Response to Interim Report of the Commission on Ending Childhood Obesity

June 2015

The Dietitians Association of Australia (DAA) is the national association of the dietetic profession with over 5800 members, and branches in each state and territory. DAA is a leader in nutrition and advocates for food and nutrition for healthier people and healthier nations. DAA appreciates the opportunity to provide feedback on the *Interim Report of the Commission on Ending Childhood Obesity* by the World Health Organisation.

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DAA interest in this consultation

As the leading nutrition and dietetic organisation in Australia, DAA is concerned about the prevention and management of childhood obesity in Australia and internationally.

DAA is responsible for the accreditation of university training courses for dietitians in Australia. Graduates of accredited courses are eligible to join the Accredited Practising Dietitian (APD) program which is the basis for self regulation of the dietetic profession in Australia. APDs have the skills and knowledge to work in a variety of settings including clinical practice, community and population health, food service, food industry, and media communications to prevent and manage childhood obesity.

Discussion

DAA finds the report to be comprehensive and agrees generally with the content and policy options outlined in the document. We offer the following specific comments for consideration.

Question 1 Are there issues that have been overlooked

Additional material

DAA suggests referencing the work of John J Reilly in the *Introduction* section, in particular the systematic review published in 2003 which considered the health consequences of obesity.[1]

Pregnant women

Item 44 predominantly discusses maternal undernutrition. Excessive weight gain during pregnancy is a problem in many countries and poses short and long term risks for the child. DAA would like to see more discussion about the importance of managing excessive gestational weight gain and reference to recent work in this area, such as that of De Jersey and colleagues from Queensland Australia.[2]

Specific focus on families

The consultation document mentions family interventions but DAA would like to see a greater focus on families, not just mothers or women.

The role of fathers warrants more attention. DAA is aware of excellent programs in Australia for example which are demonstrating better outcomes for both fathers and their children.[3]

School age child and adolescent

The section on school age children and adolescents includes relevant content but could be strengthened by additional material. For example food programs before and after school provide models of healthy eating in addition to ensuring children from poor households can attend in class because they have eaten before class. There are national and state guidelines in Australia for guidelines for food selection and preparation in school canteens. Dietitians in Tasmania have worked with schools to develop healthy fundraising guidelines for schools.

Programs must meet the needs of children and adolescents from culturally and linguistically diverse backgrounds, and those with special needs related to disabilities.

Workforce issues - Training

DAA agrees with policy options for strategic objective 3 that staff should be trained. Preparation is essential for dietitians as leaders in this area in order to deliver appropriate advice and support to patients and the health sector. Similarly other health professionals and community workers require training to ensure readiness at entry to the workforce. There is a need for post graduate training and for continuing development for health professionals and community workers to maintain and extend skills and knowledge in nutrition and physical activity.

DAA has recently indentified that training courses in the vocational education sector in Australia lack appropriate content in nutrition. This means that community workers may not have the skills and knowledge they need to support obesity initiatives in the community. DAA has responded to this by providing feedback to public consultations of the Community Services and Health Industry Skills Council as training packages are renewed.

Cooking skills

There is no mention of cooking skills in the document. There has been a decline in cooking skills in Western countries[4] with women working outside the home and an increase in the use of ready to eat meals. Adults may not have the skills needed to teach children at home about cooking, planning meals and budgeting, so it is important that children learn this and how to purchase, prepare and store foods for good health in school. Programs which engage with families can assist parents to gain skills and knowledge.

Question 2 How can your entity contribute

DAA would like to see more recognition of the contribution which dietitians can make in the prevention and management of obesity. APDs in Australia and dietitians in other countries have the practical skills, knowledge and experience to lead and participate in the development, implementation, and evaluation of childhood obesity programs.

DAA as an organisation can advocate for action on childhood obesity, ensure that competency standards for entry level practice are adequate for childhood obesity management, provide continuing professional development for APDs, and contribute to the development of initiatives.

Question 3 What are the enablers

National Nutrition Policy

DAA considers that policies on childhood obesity should sit within the broader framework of a national nutrition policy. Unfortunately Australia has not had a national nutrition policy since 1992. DAA understands this is on the work schedule for the Australian Government but there appears to be little progress.

Stakeholder engagement

Relevant and timely stakeholder engagement from the outset is needed to ensure appropriate skills and knowledge are available for program development, implementation and evaluation. This is important in gaining commitment from stakeholders.

Minimum data set

The development of an agreed minimum data set would assist in program evaluation without excessive burden. It would also promote consistency in analysis and evaluation within and across programs, and support the development of software for efficient data collection.

Funding

Access to funding would enable more people to get individual assistance. For example in Australia people with chronic disease such as diabetes can access up to five consultations per year with designated allied health professionals under Medicare through team care arrangements.[5] At present obesity alone does not make a person eligible, so considering obesity as a chronic disease for the purposes of the program is necessary. Furthermore, dietitians and other allied health professionals such as exercise physiologists must see clients in person to be eligible for Medicare chronic disease items. This is unfortunate as people living in remote areas have less

access to health professionals and teleconferencing would provide an adequate substitute for in person consultations for many clients.

Question 4 What are the potential barriers

The lack of funding to support ongoing initiatives and specific programs for individual, groups and communities is a barrier.

Reductions in the workforce in several Australian states has reduced capacity to address childhood obesity.

Limited dissemination of current education materials, for example, the Australian Government has not made funds available for ongoing printing of the 2013 Australian Dietary Guidelines. Online versions are available, but these lack flexibility for use in a variety of settings with children, families and other stakeholders.

References

1. Reilly JJ, Methven E, McDowell ZC, Hacking B, Alexander D, Stewart L, Kelnar CJH. Health consequences of obesity. Arch Dis Child 2003; 88 748-752 doi:10.1136/adc.ii.9.748
2. De Jersey SJ, Ross LJ, Himstedt K, McIntyre HD, Callaway LK. Weight gain and nutritional intake in obese pregnant women: Some clues for intervention. Nutr Dietet 2011; 68: 53–59 doi: 10.1111/j.1747-0080.2010.01470.x
3. Morgan PJ, Collins CE, Plotnikoff RC, Callister R, Burrows T, Fletcher R, Okely AD, Young MD, Miller A, Lloyd AB, Cook AT, Cruickshank J, Saunders KL, Lubans DR. The 'Healthy Dads, Healthy Kids' community randomized controlled trial: A community-based healthy lifestyle program for fathers and their children. Prev Med 2014; 61: 90-99
4. Lindsey P Smith LP, Shu Wen Ng SW, Popkin BM. Trends in US home food preparation and consumption: analysis of national nutrition surveys and time use studies from 1965–1966 to 2007–2008. Nutr J 2013; 12:45 http://www.nutritionj.com/content/12/1/45
5. Chronic disease management. http://www.health.gov.au/internet/main/publishing.nsf/content/health-medicare-health_pro-gp-pdf-allied-cnt.htm