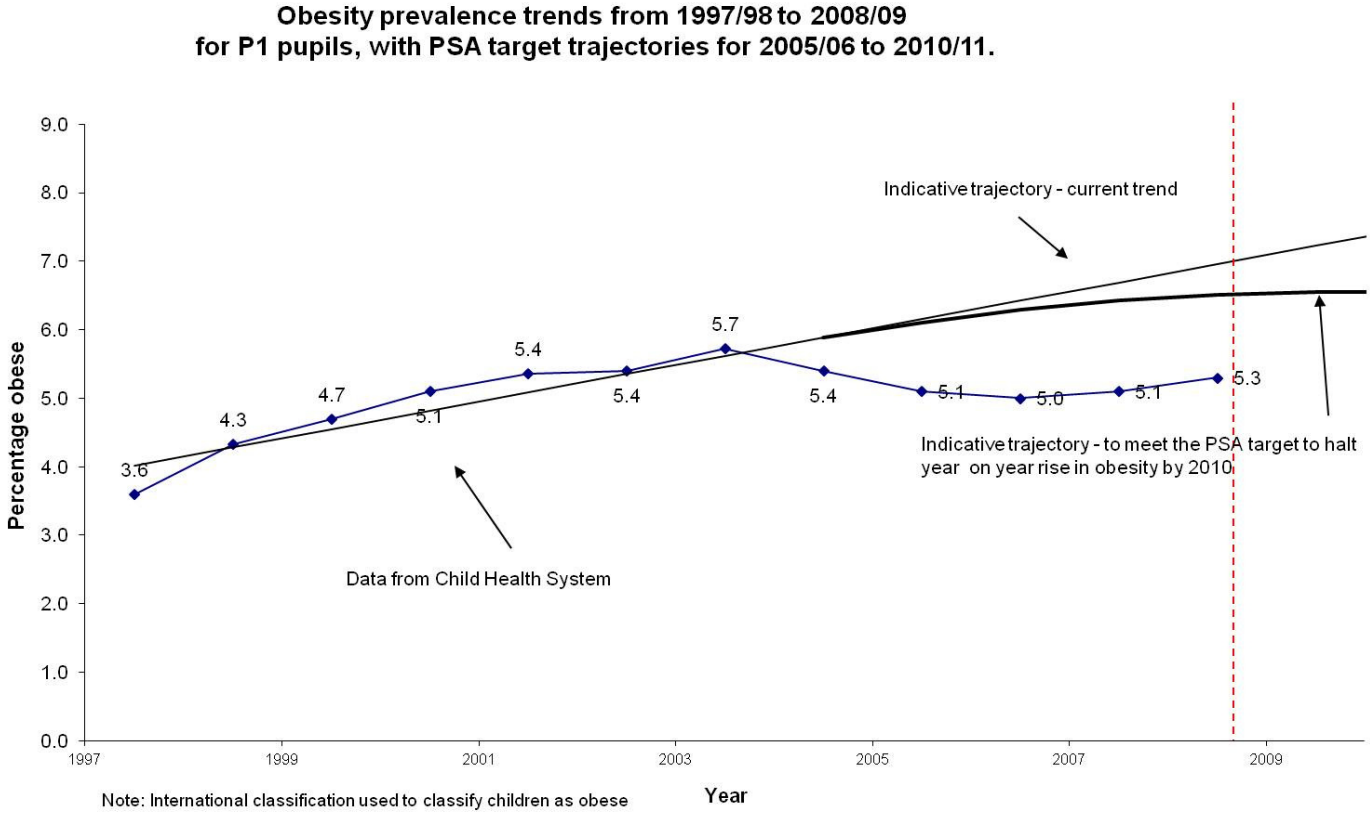
2.12 The following table (Table 2) shows that the number of children considered overweight has actually not shown the expected growth to date. The rate of children aged around five considered overweight has remained steady at around 16%. Obesity prevalence has also shown this trend with the percentage of children aged around five considered obese remaining around 5%.

All	**2003-04**	**2004-05**	**2005-06**	**2006-07**	**2007-08**	**2008-09**
Overweight	16.9%	16.2%	15.4%	16.7%	15.7%	17.2%
Obese	5.7%	5.4%	5.1%	5.0%	5.1%	5.3%
Overweight & Obese	22.6%	21.6%	20.5%	21.7%	20.7%	22.5%
Boys						
Overweight	14.7%	14.3%	13.0%	14.5%	13.7%	15.0%
Obese	4.5%	4.7%	4.5%	4.7%	4.4%	4.5%
Overweight & Obese	19.2%	19.0%	17.5%	19.2%	18.1%	19.5%
Girls						
Overweight	19.2%	18.2%	17.9%	19.0%	17.7%	19.5%
Obese	6.9%	6.2%	5.8%	5.3%	5.7%	6.2%
Overweight & Obese	26.1%	24.4%	23.7%	24.3%	23.4%	25.6%

Project Support Analysis Branch, DHSSPS
September 2011
Source: Health and Social Services Board (HSSB) Child Health System
Notes: Eligible children are those aged between 4.5 to 5.5 where data provided includes Body Mass Index (BMI), gender and age at examination.
IOTF - International Obesity Task Force
Categorised by IOTF range for Underweight (-1,-2,-3), Overweight (+1) and Obese (+2)

2.13 The following graph sets out the percentage of children in Northern Ireland aged 4 ½ to 5 ½ classified as either overweight or obese, using the international approach, from 1997-98 to 2008-09. The figures show that the 2004/05 upward trend has leveled out at around 5%.

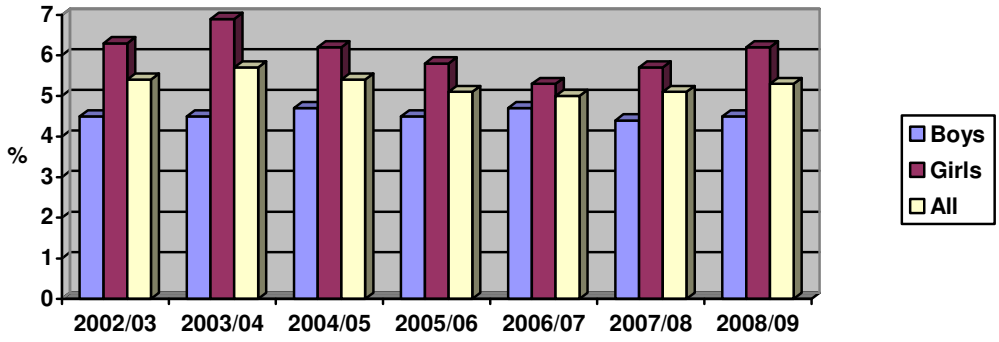
Figure 9



Note:
1. Data for 1997/98 to 2008/09 is from the Child Health System and data from 2005/6 to 2010/11 is a possible trajectory not based on the delivery plan, which is merely indicative of possible changes.
2. Trajectory is based on the assumption of a linear decrease in the year on year increase in obesity from the 1997/98 - 2004/05 trend.
3. Note that this data is subject to sampling errors.
4. Trends produced using the "weighted least squares" technique.
5. International classification used to define obesity levels in children of each age and sex

2.14 An annual breakdown of the Child Health System figures in percentage terms are included in the graph below:

Figure 10: Percentages of the prevalence of Obesity in Northern Ireland Children



Source: Information & Analysis Directorate: Child Health System

Mortality, Treatment and related diseases

2.15 Over the past few years only a very few individuals have died directly due to obesity (see table 3 below). However, when looked at in a wider perspective obesity can be linked to a number of other diseases such as Type II Diabetes, Circulatory deaths, Coronary Heart Disease, Strokes and a number of Cancers. It is thought that obesity has been a contributory factor in a number of these deaths which account for a much greater proportion of overall mortality. However it is difficult to assess how strong the link is with obesity and these deaths, as there is no official classification of obesity related deaths.

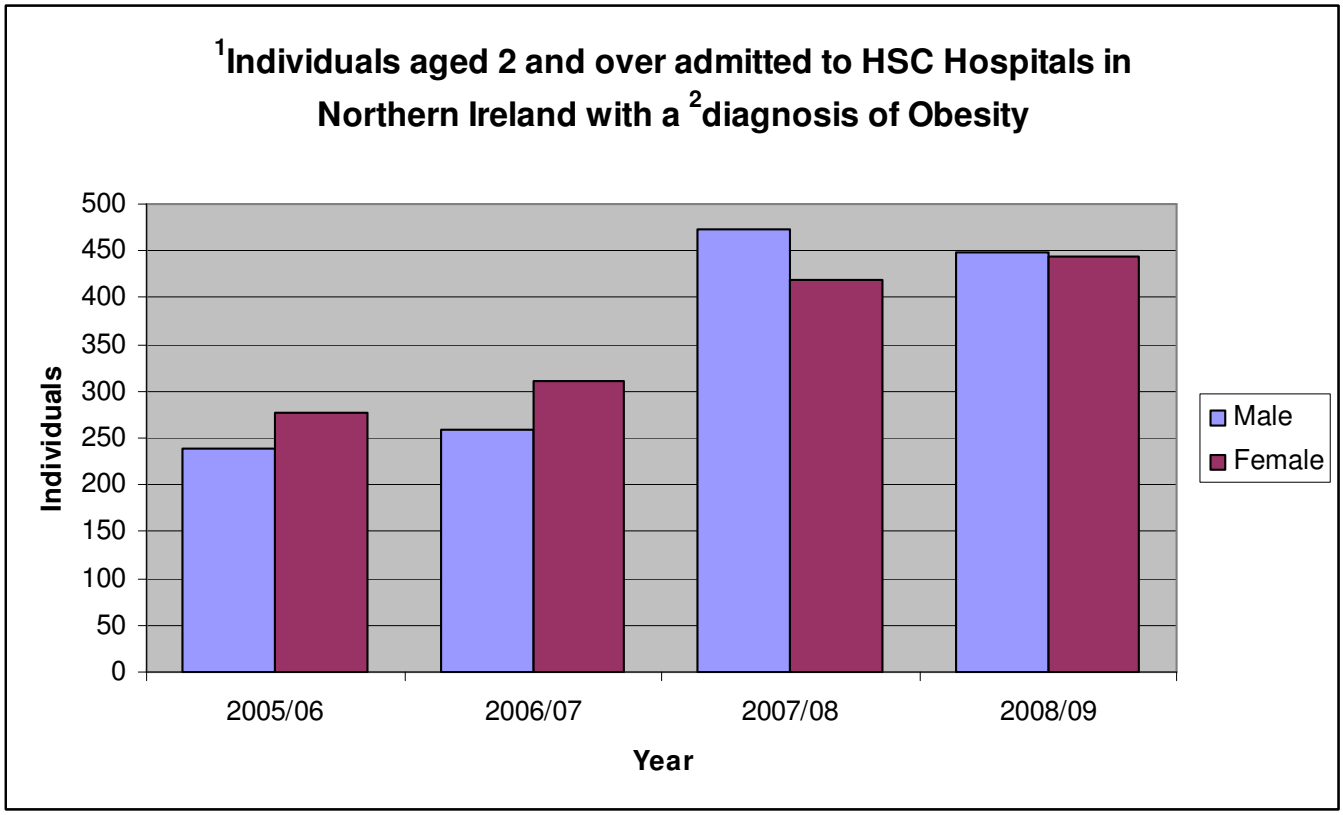
Table 3: Number of deaths related directly to obesity. Hospital Inpatient System

	2006	**2007**	**2008**
Male	6	2	2
Female	3	4	1
Total	9	6	3

2.16 The Hospital Inpatient System collects information on those admitted to Health and Social Care Hospitals in Northern Ireland with a diagnosis of obesity. From 2005/06,

we have seen a general upward trend in these figures from 600 admissions in 2005/06 to 973 in 2008/09. The following graph provides a gender breakdown of these figures.

Figure 11



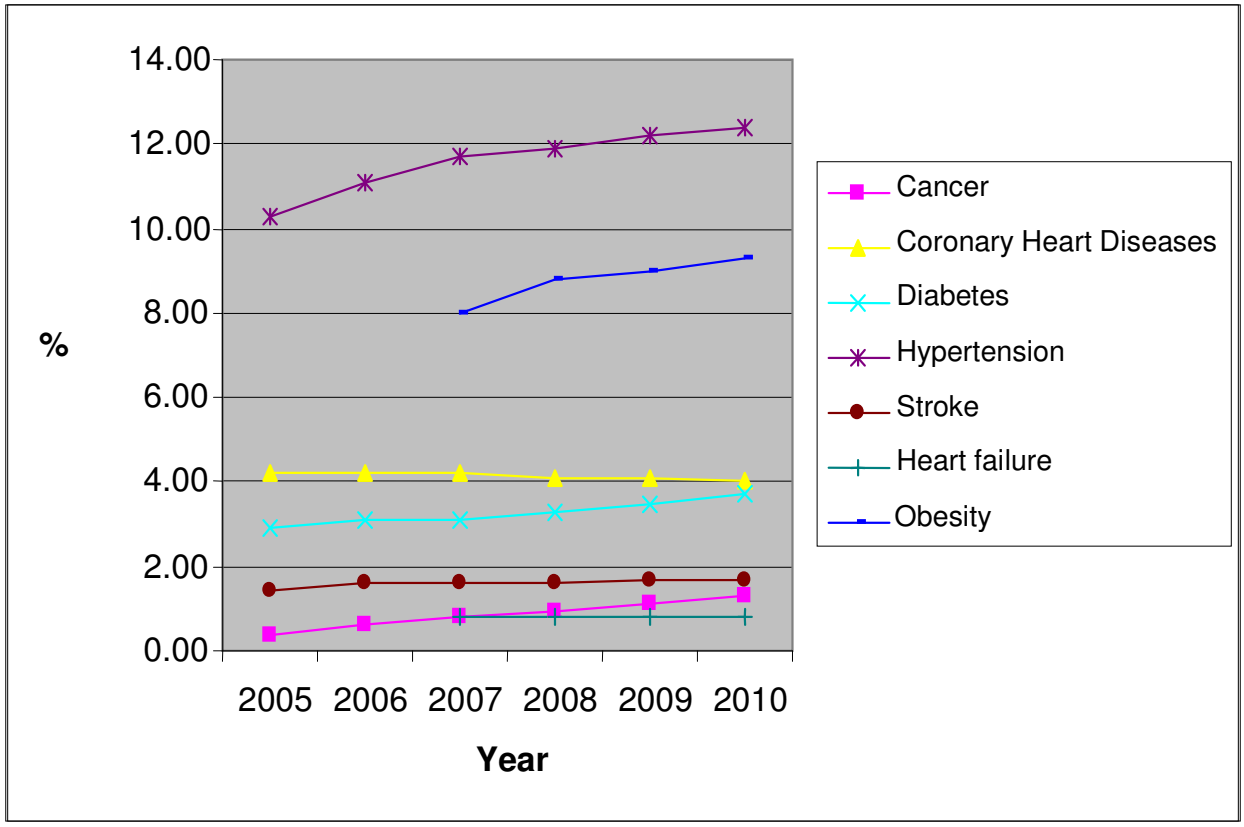
Source: Hospital Inpatient System

Note: [1]Individuals have been approximated by matching patient's date of birth, sex and postcode.

[2]International Classification of Diseases 10th Revision (ICD10) code E66 was used to identify Obesity. This code was searched for in any of the seven diagnostic fields in the Hospital Inpatient System.

2.17 There are also prevalence figures for certain diseases that can be related to obesity. These include some cancers, coronary heart disease, diabetes, hypertension, stroke and heart failure. In addition, levels of obesity can be taken from the same Quality and Outcomes Framework (QOF) Registers, and plotted beside the relevance of these diseases. The following graph shows the trends in these since 2005.

Figure 12: Trends in obesity related diseases.



Physical Activity and Food and Nutrition

Adults

2.18 The Northern Ireland Adult Sport and Physical Activity Survey 2010 (SAPAS) collected data on adult participation in sport and physical activity and range of other health and wellbeing factors including self reported BMI and general heath, consumption of fruit and vegetables, smoking behaviour and the level of perceived happiness. SAPAS is the largest and most comprehensive piece of research on sport and physical activity undertaken in Northern Ireland. It delivers a complete and very detailed picture of adults' physical activities across four life domains including home, work, active travel and sport and recreation. Key headline findings from SAPAS are:

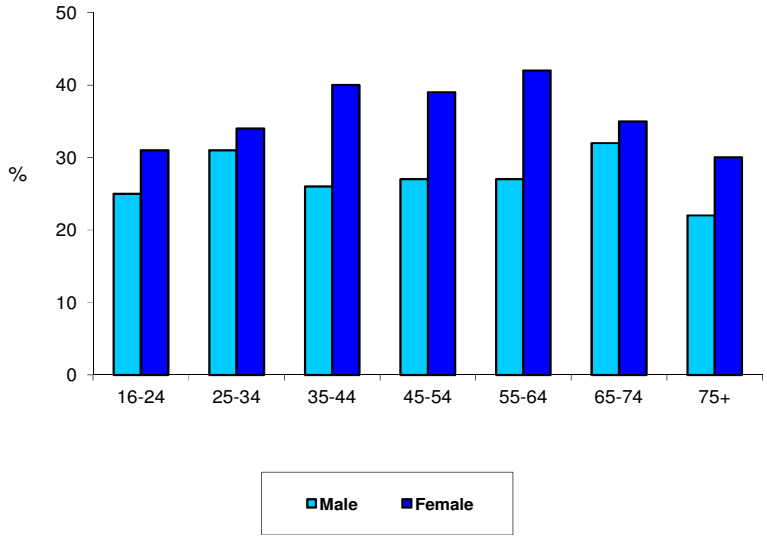
- 35% of respondents achieve the Chief Medical Officer's recommended level of physical activity;
- Most physical activity is done at home, followed by activities at work;
- The most important physical activities in the work domain are manual labour and walking about while at work. The work domain as a source of physical activity is especially relevant for men and people from lower social classes;
- The main physical activities in the home relate to housework, DIY and gardening. The contribution of the home domain to overall levels of physical activity is especially relevant for women and older people;
- There are no major differences regarding overall physical activity levels between social classes or by deprivation; and
- Physical activity is related to a healthy body mass index (BMI) and healthy eating behaviour.

2.19 The HSWB Survey 2005/06 collected information on the proportion of adults (aged 16 years and over) who eat on average five portions of fruit or vegetables per day. Just over a quarter (27%) of adults said they eat on average five portions of fruit or vegetables per day. Women were more likely to have eaten on average five portions of fruit or vegetables per day (31%) than men (22%). Respondents aged 55-64 (34%)

were more likely to eat five portions of fruit and vegetables per day than those aged 75 and above (18%) or 16-24 (20%) year olds.

2.20 The new Health Survey for Northern Ireland 2010/11 reported that whilst eighty-six percent of respondents said they were aware of the Department of Health advice to have at least 5 portions of fruit or vegetables each day, the proportion of respondents assessed as meeting this guideline was 33%, which is a higher percentage than the previous survey.

Figure 13. Respondents who consume 5 or more portions of fruit or vegetables each day by age and sex



Health Survey for Northern Ireland 2010/11

2.21 The HSWB Survey 2005/06 also collected information on the proportion of adults (aged 16 years and over) who take part in physical activity. Less than a third (30%) of all people take above the recommended level of physical activity of at least 30 minutes per day on 5 days a week. Men (33%) were more likely than women (28%) to have taken above the recommended level of physical activity. The highest proportion of

adults taking above the recommended level of physical activity was reported in the 25-34 age group (38%), falling to 13% in those aged 75 and over.

2.22 In addition, the 2005/06 survey indicated that 23% of all people aged 16 years and over could be classed as sedentary. That is, they have not performed any activity of at least a moderate level, lasting 20 minutes, on at least one occasion in the last 7 days. The elderly are considerably more likely to be sedentary, over three fifths (63%) of people aged 75 years and over were sedentary in comparison to only 10% of 16- 24 year olds.

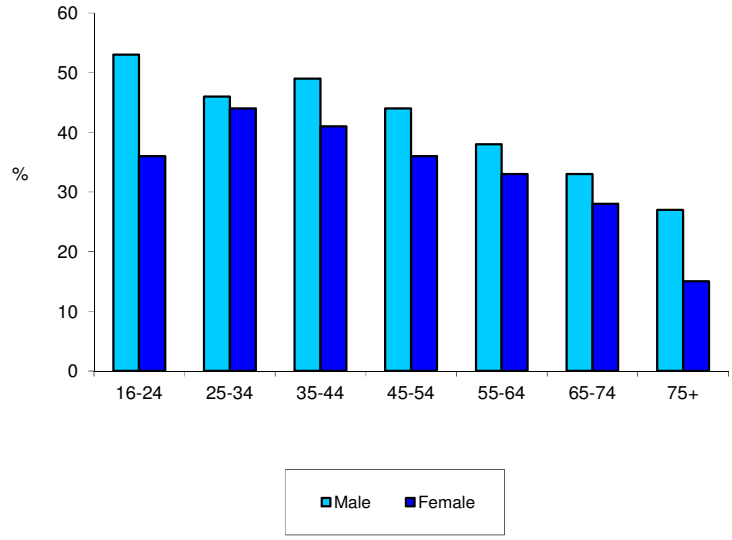
2.23 Furthermore the 2005/06 survey reported that over a quarter (29%) of men and approximately a third (33%) of women said they had an injury/disability/medical condition which limits their physical activity; however this did not necessarily stop them from taking above recommended levels. Less than a fifth (16%) of respondents who said they had an injury/disability/medical condition of this sort took above the recommended level of physical activity.

2.24 The new Health Survey for Northern Ireland 2010/11 reported that 38% of respondents were meeting the Chief Medical Officers recommended levels of physical activity, with males (44%) more likely to meet these levels than females (35%), which is an increase from the last survey results.

2.25 The proportion of respondents meeting the recommended level of physical activity varied by age, ranging from 19% amongst those aged 75 and over to 45% of those in the 25-34 age-group.

2.26 The Survey also reported that 25% of respondents can be classed as sedentary, 28% of females and 21% of males. The proportion of respondents classified as sedentary increased with age, from 14% amongst 16-24 year olds to 62% of those aged 75 and over.

Figure 14. Respondents meeting the recommended physical activity levels by age and sex



Health Survey for Northern Ireland 2010/2011

2.27 In July 2011, new guidelines on being physically active were published. The new guidelines are UK wide and have been endorsed by the Chief Medical Officers in each of the four countries. They are broadly consistent with the previous guidelines however they offer more flexibility in respect of the amount and type of physical activity people should aim to do[20].

Children

2.28 Further information obtained from the 2010 Young Persons' Behaviour and Attitudes Survey (YPBAS) provides nutritional information and physical activity data for children in Year 8 through to Year 12 broken down by gender, age and religion.

2.29 The survey shows that just 13% of the young people surveyed consumed five or more portions of fruit or vegetables each day. Just over half (54%) of pupils eat fruit and 44% eat vegetable and salads, at least once a day. 39% of all pupils interviewed for the survey said that they would like to see more healthy food available in school.

2.30 The 2007 survey noted that younger children, Form1/Year 8, were more likely to eat 5 or more portions of fruit and vegetables (22%) each day, and the prevalence generally goes down as age increases (16% in Form 2/Year 9, 13% in Form 3/Year 10, 14% in Form 4/Year 11, and 11% in Form 5/Year 12). With regard to community/religious background, similar proportions from the protestant (14%) and catholic (15%) communities ate five or more portions of fruit and vegetables per day compared to 21% of those who were affiliated with some other community/religious grouping.

2.31 Furthermore the 2010 YPBAS found that 90% had participated in physical activity in the week prior to the survey that made them out of breath or hot and sweaty. Almost half (48%) of these pupils did so for a total of at least 60 minutes each day for 4 or more days that week.

2.32 In the week prior to the survey, 27% of pupils spent more than 10 hours watching TV, videos or DVDs and the same proportion (27%) spent more than 10 hours playing computer or console games.

2.33 The 2007 survey found that those in Form 1/Year 8 (22%) and Form 2/Year 9 (18%) were more likely to undertake at least 60 minutes of activity every day. The survey also noted that generally this prevalence of taking at least 60 minutes of activity decreases as age increases (14% in Form 3/Year 10, 12% in Form 4/Year 11, and 8% in Form 5/Year 12). Taking part in physical activity is similar between religious/community groupings (84% in the protestant community, 84% in the catholic community, and 81% in the other grouping).

Cost of Obesity

2.34 The financial costs of obesity are high, and rising rapidly as the prevalence of obesity increases. Making precise or comprehensive estimates of the cost is difficult but as the following figures indicate it can amount to billions of pounds each year.

2.35 A House of Commons Health Committee Report (2003-04) estimated the cost of obesity at £3.7bn per year[21]. In addition, the Foresight Report on Obesity estimated that the NHS costs attributable to overweight and obesity are projected to double to

£10 billion per year by 2050, and the wider costs to society and business are estimated to reach £49.9 billion per year (at today's prices)[22].

2.36 The Northern Ireland Clinical Resource Efficiency Support Team (CREST) on managing obesity also estimated that just stopping the year-on-year increase in levels of obesity would save the Department £210 million over the next twenty years (June 2005). The recent Northern Ireland Audit Office report refers to a number of the consequences of obesity and diabetes. It reports that the treatment of those suffering from diabetes is reckoned to cost the health services across the UK around £1 million every hour[23].

CHAPTER 3 – MEETING THE CHALLENGE OF OBESITY - THE APPROACH SO FAR

Introduction

3.1 The impact on individual and societal health from overweight and obesity has been recognised for many years, although it currently has a much higher profile. In Northern Ireland, the importance of addressing the 'energy equation' has also been identified as significant. This Chapter describes the approaches that have been taken to address obesity in recent years.

Policy Background in Northern Ireland

3.2 The Northern Ireland Assembly's Programme for Government 2002-2005[24] identifies "working for a healthier people" as one of five overarching priorities, and Investing for Health (IfH) published in March 2002 sets out how these commitments are to be met. IfH outlines the approach to improving health and wellbeing, reducing health inequalities and provides a framework for action to achieve this commitment.

3.3 However, even before the publication of IfH, the Department of Health, Social Services and Public Safety (DHSSPS) recognised the relationship between a healthy diet, physical activity and good health, especially in respect of Coronary Heart Disease. For example, these issues were key elements in the "Change of Heart" programme that operated in the 1980s and 1990s. Subsequently work was undertaken to develop separate food and nutrition and physical activity action plans. However, more recently there has been a greater acceptance of the need to develop an integrated approach to obesity.

3.4 The Ministerial Group on Public Health (MGPH) became particularly concerned about the rising levels of obesity among children and young people in Northern Ireland. Therefore, in 2004 MGPH established the Fit Futures Taskforce to examine options for preventing overweight and obesity in children and young people, and to make recommendations for integrated, cross-Departmental action to the MGPH.

Development of Fit Futures

3.5 To take forward this work, the Fit Futures Taskforce initiated wide-ranging research and engagement. To develop the evidence base for the recommendations the research aspect included developing a local research and information baseline; reviewing international evidence; and looking at approaches in other countries. In addition, a number of consultation and engagement events were held with key stakeholders, including young people and their parents/carers. Literature and desk reviews were also commissioned which looked at the evidence base relating to prevention and good practice.

Summary of the Fit Futures Report

3.6 The final report of the Fit Futures Taskforce was published in 2006, and it identified over 70 recommendations for action. One of the key points made by the report was the recognition that, given the 'obesogenic environment', DHSSPS could not effectively address this issue on its own. It therefore contained a joint target, between DHSSPS, the Department of Education (DE), and the Department of Culture, Arts and Leisure (DCAL), "to halt the rise in obesity in children by 2010".

3.7 The key principles of Fit Futures are:

- providing leadership and leading by example;
- building on existing good practice;
- adopting an holistic and long-term approach;
- focussing on environmental and lifestyle factors;
- being positive and encouraging to help young people develop a sense of self esteem and self worth;
- adopting a population approach;
- reflecting the importance of early years and role of parents and carers;
- recognising schools fulfil a key role;
- recognising the importance of basic knowledge and skills in the community; and
- being evidence based.

Fit Futures Implementation Plan

3.8 Based on the responses to the Fit Futures report, an Implementation Plan was developed and published for consultation in February 2007[25]. This consultation process was used to inform further policy development on this issue. Following the consultation period consideration was given to the comments received and to the emerging policy environment.

3.9 Shortly after the publication of the implementation plan, strategic and policy developments in Northern Ireland and elsewhere reinforced the need to develop a whole population approach to the issues. However, the recommendations from Fit Futures remain central to this Framework.

Progress

3.10 Significant progress has been made by all key stakeholders in support of the delivery of Fit Futures, and the ongoing work on physical activity and food and nutrition. A range of initiatives has been undertaken and put in place at both the regional and local level which target various population groups and settings, including:

- the development of public information campaigns and supporting materials;
- delivery of relevant training and support;
- development of nutritional guidelines in key settings, particularly schools;
- community based initiatives on food and physical activity;
- the introduction of the curriculum sports programme for primary schools, which enables pupils to develop their physical literacy skills working with coaches from the GAA and IFA;
- support, advice and guidance for professionals;
- improved support in health care settings, including physical activity referrals;
- strengthened code of conduct for advertising high fat, sugar, or salt foods to children;
- improved evidence and research base; and
- work with industry, including progress on reformulation and improved labelling.

Obesity Policy Developments

3.11 As mentioned previously, tackling obesity is recognised as a particular problem across the developed world, and the influence and efficacy of the 'obesogenic environment' as a major factor in affecting obesity is now widely acknowledged. This has been reflected in a number of recent developments.

Europe

3.12 The European Charter on counteracting obesity was adopted at the WHO European Ministerial Conference on Counteracting Obesity at Istanbul, Turkey in November 2006[26]. The same conference looked at policy developments across a range of European countries. A paper by WHO Europe entitled *Nutrition, Physical Activity and Prevention of Obesity: Recent Policy Developments in the WHO European Region* – provides a very useful summary of these developments[27].

3.13 In addition, there have been various innovative approaches adopted across the world and these have been used to inform the development of this Framework, particularly those approaches that seem to be showing some effectiveness. In this respect particular attention has been paid to *Healthy Weight, Healthy Lives* in England[28]. *The Healthy Eating–Healthy Action/Oranga Kai–Oranga Pumau Strategy Framework* (HEHA Strategy) in New Zealand[29] and the French *EPODE*[30] - a "methodology designed to involve all relevant local stakeholders in an integrated and concrete prevention program aimed at facilitating the adoption of healthier lifestyles in the everyday life".

3.14 In the rest of the United Kingdom and the Republic of Ireland, there are strategies which have been taken forward in each region including:

- *Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight*;
- The Welsh draft document *Obesity Pathway*;
- *Obesity - The Policy Challenges*. The Report of the National Taskforce on Obesity 2005 from the Republic of Ireland; and
- *Healthy lives, healthy people: Our strategy for public health in England.*

Foresight

3.15 Foresight is the Westminster Government's science futures 'think tank' based in the Government Office for Science. The aim of the programme is to build on the scientific evidence base to provide challenging visions of the future to help inform government strategies, policies and priorities. In 2005, the Westminster Government commissioned Foresight to carry out a systematic review of obesity.

3.16 Foresight reported its findings *'Tackling Obesities: Future Choices' – Project Report* in October 2007[31] – and it has informed local policy development and the Department's decision to undertake a life course approach to preventing obesity. The UK wide project looked at how to respond to the prevalence of obesity in the UK over the next 40 years, and its key findings include:

- most adults in the UK are already overweight. Modern living ensures every generation is heavier than the last – `Passive Obesity';
- by 2050, 60% of men and 50% of women could be clinically obese, without action obesity-related diseases will cost an extra £45.5 billion per year;
- the obesity epidemic cannot be prevented by individual action alone and demands a societal approach;
- tackling obesity requires far greater change than anything tried so far, and at multiple levels; and
- preventing obesity is a societal challenge, similar to climate change – it therefore requires partnership between government, science, business and civil society.

Northern Ireland Health Committee Inquiry into Obesity

3.17 In January 2009, the Northern Ireland Assembly's Health Committee undertook an inquiry into obesity. The aims of the inquiry were to:

- assess the scope and appropriateness of the current approach to the prevention of obesity and the promotion of lifestyle change;
- examine the availability of weight management or other intervention services to tackle obesity related ill health; and,

- consider what further action is required, taking account, as appropriate, of the potential to learn from experience elsewhere.

3.18 The Health Committee's Report into Obesity, which contained 24 recommendations, was subsequently published in October 2009. The Inquiry has been a significant driver for ensuring that there is a focus within the Assembly on addressing obesity, with a particular emphasis on a cross-government and cross-sectoral approach to obesity prevention. The importance of the Inquiry has been acknowledged, and its timing has meant that its recommendations have been able to inform the development of this Framework. The report can be viewed on the Northern Ireland Assembly website at: http://archive.niassembly.gov.uk/health/2007mandate/reports/report10_09_10R_.htm

How Best to Tackle Obesity

3.19 The Foresight Report, with its emphasis on the 'obesogenic environment', clearly indicates that any approach which aims to prevent obesity has to be wide-ranging, multi-sectoral, long-term, and above all, integrated. It would also have to address the drivers of obesity, and one of the key challenges here is that many of the drivers are external to the individual. This highlights the difficulties involved in addressing obesity through targeting an individual's lifestyle.

Developing the Obesity Prevention Framework

3.20 The Department established the cross-sectoral Obesity Prevention Steering Group (OPSG) in 2008 to oversee and drive forward Fit Futures, and to begin the development of a life course Framework to tackle obesity in the rest of the population. The OPSG has a supporting structure of four Advisory Groups to look at specific issues relating to obesity and these cover: Physical Activity; Food and Nutrition; Prevention, Education and Public Information; and Data and Research.

3.21 In order to develop this Obesity Prevention Framework, the OPSG initiated a five-stage process based on the 'logic model' approach. This facilitated the discussion of the main issues; opportunities to consider examples and case studies of good

practice; identification of gaps in our knowledge, data and understanding; and to put in place a long term, outcome-focused strategic response.

3.22 Throughout the process a range of Government Departments and other key stakeholders including the community/voluntary sector, health and social care organisations, academics, etc. have been involved in the development and writing process. This has involved representation on the OPSG and related Advisory Groups, bi-lateral meetings, and specific stakeholder events to improve co-ordination, ensure buy-in, and to try to develop a range of “obesity champions” in various organisations.

CHAPTER 4 – PREVENTION FRAMEWORK

Introduction

4.1 As Chapter 3 highlighted, there is now a general acknowledgement that the optimum approach to overweight and obesity prevention is based on integration and co-ordination. WHO Europe in their 2006 European Charter has recognised this approach on counteracting obesity[32], which argued strongly that action against obesity should be linked to overall strategies to address non-communicable diseases and health improvement activities. It also called for a Framework that linked the main factors, policy tools and settings to translate principles into action. Therefore, the Department initiated and facilitated a five-stage process to enable this Obesity Prevention Framework to be developed. The focus of the development process was on producing an integrated approach to delivering a range of outcomes – in the short, medium and long-term.

Prevention

4.2 Overall, evidence suggests that the prevention of obesity is the most realistic, efficient and cost-effective approach for dealing with childhood and adult obesity. This is due to the relative lack of success of treating obesity once it has become established and because the health consequences of obesity are cumulative and not reversed completely with weight loss.

4.3 The World Health Organisation defines prevention as 'approaches and activities aimed at reducing the likelihood that a disease or disorder will affect an individual, interrupting or slowing the progress of the disorder or reducing disability'. Prevention has been described as working at three different levels:

- **Primary prevention** is targeted at reducing the likelihood of the development of a disease or disorder.
- **Secondary prevention** aims to interrupt, prevent or minimise the progress of a disease or disorder at an early stage.
- **Tertiary prevention** focuses on halting the progression of damage already done.

4.4 It could be argued that this typology doesn't always fit well with a complex, multifactorial condition such as obesity, and could be replaced by the following three types:

- **Universal/public health prevention** – directed at everyone in the community;
- **Selective prevention** – directed at high-risk individuals and groups; and
- **Targeted prevention** – directed at those with existing weight problems and those at high risk of diseases associated with overweight.

4.5 Using this approach enables us to show that, while the focus of this Framework is on the prevention of obesity in Northern Ireland, it clearly recognises the need for actions aimed at those who are already overweight and obese. The Framework sets out the outcomes we need to achieve this, as well as ensuring that all prevention messages are also targeted at this group.

Weight management

4.6 There are already significant numbers of obese people requiring treatment, and the numbers will rise regardless of any short-term measures. Many of these people will have co-morbidities and will be at risk of further weight gain over time. In Northern Ireland, there are specific services and guidance available on issues related to weight management, including the Northern Ireland CREST guidance[33] produced in 2005 and relevant NICE guidance[34]. Therefore, while the focus of this Framework is on prevention, it also recognises that there is a wide range of initiatives which cover a spectrum of activity in the prevention of weight gain, including weight loss and maintenance, and the management of weight-related risk factors.

4.7 Notwithstanding that, it is essential that there is a focus on, and promotion of, the positive outcomes of maintaining a healthy weight, rather than highlighting the negative consequences. This should ensure that living a healthy lifestyle is seen as the fun, positive and appealing alternative. Furthermore, the Framework promotes the balance of healthy nutrition and physical activity and empowers people to make healthy choices.

Approach

4.8 The obesity epidemic does not just affect children and young people. Therefore, any response must seek to prevent and address overweight and obesity across the entire life course. Focusing on one particular group or setting will not be enough. By taking a population wide, life course approach this Framework is clearly setting out that it is never too late or too early for an individual or a population group to undertake initiatives and activities to prevent obesity.

Overarching Aim

4.9 This Framework aims to:

- Empower the population of Northern Ireland to make healthy choices, reduce the risk of overweight and obesity related diseases and improve health and wellbeing by creating an environment that promotes a physically active lifestyle and a healthy diet.

Overarching Target

4.10 The following overarching targets will also be set in respect of this issue:

Adults

- To reduce the level of obesity by 4% and overweight and obesity by 3% by 2022.

Children

- A 3% reduction of obesity and 2% reduction of overweight and obesity by 2022 Baseline: Health Survey Northern Ireland 2010-11

4.11 The target is in two parts; the proportion that are obese and the proportion that are overweight and obese. This allows us to better show progress and movement between the two groups, and thus the actual success of the strategy.

4.12 As set out in Chapter 2, we have a limited dataset to describe changes in the prevalence of overweight and obesity in recent years. This makes it difficult to set a definitive target; however, it is important to set an overall target and ambition for the

Framework. Given this, we will revisit the target following further publication of the Northern Ireland Health Survey and we may revise the target after 3 years based on new information.

Objectives

4.13 As set out in this document, overweight and obesity are caused by a complex system of interlinked factors and dynamics. However, prevention is typically taken forward through action to address two main areas: diet and nutrition; and physical activity. Acknowledging this, two overarching objectives have been set for the Framework:

- increase the percentage of people eating a healthy, nutritionally balanced diet; and
- increase the percentage of people meeting the CMO guidelines on physical activity.

Principles and Values

4.14 The Framework has been developed within the context of a number of guiding principles and values. These are set out in the table below, and it is essential that these also underpin the Framework's implementation:

Principles & Values	**Description**
Shared Responsibility	Obesity is complex and multi-faceted. Effectively preventing this issue will require a coordinated approach, a shared responsibility, and commitment, across Departments, Sectors, Communities, and Individuals.
Integrated	To maximise the impact of any interventions, programmes or initiatives, they must take an integrated approach – particularly seeking to bring together the issues of healthy eating and physical activity.
Positive, Person Centred, Non-Judgmental and Empowering	Each person has individual circumstances, experiences and needs. By developing and delivering services that seek to extenuate the positive and are congruent, respectful and relevant to each person, people can be empowered to make healthier choices.

Equity and Inclusion	Each person has equal worth and rights regardless of differences in race, gender, age, ability, religious belief, political affiliation, cultural outlook, origin, sexual orientation, citizenship, nature, lifestyle, level of deprivation or geographical location.
Partnership and Working Together	Effective partnership has a greater potential to impact on the complex area of obesity rather than fragmented actions carried on in isolation. This Framework will seek to ensure joint action at every level of implementation.
Evaluation, Evidence and Good Practice Based	A commitment to taking action informed by evidence about what the problems are, 'what works', and by information on cost-effectiveness. The Framework will also seek to improve the evidence base by ensuring that appropriate evaluations are undertaken.
Consultation, Engagement, and Transparency	Support for, and commitment to, continued consultation, engagement and communication with key stakeholders at every level.
Long-Term Focus	There is no simple or immediate solution to the complex issues of overweight and obesity. A sustained, long-term strategic approach, with measured shorter-term milestones, must therefore be taken.
Value for Money	Work must be taken forward in a way that maximises impacts and their cost-effectiveness.
Addressing Local Need	Local needs should be identified and the appropriate resources effectively used by local stakeholders and organisations. Any local action must take into consideration with plans already developed.
Built on Existing Work	It is recognised that there is much good work already underway, particular in relation to Fit Futures. This Framework and its implementation, should seek to build on this good work where possible.

Social Determinants of Health

4.15 In Chapter 1, the issue of obesity and inequality was raised, as were the social determinants of health and wellbeing. Discussion of the causes of obesity, and the nature of the 'obesogenic environment', has led to a closer focus on those societal changes or factors which have encouraged populations to be inactive and to

increase their food intake. Our everyday behaviours that are strongly related to health, such as eating and being active, are intricate parts of our socio-cultural behaviours and our collective environment, but quite how these factors inter-relate remains unclear.

4.16 Deprivation is also a key determinant in health and obesity status. In developed countries studies have reported that body size and place of residence are related. A study in Glasgow reported increasing average BMI in four neighbourhoods with rising levels of deprivation[35]. Also in Glasgow, individuals living in more deprived areas had greater exposure to out of home eating outlets in their neighbourhood. Low levels of neighbourhood disorder and the presence of high street facilities has been found to be associated with lower levels of obesity.

4.17 However, as the study reported, the socio-cultural impact of our lifestyle on energy balance and obesity stretches beyond social networks, deprivation and neighbourhoods. It is a complex web of related behaviours that merits further exploration.

Behaviour Change

4.18 One of the key challenges in overweight and obesity prevention is in bringing about a behaviour change in individuals. While mass media and other population-based campaigns can increase knowledge and raise awareness, the actual attitudinal and associated behavioural change is often far more difficult to achieve.

4.19 It is argued that one way the Government can influence behaviour is through regulation and legislation. However there is an increasing acknowledgement of the need to take a different approach as well, one that actually looks at changing behaviours, A paper published by the Cabinet Office (*Applying Behaviour Insight to Health*) [36] sets out that,

> *"The Government can influence people's behaviour in a number of different ways. Tough laws could be implemented, with fines for those who fail to comply with new legislation, and bans could be introduced that prevent*

people from eating certain types of food or engaging in particular types of activities.

But, as this paper shows, there are many options between bans and doing nothing – the false choice implied by some commentators. We can give citizens more or better information. We can prompt people to make choices that are in line with their underlying motivations. And we can help to encourage social norms around healthier behaviours…" (Page 4)

4.20 *Applying Behavioural Insight to Health* is built upon a previous report, *Mindspace* [37] influencing behaviour through public policy, and it sets out the key elements of the Mindspace approach, which are:

Mindspace	
Messenger	We are heavily influenced by who communicates information
Incentives	Our responses to incentives are shaped by predictable mental shortcuts such as strongly avoiding losses
Norms	We are strongly influenced by what others do
Defaults	We 'go with the flow' of pre-set options
Salience	Our attention is drawn to what is novel and seems relevant to us
Priming	Our acts are often influenced by sub- conscious cues
Affect	Our emotional associations can powerfully shape our actions
Commitment	We seek to be consistent with our public promises, and reciprocate acts
Ego	We act in ways that make us feel better about ourselves

4.21 It is also acknowledged that face-to-face work with individuals who are already overweight/obese is also a way to achieve behavioural change, and it is anticipated that a wide range of approaches to behavioural change will be reflected in the implementation plan developed to achieve the outcomes which follow in the next section.

Focus on Outcomes

4.22 Chapter 5 sets out a range of short, medium, and long-term outcomes that key stakeholders are seeking to deliver in relation to obesity. Outcomes are the changes, benefits or other effects that happen as a result of an organisation's activities. Adopting an outcome approach means planning and managing the work so as to bring about particular results.

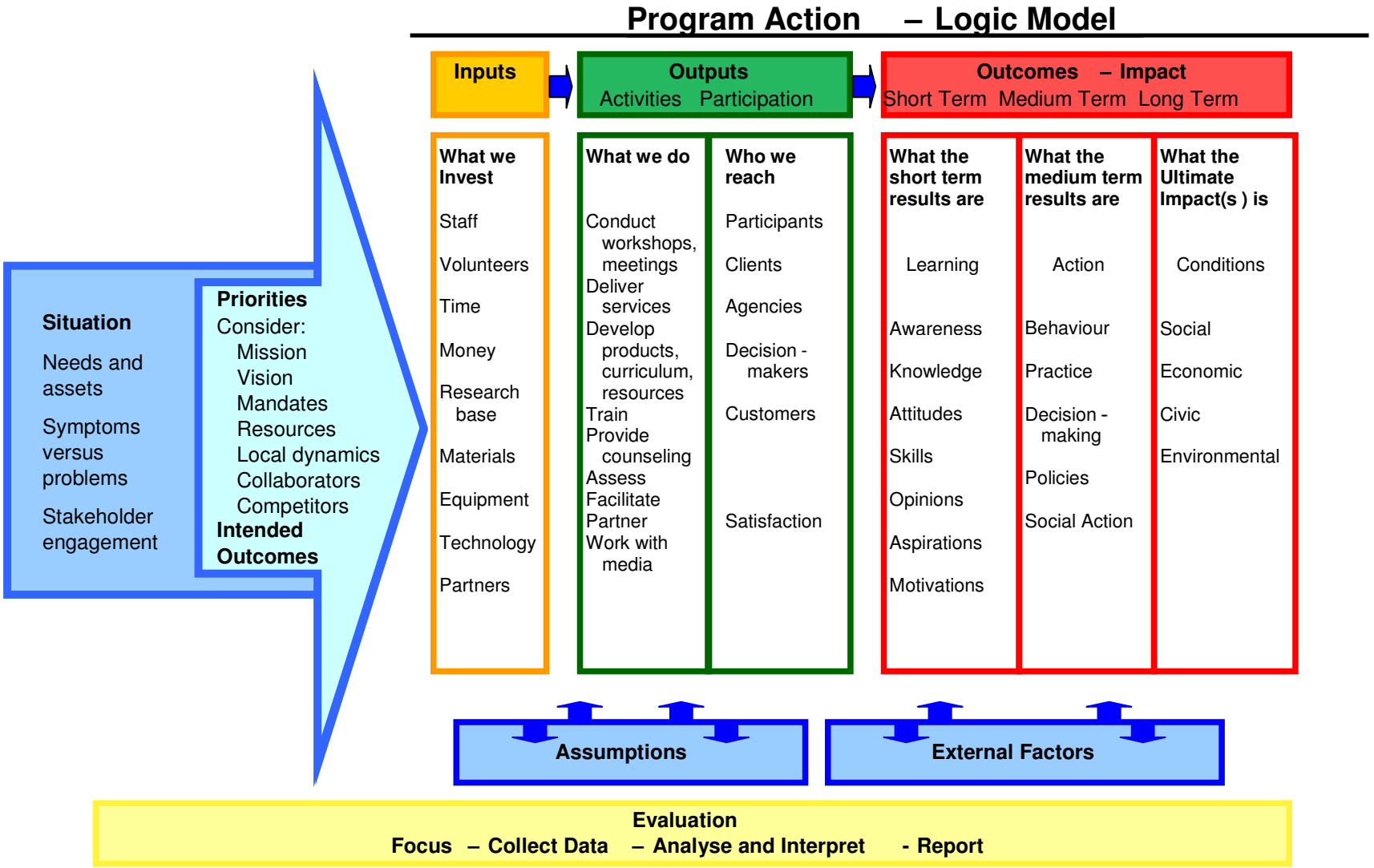
4.23 By taking an outcome approach, the focus is on the achievements that can be made over the next ten years, and the benefits that could be realised by our society. In Chapter 5, the outcomes are set out by the timeframe in which they should be delivered:

- Short-term Outcomes: 2012-2015
- Medium-term Outcomes: 2016-2019
- Long-term Outcomes: 2020-2022

The Logic Model

4.24 The outcomes being taken forward though this Framework have been developed and are set out using the logic model approach. A logic model is a systematic way of presenting the major components of a program or strategy, including planning, management, and evaluation. A logic model is a diagram, and accompanying narrative, that describes the key causal relationships among program elements and the problem to be solved. It draws a direct relationship between the activities that are undertaken with the long-term impacts that are to be achieved and helps gain clarity on "what we do" versus what is trying to be achieved. This is described in Figure 15.

Figure 15: Logic Model Example.

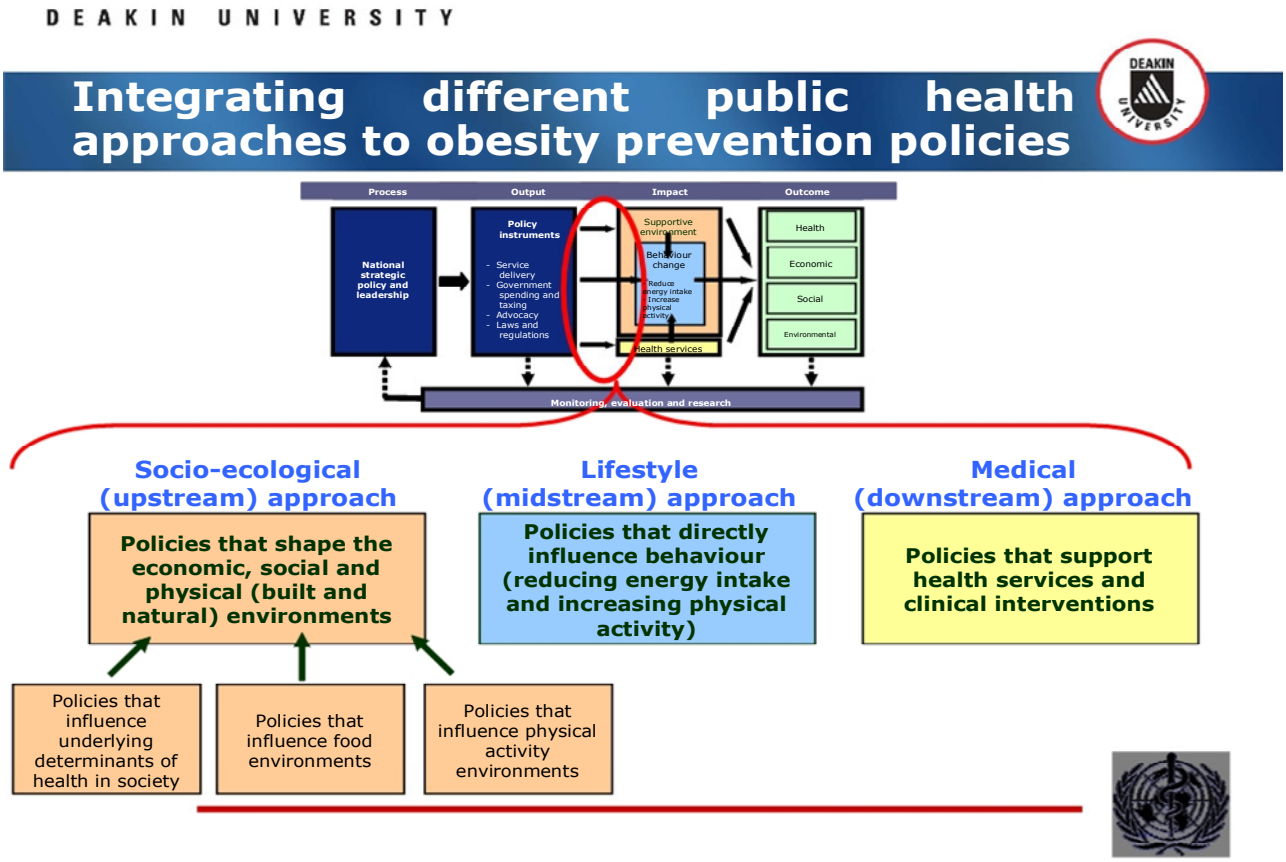


Source: Taylor-Powell, E., Henert, E. (2008) Developing a Logic Model: Teaching and Training Guide. Retrieved April 2010 from, University of Wisconsin-Extension-Cooperative Extension, Program Development and Evaluation Unit Web site: https://sites.aces.edu/group/commhort/vegetable/Vegetable/logic_model_uwex.pdf

Cross-Sectoral Action to Address the Obesogenic Environment

4.25 The wide range of research, reports and policies set out in Chapter 3; highlight the need for a cross-Departmental, cross-sectoral, integrated approach to this issue. The Foresight Report commented extensively on the 'obesogenic environment', and highlighted the fact that many of the upstream issues relating to prevention were outside of the health sector's responsibility and possible influence. One particular feature of the 'obesogenic environment' is that a number of sectors and Government Departments affect obesity through their own policies and strategies. This relationship is usefully demonstrated in Figure 16.

Figure 16



Source: http://onlinelibrary.wiley.com/doi/10.1111/j.1467-789X.2008.00524.x/pdf[38]

4.26 One example of this synergy and inter-relatedness between different policies is how a combination of urban design, land use patterns, and transportation systems promotes walking and cycling, which helps create active, healthier, and more liveable communities. It is therefore vital that those with an influence on these wider sectors are part of the process, and buy into the need to deliver on this agenda. It is for this reason that a list of lead and delivery partners has been set against each outcome, ensuring that everyone acknowledges, and fully plays, their part.

4.27 It is particularly important that this co-relationship is recognised and acknowledged, and that a synergistic relationship between this Framework and other policies and strategies is developed and nurtured. It should be noted that effective implementation of this Framework will also help other sectors deliver on their aims, objectives, and strategies. For example, a healthier workforce is likely to be more productive, and produce greater economic benefits for society. However, there are also possible challenges in respect of the relationship between lifestyle behaviours (and their respective strategies) and, for instance, mental health promotion, where there is a clear inter-relatedness and inter-connectedness between concepts such as self-esteem, locus of control and positive mental well-being.

4.28 This coordinated approach could be delivered through a sharing of Public Service Agreements (PSAs) in respect of Departments, and a sharing of objectives and recognition in business plans in respect of all agencies and organisations. There is also obvious and potential scope in respect of Health Impact Assessments and 'health in all policies', and these are something that should be further encouraged and implemented across Government. This may take some time, but in the short-term the structures and priorities identified in existing strategies should be used to ensure that the issues identified in terms of physical activity and food and nutrition are effectively addressed. To this end, there would appear to be key linkages between this Framework and the following current (but not exhaustive) draft and existing strategies and action plans. The links to these are in Annex E which also include additional references to other related strategies, policies and action plans:

- Active Travel Strategy (under development - DRD)
- Breastfeeding Strategy (DHSSPS)
- Cardiovascular Framework (DHSSPS)
- Early Years Strategy (under development - DE)
- Extended Schools (DE)
- Fit Futures (DHSSPS)
- Food in Schools Policy (under development - DE)
- Investing for Health (DHSSPS)
- Neighbourhood Renewal (DSD)
- Planning Policy (DoE)
- Play and Leisure Policy Statement (OFMDFM)
- Promoting Mental Health and Wellbeing (Under development - DHSSPS)
- Regional Development Strategy (DRD)
- Regional Transportation Strategy (DoE)
- Sport Matters (DCAL)
- Strategy for Children and Young People (OFMDFM)
- Sustainable Development Strategy (OFMDFM)

Life Course Stages

4.29 The Foresight Report highlights the importance of addressing the issue across the life course. It states that "it is critical to note that there is no one point in the life course where intervention is particularly successful but that progress through life offers a number of naturally occurring opportunities"[39].

4.30 The life course approach also features in the Marmot Review where it is demonstrated as an important consideration to sustainability and to the improvement of the current health inequalities ensuring a healthier quality of life for all people from birth to death. [40]

4.31 The approach taken within this document reflects this life course approach, and three life course stages have therefore been developed within which key outcomes and interventions can be delivered. These stages are set out below:

- pre-conception, antenatal, maternal and early years;
- children and young people; and
- adults and the general population.

4.32 The stages were identified in the policy development process as key groupings in which action could be delivered. The stages reflect the importance of intervening early (from pre-conception); the key role that has been played by the education and youth sectors; and the need make the societal shift and behavioural change that is necessary to tackle the issue in the rest of the population.

4.33 The use of these life course stages should not preclude any work that targets those in multiple life course stages, at the interfaces between different life course stages, or inter-generational work.

Target groups

4.34 Following the prevention model described earlier, the population approach being proposed needs to be complemented by targeted actions and intervention for groups with disproportionately high rates of overweight and obesity. In respect of Northern Ireland, and in line with those efforts to address health inequalities, this should include people in lower socio-economic groups and living in areas of deprivation. In addition, interventions aimed at young children and pregnant women may have a significantly higher impact.

4.35 It is also clear from examples elsewhere that it is vital to engage with (and empower) local communities, and particularly families, to help develop and deliver local solutions. If local initiatives are to be utilised and be effective it is essential that these are the kind of services that local communities want and need.

4.36 There may also be a need, where appropriate and locally identified, to target initiatives to those identified as “at risk of obesity”, including those with a disability, some ethnic minority groups, etc.

Settings

4.37 The Framework also recognises and acknowledges that the outcomes could be grouped into a range of settings which may assist the implementation of the Framework. This information will be made available to the steering and implementation groups for their consideration.

Indicators

4.38 Approaching obesity prevention through tackling the ‘obesogenic environment’ has particular challenges when choosing indicators to measure impact and progress. The Data and Research Advisory Group has been especially mindful of this issue. In developing the outcomes set out in Chapter 5, and in setting milestones to show progress against the Framework’s overarching aim, target, and objectives, a range of proxy indicators has been developed and these are set out alongside the long-term outcomes.

4.39 However, it is recognised that there is a wide range of determinants of obesity which is outside the direct responsibility of this Framework; therefore it is important to contextualize the progress by also looking at indicators such as:

- levels of poverty (childhood poverty in particular);
- levels of community involvement; and
- levels of positive mental well-being.

Structure of Framework

4.40 In developing this Framework, based on the logic model and its emphasis on outcomes, an overall approach has been developed, a set of pillars identified, focus placed on a number of themes, and integral ‘threads’ run through the outcomes. These are described in more detail on page 61.

Pillars

4.41 The policy development process clearly highlighted that there were three main areas, or supporting pillars, that can help to prevent and address obesity.

4.42 The energy balance diagram (page 16) highlights that weight changes are driven by differences between energy in and energy out. The main ways to impact on energy in and energy out are through the food consumed and the physical activity undertaken. Therefore, “Food and Nutrition” and “Promoting Physical Activity” are two of the fundamental supporting pillars in this Framework.

4.43 In addition, it is essential to continue to learn, research, and improve the evidence base to inform good practice and ensure resources are being effectively utilised to prevent and address obesity. It is also vital that this evidence and knowledge base is translated into improved policy and practice. Progress must be monitored to demonstrate impact and to identify areas for future development. Ideally this should involve a clear research agenda being developed. There is important work already being done in this respect by the Centre of Excellence, the PHA and the IPH. Thus, “Data and Research” is the third fundamental pillar of the Framework.

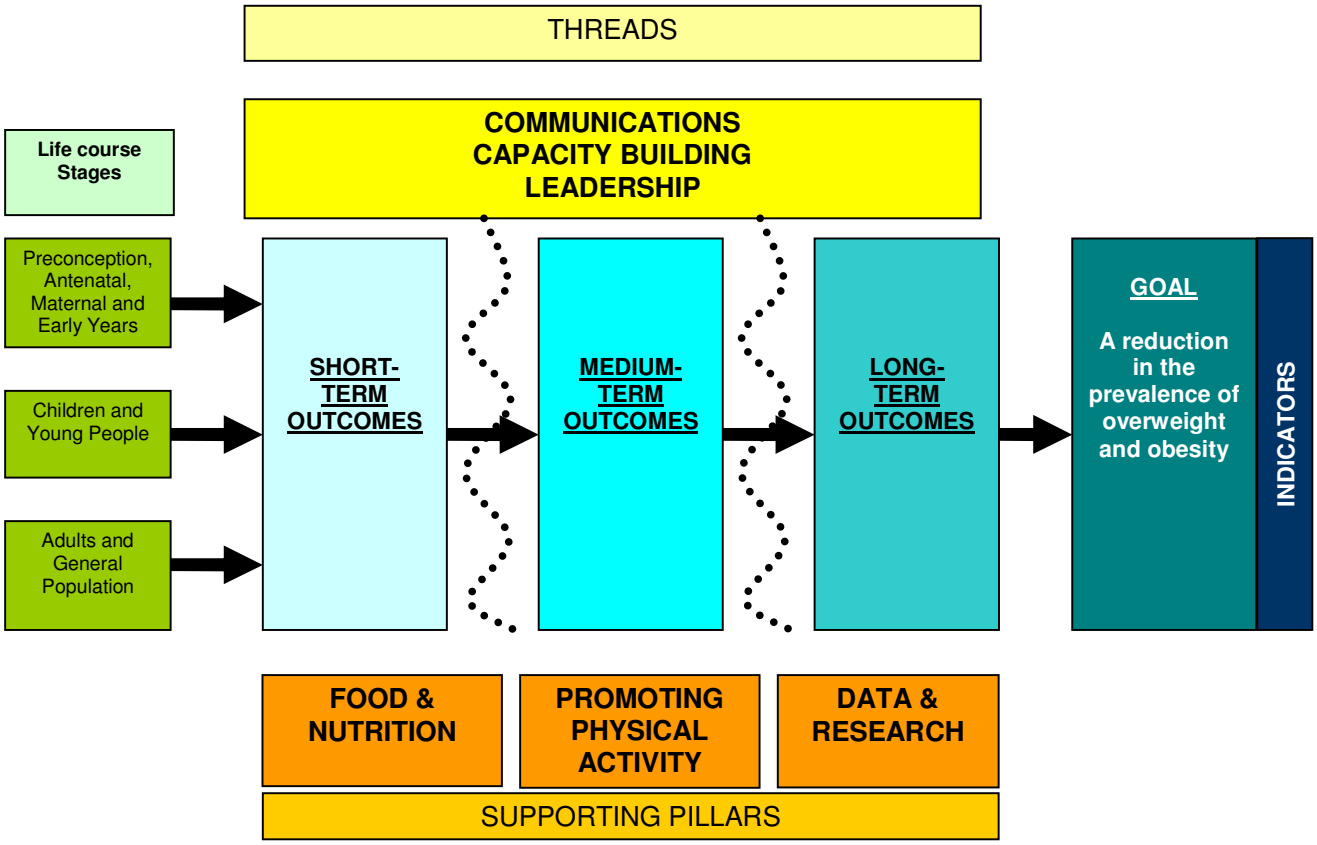
Threads

4.44 There are a number of key elements that run throughout the logic model, life course stages, and supporting pillars. These are communication, capacity building, and leadership. These elements, known as “threads”, are essential to ensuring that the Framework is effectively delivered and embedded throughout Northern Ireland.

Summary

4.45 The following diagram describes the overarching structure of the Framework.

Figure 17: Structure of the Framework



CHAPTER 5 OUTCOMES

Introduction

5.1 So far, the Framework has described the nature, scale and prevalence of obesity in Northern Ireland. It has set out its causes and highlighted the inter-relatedness of those factors that have led to a rapid increase in obesity in recent years. These factors are seen as operating within an 'obesogenic environment' and the range of outcomes set out in this chapter has been developed to address these factors.

5.2 Acknowledging that the factors are inter-related, the Framework recognises through its pillars that there are particular issues associated with food and nutrition and physical activity. It also recognises that there needs to be a special emphasis on research, surveillance, monitoring and evaluation.

Short-term Outcomes

5.3 The outcomes have been developed based on the logic model approach with a range of short, medium and long-term outcomes. For the most part, these were developed through the work of the advisory groups, supported by additional workshops and bi-lateral meetings and therefore represent the informed view of a range of practitioners who work in this area.

5.4 The list of short-term outcomes is extensive. It is recognised that implementing all of these will exert significant pressure on existing resources, both financial and staffing, with additional funding likely to prove problematic.

5.5 The Public Health Agency, who will be tasked with implementing those health-related aspects of the Framework, will therefore be expected to prioritise, amend if necessary, and action those short-term outcomes they assess as being most appropriate in terms of efficacy, effectiveness and evidence base. In doing so they will continue to work in partnership with the key stakeholders and delivery organisations as set out in the menu of short term outcomes.

5.6 Outcomes have been grouped by life course stage (Pre-conception, antenatal, maternal, and early years; Children and young people; and Adults and the general population) and the supporting pillars (food and nutrition; promoting physical activity; and data and research). However, it is also acknowledged that in some instances there are broader, more integrated outcomes, and here outcomes have been grouped under the heading of '*integrated prevention'*. Appropriate proxy indicators have also been included.

<table>
<tr><th colspan="5">PRE-CONCEPTION, ANTENATAL, MATERNAL and EARLY YEARS</th></tr>
<tr><td colspan="5">INTEGRATED PREVENTION</td></tr>
<tr><td colspan="2">Short-Term Outcomes / Outputs
(2012-2015)</td><td>Medium-Term Outcomes
(2016-2019)</td><td>Long-Term Outcomes
(2020-2022)</td><td>Indicators</td></tr>
<tr><td>Outcome</td><td>Delivery Partners</td><td></td><td></td><td></td></tr>
<tr><td>1. People trying to conceive and expectant parents receive information and guidance on nutrition and recommended levels of physical activity.</td><td>HSC, DHSSPS, Vol/Com, Safefood.</td><td rowspan="2">Parents, carers and those trying to conceive are better informed about nutrition and recommended levels of physical activity and interventions are in place for those parents identified as being at-risk of obesity.</td><td rowspan="2">Lower prevalence of overweight and obesity in pregnant women.</td><td rowspan="4">% of overweight/obese expectant mothers. [1].</td></tr>
<tr><td>2. Overweight and obese expectant mothers have the opportunity to access evidence based weight management interventions developed for expectant mothers.</td><td>HSC, DHSSPS, District Councils.</td></tr>
<tr><td>3. Initiatives and programmes on nutrition and physical activity within all Early Years settings reviewed.</td><td>HSC, IPH, District Councils, DHSSPS, DE, Sport NI, DCAL, Vol/Com.</td><td>All Early Years settings deliver evidence based initiatives and programmes in respect of nutrition, physical activity and play.</td><td rowspan="2">Early identification of children at risk of obesity.</td></tr>
<tr><td>4. Health and Social Care Professionals identify, and provide appropriate interventions or signposting, for young children who are, or are at-risk of, overweight/obesity.</td><td>HSC, DHSSPS, Vol/Com, District Councils.</td><td>Children at-risk of obesity are identified and signposted to appropriate interventions.</td></tr>
</table>

FOOD & NUTRITION				
5. New *Breastfeeding Strategy* in place and being implemented.	**DHSSPS**, HSC, Com/Vol.	Those specific actions identified within the Breastfeeding Strategy have been achieved.	The majority of mothers breastfeed and delay weaning until 6 months.	% of mothers breastfeeding at: • birth; • discharge from hospital; • at 10-14 days; • 6 weeks; • 3 months; and • 6 months. [2.] % of infants introduced to weaning foods at six months. [3.] % of Early Years providers compliant with nutritional standards. [4.] % of young children eating appropriate portions of fruit/veg per day. [5]
6. Parents/carers provided with consistent evidence based advice on infant nutrition from health care professionals.	**HSC**, DHSSPS, Vol/Com, Safefood, FSA, District Councils.			
7. Minimum nutritional standards in place for all voluntary, community and private Early Years settings, and compliance monitored.	**DHSSPS**, RQIA, HSC, DE, FSA.	Early Years settings supported to comply with the nutritional guidelines requirements outlined in the minimum standards for childcare providers.	Consistent approach to healthy food within Early Years settings.	
8. Voluntary, community and private Early Years settings supported to comply with minimum nutritional standards for childcare providers.	**HSC**, DHSSPS, FSA, District Councils.			
9. Food and nutrition initiatives increase nutritional knowledge, practical nutrition and food skills in a variety of voluntary, community and private Early Years settings, including parent/carer and toddler groups. This should include healthy weaning and the use of non-sweet based reward systems.	**HSC**, FSA, DHSSPS, Safefood, District Councils.	Increase practical skills, awareness and knowledge to enable young children and their parents/carers to make healthy choices.		

PROMOTING PHYSICAL ACTIVITY				
10. The new CMO Physical Activity Guidelines for Early Years published and disseminated.	**DHSSPS**, **HSC**, Sport NI, DCAL, Vol/Com.	The new CMO physical activity guidelines are implemented.	Physical activity levels of children are increased.	
11. Voluntary, community and private Early Years settings comply with the new CMO Physical Activity Guidelines for Early Years.	**HSC**, Sport NI, DCAL, Vol/Com.			
12. Healthcare professionals, childcare workers and those working in Early Years settings receive relevant information and training on physical activity and the new CMO Guidelines.	**HSC**, DHSSPS, DCAL, Vol/Com, District Councils.			
13. Implementation plan published to deliver the aims and objectives of the *Play and Leisure Policy Statement*.	**OFMDFM**, Playboard, District Councils, Vol/Com, DE, DoE, DSD, HSC, DCAL, DHSSPS.	Increased opportunities for play, particularly in areas of deprivation.		
14. Children and families have access to safe facilities for play and physical activity in their locality, particularly in areas of deprivation.	**District Councils**, Playboard, Vol/Com, DoE, DHSSPS, DSD, DCAL, Sport NI, OFMDFM, HSC, Private Sector.			

CHILDREN AND YOUNG PEOPLE				
INTEGRATED PREVENTION				
Short-Term Outcomes / Outputs (2012-2015)		**Medium-Term Outcomes** (2016-2019)	**Long-Term Outcomes** (2020-2022)	**Indicators**
Outcome	**Delivery Partners**			
1. More effective use and sharing of existing facilities and equipment within and between education, District Councils and local communities.	**District Councils**, **DE**, DCAL, Vol/Com, Private Sector.	Increased access to obesity prevention information, resources and facilities.	Children and young people make healthy food and physical activity choices.	Prevalence of diet associated risk factors diagnosed in children and young people.[6] % of overweight and obese children in P1.[7] % of screen time spent by children and young people.[8]
2. Initiatives and programmes on nutrition, physical activity and play within children and young people's settings reviewed.	**HSC**, IPH, District Councils, DHSSPS, DE, Sport NI, DCAL, Vol/Com.			
3. Relevant circulars to FE Colleges relating to obesity, food and nutrition and recommended levels of physical activity guidance updated as necessary.	**DEL**, FE Colleges, DE, HSC.			
4. Those in University and FE Colleges supported to be more physically active, to eat healthily and develop practical food skills.	**FSA**, **Safefood**, DHSSPS, HSC, DEL, DRD, NUS, Colleges, Universities, District Councils.			
5. Those who work in the youth sector and Jobskills/Training Centre students are supported and trained to encourage promotion of a healthy diet and recommended levels of physical activity.	**HSC**, DHSSPS, DE, DCAL, Sport NI, FSA, Vol/Com.			

6. The importance of addressing health issues in education settings continues to be recognised and school development planning regulations continue to require schools to have policies in place to promote the health and wellbeing of students.	**DE**, **DHSSPS**, ESA[1], HSC.	Increased access to obesity prevention information, resources and facilities.	Children and young people make healthy food and physical activity choices.	
7. Continued delivery of the Pupils Emotional Health and Wellbeing Programme.	**DE**, **DHSSPS**, **ESA**, **HSC**.			
FOOD & NUTRITION				
8. *Pending Ministerial and Executive agreement – finalised Food in Schools Policy implemented and monitored.*	**DE, DHSSPS**, CCEA, ESA, HSC, FSA, Safefood.	Children and young people have access to a range of healthy foods throughout education settings.	Children and young people are making healthy food choices.	% of young children with dental decay.[9.] % of children and young people making healthier food choices consuming 5 or more portions of fruit/veg per day.[10.]
9. All schools meet the nutritional standards for lunches and 'other food and drinks' including breakfast clubs and vending machines.	**DE**, ESA.			
10. Regional approach to Breakfast Clubs and Healthy Breaks initiatives adopted.	**HSC**, DE, DHSSPS, District Councils, ESA.			
11. Initiatives in place to increase uptake of school meals, particularly free school meals.	**DE**, ESA, HSC.			

[1] Until ESA is established on 1 April 2013, reference to it should be interpreted to mean one or more of DE's education partners i.e. 5ELBs, YCNI and CCMS

12. Home Economics remains a compulsory curriculum element for all students in Key Stage 3.	**DE**, ESA.	Increased practical skills, awareness and knowledge to enable children and their families to make healthy choices.	Children, young people and young adults are making healthy food choices.	Level of exposure of children and young people to advertising of high salt, sugar, fat products or alcohol.[11]
13. Options considered for primary school children to develop practical food skills in line with the Food Competences Framework.	**DE**, CCEA, ESA, DHSSPS, HSC, FSA, Safefood.			
14. Children, young people and their families provided with information in respect of nutrition.	**HSC**, DHSSPS, FSA, Safefood, Vol/Com.			
15. Work undertaken with other jurisdictions to monitor and further consider restrictions of advertising products with high fat, salt, sugar and alcohol to children and young people.	**UK Jurisdictions**, OFCOM, RoI, IPH, DHSSPS, FSA.	Reduction in children's exposure to high fat, salt, sugar and alcohol advertising.		
16. Youth sector settings have healthy food policies in place.	**HSC**, DE, ESA, District Councils, FSA.	Young people have increased practical food skills and knowledge.		
17. Young people, including those in or leaving care, and those deemed to be at risk of overweight and obesity, provided with opportunities to develop knowledge and practical food skills.	**HSC**, DHSSPS, Vol/Com, Safefood, FSA, District Councils.			

PROMOTING PHYSICAL ACTIVITY				
18. PE remains a compulsory curriculum element for all students through all Key Stages.	**DE**, DCAL, ESA, HSC, Sport NI, DRD, DHSSPS.	Schools encourage and enable participation in physical activity.	A greater proportion of children and young people are achieving recommended levels of physical activity.	% of children (11-16 years) who are members of a club or team not connected with their school that involved them taking part in sport and physical activity. [12] % of children (11-16 years) who played any sport, exercise, or played actively that made them out of breath or hot and sweaty. [13] % of children (11-16 years) who spent two hours or more per week doing PE or games at school. [14.]
19. *Subject to the outcome of a review of DE budget allocations,* continued delivery of the Curriculum Sports Programme.	**DE**, **DCAL**, **ESA**, **HSC**, **Sport NI**, **DRD**, **DHSSPS**.			
20. Baseline established on the number of children of compulsory school age participating in a minimum of 2 hours physical education per week, and schools encouraged and supported to achieve this.	**DCAL**, **DE**, ESA, HSC, Sport NI, DRD, DHSSPS.			
21. Every child in Northern Ireland over the age of 8 provided with the opportunity to participate in at least 2 hours per week of extra-curricular sport, physical recreation or play.	**DCAL**, **DE**, ESA, HSC, Sport NI, DRD, District Councils, DHSSPS.			
22. The new CMO Physical Activity Guidelines for children and young people published and disseminated.	**DHSSPS**, **HSC**, Sport NI, DCAL, Vol/Com, DRD.	Children and young people have greater knowledge about recommended levels of physical activity and have more opportunities to participate.		
23. Children and young people can access opportunities and facilities for physical activity and play within their local community.	**DCAL**, HSC, DHSSPS, DE, Sport NI, DSD, Vol/Com, District Councils.			

ADULTS AND GENERAL POPULATION				
INTEGRATED PREVENTION				
Short-Term Outcomes (2012-2015)		**Medium-Term Outcomes** (2016-2019)	**Long-Term Outcomes** (2020-2022)	**Indicators**
Outcome	**Delivery Partners**			
1. Consistent, coordinated and integrated campaign developed in respect of nutrition and physical activity, the focus of which is informed by the evidence base and regional/local research.	**HSC**, FSA, DHSSPS, Vol/Com, Sport NI, Safefood.	Increased awareness and knowledge of the general population in regard of healthy eating and physical activity messages.	Levels of overweight and obesity in the general population reduced.	Prevalence of overweight and obesity in adults.[15.] Occurrences of obesity related diseases.[16]
2. Initiatives and programmes on nutrition and physical activity for adults and the general population reviewed.	**HSC,** IPH, DHSSPS, District Councils, FSA, Safefood.			
3. Policy makers encouraged and supported to complete Health Impact Assessments on relevant policies.	**DHSSPS**, Govt Depts, District Councils, Public Sector.	Impact on the obesogenic environment considered during development of relevant policies.		
4. Health and Social Care Professionals identify, and provide appropriate interventions or signposting, for those adults who are, or at-risk of, overweight/obesity.	**HSC**, DHSSPS, Vol/Com, District Councils.	Improved obesity management pathways available.		
5. Relevant recommendations from the Cardiovascular Framework implemented.	**HSC**, DHSSPS, DCAL Sport NI, Vol/Com.			

FOOD & NUTRITION				
6. Targeted healthy food initiatives in place.	**HSC**, DHSSPS, District Councils Vol/Com, FSA, Safefood, HFfA.	Increased knowledge and greater awareness of healthy food practices in the adult population.	A greater proportion of adults eat a healthy diet.	Awareness of '5-a-day' healthy eating.[17] % of adults adopting the 5-a-day guidelines.[18] % of adults experiencing food poverty.[19.] % of food manufacturers currently reformulating.[20.]
7. Labelling of alcoholic containers increases awareness of the calorific content of alcohol.	**UK Jurisdictions**, DHSSPS, Alcohol Industry.			
8. Families, groups and communities in areas of deprivation supported to increase knowledge of good nutrition, practical cooking skills and food budgeting.	**HSC**, DHSSPS, FSA, Vol/Com, DSD, District Councils, Safefood.			
9. Coordinated approach to address food poverty developed.	**HSC**, DHSSPS, PHA, FSA, HFfA, Vol/Com, Safefood, District Councils, OFMdFM, CDHN, NICVA.	Local support, resources, and facilities available to those experiencing food poverty.		
10. Nutritional standards in social care settings (including nursing and residential homes and facilities for people with learning disability and mental health conditions) revised and implemented.	**HSC**, DHSSPS, FSA, Vol/Com.	Mandatory implementation of nutritional standards in social care settings.	Healthier food options are available and accessible to the whole population.	
11. Northern Ireland food manufacturers continue to be encouraged to reformulate their food to reduce saturated fat, sugar, salt, calorific value and provision of smaller portion sizes of energy dense foods.	**FSA**, District Councils, Food Industry, Invest NI, Private Sector.	Food products and catering meals are healthier and are better labelled.		
12. Pre-packed foods labelled with simple, easy to understand, front of pack nutritional information to allow consumers to make an informed choice.	**FSA**, HSC, Vol/Com, Food Industry, District Councils, Invest NI, Safefood.			

13. Food retailers encouraged and enabled to consider reducing point of sale placement of foods which are high in fat, salt, sugar and increasing exposure to promotion of healthier foods.	**FSA**, HSC, District Councils, Invest NI, Safefood Food Industry.	Increased availability and consumption of healthy foods, particularly fruit and vegetables.	Healthier food options are available and accessible to the whole population.	
14. Improved nutritional content of menu choices including regulation of portion sizes and the provision of appropriate nutritional information for consumers by caterers.	**FSA**, HSC, District Councils, Food Industry, Invest NI, Safefood.			
15. Minimum Nutritional Standards developed for all public sector procurement of food and drink.	**HSC, FSA, Safefood,** DHSSPS, District Councils.	All work settings implement healthy nutrition guidelines.		
16. All public sector facilities (including those open to the public, e.g. leisure centres, council facilities) have in place and comply with minimum nutritional standards and nutritional polices including healthy vending.	**District Councils,** HSC, FSA, DHSSPS, Food Industry.			
17. Nutritional education qualifications incorporated into training programmes for those who work in the food and hospitality sectors through the relevant Sector Skills Council.	**FSA**, HSC, DEL, District Councils, Private Sector, the BDA.			

Promoting Physical Activity				
18. Employees are supported and encouraged to be more active in the workplace and undertake less sedentary behaviour.	**HSC**, DETI, DHSSPS, DCAL, DRD, HSE, District Councils, Private Sector, BITC.	Adults are more physically active in the workplace.	A greater proportion of adults achieving the recommended levels of physical activity.	% of adults who are sedentary. [21.] % of adults aware of the physical activity guidelines recommended by the Chief Medical Officer. [22.] % of adults (16+) meeting the levels of physical activity recommended by the Chief Medical Officer. [23.] % of women (16+) meeting the levels of physical activity recommended by the Chief Medical Officer. [24.]
19. Reviews of planning policies take account of the impact of planning on health and opportunities for sustainable physical activity.	**DoE**, DRD, DCAL, CAAN, DHSSPS, District Councils, NIHE.	Transport and planning policies provide opportunities for active lifestyles for all.		
20. Greater access to public and privately owned land.	**DoE**, **CAAN**, District Councils, All Government Departments, Forest Service.			
21 Joint undergraduate module on healthy urban planning developed.	DRD, DHSSPS, DoE, HEIs, BHC.			
22. Active Travel Strategy developed for Northern Ireland.	**DRD**, DARD, DoE, HSC, DCAL, Vol/Com, CAAN.			

23. The new CMO Physical Activity Guidelines for adults and older people published and disseminated.	**DHSSPS**, **HSC**, Sport NI, DCAL, Vol/Com, DRD.	Increased knowledge, awareness and a positive attitude towards taking part in recommended levels of physical activity.	Greater proportion of adults achieving the recommended levels of physical activity.	% of adults (16+) meeting the levels of physical activity recommended by the Chief Medical Officer through 'getting about' (which includes walking and cycling). [25]
24. More people are aware of and have access to local facilities and opportunities for organised and non-organised physical activity.	**HSC**, DCAL, District Councils Sport NI, Vol/Com.			
25. *Sport Matters Strategy* implemented.	**DCAL,** DHSSPS, HSC, Sport NI, District Councils, Vol/Com.	Increased opportunities and improved access to physical activity facilities.		
26. Greater involvement of under-represented groups in recommended levels of physical activity.	**HSC**, DCAL, DHSSPS, Sport NI, District Councils, Vol/Com.			
27. Community and Voluntary sector supported to provide increased opportunities for participation in recommended levels of physical activity.	**HSC.** DCAL, Sport NI, DHSSPS, Vol/Com, District Councils.			

<table>
<tr><th colspan="4">DATA & RESEARCH</th></tr>
<tr><th colspan="2">Short-Term Outcomes (2012-2015)</th><th>Medium-term Outcomes (2016-2019)</th><th>Long Term Outcomes (2020-2022)</th></tr>
<tr><th>Outcome</th><th>Delivery Partners</th><th></th><th></th></tr>
<tr><td>1. Action Plan developed to ensure sustained collection of robust data in respect of obesity.</td><td>HSC, QUB, IPH, Safefood, CIEH, FSA, UU, Vol/Com.</td><td rowspan="3">Valid, reliable and sustainable improved monitoring and surveillance data on overweight and obesity.</td><td rowspan="7">Obesity strategy, policy, research and practice supported by a robust knowledge/evidence base.</td></tr>
<tr><td>2. Obesity Hub developed to ensure the linking and co-ordination of data from multiple measurements and monitoring.</td><td>HSC, IPH, QUB, UU, Safefood, Sport NI.</td></tr>
<tr><td>3. Progress measured against the target and all the indicators set out in this Framework.</td><td>HSC, IPH, QUB, UU.</td></tr>
<tr><td>4. Monitoring and evaluation toolkit developed and used.</td><td>HSC, Safefood, Obesity Hub, IPH, UU, QUB.</td><td>All initiatives are robustly evaluated against agreed criteria.</td></tr>
<tr><td>5. Research needs of the Framework identified and a research programme developed, potentially covering:
• determinants of overweight and obesity;
• good practice;
• economic and social impacts; and
• sustainability.</td><td>HSC, UU, QUB, Safefood, Sport NI, IPH, CIEH.</td><td rowspan="3">Improved knowledge of determinants of overweight and obesity and its impacts translated into policy and practice.</td></tr>
<tr><td>6. Audit undertaken of existing research and evaluations, and the information collated on a live database.</td><td>HSC, IPH, UU, QUB, Safefood, CIEH.</td></tr>
<tr><td>7. Improved service delivery and policy development through the analysis and dissemination of information from surveillance, evaluation and wider research.</td><td>HSC, IPH, UU, QUB, Safefood, FSA, Sport NI, Obesity Hub.</td></tr>
</table>

CHAPTER 6 – DELIVERY

Implementation

6.1 Feedback from the Framework's wide ranging engagement and consultation process has consistently highlighted that enhanced co-ordination across Government Departments, different sectors and at community level is crucial if a reduction in overweight and obesity levels is to be achieved. This is also highlighted in the current literature on this issue and is at the heart of the Foresight Report.

6.2 Therefore, enhancing co-ordination and the establishment of a robust performance management mechanism are critical to the successful delivery of this Framework. It is vital that progress is closely monitored, measured and that organisations are held to account.

6.3 The role, remit and terms of reference of the OPSG will be reviewed and it will become the body which oversees and monitors the overall progress of the Framework and the implementation of cross-Departmental actions. For the outcomes which fall to non-Departmental organisations, the PHA will be asked to establish an implementation group to prioritise, coordinate and drive forward action to achieve these.

Delivery Partners

6.4 Lead and delivery partners have been identified for each outcome. These partners have a specific interest or responsibility for achieving the outcome and should work together to ensure that the outcome is effectively delivered. The lead delivery partner holds the overall responsibility for implementation and for reporting progress.

Costing the Framework

6.5 DHSSPS allocated around £800,000 per year to the implementation of Fit Futures. In addition, a further £550,000 and £300,000 is allocated for work in relation to promoting physical activity and improving food and nutrition respectively.

6.6 Some of the actions identified in the Framework will be resourced through existing funding structures (such as Fit Futures and Investing for Health) and, through the resetting of priorities, additional resources may also be made available. It will therefore be for the implementation group lead by the Public Health Agency to identify key priorities for delivery in the short term.

6.7 The draft Programme for Government, which went out for consultation in November 2011, recommended investing £7.2 million in programme to tackle obesity over the following three years.

- 2012-2013 – Invest £2m in tackling obesity through support of Obesity Prevention Framework
- 2013-2014 – Invest £2.4m in tackling obesity through support of Obesity Prevention Framework
- 2014-2015 – Invest £2.8m in tackling obesity through support of Obesity Prevention Framework

Annexes

Annex A

Data Sources Supporting the Indicators and Tables related to Chapter 2

Indicator	Source
1	Antenatal clinics upon collection at 'booking in' appointment of the health check for expectant mothers (at around 12-14 weeks).
2	Infant Feeding Survey (IFS) 2005, 2010 / Child Health System (CHS)
3	Infant Feeding Survey
4	To be developed
5	Health Survey Northern Ireland 2010-11 will provide this data for 2-15 year olds.
6	National Diet & Nutrition Survey (NDNS) Using 'marker' foods including: • sugary fizzy drinks and squashes; • confectionery; • chips and other fried foods; • meat products, such as sausages, burgers, meat/chicken pies etc; and • fruit and vegetables.
7	Child Health System (CHS)
8	Kids Life and Times Survey / Young Persons' Behaviour and Attitudes Survey (YPBAS) / Safefood 2013+ YPBAS (11-16 year olds) – related questions since 2003 are detailed below: 2003 Qn: On how many days during the last week have you... - watched TV, videos, DVDs? - played computer games? [0..7 days] 2007 Qn: (a) On school days, how many hours do you usually spend... (b) On Saturdays/Sundays, how many hours do you usually spend... - watching TV, videos, DVDs? - playing computer games? [none, less than 2 hours, 2-5 hours, more than 5 hours] 2010 Qn: In the last week, how many hours did you spend... (a) watching TV, videos, DVDs? (b) playing computer games? [none, less than 10 hours, 10-20 hours, more than 20 hours]
9	Child Dental Survey 2003
10	YPBAS - related questions since 2003 are detailed below: 2003 Qn: How often would you eat 5 or more portions of fresh fruit/vegetables a day? [every day, most days, 2-3 times a week, once a week, less than once a

	week, occasionally, never] 2007 & 2010 Qn: How many portions of fruit/vegetables (including fresh, dried, tinned, juiced & frozen) do you usually eat each day? [0..5, more than 5]
11	OFCOM
12	YPBAS 2007 & 2010 Qn: Are you a member of any other clubs or teams not connected with your school that involves you taking part in sport or physical activity? [Yes, No]
13	YPBAS 2007 & 2010 Qn: In the last 7 days, have you played any sport, done any exercise or played actively that made you out of breath or hot and sweaty? [Yes, No]
14	YPBAS 2007 & 2010 - related questions since 2007 are detailed below 2007 Qn: How long do you actually spend taking part in sports or physical activity as part of PE/games lessons in school each week? (Do not include: Any time taken to get to the gym/sports hall/playing fields, time spent changing) [More than 3 hours, about 3 hours, about 2 hours, about 1 hour, about 1/2 hour, 0 hours] 2010 Qn: Thinking about organised PE or games or playing for a school team How long do you spend doing these organised activities each week? (Do not include any time taken to get to the gym/sports hall/playing fields/time spent changing) [More than 3 hours, about 3 hours, about 2 hours, about 1 hour, about 1/2 hour, 0 hours]
15	HSWB 2005-06 / Health Survey NI (16+) from 2010 - from BMI calculations
16	Diabetes UK / Hospital or GP records
17	Health Survey NI (aged 16+) from 2010 Qn: The Department of Health advises people to eat a certain number of portions of fruit and vegetables every day as part of a healthy diet. At least how many portions do you think people are advised to eat every day?
18	HSWB 2005/06 / Health Survey NI (aged 16+) from 2010 / Northern Ireland Sport and Physical Activity Survey (SAPAS). Qn: On average how many portions of fruit do you eat each day? [1..9] Qn: And on average how many portions of salad or vegetables, including fresh, frozen, tinned or dried do you eat each day? [1..9]
19	Health Survey Northern Ireland (aged 16+) from 2010
20	Food Standards Agency (FSA)
21	HSWB 2005-06 / Health Survey NI (aged 16+) from 2010 - Derived variable (sedentary) / SAPAS
22	Health Survey NI (aged 16+) from 2010 / SAPAS Qn: I would now like to ask you some questions about moderate intensity physical activity. By moderate intensity physical activity I mean that the activity makes you out of breath or causes you to sweat. This includes

	all types of moderate intensity activity such as sport, housework, gardening, DIY or walking. What do you think is the recommended minimum amount of moderate intensity physical activity needed for a healthy life style? [16 separate answer categories]
23	Health Survey NI (aged 16+) from 2010 / SAPAS Qn: The government's Chief Medical Officer recommends that a total of at least 30 minutes a day moderate intensity physical activity on five or more days a week brings about health benefits. In a typical week do you achieve this recommended level? [Yes, No] SAPAS
24	HSWB 2005-06 / Health Survey NI (aged 16+) from 2010 / SAPAS Qn: The government's Chief Medical Officer recommends that a total of at least 30 minutes a day moderate intensity physical activity on five or more days a week brings about health benefits. In a typical week do you achieve this recommended level? [Yes, No] **X Gender**
25	HSWB 2005-06 / Health Survey NI (aged 16+) from 2010 / SAPAS No single question included in HSNI 2010 to capture this information.

Annex B

Equality impact assessment

Equality Considerations - Northern Ireland Act 1998

Section 75 (S75) of the Northern Ireland Act 1998 places the following statutory requirements on each public authority:

> "(1) A public authority shall in carrying out its function relating to Northern Ireland have due regard to the need to promote equality of opportunity–
>
> (a) between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
>
> (b) between men and women generally;
>
> (c) between persons with a disability and persons without; and
>
> (d) between persons with dependants and persons without.
>
> (2) Without prejudice to its obligations under subsection (1), a public authority shall in carrying out its functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group"

Policy Aim and Groups Affected

The Obesity Prevention Framework seeks to empower the population of Northern Ireland to make healthy choices and reduce the level of harm related to overweight and obesity, by creating an environment that supports and promotes a physically active lifestyle and a healthy diet. This Framework will affect the whole population and impact on all S75 groups with particular outcomes specific to those of lower socio-economic groups. Many of the main policies and programmes referred to in this assessment will be or have already been subject to an equality impact assessment. This assessment, therefore, focuses on an overall assessment of differential impacts upon relevant groups and on those policies and programmes which are being established directly as part of the Framework and which will not be subject to separate consultation.

Consideration of Available Data and Research

The following information about obesity, physical activity and nutrition has been reviewed and includes:

- Foresight: 'Tackling Obesities – Future Choices;
- Information & Analysis Directorate: Northern Ireland Health and Social Wellbeing Survey (HSWB);
- Health Survey for Northern Ireland;
- Young Persons' Behaviour and Attitudes Survey;
- 'Healthy Weight, Healthy Lives: A Cross-Government Strategy for England'; and
- Fit Futures Implementation Plan

In addition, account has been taken of the analysis of equality considerations conducted by the Fit Futures Taskforce in its report to the Ministerial Group on Public Health in March 2006.

Assessment

Obesity is a major risk factor for a range of chronic illnesses. The 2005 Northern Ireland HSWB found that overall 59% of all adults measured were either overweight (35%) or obese (24%). The 2005 Survey also reported that 64% of adult males and 54% of adult females were either overweight or obese (compared to 63% and 50% for men and women respectively in the 1997 survey). The Northern Ireland Survey 2010/11 reported that 59% of adults measured were either overweight (36%) or obese (23%). A similar proportion of males and females were obese however males were more likely to be overweight (44%) than females (30%). These figures have remained broadly unchanged since the previous HSWB survey results in 2005/06.

The 2010/11 survey also showed that a third of respondents reported consuming 5 or more portions of fruit or vegetables a day with females more likely to be meeting this guideline than males (36% and 27% respectively). In relation to children, aged 2-15 years, 8% were assessed as being obese based on the International Obesity Task Force guidelines, 8% of boys and 9% of girls; and 38% of respondents were classified as meeting the

recommended level of physical activity, with males (44%) more likely to be than females (35%).

We do not have robust source of information on how religion, political opinion, racial group, sexual orientation, having dependants or marital status affects the prevalence of obesity.

'A Fitter Future for All' aims to reduce the rising prevalence of obesity and the impact on population health of its related harm. Key findings from consideration of available evidence include:

- The 2005 Northern Ireland HSWB found that overall 59% of all adults measured were either overweight (35%) or obese (24%). From these figures it indicated that 64% of adult males and 54% of adult females were either overweight or obese
- The study also found that 29% of young men aged 16-24 and 32% of young women were either overweight or obese.
- In 2005, using the International Approach, the health and wellbeing survey showed that nearly one in ten (9%) of children aged between 2-10 years were obese. Just under one in six (17%) were either overweight or obese.
- Through analysis of the 2005/06 HSWB Survey, It should be noted that these figures are subject to confidence intervals. Unfortunately, it is not possible to breakdown these figures by dependants, sexual orientation or political opinion; a race breakdown is possible, but not feasible as 99.4% of survey respondents are of 'white' ethnic background.
- There is no significant difference in levels of obesity between various religious groups (Catholic 26%, Protestant 23%, Other 18%, None/refused/missing 24%). In terms of marital status, those who are single are less likely to be obese (17%) compared to those who are married (27%), separated (30%), divorced (31%) or widowed (28%).
- Those who have a long standing illness, disability or infirmity have higher rates of obesity (33%) than those who do not (19%), however levels of overweight are similar (36% compared to 34%).

Overall Conclusion

'A Fitter Future for All' takes a life course approach to tackling the prevalence of obesity across Northern Ireland. The Framework further develops the Fit Futures Implementation plan (which was aimed at reducing the prevalence of obesity in children) to encompass all life stages. The Framework recognises the need for cross-Departmental and inter-agency working and also working through a number of settings including education and communities to ensure success. The Framework recognises that whilst all sections of the population are at risk, certain groups may be at a slightly higher risk – and these will be targeted in the outcomes that seek to address those at risk of obesity. The Framework, therefore, seeks to encourage policies and programmes to consider the impact of obesity in their action plans. The Department considers that the Obesity Prevention Framework should impact positively on the health and emotional wellbeing of the entire population. The Department considers that the Framework does not adversely impact on any of the S75 groups and therefore a full Equality Impact Assessment is not required.

Annex C

Acronyms

BDA	British Dietetic Association
BITC	Business in the Community
BMI	Body Mass Index
CAAN	Countryside Access Activities Network
CCEA	Councils for the Curriculum, Examinations and Assessment
CDHN	Community Development Health Network
CHS	Child Health System
CIEH	Chartered Institute of Environmental Health
CMO	Chief Medical Officer
CREST	Clinical Resource Efficiency Support Team
DARD	Department of Agriculture and Rural Development
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DETI	Department of Enterprise, Trade and Investment
DFP	Department of Finance and Personnel
DHSSPS	Department of Health, Social Services and Public Safety
DoE	Department of the Environment
DoH/DH	Department of Health (England)
DoHC	Department of Health and Children (Ireland – now Department of Health)
DRD	Department for Regional Development
DSD	Department for Social Development
ELBs	Education Library Boards
EQIA	Equality Impact Assessment
ESA	Education and Skills Authority
FE	Further Education
FSA	Food Standards Agency
HAZs	Health Action Zones
HIA	Health Impact Assessment
HE	Higher Education
HFfA	Healthy Food for All
HSC	Health and Social Care
HSE	Health and Safety Executive
HSNI	Household Survey Northern Ireland
HSSBs	Health and Social Services Boards
HSWB	Health and Social Wellbeing Survey
IfH	Investing for Health
IOTF	International Obesity Task Force
IPH	Institute of Public Health Ireland
MGPH	Ministerial Group on Public Health
NAO	National Audit Office
NICE	National Institute for Health and Clinical Excellence

NICVA	Northern Ireland Council for Voluntary Action
NISRA	Northern Ireland Statistics and Research Agency
NOO	National Obesity Observatory
NUS	National Union of Students
OFMDFM	Office of the First Minister and deputy First Minister
OPSG	Obesity Prevention Steering Group
PHA	Public Health Agency
PSA	Public Service Agreement
QUB	Queens University Belfast
RQIA	Regulation and Quality Improvement Authority
UU	University of Ulster
VOL/COM	Voluntary / Community
WHO	Word Health Organisation

Annex D

Stakeholder Representation

Action Cancer
Antrim Borough Council
Antrim Hills Spring Water
ARC Healthy Living Centre
Ards Borough Council
Armagh and Dungannon Council
Banbridge Council
Belfast City Council
Belfast Education and Library Board
Belfast Health and Social Care Trust
British Dietetic Association
British Heart Foundation
British Medical Association
Business in the Community Northern Ireland
Carrickfergus Borough Council
Castlereagh Borough Council
CAWT – Cooperation and Working Together
Ceara School
Chartered Institute of Environmental Health
Coleraine Borough Council
Compass Group UK (providers of contract catering services)
Cookstown District Council
Council for the Curriculum, Examinations and Assessment
Craigavon Borough Council
Craigavon Civic Centre (Catering Management)
Cultural and Leisure Officers Association
Dairy Council
Department of Agriculture and Rural Development
Department for Culture, Arts and Leisure
Department of Education
Department of Enterprise, Trade and Investment
Department of Employment and Learning
Department of Health, Social Services and Public Safety
Department of Regional Development
Department of Social Development
Derry City Council
Diabetes UK
Dungannon and South Tyrone Borough Council
Early Years
Environmental Health Committee (inc. Eastern and Southern Groups)
Erne Hospital
Fermanagh District Council
Food Standards Agency Northern Ireland

Golden Popcorn Ltd
Henderson Foodservice
Henderson Group
Institute of Public Health, Ireland
Ireland and Northern Ireland's Population Health Observatory
Julie's Kitchens Fast Foods
Larne Borough Council
Limavady Council
Lisburn City Council
Loreto College
Mash Direct (vegetable growers and packers)
Mount Charles Catering Ltd.
Newry and Mourne Borough Council – Locality Support Services
Newry Sports Centre
Northern Ireland Chest, Heart and Stroke Association
Northern Ireland Food Advisory Committee
Northern Ireland Food and Drink Association
Northern Ireland Local Government Association
Northern Ireland Statistic Research Agency
North Eastern Education and library Board
Obesity Knowledge Hub
Public Health Agency
Northern Health and Social Services Board
Eastern Health and Social Services Board
Western Health and Social Services Board
Northern Health and Social Care Trust
Southern Health and Social Care Trust
Western Health and Social Care Trust
Health and Social Care Research & Development Division
Public Health Alliance
Playboard
Queens University Belfast
Robert Gordon University, Aberdeen – Counterweight Programme
Rockwell Water
Safefood
Skills Active
Sodexo (food services and facilities management)
South-Eastern Education and Library Board
Southern Education Library Board
Southern Group Environmental Health Committee
Southern Investing for Health Partnership
Southern Regional College and South West College
Sport Northern Ireland
Stranmillis University College
SUSTRANS
Tesco Northern Ireland
University of Ulster
UnLtd.

Western Education and Library Board
Willowbrook Foods

Discussions have also taken place with obesity teams from:

Department of Health and Children (Republic of Ireland);
Department of Health (England);
Department of Health and Community Care (Scotland); and
Department of Health and Social Services (Wales)

Annex E

Related Strategies, Links and References

Breastfeeding Strategy
http://www.dhsspsni.gov.uk/breastfeeding.pdf

Cardiovascular Framework
http://www.dhsspsni.gov.uk/cardiovascular_health_and_wellbeing_service_framework_pid.pdf

Early Years Strategy
http://www.deni.gov.uk/index/pre-school-education-pg/16-draft-early-years-strategy-consult-pg.htm

Evaluation of the Progress Made in the Implementation of the Food-Based Nutritional Standards and General Approaches to Promoting Healthy Eating in Schools in Northern Ireland
http://dera.ioe.ac.uk/934/1/evaluation-of-the-progress-made-in-the-implementation-of-the_food-based-nutritional-_standards-school-food-top-marks-executive-summary.pdf

Extended Schools: Schools, Families, Communities – working together
www.deni.gov.uk/extended_schools_-_revised_18-9-06.pdf

Fit Futures
www.dhsspsni.gov.uk/showconsultations?txtid=22125

Food in Schools Policy
www.deni.gov.uk/food_in_schools_policy_-_consultation_-_draft_policy_-_english_pdf.pdf

Health and Social Wellbeing Survey for Northern Ireland 2005/06
http://www.csu.nisra.gov.uk/survey.asp153.htm

Investing for Health
http://www.dhsspsni.gov.uk/index/phealth/php/ifh.htm

Lifetime Opportunities Strategy: Government's Anti-poverty and social inclusion Strategy for Northern Ireland
www.ofmdfmni.gov.uk/antipovertyandsocialinclusion.pdf

Nutritional Standards for Other Food and Drinks in Schools
http://www.belb.org.uk/Downloads/c_nutritional_standards_for_other_food_in_schools.pdf

Nutritional Standards for School Lunches
http://www.deni.gov.uk/de1_09_125640__nutritional_standards_for_school_lunches__a_guide_for_implementation_3_-2.pdf

Health Survey for Northern Ireland results 2010/11
http://www.northernireland.gov.uk/index/media-centre/news-departments/news-dhssps/news-dhssps-151111-health-survey-northern.htm?WT.mc_id=rss-news

Obesity and Type II Diabetes - Northern Ireland Audit Office Report
http://www.niauditoffice.gov.uk/pubs/onereport.asp?arc=True&id=227&dm=0&dy=0

Oral Health Strategy
http://www.dhsspsni.gov.uk/2007_06_25_ohs_full_7.0.pdf

Planning Policy
http://www.planningni.gov.uk/index/policy/policy_publications/planning_statements.htm

Play and Leisure Policy
http://www.ofmdfmni.gov.uk/index/equality/children-young-people/play-and-leisure-policy.htm

Regional Development Strategy
http://www.drdni.gov.uk/shapingourfuture/

Regional Transportation Strategy for Northern Ireland 2002-2012
http://www.drdni.gov.uk/index/transport_planning.htm

School Food: Top Marks: The Essential Guide
http://www.deni.gov.uk/de1_09_125651__school_food__the_essential_guide-2.pdf

Sports Strategy – Sport Matters
http://www.dcalni.gov.uk/index/sport/sport_matters.htm

Sustainable Development Strategy
http://www.ofmdfmni.gov.uk/sustain-develop.pdf

The Ten Year Strategy of Children and Young People
http://www.ofmdfmni.gov.uk/index/equality/children-young-people/children-and-young-people-strategy.htm

Food in Schools Forum
Northern Ireland Audit Office report into Promoting Good Nutrition Through Healthy School Meals
http://www.niauditoffice.gov.uk/pubs/onepress.asp?arc=False&id=254&dm=0&dy=0

ADDITIONAL LINKS
Preventing Overweight and Obesity in Scotland: A Route Map Towards Healthy Weight;
http://www.scotland.gov.uk/Publications/2010/02/17140721/0

The Welsh draft document Obesity Pathway
http://wales.gov.uk/consultations/healthsocialcare/obesitypathway/?lang=en

Obesity- The Policy Challenges. The Report of the National Taskforce on Obesity 2005 from the Republic of Ireland
http://www.dohc.ie/publications/report_taskforce_on_obesity.html

Global Strategy on Diet, Physical Activity and Health (2004)
World Health Organisation
http://www.who.int/dietphysicalactivity/goals/en/index.html

Dietary interventions and physical activity interventions for weight management before, during and after pregnancy – NICE public health guidance 27
http://www.nice.org.uk/nicemedia/live/13056/49926/49926.pdf

Slán 2007 Survey of Lifestyle, Attitudes and Nutrition in Ireland
http://www.dohc.ie/publications/slan07_report.html

Low Income Diet and Nutrition Survey – Food Standards Agency
http://www.food.gov.uk/science/dietarysurveys/lidnsbranch/

NICE weight management in pregnancy guidance to help tackle rise in maternal obesity
http://www.nice.org.uk/newsroom/news/WeightManagementInPregnancyGuidance.jsp

Annex F

Endnotes

[1] The Annual Report of the Chief Medical Officer for Northern Ireland 2006
http://www.dhsspsni.gov.uk/cmoannualreport2006.pdf

[2] Obesity: Preventing and managing the global epidemic. Report on a WHO Consultation. Technical report series, no. 894. WHO, 2001.
http://www.who.int/nutrition/publications/obesity/WHO_TRS_894/en/index.html

[3] Fit Futures, Investing for Health, Department of Health, Social Services and Public Safety January 2006 Ref 126/2005 http://www.dhsspsni.gov.uk/ifh-fitfutures.pdf

[4] Foresight – Tackling Obesities: Future Choices – Project Report October 2007
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