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For the **Joint Action and Learning Initiative** see http://www.section27.org.za/2010/11/23/jali/

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A framework convention on obesity control?

Your Editorial (Aug 27, p 741)[1] proposing a framework convention on obesity control is the latest call in *The Lancet*'s pages for new international laws to address various issues including alcohol,[2] counterfeit drugs,[3] and impact evaluations.[4] Yet there is little evidence to show that such laws achieve results commensurate with their substantial costs, especially when compared with other policy options.

The direct costs associated with the drafting, ratification, and enforcement of international laws include not only countless meetings, air travel, and legal fees, but also duplicative governance structures—ie, conferences of parties and secretariats—which must forever be maintained. Indirectly, there are opportunity costs in focusing limited resources, energy, and rhetorical space on one particular issue and approach such that other important initiatives will realistically have to be shelved.

The legalisation of global health issues otherwise left in the political domain has the additional disadvantages of prioritising process over outcomes, consensus over diversity, generality over specificity, states over non-state actors, and lawyers over health researchers. International law is often vague on specific commitments, slow to be implemented, hard to enforce, and difficult to update. It constrains future decision-making and crowds out alternative approaches.[5] Confusing patchworks of issue-specific laws might also deepen challenges in global governance for health.

Non-binding "soft laws" such as WHO's codes on breastmilk and health worker migration could have similar effects, fewer costs, stronger language, and greater coverage. Before embarking on new solitary initiatives, research is needed on the full range of legal and other normative approaches and on how they can be integrated with existing mechanisms to avoid the proliferation of new governance platforms.

We declare that we have no conflicts of interest.

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In your Aug 27 Editorial,[1] you ask who will take the lead in creating a framework convention for obesity control. We agree that international law has an untapped potential to substantially improve global health. Yet this potential must be applied not only to obesity, tobacco, or other single health hazards, but also to global health as a whole, to respond, in a coordinated manner, to the health deprivations and inequities that stain our world.[2]

The Joint Action and Learning Initiative on National and Global Responsibilities for Health is exploring a framework convention on global health to establish a post-Millennium-Development-Goals framework to reduce health inequities and strengthen global governance grounded in the human right to health.[3] Taxation, marketing, and other legal tools needed to reduce obesity would come within the ambit of such a convention. We must reach not only the health sector, but also other sectors that have powerful health effects, such as agriculture, trade, and the environment.

The UN Secretary-General has called for the AIDS response to "set the stage for a future United Nations framework convention on global health."[4] And in WHO's reform agenda, Margaret Chan proposed a framework for global health.[5] Why not be bolder and use the organisation's far-reaching constitutional powers to reduce obesity, and even imagine a future for a framework convention on global health?

We declare that we have no conflicts of interest.

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The battle against obesity: lessons from tobacco

The Lancet's Obesity Series (Aug 27)[1] profiles the most important current non-communicable threat to health.[2] Unless successfully addressed, the attendant health-economic costs are unsustainable.[1–3]

There are striking parallels between obesity and cigarette smoking; we believe this comparison to be fruitful (webappendix). People's second and third decades seem pivotal to susceptibility to both risk factors.[2] Whereas many initiatives against smoking have been partly successful—eg, embracing harm reduction, tobacco substitution, and understanding why people start smoking or successfully desist[4]—there is little evidence for interventions that produce lasting effects on current degrees of overweight and obesity.[1,5]

Medicine and society have allowed weight gain, overweight, and obesity to develop into the accepted norm. To become, or to stay, overweight needs to be much harder. Although not underestimating the complexity, we advocate:

- A simple, universal, system for people to understand their previous, current, predicted, and desirable weights, and the health implications thereof (eg, "life weight charts" extending from adolescence to old age). This system could help stop obesity from seeming like someone else's problem.
- Early detection of obese children, with targeted educational intervention programmes for individuals and their families.
- Legislative or policy action that targets individual choices about energy expenditure, retarding or reversing inertial upwards drift in societal weight.
- Aggressive intervention for the seriously obese (ie, those with a body-mass index >35 kg/m^2) by exhortation, taxation, and increased health-care insurance premiums, coupled with positive presentation of change options.
- Mandating corporate responsibilities about production, distribution, pricing, and taxation of foodstuffs.

We declare that we have no conflicts of interest.

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Neglected tropical diseases and the HIV prevention agenda

We applaud Nancy Padian and colleagues (July 16, p 269)[1] for their thorough Review of the HIV prevention research agenda. Although Padian and colleagues address many crucial ways to break the transmission cycle, we point out one important omission: the intersection between HIV transmission and neglected tropical diseases (NTDs). With increasing evidence that infections such as female urogenital schistosomiasis (FUS) and helminthiases substantially increase the risk of HIV infection and speed disease progression,[2] it is essential that we no longer ignore the importance of the NTDs in the context of the HIV epidemic.

Specifically, preliminary research[3] has shown a three-fold increase in sexual transmission and incidence of HIV/AIDS in women with genital ulcers caused by FUS, as well as a substantial geographical overlap between areas of high HIV prevalence and regions where FUS is endemic.[4] Evidence also suggests that deworming reduces HIV viral load[5] and that maternal helminth infection increases risk of mother-to-child HIV transmission.[4]

Mounting evidence supports the addition of this intersection between HIV/AIDS and NTDs to the HIV prevention research agenda. Since treatments for several NTDs are cheaply available,[4] integration of NTD and HIV/AIDS delivery platforms offers a rare and substantial opportunity for efficiency and savings, particularly in the face of escalating financial constraints to the maintenance and escalation of HIV/AIDS treatment. Finally, increased research to establish the population-level effects of NTDs on HIV/AIDS will offer an avenue for better understanding, prevention, and treatment of both HIV and several long-neglected infections of the "bottom billion".

For ***The Lancet's*** **Obesity Series** see http://www.thelancet.com/series/obesity

See **Online** for webappendix