Intersectoral Action on Child Obesity in New York, London, and Cape Town

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CUNY SCHOOL OF PUBLIC HEALTH
Overview

1. Intersectoral action (ISA) and child obesity
2. Case study methods
3. Three cities
4. Context and initiation
5. Policy and program design and implementation
6. Processes and impact
7. Successes and challenges
8. Recommendations
9. Summary
10. Acknowledgements
ISA, Child Obesity & NCDs

- Primordial prevention
- Whole-community approach
- Cities & urbanization
## Case Studies

<table>
<thead>
<tr>
<th></th>
<th>New York</th>
<th>London</th>
<th>Cape Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timeframe</td>
<td>2006-2012</td>
<td>2006-2012</td>
<td>2013</td>
</tr>
<tr>
<td>Number of Cases</td>
<td>5</td>
<td>5</td>
<td>12 interviews</td>
</tr>
<tr>
<td>Focus</td>
<td>Child obesity</td>
<td>Child obesity</td>
<td>Diet-related NCDs</td>
</tr>
</tbody>
</table>
## Three Cities

<table>
<thead>
<tr>
<th>Total population</th>
<th>New York</th>
<th>London</th>
<th>Cape Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>8,175,133</td>
<td>7,830,000</td>
<td>3,497,097</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Average population density</th>
<th>New York</th>
<th>London</th>
<th>Cape Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>9,814 pp/km²</td>
<td>4,959 pp/km²</td>
<td>1,425 pp/km²</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Poverty</th>
<th>New York</th>
<th>London</th>
<th>Cape Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>17%</td>
<td>20%</td>
<td>30%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Unemployment</th>
<th>New York</th>
<th>London</th>
<th>Cape Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>9%</td>
<td>7%</td>
<td>25%</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Race/ ethnicity</th>
<th>New York</th>
<th>London</th>
<th>Cape Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>44%</td>
<td>66%</td>
<td>19%</td>
</tr>
<tr>
<td>Black</td>
<td>26%</td>
<td>14%</td>
<td>35%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>27%</td>
<td>16%</td>
<td>2%</td>
</tr>
<tr>
<td>Asian</td>
<td>13%</td>
<td>4%</td>
<td>2%</td>
</tr>
<tr>
<td>Mixed</td>
<td>4%</td>
<td>4%</td>
<td>44%</td>
</tr>
<tr>
<td>Other</td>
<td>13%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Child obesity</th>
<th>New York</th>
<th>London</th>
<th>Cape Town</th>
</tr>
</thead>
<tbody>
<tr>
<td>21.7% of children between 6 and 12</td>
<td>21.8% of children aged 10 and 11</td>
<td>5.6% of youth between 13 and 18</td>
<td></td>
</tr>
</tbody>
</table>
Context & Initiation:

New York

- Health Code
- Office of School Health
- Both targeted & universal
- The healthy choice should be the easy choice
  - Food Safety for the 21st Century

Training and outreach for doctors & school nurses
School gardens, cooking, and nutrition
Move-to-Improve & Fitnessgram, Social marketing

Healthy Bodegas, Health Bucks, FRESH, Green Carts

Regulating daycare and school food environments
Transfat ban, calorie labeling, soda size limits
Nutritional standards on municipal procurement & vending
465 km of bike lanes
Active Design Guidelines
Context & Initiation:

London

National
Call for Action on Obesity and the National Healthy Schools Programme

Health and Social Care Act 2012
Context & Initiation:

CAPE TOWN

- Intergovernmental Relations Framework Act (2005)
- Quadruple burden of disease (2011)
- National Strategy (2012)
- Urban-global-nutrition transition
- High deprivation and food insecurity
- High residential segregation and inequality
- Western Cape Democratic Alliance

Double burden of over- and under-nutrition

Design & Implementation: New York

Reversing the Epidemic: The New York City Obesity Task Force Plan to Prevent and Control Obesity
May 2012

1. Expand nutrition and wellness programs in schools
2. Install water jets in school cafeterias
3. Expand school gardening
4. Install salad bars in all schools
5. Regulate nutrition at city-licensed summer camps
6. Increase physical activity for elementary school children
7. Add playground attendants to lead active play in parks
8. Share play spaces across programs for early childhood and adults
9. Increase active transport to school
Design & Implementation:

London

*London Health Improvement Board*

2011- March 2013

- London Obesity Framework
- Aims to engage “broadest set of stakeholders possible”
- Receives 3-6% of Local Authority public health funds
- Healthy Schools
- Established the London Health Commission, report due in autumn 2014

*London Health Board*

April 2013 -

- Prioritizing action on vertical coordination of health care delivery
- Acknowledges that child obesity, asserts that interventions should be locally driven

*LA Directors of Public Health and Health and Wellbeing Boards*

April 2013 -

- Responsibility for Public Health from PCTs to LAs
- Public Health Outcomes Framework will be used to assess accountability, e.g. NCMP
“There is no indication that drivers of the obesity epidemic in Africa are different to those in the developed world - however, the antecedents are more complex.”

Dr. Vicky Lambert

Design & Implementation: Cape Town

National
South African Declaration on the Prevention and Control of Non-communicable Diseases 2013-2017
Salt regulation

Provincial
Transversal Committee on Healthy Lifestyles
Professional Development on DSoH and HIA

Municipal
Urban agriculture
School food
Food policy gap
Key Processes

1. Identifying windows of opportunity
2. Establishing infrastructure and incentives for communication and cooperation across sectors
3. Legislative and non-legislative policymaking
4. Public health surveillance and program evaluation
5. Environmental health and food environment
6. Interaction between national, regional, and municipal authorities
Impact

New York

- **Greatest Declines**
  - Whites

- **Significant drop in obesity since 2006**

- **Modest Declines**
  - Blacks and Hispanics

- **Increased inequality**
Successes

1. Reduction or leveling off of prevalence
2. Initiation of ISA on child obesity
3. Leveraging local authority
4. Regulating relevant elements of the city
5. Increased efficiency
Challenges

1. Addressing social determinants
2. Extending primary care to include prevention
3. Food industry influences on public-sector action
4. Building consensus and sustaining momentum
5. Engaging diverse constituencies
6. Sectoral silos
Implications

1. Set and monitor health equity goals and indicators
   New York: Reduce the percentage of children who are obese by 15% (20.7% to 17.6%)

2. Address poverty as a social determinant of child health

3. Train workers in non-health city agencies in basic public health concepts

4. Create mechanisms for sharing the costs and savings of ISA

5. Establish accountability for coordinating efforts and evaluations
Summary

• Cities have an imperative to respond to NCDs

• ISA can develop from uncoordinated activities

• Reducing health inequality is more challenging than reducing prevalence

• Structure of government and leadership shape windows of opportunity

• ISA requires formal and informal mechanisms for collaboration

• Change takes time
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