END CHILDHOOD OBESITY

1. PROMOTE INTAKE OF HEALTHY FOODS
2. PROMOTE PHYSICAL ACTIVITY
3. PRECONCEPTION AND PREGNANCY CARE
4. EARLY CHILDHOOD DIET AND PHYSICAL ACTIVITY
5. HEALTH, NUTRITION AND PHYSICAL ACTIVITY FOR SCHOOL-AGE CHILDREN
6. WEIGHT MANAGEMENT

END CHILDHOOD OBESITY
IMPLEMENT COMPREHENSIVE PROGRAMMES THAT PROMOTE THE INTAKE OF HEALTHY FOODS AND REDUCE THE INTAKE OF UNHEALTHY FOODS AND SUGAR-SWEETENED BEVERAGES BY CHILDREN AND ADOLESCENTS.

1. Ensure that appropriate and context-specific nutrition information and guidelines for both adults and children are developed and disseminated in a simple, understandable and accessible manner to all groups in society.

1.1 Implement an effective tax on sugar-sweetened beverages.

1.2 Implement the Set of Recommendations on the Marketing of Foods and Non-alcoholic Beverages to Children to reduce the exposure of children and adolescents to, and the power of, the marketing of unhealthy foods.

1.3 Develop nutrient-profiles to identify unhealthy foods and beverages.

1.4 Establish cooperation between Member States to reduce the impact of cross-border marketing of unhealthy foods and beverages.

1.5 Implement a standardized global nutrient labelling system.

1.6 Implement interpretive front-of-pack labelling, supported by public education of both adults and children for nutrition literacy.

1.7 Require settings such as schools, child-care settings, children’s sports facilities and events to create healthy food environments.

1.8 Increase access to healthy foods in disadvantaged communities.
IMPLEMENT COMPREHENSIVE PROGRAMMES THAT PROMOTE PHYSICAL ACTIVITY AND REDUCE SEDENTARY BEHAVIOURS IN CHILDREN AND ADOLESCENTS.

2.1 Provide guidance to children and adolescents, their parents, caregivers, teachers and health professionals on healthy body size, physical activity, sleep behaviours and appropriate use of screen-based entertainment.

2.2 Ensure that adequate facilities are available on school premises and in public spaces for physical activity during recreational time for all children (including those with disabilities), with the provision of gender-friendly spaces where appropriate.

INTEGRATE AND STRENGTHEN GUIDANCE FOR NONCOMMUNICABLE DISEASE PREVENTION WITH CURRENT GUIDANCE FOR PRECONCEPTION AND ANTENATAL CARE, TO REDUCE THE RISK OF CHILDHOOD OBESITY.

3.1 Diagnose and manage hyperglycaemia and gestational hypertension.

3.2 Monitor and manage appropriate gestational weight gain.

3.3 Include an additional focus on appropriate nutrition in guidance and advice for both prospective mothers and fathers before conception and during pregnancy.

3.4 Develop clear guidance and support for the promotion of good nutrition, healthy diets and physical activity, and for avoiding the use of and exposure to tobacco, alcohol, drugs and other unhealthy substances.
PROVIDE GUIDANCE ON, AND SUPPORT FOR, HEALTHY DIET, SLEEP AND PHYSICAL ACTIVITY IN EARLY CHILDHOOD TO ENSURE CHILDREN GROW APPROPRIATELY AND DEVELOP HEALTHY HABITS.

4.6 Provide clear guidance and support to caregivers to avoid specific categories of foods (e.g. sugar-sweetened milks and fruit juices or energy-dense, nutrient-poor foods) for the prevention of excess weight gain.

4.7 Provide clear guidance and support to caregivers to encourage the consumption of a wide variety of healthy foods.

4.8 Provide guidance to caregivers on appropriate nutrition, diet and portion size for this age group.

4.9 Ensure only healthy foods, beverages and snacks are served in formal child care settings or institutions.

4.10 Ensure food education and understanding are incorporated into the curriculum in formal child-care settings or institutions.

4.11 Ensure physical activity is incorporated into the daily routine and curriculum in formal child care settings or institutions.

4.12 Provide guidance on appropriate sleep time, sedentary or screen-time, and physical activity or active play for the 2-5 years of age group.

4.13 Engage whole-of-community support for caregivers and child care settings to promote healthy lifestyles for young children.
IMPLEMENT COMPREHENSIVE PROGRAMMES THAT PROMOTE HEALTHY SCHOOL ENVIRONMENTS, HEALTH AND NUTRITION LITERACY AND PHYSICAL ACTIVITY AMONG SCHOOL-AGE CHILDREN AND ADOLESCENTS.

5.1 Establish standards for meals provided in schools, or foods and beverages sold in schools, that meet healthy nutrition guidelines.

5.2 Eliminate the provision or sale of unhealthy foods, such as sugar-sweetened beverages and energy-dense, nutrient-poor foods, in the school environment.

5.3 Ensure access to potable water in schools and sports facilities.

5.4 Require inclusion of nutrition and health education within the core curriculum of schools.

5.5 Improve the nutrition literacy and skills of parents and caregivers.

5.6 Make food preparation classes available to children, their parents and caregivers.

5.7 Include Quality Physical Education in the school curriculum and provide adequate and appropriate staffing and facilities to support this.
PROVIDE FAMILY-BASED, MULTICOMPONENT, LIFESTYLE WEIGHT MANAGEMENT SERVICES FOR CHILDREN AND YOUNG PEOPLE WHO ARE OBSESE.

6.1 Develop and support appropriate weight management services for children and adolescents who are overweight or obese that are family-based, multicomponent (including nutrition, physical activity and psychosocial support) and delivered by multi-professional teams with appropriate training and resources, as part of Universal Health Coverage.
 ACTIONS AND RESPONSIBILITIES FOR IMPLEMENTING THE RECOMMENDATIONS

WHO

A. Institutionalize a cross-cutting and life-course approach to ending childhood obesity across all relevant technical areas in WHO headquarters, regional and country offices.

B. Develop, in consultation with Member States, a framework to implement the recommendations of the Commission.

C. Strengthen capacity to provide technical support for action to end childhood obesity at global, regional and national levels.

D. Support international agencies, national governments and relevant stakeholders in building upon existing commitments to ensure that relevant actions to end childhood obesity are implemented at global, regional and national levels.

E. Promote collaborative research on ending childhood obesity with a focus on the life-course approach.

F. Report on progress made on ending childhood obesity.

International organizations

A. Cooperate to build capacity and support Member States in addressing childhood obesity.
International organizations

A. Cooperate to build capacity and support Member States in addressing childhood obesity.

Members States

A. Take ownership, provide leadership and engage political commitment to tackle childhood obesity over the long term.

B. Coordinate contributions of all government sectors and institutions responsible for policies, including, but not limited to: education; food, agriculture; commerce and industry; development; finance and revenue; sport and recreation; communication; environmental and urban planning; transport and social affairs; and trade.

C. Ensure data collection on BMI-for-age of children - including for ages not currently monitored - and set national targets for childhood obesity.

D. Develop guidelines, recommendations or policy measures that appropriately engage relevant sectors – including the private sector, where applicable – to implement actions, aimed at reducing childhood obesity, as set out in this report.
**Nongovernmental organizations**

A. Raise the profile of childhood obesity prevention through advocacy efforts and the dissemination of information.

B. Motivate consumers to demand that governments support healthy lifestyles and that the food and non-alcoholic beverage industry provide healthy products, and do not market unhealthy foods and sugar-sweetened beverages to children.

C. Contribute to the development and implementation of a monitoring and accountability mechanism.

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**The private sector**

A. Support the production of, and facilitate access to, foods and non-alcoholic beverages that contribute to a healthy diet.

B. Facilitate access to, and participation in, physical activity.
**Philanthropic foundations**

A. Recognize childhood obesity as endangering child health and educational attainment and address this important issue.

B. Mobilize funds to support research, capacity-building and service delivery.

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**Academic institutions**

A. Raise the profile of childhood obesity prevention through the dissemination of information and incorporation into appropriate curricula.

B. Address knowledge gaps with evidence to support policy implementation.

C. Support monitoring and accountability activities.
The overarching goals of the Commission on Ending Childhood Obesity are to provide policy recommendations to governments to prevent infants, children and adolescents from developing obesity, and to identify and treat pre-existing obesity in children and adolescents.

The aims are to reduce the risk of morbidity and mortality due to noncommunicable diseases, lessen the negative psychosocial effects of obesity both in childhood and adulthood and reduce the risk of the next generation developing obesity.
PREVALENCE OF OVERWEIGHT IN CHILDREN UNDER 5 YEARS OF AGE, BY WHO REGION AND WORLD BANK INCOME GROUP, COMPARABLE ESTIMATES, 2014
In absolute numbers more overweight and obese children live in low- and middle-income countries than in high-income countries.

Childhood obesity is a strong predictor of adult obesity, which has well known health and economic consequences, both for the individual and society as a whole.
Without joint ownership and shared responsibility, well-meaning and cost-effective interventions have limited reach and impact.

STRATEGIC OBJECTIVES

No single intervention can halt the rise of the growing obesity epidemic. To successfully challenge childhood obesity requires addressing the obesogenic environment as well as critical elements in the life-course.
Major goals of addressing the environmental components include improving healthy eating and child physical activity behaviours.

Many factors influence the obesogenic environment, including political and commercial factors (trade agreements, fiscal and agricultural policies and food systems); The built environment (availability of healthy foods, infrastructure and opportunities for physical activity in the neighbourhood);

Social norms (body weight and image, cultural norms regarding the feeding of children and the status associated with higher body mass in some population groups, social restrictions on physical activity) and family environment (parental nutrition knowledge and behaviours, family economics, family eating behaviours).
Developmental factors change both the biology and behaviour of individuals from before birth and through infancy, such that they develop with a greater or lesser risk of developing obesity.

The Commission considers it essential to address both the environmental context and three critical time periods in the life-course: preconception and pregnancy, infancy and early childhood and older childhood and adolescence.
TREAT CHILDREN WHO ARE OBESE TO IMPROVE THEIR CURRENT AND FUTURE HEALTH

When children are already overweight or obese, additional goals include reduction in the level of overweight, improvement in obesity-related comorbidities and improvement in risk factors for excess weight gain. The health sector in each country varies considerably and will face different challenges in responding to the need for treatment services for those with obesity. However, the management of children with overweight and obesity should be included in effective services extended under Universal Health Coverage.
The Commission recognizes that the scope of potential policy recommendations to address childhood obesity is broad and contains a number of novel elements, including a focus on the life-course dimension and on the education sector. A multisectoral approach will be essential for sustained progress.

Countries should measure BMI-for-age to establish the prevalence and trends in childhood obesity at national, regional and local levels. They should also gather data on nutrition, eating behaviours and physical activity of children and adolescents across different socioeconomic groups and settings. Although some data are collected (21), there remains a significant gap for children over 5 years of age that needs addressing. This data will guide the development of appropriate policy priorities and provide a baseline against which to measure the success of policies and programmes.
## Relative risks associated with obesity

<table>
<thead>
<tr>
<th>Greatly elevated (&gt;3)</th>
<th>Moderately Elevated (2-3)</th>
<th>Slightly increased (1-2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NIDDM</td>
<td>CHD</td>
<td>Cancer breast cancer (in post menopausal women), endometrial, colon</td>
</tr>
<tr>
<td>Gallbladder disease</td>
<td>Hypertension</td>
<td>Reproductive hormone abnormalities</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>Osteoarthritis</td>
<td>Polycystic ovary syndrome</td>
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<tr>
<td>Insulin Resistance</td>
<td>Hyperuricemia and gout</td>
<td>Impaired fertility</td>
</tr>
<tr>
<td>Breathlessness</td>
<td></td>
<td>Low back pain Anesthesia complications</td>
</tr>
<tr>
<td>Sleep apnea</td>
<td></td>
<td>Fetal defects in maternal obesity</td>
</tr>
</tbody>
</table>

**WHO TRS 894 Obesity: Preventing and Managing the Global Epidemic**
Deaths attributable to 16 leading risk factors: all countries, 2001

Adapted from World Health Report 2003
Obesity is the main target in the US government’s latest dietary guidelines. But can this advice really make a difference?

“If people want French fries and a double cheeseburger we’re gonna give them that.” — Bob Goldin

*Nature*’s reporters sift through the heady mix of politics and science to get a taste of things to come.
Individual responsibility

Change in the Environment

Uauy and Monteiro 2004
The Two Key Words

Personal Responsibility

“It’s about personal responsibility”

DHHS Surgeon General

“... we have to continue to work hard to spread the gospel of personal responsibility.”

President of the National Restaurant Association

“Personal responsibility is a very important part of this because we can’t look at someone else to solve our problems.”

DHHS Secretary
Sir George Alleyne
Director Emeritus
Pan American Health Organization (PAHO)

Dr Constance Chan Hon Yee
Director of Health Department of Health Hong Kong Special Administrative Region China

Ms Helen Clark
Administrator
United Nations Development Programme (UNDP)

Sir Peter Gluckman (co-chair)
Chief Science Advisor to the Prime Minister of New Zealand & Liggins Institute University of Auckland New Zealand

Mr Adrian Gore
Founder and Chief Executive Officer Discovery Group South Africa

Ms Betty King
Former Ambassador
Permanent Mission of the United States of America to the United Nations Office and other International Organizations at Geneva

Ms Nana Oye Lithur
Minister of Gender, Children and Social Protection Ghana

Dr David Nabarro
Coordinator, Scaling up Nutrition (SUN) Movement Special Representative of the UN Secretary General for Food Security and Nutrition Coordinator for the High Level Task Force

Dr Sania Nishtar (co-chair)
Founder, Heartfile Pakistan

Ms Paula Radcliffe
Athlete and parent United Kingdom

Professor Hoda Rashad
Research Professor and Director Social Research Center American University in Cairo Egypt

Professor K. Srinath Reddy
President Public Health Foundation of India Institute of Studies in Industrial Development (ISID) Campus India

Dr Jacques Rogge
Honorary President International Olympic Committee (IOC) Switzerland

Ms Sachita Shrestha
Youth Advocate Nepal

Dr Colin Tukuitonga
Director-General Secretariat of the Pacific Community (SPC) New Caledonia
Ensure that appropriate and context specific nutrition information and guidelines for both adults and children are developed and disseminated in a simple, understandable and accessible manner to all groups in society.
Physical activity can reduce the risk of diabetes, cardiovascular disease and cancers, and improve children’s ability to learn, their mental health and well-being.
The care that a woman receives before, during and after pregnancy has profound implications for the later health and development of her child.

INTEGRATE AND STRENGTHEN GUIDANCE FOR NONCOMMUNICABLE DISEASE PREVENTION WITH CURRENT GUIDANCE FOR PRECONCEPTION AND ANTENATAL CARE, TO REDUCE THE RISK OF CHILDHOOD OBESITY.

3.4

Develop clear guidance and support for the promotion of good nutrition, healthy diets and physical activity, and for avoiding the use of and exposure to tobacco, alcohol, drugs and other toxins.
PROVIDE GUIDANCE ON AND SUPPORT FOR HEALTHY DIET, SLEEP AND PHYSICAL ACTIVITY IN EARLY CHILDHOOD TO ENSURE CHILDREN GROW APPROPRIATELY AND DEVELOP HEALTHY HABITS.

4.1
Enforce relevant measures to promote International Marketing Code for breast milk Substitutes, as subsequent Assembly recommendations suggest.

4.2
Ensure all facilities for the Ten Steps to Successful Breastfeeding.
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However, the management of children with overweight and obesity should be included in effective services extended under Universal Health Coverage.