World Obesity Federation’s response to WHO Discussion Paper ‘Draft recommendations for the prevention and management of obesity over the life course, including potential targets’

World Obesity Federation reports in 2019\(^1\) and 2020\(^2\) show that no country is on track to meet the WHA NCD targets, reinforcing the need for a much more robust and well-coordinated response. As such, we welcome the draft recommendations and congratulate WHO on the efforts to produce this paper. This marks an important moment where our improved understanding of the complexities and drivers of obesity are being used to develop comprehensive policy recommendations for prevention and treatment in adults and children alike.

World Obesity calls on Member States to request WHO’s Executive Board to adopt this document as a draft resolution to be presented before the 75\(^{th}\) World Health Assembly. We also invite international organisations and other relevant stakeholders to collaborate with Member States to mark World Obesity Day annually on March 4\(^{th}\).

The document highlights a number of important considerations for the prevention, treatment and management of obesity throughout the lifecourse, and steps that are needed to help support people living with obesity and countries to meet the existing targets. In particular, we welcome that the draft:

- Recognises obesity as a complex multifactorial disease
- Acknowledges the stigma and bias experienced by people living with obesity in different geographies and cultures
- Recognises the need to prevent and manage obesity throughout the lifecourse
- Makes recommendations for improving the training of healthcare providers (HCPs) in obesity management
- Makes recommendations for obesity to be included in universal health coverage (UHC) packages, and managed through multidisciplinary teams
- Recognises the need to build on existing strategies, such as ECHO and the Global Action Plan on NCDs
- Highlights the importance of regulating food environments through taxation and incentives

However, there are a number of important areas where the document could be improved to ensure that it is comprehensive and formulates meaningful recommendations that can help stimulate change. Specifically, we would urge to strengthen the following areas:

- Ensure the recognition and urgent need to address commercial determinants of health in efforts to prevent, manage and treat obesity
- Improve health services including ensuring equitable access, financing, and training of healthcare professionals

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Make recommendations to develop strong monitoring and accountability frameworks which encompass and hold accountable all actors in the obesity agenda, and ensure the necessary resources are available and accessible to all

Ensure that the proposed recommendations are adaptable across different settings

Overarching framework

Although the document calls for multisectoral approaches and covers a comprehensive range of actions, it lacks an overarching framework that Member States can adopt (and be held accountable towards) to help shape the implementation of national obesity plans. In 2020, World Obesity in consultation with its members, developed the ROOTS framework which sets out an integrated, equitable, comprehensive and person-centred approach to addressing obesity (Annex 1). The framework is based on five key pillars which encompass recognition of obesity as a disease, enhanced monitoring and surveillance, prevention of obesity throughout the lifecourse, the provision of improved health services and treatment for people living with obesity, and the need for a systems approach. We strongly encourage such an approach to be included in the recommendations, and for WHO and Member States to integrate this framework and associated principles into their approach for addressing obesity, especially when developing national action plans.

- ADD before P40: Adopt the ROOTS framework principles in their approach to defining, understanding and addressing obesity. See: [https://www.worldobesity.org/what-we-do/our-policy-priorities/the-roots-of-obesity](https://www.worldobesity.org/what-we-do/our-policy-priorities/the-roots-of-obesity)

The following recommendations are structured around this framework.

R – Recognise that obesity is a disease in its own right as well as a risk factor for other conditions

Definition and categorisation of obesity: WHO’s own definition of obesity is abnormal and/or excessive accumulation of body fat that presents a risk to health, yet this is missing from the text. The role of epigenetics in causing obesity is also not adequately referenced. The failure to categorise obesity as a chronic disease is an important omission; its inclusion could help strengthen obesity action within the context of existing NCD policy frameworks, initiatives and targets. Furthermore, throughout the document it would be more accurate to refer to overweight as pre-obesity (overweight) to recognise that weight is not the only consideration.

- ADD to P1: Given the complexity of obesity, policy and advocacy interventions need to set out an integrated, equitable, comprehensive and person-centred approach to address obesity, with immediate action across the obesity spectrum from prevention to treatment.

- ADD after P1: 40% to 70% of obesity can be attributed to genetics, with close to 100 different genes identified as strongly associated with obesity. With some individuals being at increased risk due to certain predispositions, obesity will occur as a consequence of the interaction of our genes with our obesogenic...
environments, and impact our behaviours and bodies in a number of ways affecting appetite, satiety, metabolism, body-fat distribution and are exacerbated less by amount than type of calories ingested.

- **ADD to P2**: Waist circumference and waist-hip ratio have also been recognised as additional indicators for identifying individuals at increased risk of obesity-related morbidity.

**People first language and stigma**: There are a number of examples throughout the document where people first language is not used. People first language puts the individual before the disease which helps prevent dehumanising individuals, over simplifying obesity and reinforcing common misconceptions about obesity which contribute to weight stigma. Related to this, stigma in the health system has been identified as a major barrier to people living with obesity accessing quality care and increased training of health providers is required to ensure they can approach the topic in a sensible, culturally appropriate, non-stigmatising manner.

- **REPLACE P5**: Childhood obesity is likely to track into adulthood and increase the risk of various NCDs in adulthood
- **ADD after P18**: Governments should ensure national plans include actions that address the inequalities and stigma faced by people living with obesity, for instance in schools, healthcare settings and local communities. Local governments should ensure that all aspects of the legal framework and policies under its control promote and protect health.
- **ADD after P27**: Develop social and legal protections against weight bias, stigma, and discrimination. Weight-based discrimination should be included in Human Rights Acts, and schools and government policies.
- **ADD after P32**: Provide education about the multifaceted roots of obesity, recognising the complexities, to help address stigma and weight bias.
- **ADD before P35**: Advocate to change the common narrative which frames obesity as the responsibility of the individual and further detracts from support for comprehensive prevention, treatment and management measures. This should recognise that obesity is often driven by forces outside of a person’s control, including biology, genes, mental health, access to healthcare and exposure to ultra-processed foods, as well as factors that lie outside of the health sector and are influenced by economic, environmental, commercial and social determinants.

**Recognise the importance of lived experience**: ‘Lived experience’ is one of the most valuable insights that can help inform a policy, whether it be lived experience of obesity or other NCDs. Of particular importance in the context of obesity policies is the meaningful engagement of People living with obesity (PLWO) which helps amplify the needs and concerns of PLWO and help ensure policies and services available are non-stigmatising, sustainable and promote health equity an empowers people to act on individual, community, societal and global level.

- **ADD after P18**: Utilise the skills, experience and knowledge of civil society and people with lived experience – particularly people living with obesity and young people – in the development, implementation and monitoring of obesity policy and planning
- **ADD after P16**:  
  - Meaningful inclusion of people living with obesity in all policymaking processes from development to implementation and evaluation
  - Acknowledgement of the pervasiveness of weight stigma and bias, including among health care professionals and policymakers as well as the general public
  - Incorporation of the rights of people with obesity within human rights legislation, workplace discrimination legislation, healthcare systems and education
O – Obesity monitoring and surveillance must be enhanced to strengthen effective strategies for preventing and treating obesity.

**Surveillance and monitoring systems:** Currently, there is a lack of a robust monitoring and surveillance system for obesity, making it challenging to track progress and hold Member States and other relevant stakeholders accountable.

- **REPLACE P18:** Governments should establish robust surveillance systems, including rolling measurement programmes to identify trends, drivers and priority populations. They should also fund research on the drivers and solutions for obesity and share information with other countries.

- **ADD after P25:** Integrate obesity surveillance into primary and secondary healthcare, and generate data which allows the disaggregation of deaths for which obesity is the main cause.

- **CHANGE P34:** Monitor policy and programme implementation in different sectors, including access to health care, physical activity environments, food systems, quality of care, capacity of health care workers. Where possible, this should draw from the methodology of existing frameworks such as the INFORMAS framework\(^3\) for monitoring food environments.

**Robust accountability frameworks:** Related to monitoring and surveillance, the adoption of an accountability framework based on ROOTS to support these recommendations would increase the accountability of Member States and other relevant stakeholders to act and ensure the necessary resources are available and accessible to all. This would also allow to share evidence of best-practices and learn from previous wins and challenges when developing and implementing new policies/interventions.

- **ADD to end of (d)P26:** Implemented policies should be legally-binding and mandatory, rooted in strong monitoring and evaluation frameworks.

- **ADD after P36:** Hold governments and other actors to account for their implementation of these recommendations, based on existing frameworks or encourage the adoption of newly developed frameworks such as ROOTS.

- **ADD to P47:** Work with Member States to develop a monitoring and evaluation accountability framework to support these recommendations and targets.

- **ADD after P51:** The Executive Board requests WHO to work with Member States to develop a monitoring and evaluation accountability framework to support the implementation of recommendations and targets.

**Strengthening the evidence base:** There is a need for purposeful action to strengthen the evidence base, which is currently skewed towards small scale, short term, individual level actions rather than the systemic changes that will be necessary to transform the unhealthy environments that contribute to obesity. These recommendations should call for the need for robust evidence on how to reshape complex food, physical activity, commercial and other systems to achieve meaningful improvements in health and environmental outcomes.

In addition, our current knowledge and evidence on obesity is largely HIC focused, despite the fact that LMICs are experiencing the greatest rise in obesity rates. Data is often scarce in LMICs, and these recommendations should

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\(^3\) https://www.informas.org/
highlight the need to expand the evidence base across different cultures and contexts. More investment in research is needed. Global health philanthropies and academics should fund research to better understand the context, determinants, health systems and possible solutions for obesity in LMICs and other low-resource settings.

- **ADD to P37:** with a particular attention to better understanding screening tools, the context, determinants and possible solutions in LMICs and other low-resource settings.
- **ADD additional recommendations for parts of government finance agencies after P34:**
  - *Invest in research in obesity policy and practice to promote best practice and evidence-based solutions. Despite LMICs experiencing the greatest rise in obesity rates, data is often scarce. We urgently need to increase investments in that field and expand the evidence base across different cultures. Global health philanthropies and academics should fund research to better understand the context determinants and possible solutions for obesity in LMICs and other low-resource settings*
  - *Support global research on the obesity to improve the fundamental understanding of the biology of obesity, which will ultimately improve care.*
- **ADD additional recommendations for philanthropic foundations after P39:**
  - *Mobilise funds to support research, capacity building and service delivery. Philanthropic foundations are uniquely placed to make significant contributions to global public health and can also engage in monitoring and accountability activities.*

**O – Obesity prevention strategies must be developed, tested and implemented across the life course, from pre-conception, through childhood, and into older age.**

**Commercial determinants:** Crucially, the document fails to mention the commercial determinants of health. Working with economic actors in the food system will be essential, while ensuring robust governance mechanisms are in place to minimise conflicts of interest. We would like to see this document drawing from the 2021 WHA Social Determinants of Health resolution, as well as the growing body of evidence on the commercial determinants of health, especially around the role of ultra-processed foods in driving obesity.

- **ADD before P26:** The proliferation of ultra-processed foods and foods high in fat, sugar and salt is of concern, particularly in LMICs which also have high levels of undernutrition. Governments need to implement double-duty actions to address all forms of malnutrition including underweight, stunting, wasting, and pre-obesity (overweight)/obesity. Undernutrition and pre-obesity (overweight)/obesity are co-dependent and share common roots including biological, environmental, economic and social factors, and many countries have overlapping forms of malnutrition.
- **ADD before P26:** Address the commercial determinants of health by implementing policies, including graphic front-of-package labelling, taxation, regulations and legislation to create health promoting food environments.
ADD before P26: Policies, partnerships and dialogues relating to nutrition must adopt rigorous principle of engagement to prevent commercial interests from undermining health goals. Strengthen accountability systems to create healthy food environments. Holding public and private sector actors to account for actions can help monitor progress and incentivise change, as well as help to mitigate some of the impacts of commercial determinants of health.

ADD before P44: Finalise the draft guidance on managing conflicts of interest in nutrition that were developed in 2017 to support Member States with managing conflicts of interest and reducing risk of undue influence on policies by commercial actors.

ADD after P32: Schools should develop nutrition policies following appropriate national guidelines promoting a lower consumption of foods high in fat, sugar and salt, and encourage the consumption of whole grains, fruits, vegetables and support the establishment of healthy behaviour environments.

T – Treatment of obesity – including behavioural, pharmacological, digital, nutritional, physical activity based and surgical interventions – should be accessible to all people with obesity

Improving health care provision: While the document covers obesity throughout the life course, it places a greater emphasis on care for children with obesity. While much of this is historic due to previous WHO work, it is vital that healthcare provision for adults is addressed as an equal priority, and that WHO develops guidance accordingly. As well as the multidisciplinary teams and increased training for HCPs that are outlined in the document already, patient care may be further improved by making obesity a recognised medical speciality.

ADD after P19: Develop care guidelines and recommendations to address obesity through the life course including pre-conception/pregnancy, childhood, adolescence, adulthood and older age. Adult throughout the life stage should have access to prevention, screening, diagnosis, nutrition, counselling, psychological support, treatment and management services.

CHANGE P20: Include obesity management among the core tasks of primary care. [ADD: This will require an increase in available funding as well as more evidence-based guidelines and increased training of health care professionals to ensure they are able to approach the topic in a sensible, culturally appropriate, non-stigmatising manner.] Healthcare benefit plans should include coverage for a range of obesity prevention and management services with guaranteed financial protection.

CHANGE P21: All pregnant individuals would benefit from receiving healthy lifestyle guidelines and support for nutrition, physical activity, sleep, cessation of substance use such as tobacco and alcohol. Maintaining a healthy lifestyle in pregnancy has physical and mental health benefits for both mother and future child. Healthcare professionals should assess the individual context of each person planning a pregnancy, experiencing a pregnancy, and in the postpartum period to effectively address the root causes of excess weight and support them with healthy weight management before, during and after their pregnancy; this includes aiming for healthy gestational weight gain within recommended ranges, and avoiding post-partum weight retention.

4 https://www.who.int/nutrition/consultation-doi/nutrition-introductory-paper.pdf
• **ADD to P23:** UHC is underpinned by a human right to enjoy the highest attainable standard of physical and mental health. Governments have a responsibility to reduce the health and social consequences of obesity.

• **ADD a specific point on obesity training before P45:** Healthcare professionals should be trained in treating and managing obesity to improve the level of care and positive outcomes for people with Obesity. This includes graduate programmes as well as training courses for existing health professionals.

**Mental Health:** The relationship between mental health and obesity, both as a driver and a complication, is increasingly evident. Supporting the mental health as well as physical health of people living with obesity is vital in any multidisciplinary services to support the management of obesity. There are multiple places throughout the document where the mental health considerations of obesity can be made explicit.

• **ADD after P7:** People living with obesity are more likely to experience severe mental health consequences that lead to lower levels of self-esteem, higher likelihood of being bullied, as well as poor psychosocial outcomes, mediated by external and internal weight bias and stigma. Psychological impacts include poor body image, anxiety, stress and depression. Preventing and treating obesity therefore provides an important opportunity to halt a course to poor health and social outcomes.

• **CHANGE P24:** Integrate obesity into multidisciplinary teams to ensure people with obesity get adequate support and treatment, including for the comorbidities of obesity and mental health. Provide equitable access to care for all who want/need it.

**S – Systems-based approaches should be applied to the treatment and prevention of obesity.**

**Obesity in all policies:** We commend the whole-of-government and whole-of-society approach called for but would like to see greater recognition of the environmental and social roots of obesity in the actions identified, as well as more explicit reference to human rights. Alongside food system policies, government action is needed to promote physical activity. The need for regulatory policies to enforce the development and design of built environments that support active living should be included in the document. Many of the structural actions for addressing obesity have huge co-benefits for undernutrition and the environment, as recognised by The Lancet Commission on the Global Syndemic of Obesity, Undernutrition and Climate Change.

• **ADD [after para 3]:** An environment is defined as obesogenic when it adversely affects healthy nutrition and physical activity. Today, we live in environments where proliferation of cheap and available high energy density food dominates, while opportunities to be physically active are reduced, consequently causing excess weight gain. Obesity is thus not a matter of personal failure, but a disease state developed in response to an obesogenic environment.

• **REPLACE P16:** Given the complexity of obesity, policy and advocacy interventions need to set out an integrated, equitable, comprehensive and person-centred approach to address obesity, with immediate action across the obesity spectrum from prevention to treatment, including:
  - Whole-of-government and whole-of-society approach [ADD: and ensure policies and interventions consider the role and importance of different environments including the education, health, food, social protection and water and sanitation systems.]

• **ADD after P16:**
Government efforts to address obesity and create healthy, safe and sustainable living environments should be guided by human rights principles, including rights of children, rights to food and rights to health, amongst others.

- ADD after P18: Government should recognise the leadership that can stem from local leaders such as politicians, mayors, bureaucrats and policy makers and their influence over social determinants of health. Local governments should recognise the importance of adopting systemic and multisectoral approaches to address all forms of malnutrition and the importance of regulations in creating health promoting environments. Local governments should ensure that all aspects of the legal framework and policies under its control promote and protect health.

- ADD before P26: Food systems interventions should address the root causes of malnutrition and incorporate health in all policies approaches. Governments should favour the implementation of double-duty actions to simultaneously address undernutrition, obesity and other diet-related NCDs. These should be multi-sectoral and focus on engaging with all relevant actors.

- REPLACE P27: Design social protection programmes to help address health and socioeconomic inequities. This should include but not be limited to programmes that facilitate the access to healthy diets, green spaces, health services, employment and education.

- ADD before P28: Health should be integrated in spatial and financial planning strategies at all times. Planned interventions should focus on generating changes in social, physical, commercial and individual environments, with a focus on people’s well-being.

- ADD before P28: Policies to facilitate and promote active lifestyles should be implemented and encompass cross-sector, multi-stakeholder collaboration to build walking and cycling infrastructure, increase the access and quality of public open and green spaces, improve road safety, and promote active transport, among other things.

Obesity in the global health agenda: At present the document focuses disproportionately on assumptions and research carried out in HICs, and as such focuses on a HIC narrative of obesity, whereas rates are rising most rapidly, and with fewest resources, in LMICs. It is vital that policies and actions are adapted and identified for a range of settings. Overweight and obesity, including how it is perceived, are affected by differences in culture and geography amongst other factors, and these recommendations should reflect this. Decolonising obesity by incorporating the diversity of evidence and experiences worldwide will lead to the development of appropriate solutions. Recognising that addressing obesity has much wider benefits for global health and development is important and should be reflected in the document. While not explicitly included in the SDG framework, obesity has relevance across a number of the SDGs. Triple-duty actions that simultaneously address obesity, undernutrition and climate change should be implemented as cost-effective interventions. Furthermore, the evidence that obesity is an independent and leading risk for complications and mortality from COVID-19 clearly demonstrates that it is a global health security issue and a disease requiring urgent action now and in preparation for future pandemics.

- ADD to P8: Failing to act on obesity thus holds back economic development and will inhibit progress towards the Sustainable Development Goals and the Triple Billion Targets.

- ADD additional recommendations for parts of government development aid agencies after P34: Commit to invest in obesity programmes as part of overseas development aid.
TARGETS

The proposed targets are sound, and draw on measures that are monitored by WHO as part of existing programmes of work. However, arguably the targets proposed are conservative, and we would encourage the inclusion of additional targets in line with the recommended actions laid out in the document.

To ensure targets can be monitored in an accountable way, all governments should establish robust surveillance systems, including rolling measurement programmes to identify trends, drivers and priority populations.

Two additional process targets we propose include:

- The number of countries with national action plans for obesity in adults and children
- The number of health care professionals who have received specialise training in obesity science and management.

Other targets that could be considered include national expenditure on obesity research, number of obesity centres of excellence, inclusion of obesity in health financing packages/UHC and number of governments recognising obesity as a disease.

This document has been prepared collaboratively by the World Obesity Federation, with input from the following members, committee members and non-state actors:

European association for the Study of Obesity (EASO)

Obesity Action Coalition (US/Global)

Obesity Canada

The Obesity Society of Nigeria

Bangkok Association of Regenerative Health and The Study of Obesity

Malaysian Association for the study of Obesity

HASOMED (Greece)

NASO (Netherlands)

Romanian Association for the Study of Obesity

All India Association for Advancing Research in Obesity

The Obesity Society (USA)
United World Against Diabetes (India)

Uruguayan Society for the Study of Obesity (SUEO)

ABESO (Brazil)

Salvadoran Obesity Association (ASOBE)

Obesidade Brasil

Australia New Zealand Obesity Society (ANZOS)

Obesidades (Mexico)

Slovak Obesity Association (SOA)

Hungarian Society for the Study of Obesity

UK Association for the Study of Obesity (ASO)

Wellness for Greatness Kenya

Lebanese Society for Endocrinology, Diabetes and Lipids (LSEDL)

Norwegian Association for the Study of Obesity

Global Obesity Patient Alliance (GOPA)

The Mexican Obesity Society (SEO)

Gasol Foundation (Spain/Global)

WOF Executive Board and Committee members: John Wilding (President, UK), Louise Baur (President-elect, Australia), Donna Ryan (Past President, US), Alafia Samuels (Chair of Policy & Prevention Committee, Jamaica), Kent Buse (Policy & Prevention Committee, UK), Karine Clement (Board Member, France), Tollelah Oni (Policy & Prevention Committee, UK/South Africa), Joe Proietto (Chair of Clinical Care Committee, Australia), Harry Rutter (Policy & Prevention Committee, UK), Camila Corvalán (Policy & Prevention Committee, Brazil), Jean-Claude Mbanya (Policy & Prevention Committee, Cameroon), Mary L’Abbe (Policy & Prevention Committee, Canada), Patty Nece (Policy & Prevention Committee, US), Mychelle Farmer (Policy & Prevention Committee), Joanna Ralston (CEO and Board Secretary, US/UK), Jason Halford (EASO, UK), Simon Barquera (Policy & Prevention Committee, Mexico).

Non-state actors: International Diabetes Federation (IDF), Movendi International
Recognise officially that obesity is a chronic, multifactorial disease as well as a driver of other diseases, with serious implications for individuals, families, societies and economies.

- Develop, fund, and accelerate to scale strategies to address obesity, including resourcing and implementing a comprehensive evidence-based multi-sector national obesity plan, informed by existing chronic disease management principles and practice.
- Ensure a ‘whole of government’, cross-departmental approach to action on obesity, including the ministries of [health, education, finance, treasury, agriculture, commerce, welfare, media/culture – etc. as appropriate].
- Integrate obesity in existing chronic disease prevention and management strategies, recognising that obesity is both a disease and a risk factor in other chronic diseases.
- Call for much greater investment in obesity prevention and treatment as a cost-effective strategy to ensure the health of individuals, families and society, and to ensure the sustainability of the health system.
- Utilise the skills, experience and knowledge of civil society – particularly people living with obesity and young people – in the development, implementation and monitoring of obesity planning and strategy.
- Include obesity prevention, treatment and management within universal health coverage packages.
- Incorporate the rights of people with obesity within human rights legislation, workplace regulations, healthcare systems and education, and ensure that legislative tools are used effectively to tackle pervasive and unacceptable stigma, discrimination and bullying.
• Ensure national plans include actions that address the inequalities and stigma faced by people with obesity, for instance in education, in health care settings and in the workplace.
• Build gender inequality considerations into all obesity policymaking.
• Collaborate with researchers, health care professionals, people living with obesity and policymakers to analyse the implications of treating obesity as a chronic disease for clinical practice and public policy.
• Publicly acknowledge that weight bias and stigma are barriers to helping people with obesity.
• Use people-first language at all times when communicating about obesity.
• Incentivise the creation of anti-stigma policies in schools, workplaces and health care settings.
• Implement the WHO’s Best Buys in Non-communicable Diseases, including taxation of unhealthy food products, with the revenue being spent on advancing prevention and control of NCDs including obesity.
• Educate, encourage and empower city-level officials to recognise obesity as a chronic disease and to develop locally appropriate guidelines for obesity prevention and treatment.
• Reach out to other elected officials and send them World Obesity Day materials.
• Educate public health professionals about obesity as a chronic disease.
• Work with medical associations and professional bodies to recognise obesity medicine as a medical specialty.

**Obesity monitoring and surveillance, and innovative research into the causes and effective strategies for preventing and treating obesity, must be vigorously promoted and supported.**

• Establish and fund monitoring and evaluation systems that are reliable, regularly conducted and fit-for-purpose, to enable a full understanding of obesity prevalence, its determinants, treatment, costs and policy implementation.
• Work across geographic regions (e.g. the European Union or CARICOM) to ensure up-to-date, robust, transparent, comparable reporting on obesity, including progress towards national and international obesity and nutrition targets and goals.
• Support and fund independent research programmes to identify, test and pilot prevention and treatment solutions.
• Fund and act upon surveillance and research into the effects of commercial determinants on obesity.
• Fund and act upon surveillance and research into the effects of social determinants on obesity.
• Require research funded by government to actively seek the involvement of people with obesity in the development, prioritisation and conduct of research.
• Utilise all forms of monitoring and surveillance, including case studies, benchmarking, shadow reporting and scorecards developed by civil society.
• Provide technical assistance and share knowledge in evaluation of obesity to other contexts (e.g. evaluation of national action plans or implementation of the WHO Best Buys).
Obesity prevention strategies must be developed, tested and implemented across the life course, from pre-conception, through childhood, and into older age.

- Implement, monitor and fund comprehensive freely/widely available programmes to promote good nutrition, physical activity, health and wellbeing.
- Design, implement and monitor the impact of appropriately targeted public behaviour-change/social-marketing campaigns.
- Ensure that publicly funded health literacy programmes include obesity prevention and target all generations.
- Strengthen consumers’ rights to product and health-related information.
- Adopt and promote an evidence-based and nationally appropriate nutrient profiling model (such as that developed by WHO/Europe) for use by manufacturers, retailers and media, to guide the formulation, labelling and marketing of food and beverages.
- Mandate a clear food labelling system to clearly identify foods high in fat, salt, sugar and calories, based on a comprehensive nutrient profiling system.
- Provide safe water and promote its consumption across the whole population.
- Work to ensure that the recommendations of the World Health Organization’s Global Action Plan on Physical Activity 2018–2030: More Active People for a Healthier World (GAPPA) are implemented across all communities.
- Protect and promote access to green spaces in urban areas, including community gardens, orchards and parks.
- Establish regulations and standards for social support programmes based on national and international dietary guidelines.
- Ensure good nutrition and appropriate physical activity access for vulnerable populations, such as those living in or using in care facilities.
- Support and incentivise workplace interventions on obesity prevention of obesity and, where applicable, treatment and management.
- Implement health promotion programmes for all public-sector employees, including incentivising and promoting access to nutritious food and active transport options.
- Remove HFSS products from public settings, including schools, hospitals and government institutions.
- Develop comprehensive policies to ensure that the environments within which children live, learn and play are health-promoting.
- Acknowledge and act upon the importance of the first 1,000 days as key for lifelong health.
- Provide evidence-informed advice on obesity prevention and management before conception, during pregnancy and during the lactation period, particularly for women with obesity and their partners.
- Fully implement the WHO International Code on Marketing of Breast-milk Substitutes and relevant subsequent World Health Assembly resolutions on breastmilk substitutes and complementary foods for children aged under three.
• Establish breastfeeding programmes and require access to breastfeeding facilities in the workplace
• Adopt a child-rights approach, based on international obligations set out in the UN Convention on the Rights of the Child, to protect children from the harmful effect of marketing and other commercial practices that are linked to obesity.
• Fully implement the recommendations of the World Health Organization’s Commission on Ending Childhood Obesity (ECHO), nationally and locally.
• Develop and incentivise health-promoting programmes in publicly and privately funded schools and early-years environments.
• Put in place systems that assess schools not only on academic outcomes but also on physical and mental health of students.
• Fully implement the WHO’s ‘Set of recommendations on the marketing of foods and non-alcoholic beverages to children’ (2010).
• Take strong legislative steps to ensure that children under 18 are not exposed to marketing for ultra-processed high fat/salt/sugar food and beverages.
• Levy an effective tax on sugar-sweetened beverages and analyse its administration and impact.
• Consider levying penalties on the food industry for manufacturing and supplying products of low nutritional value and rewarding best practice for companies that are committed to removing harmful products from the market.
• Incentivise the food industry to address portion size and nutrient composition of products, particularly those targeted at children and adolescents.

**Treatment of obesity, using evidence-based, dignified, non-stigmatising and person-centred approaches – including behavioural, pharmacological, digital, nutritional, physical-activity-based and surgical interventions – should be accessible to all people with obesity**

• Ensure that weight-management services are equitably offered and progressively realised for people of all ages, including as part of universal health coverage packages.
• Ensure that obesity treatment and management is included in national health insurance packages, providing access to health care professionals, psychological support, physical activity, nutrition and bariatric surgery.
• Work with private health insurance companies to ensure that obesity treatment, management and prevention is included in their health insurance packages.
• Work with relevant stakeholders to produce and promote guidelines, standards and practical tools to promote effective, evidence-based obesity care.
• Develop or adapt evidence-based and patient-centred clinical practice guidelines to support the management of obesity in primary care.
• Determine access to treatment based on locally appropriate criteria, developed by independent experts.
• Support the establishment of interdisciplinary teams to provide comprehensive and holistic care for people living with obesity.

• Build capacity of community health workers to support people with obesity in primary health care settings.

• Ensure that publicly funded health literacy programmes include obesity treatment and weight management.

• Ensure that family-based, multi-component and evidence-informed weight-management services for children can be appropriately and equitably accessed.

• Expand training for health care professionals on obesity, including mandating education on obesity prevention and treatment in medical school curricula.

• Demand that health care professionals communicate about obesity using people-first language and in a non-stigmatising way.

• Provide support and education for people living with obesity so they are empowered to seek appropriate treatment pathways and support.

• Raise awareness among people living with obesity of the existence of obesity specialists and how to contact them.

• Regulate the commercial weight-loss industry to ensure products and services offered are in line with evidence/public health programmes.

**Systems-based approaches should be applied to the management of obesity, aimed at strengthening health systems, enabling obesity’s incorporation into primary and secondary care, and addressing the environmental, social and commercial roots of obesity.**

• Integrate large-scale prevention into primary care, including training primary care clinicians to treat obesity and to prescribe viable lifestyle changes to people with obesity, taking into account specific needs and context.

• Scale up evidence-based, patient-centred, individual and population-level interventions to prevent and treat obesity across the life course.

• Fund and support civil society to build a community of empowered patient advocates.

• Provide platforms for collaboration in addressing obesity across diverse stakeholder groups, including people living with obesity, health care professionals, non-governmental organisations, local government, the private sector (as appropriate), academia etc.

• Strength local government capacity and resources to implement appropriate comprehensive city-level and community-focused interventions.

• Utilise systems thinking when planning and implementing national obesity policies

• Work with the technology sector to develop digital interventions to motivate and support obesity prevention, treatment and management.

• Strengthen capacity and resources among local government to promote healthy urban environments and fund active transport options.
• Address overweight and obesity under the framework of malnutrition in all its forms, adopting a Global Syndemic approach, particularly in low- and middle-income countries.

• Reorient agricultural and other fiscal policies related to food systems to support better nutrition and environmental outcomes.

• Incentivise nutrition policies that foster a farm-to-plate food system that is affordable, healthy and sustainable for people and planet – for example, through the use of subsidies.

• Protect international trade agreements from interference by commercial interests that may impact on public-health goals, including utilising human rights legislation to ensure agreements do not violate the right to health.

• Establish, fund and oversee mechanisms to limit conflict of interests in public-health policy and research, ensuring that commercial interests cannot undermine objective public interest decision making.