DRAFT IMPLEMENTATION PLAN for the recommendations of the Commission on Ending Childhood Obesity

WHO/NMH/PND/ECHO/16.1

Contents

INTRODUCTION

The Sustainable Development Goals[1], established by the United Nations in 2015, identify prevention and control of noncommunicable diseases as one of the health challenges of the 2030 agenda. Among the noncommunicable disease risk factors, overweight and obesity are particularly concerning and has the potential to negate many of the health benefits that have contributed to increased life expectancy. The Global action plan for the prevention and control of noncommunicable diseases 2013-2020[2] calls for a halt in the rise in obesity among adolescents and the Comprehensive implementation plan on maternal, infant and young child nutrition[3] sets a target of no increase in childhood overweight by 2025. Yet the prevalence of infant, childhood and adolescent obesity[4] is rising around the world and renewed action is needed for these targets to be met.

Obesity is not just an issue in high-income countries. Almost three quarters of the 41 million children under 5 years of age who are overweight and obese, live in Asia and Africa *(1)*. In countries where prevalence is plateauing, there are growing inequities and rates continue to increase among low socioeconomic and minority ethnic groups. Obesity can affect a child's immediate health, educational attainment and quality of life. Children with obesity are very likely to remain obese as adults and are at risk of chronic illness. Despite the rising global prevalence, there is still a lack of awareness of the magnitude and consequences of childhood obesity in many settings. This is particularly true in countries that also face problems of undernutrition, where childhood obesity prevention is not seen as a public health priority.

Recognising that progress in tackling childhood obesity has been slow and inconsistent, the Commission on Ending Childhood Obesity was established in 2014 to review, build upon and address gaps in existing mandates and strategies in order to prevent infants, children and adolescents from developing obesity. By doing so, the aim is 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.

Having reviewed the scientific evidence *(2)*, consulted with over 100 WHO Member States and considered nearly 180 online comments, the Commission developed a report containing a comprehensive, integrated package of recommendations to address childhood obesity. The Report calls for governments to take leadership and for all stakeholders to recognize their moral responsibility in acting on behalf of the child to reduce the risk of obesity *(3)*. In 2016, the Sixty-ninth World Health Assembly adopted a decision requesting WHO to develop, in consultation with Member States, an implementation plan guiding further action on the recommendations included in the Report of the Commission[5].

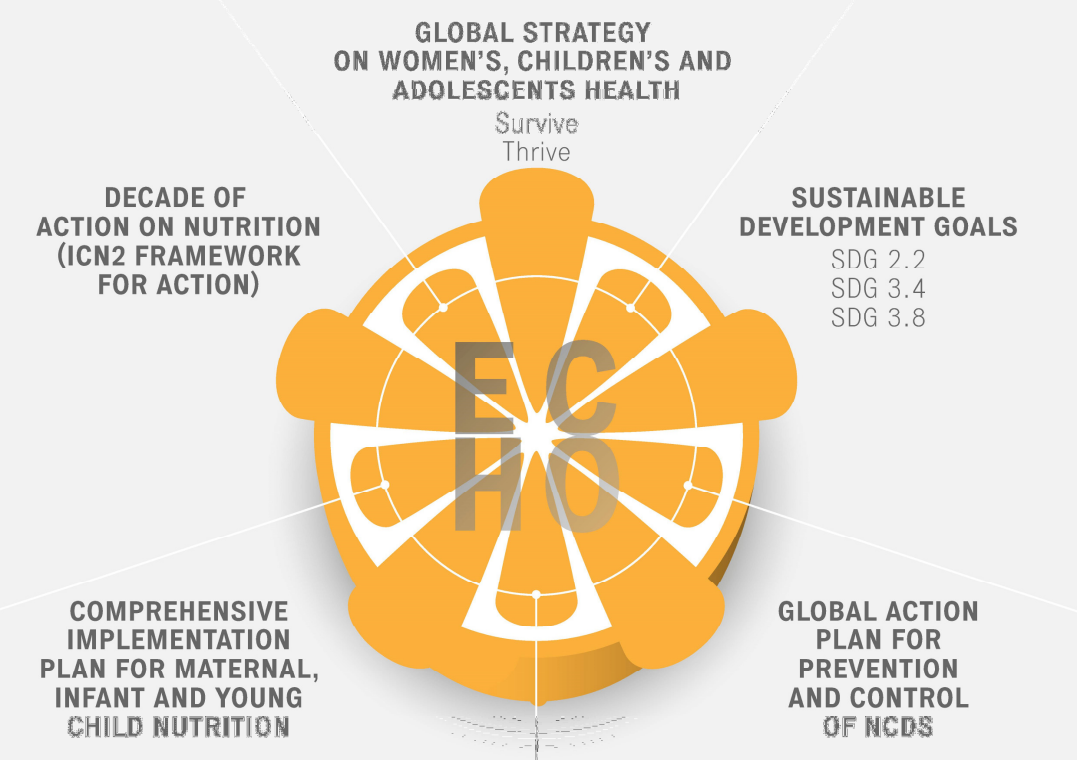
[1] https://sustainabledevelopment.un.org/
[2] WHA66.10 on the follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases
[3] WHA65.6 on the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition
[4] The Convention on the Rights of the Child defines children as those below the age of 18 years. The World Health Organization defines adolescents as those between 10 and 19 years of age. In global surveys overweight and obesity in persons aged 18 and over is reported as adult data. Therefore, in this context, childhood refers to all children under 18 years of age, including adolescents.
[5] A69/A/CONF./3

IMPLEMENTATION PLAN

Aim and scope

This Implementation Plan aims to guide Member States and other partners on the necessary actions to implement the recommendations of the Commission on Ending Childhood Obesity. It recognises that actions to end childhood obesity build upon and may be integrated into existing policies and programmes across a number of diverse domains at both global and regional levels. The goals to end childhood obesity align with the global development agenda i.e. The Sustainable Development Goals (SDG) call for an end to malnutrition in all its forms (SDG target 2.2) and a reduction in premature mortality from noncommunicable diseases (SDG target 3.4). By adding a childhood obesity prevention focus and establishing linkages between existing programmes in maternal, child and adolescent health and nutrition, and health and physical activity promotion in communities and school settings, interventions will be further strengthened and contribute to health and wellbeing targets. Addressing childhood obesity can serve to unify programmes and provide an additional emphasis to concentrate efforts for long term impact. Figure 1 shows how ending childhood obesity can draw together and add value to different strategies such as the United Nations Secretary General's Global Strategy for Women's, Children's and Adolescent's Health, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases, and the UN Decade of Action on Nutrition (2016-2025) and so contribute to improving the health and wellbeing of this generation and the next.

Fig. 1. Ending childhood obesity contributes to a number of other strategies.



Guiding principles

The Implementation Plan is based on the following guiding principles, as identified by the Commission on Ending Childhood Obesity.

The child's right to health: Government and society have a moral and legal responsibility to act on behalf of and in the best interest of the child to reduce the risk of obesity. A comprehensive response for tackling childhood obesity is consistent with the universal acceptance of the rights of the child to a healthy life as well as the obligations assumed by State Parties to the Convention of the Rights of the Child.[1]

Government commitment and leadership: Rates of childhood obesity are reaching alarming proportions in many countries, posing an urgent and serious challenge. These increasing rates cannot be ignored and governments need to accept primary responsibility in addressing this issue on behalf of the children they are ethically bound to protect. A failure to act will have major health and well-being, social and economic consequences.

A whole-of-government approach: Obesity prevention and treatment requires a whole-of-government approach in which policies across all sectors systematically consider health outcomes, avoid harmful health impacts. Current approaches are clearly insufficient and additional coordinated intervention is needed if the targets to halt the rise in obesity are to be achieved[2]. For example, the education sector plays a critical role in providing nutrition and health education, increasing the opportunities for physical activity and promoting healthy school environments. Agriculture and trade policies and the globalization of the food system impact on food affordability, availability and quality at national and local levels. In 2013, WHO Member States adopted a resolution to consider the interplay between international trade and health through multi-stakeholder dialogue[3]. Urban planning and design, and transport planning, all impact directly on opportunities for physical activity and access to healthy foods. Intersectoral government structures such as a high level inter-ministerial task force for child and adolescent health that includes obesity as one of the main tasks, can identify mutual interest and facilitate coordination, collaboration and exchange of information through coordinating mechanisms.

A whole-of-society approach: The complexity of obesity calls for a comprehensive approach that in addition to all levels of government, involves other actors, such as parents, caregivers, civil society, academic institutions, philanthropic foundations and the private sector. Moving from policy to action to prevent and reverse childhood obesity demands a concerted effort and an engagement of all sectors of society at the local, national, regional and global levels. Joint ownership and shared responsibility are essential for effective interventions to have reach and impact.

[1] Committee on the Rights of the Child: General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), para 47; CRC/C/GC/15.

[2] WHA66.10 on the follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases

WHA65.6 on the Comprehensive Implementation Plan on Maternal, Infant and Young Child Nutrition

[3] Resolution WHA59.26 on international trade and health.

Equity: Governments should ensure equitable coverage of interventions, particularly for excluded, marginalized or otherwise vulnerable population groups, who are at high risk both of malnutrition in all its forms and of developing obesity. These population groups often have poor access to healthy foods, safe places for physical activity and preventative health services and support. Obesity and its associated morbidities erode the potential improvements in social and health capital, and increase inequity.

Aligning with the global development agenda with a life-course approach: The Sustainable Development Goals (SDG) call for an end to malnutrition in all its forms (SDG target 2.2) and a reduction in premature mortality from noncommunicable diseases (SDG target 3.4). Integrating interventions to address childhood obesity with existing WHO and other initiatives, using a life-course approach, will offer additional benefits for longer-term health[1]. These initiatives include the United Nations Secretary General's Global Strategy for Women's, Children's and Adolescent's Health, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable diseases, and the Rome Declaration of the Second International Conference on Nutrition , the UN Decade of Action on Nutrition. There are a number of current WHO and other United Nations agencies strategies and implementation plans related to optimizing maternal, infant and child nutrition and adolescent health that are highly relevant to key elements of a comprehensive approach to obesity prevention. Relevant principles and recommendations can be found in documents providing guidance throughout the life-course. Initiatives to address childhood obesity should be integrated within these exiting pillars of work and build upon them to help children realize their fundamental right to health and, improve their well-being, while reducing the burden on the health system.

Accountability: Political and financial commitment is imperative in combatting childhood obesity. Commitments should be relevant to the mission of the stakeholder involved. A robust mechanism and framework is needed to monitor policy development and implementation, thus facilitating the accountability of governments and non-State actors on commitments made.

Universal Health Coverage[2]: Sustainable Development Goal target 3.8 calls for the achievement of Universal Health Coverage through integrated health services that enable people to receive a continuum of health promotion, disease prevention, diagnosis, treatment and management, over the course of a lifetime.[3] As such, access and coverage of interventions for the prevention of overweight and obesity and the treatment of children already obese, and those with overweight who are on the pathway to obesity, should be considered important elements of Universal Health Coverage.

[1] The Minsk Declaration: The Life-course Approach in the Context of Health 2020, WHO Regional Office for Europe
[2] http://www.who.int/universal_health_coverage/en/.
[3] United Nations General Assembly Resolution A/67/L36 Global Health and Foreign Policy.

Action Framework

The Commission proposed six sets of recommendations to address the obesogeneic environment, critical time points in the life-course and the treatment of children who were already obese. These recommendations can be implemented by considering:

i. the population-based interventions that would be needed to address the obesogenic environment;
ii. interventions in settings such as community, schools and child care facilities; and
iii. interventions delivered at an individual level, such as through health-care providers.

Such interventions would have an effect upon the environmental, behavioural and biological causal pathways for childhood obesity, as shown in figure 2.

Fig. 2.Ending childhood obesity action framework

ACTIONS NEEDED TO END CHILDHOOD OBESITY

The scope of potential policy recommendations to address childhood obesity is broad and contains a number of elements that bring together and strengthen a focus on the life-course dimension, on the education sector and an environmental dimension. The regional offices of WHO have developed a number of action plans that address some aspects of the recommendations below and can provide additional regional guidance to Member States *(4-7)*.

A multisectoral approach will be essential for sustained progress. The following sections will give guidance on the necessary actions Member States must consider, and the supportive actions by other stakeholders, in order to achieve the aims of this Implementation Plan.

I. Provide leadership for comprehensive, integrated, multi-sectoral action

Rationale:

Governments hold the ultimate responsibility in ensuring their citizens have a healthy start in life. Preventing childhood obesity requires the coordinated contributions of all government sectors and institutions responsible for policies. National strategic leadership includes establishing the governance structures across a variety of sectors that are necessary to manage the development and implementation of laws, policies and programmes. Dedicated resources are required for policy implementation and workforce capacity strengthening. National leadership is also necessary to manage engagement with non-State actors, such as nongovernmental organizations, the private sector and academic institutions, to successfully implement, monitor and evaluate the impact of programmes, activities and investments.

The following table proposes actions to be taken by Member States to implement the recommendation of the Commission and outlines the steps to be taken for effective action. Some countries may already have implemented some of these policies and can build upon and strengthen these.

Recommended actions from Commission	**Steps to be taken by Member States**	Available tools
a) Take ownership, provide leadership and engage political commitment to tackle childhood obesity over the long term.	**Engage regularly with parliamentarians to ensure high-level commitment to childhood obesity prevention.** **Conduct regular high level policy dialogues on childhood obesity.** **Mobilise sustainable resources to address childhood obesity.** **Prepare a budget required to implement key interventions to tackle childhood obesity.**	
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.	**Establish or expand a multi-sectoral group to coordinate policy development, implementation of interventions, monitoring and evaluation across the whole of government, including accountability systems.**	

c) Ensure data collection on BMI-for-age of children – including for ages not currently monitored – and set national targets for childhood obesity.	**Set national or local time-bound targets for childhood obesity and monitoring mechanisms.**	
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.	**Establish mechanism to coordinate and hold to account engagement of non-State actors in the implementation of interventions.** **Establish clear mechanisms/policies for the management of conflict of interest.**	

II. Interventions

Rationale:

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 through coordinated, multisectoral action that is held to account.

Member States already have a number of relevant programmes in place that provide guidance on diet and physical activity at population level, in settings such as schools and child-care, and throughout the life course. The recommendations of the Commission can help foster integration and add an additional element which will contribute to the achievement of diverse targets in maternal, infant, young child and adolescents health.

Member States differ in both the prevalence of childhood obesity, the risk factors that contribute to this issue and political and economic situation. The recommended actions below are designed to allow countries to assess which package of integrated interventions may be best implemented in their particular settings. Section IV details how to prioritise actions and develop a step-wise approach to implementation to support governments in realising these actions. To facilitate this, recommendations have been grouped where appropriate to indicate common actions that will support outcomes.

1. Actions to improve the food and physical activity environment

Rationale

An obesogenic environment is one that promotes high energy intake and physical inactivity, including sedentary behaviour. This includes the foods that are available, affordable, accessible and marketed; physical activity opportunities; and the social norms in relation to food and physical activity. Children and families need to be empowered to make healthier choices about diet and physical activity. Knowledge of healthy food and physical activity choices will be undermined if there

are conflicting messages, both through marketing in the media and in the settings where children gather. The healthy lifestyle choice needs healthy foods and opportunities to be readily available and affordable to all members of society.

The table below outlines the necessary actions to implement Recommendations 1 and 2 of the report of the Commission on Ending Childhood Obesity. Interventions to address childhood obesity should be integrated into existing activities and can build upon them to strengthen these.

Actions to promote the intake of healthy foods

Recommendations of the Commission	**Steps to be taken by Member States**	Available tools
1.1 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.	**Update guidance, as necessary, to include :** **1. information about childhood overweight and obesity and consequences for health and wellbeing** **2. guidance on the prevention of childhood obesity through healthy diet throughout the life course.** **Ensure food-based dietary guidance for children, caregivers, school staff and health professionals is disseminated in an accessible manner.**	Healthy Diet fact sheet Five keys to a healthy diet Sugars intake for adults and children Pocket guide on a healthy diet (WPRO) Be smart, drink water: A guide for school principals in restricting the sale and marketing of sugary drinks in and around schools (WPRO)
1.2 Implement an effective tax on sugar-sweetened beverages.	**Implement an effective tax on sugar-sweetened beverages.**	Technical manual on food and drink taxation to promote healthy diets (2016)
1.3 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.	**Adopt and implement legislation or regulations to restrict the marketing of foods and non-alcoholic beverages to children.**	Framework for implementation of the set of recommendations on the marketing of foods and non-alcoholic beverages to children (2012)
1.4 Develop nutrient-profiles to identify unhealthy foods and beverages. 1.6 Implement a standardized	**Set mandatory standards and specifications for nutrition labelling, in line with Codex guidelines.**	The Codex Guidelines on Nutrition Labelling (CAC/GL 2 – 1985) Nutrient Profiling : report of

global nutrient labelling system. 1.7 Implement interpretive front-of-pack labelling, supported by public education of both adults and children for nutrition literacy.	**Adopt, or develop as necessary, an interpretive front-of-pack labelling system based on best available evidence to identify unhealthy foods using a validated on nutrient profile model.**	technical meeting 2010 WHO Regional Office for Europe Nutrient profile model WHO Nutrient Profile Model for the Western Pacific Region: a tool to protect children from food marketing Nutrient Profile Model (PAHO)
1.8 Require settings such as schools, child-care settings, children's sports facilities and events to create healthy food environments.	**Set standards for the foods that can be provided or sold in child-care settings, schools, children's sports facilities and events. (see also 4.9 and 5.1) based on a food classification system (e.g. a nutrient profile model); embed the food standards in existing school food policies.**	Development of a framework on Nutrition-friendly Schools Initiative (2006) Food and nutrition policy for schools: A tool for the development of school nutrition programmes in the European Region
1.9 Increase access to healthy foods in disadvantaged communities.	**Provide access to healthy foods for disadvantaged communities, through context-appropriate mechanisms in partnership with other stakeholders.**	Fruit and vegetables for health
Actions to promote physical activity		
Recommendations of the Commission	**Steps to be taken by Member States**	Available tools
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.	**Update guidance, as necessary, to include guidance on physical activity throughout the life course.** **Ensure physical activity guidance for children, caregivers, school staff and health professionals is disseminated in an accessible manner.**	Global recommendations on physical activity for health Guide for population-based approaches to increasing levels of physical activity: implementation of the WHO global strategy on diet, physical activity and health (2007)
2.2 Ensure that adequate facilities are available on school premises and in public spaces for physical activity during recreational time for all	**Provide, in collaboration with other sectors and stakeholders, safe facilities for all children to be physically active during recreational**	Guide for population-based approaches to increasing levels of physical activity: implementation of the WHO global strategy on diet,

children (including those with disabilities), with the provision of gender-friendly spaces where appropriate.	**time.**	physical activity and health (2007) School policy framework. Implementation of the WHO Global Strategy on Diet, Physical Activity and Health Promoting physical activity in schools: an important element of a health-promoting school.

Recommendations of the Commission	**Steps to be taken by WHO**	Available tools
1.5 Establish cooperation between Member States to reduce the impact of cross-border marketing of unhealthy foods and beverages.	**Cooperate with relevant regional mechanisms to align national efforts to reduce the exposure of children to the marketing of unhealthy foods and beverages by restricting cross-border marketing.**	

2. Actions in community settings to reduce the risk of obesity through the life-course

Rationale

The risk of obesity can be passed from one generation to the next and maternal health can influence fetal development and the risk of a child becoming obese. The care that women receive before, during and after pregnancy has profound implications for the later health and development of their children. Current guidance for preconception and antenatal care focuses on the prevention of maternal and fetal undernutrition. Given changing obesogenic exposures, guidelines are needed that address malnutrition in all its forms (including excess energy intake) and later obesity risk in the offspring. Interventions to address childhood obesity risk factors also prevent other adverse pregnancy outcomes *(8)* and so contribute to improving maternal and newborn health.

The first years of life are critical in establishing good nutrition and physical activity behaviours that reduce the risk of developing obesity. Exclusive breastfeeding for the first six months of life, followed by the introduction of appropriate complementary foods, is core to optimizing infant development, growth and nutrition and may also be beneficial for postnatal weight management in women. Current global guidance for infant and young child feeding primarily targets undernutrition. It is also important to consider the risks created by unhealthy diets in infancy and childhood.

Children and adolescents are highly susceptible to the marketing of unhealthy foods and sugar-sweetened beverages and the need to protect children from marketing has been recognized [1]. Peer pressure and perceptions of ideal body image also influence children's attitudes to diet and physical activity. Although a significant number of school-age children are unfortunately not in formal education, the compulsory school years provide an easy entry point to engage this age group and embed healthy eating and physical activity habits for lifetime obesity prevention. To be successful, programmes to improve the nutrition and physical activity of children and adolescents need to engage with a number of stakeholders. The integration of activities into a health-promoting school initiative, with active engagement of the education sector will help to move this agenda forward and improve school attainment. Older children and adolescents also need to be engaged in the development and implementation of interventions to reduce childhood obesity *(9)*.

The table below outlines the necessary actions to implement Recommendations 3, 4 and 5 of the report of the Commission on Ending Childhood Obesity.

Actions for preconception and pregnancy care in health care settings		
Recommendations of the Commission	**Steps to be taken by Member States**	Available tools
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 toxins.	**Include information on the association between prospective parents' diet, physical activity and health behaviours and the risk of childhood obesity in existing preconception and antenatal care guidance.** **Disseminate guidance on healthy diet and physical activity to prospective parents whom preconception or antenatal care may not reach.**	Preconception care to reduce maternal and childhood mortality and morbidity WHO recommended interventions for improving maternal and newborn health: Integrated management of pregnancy and childbirth Pregnancy, childbirth, postpartum and newborn care A guide for essential practice Essential nutrition actions improving maternal, newborn, infant and young child health and nutrition Good maternal nutrition - the best start in life (EURO) WHO recommendations on prevention and management of tobacco use and second-hand smoke exposure in pregnancy

[1] UN Committee on the Rights of the Child (CRC), General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), 17 April 2013, CRC/C/GC/15,

		Guidelines for identification and management of substance use and substance use disorders in pregnancy
Recommendations of the Commission	**Steps to be taken by WHO**	Available tools
3.1 Diagnose and manage hyperglycaemia and gestational hypertension. 3.2 Monitor and manage appropriate gestational weight gain.	**Develop guidelines on the management of hyperglycaemia in pregnancy.** **Develop guidelines on appropriate gestational weight gain and the management of inappropriate gestational weight gain.**	Diagnostic criteria and classification of hyperglycaemia first detected in pregnancy
Actions for early childhood diet and physical activity in the community		
Recommendations of the Commission	**Steps to be taken by Member States**	Available tools
4.1 Enforce regulatory measures such as The International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions. 4.2 Ensure all maternity facilities fully practice the Ten Steps to Successful Breastfeeding. 4.3 Promote the benefits of breastfeeding for both mother and child through broad-based education to parents and the community at large. 4.4 Support mothers to breastfeed, through regulatory measures such as maternity leave, facilities and time for breastfeeding in the work place.	**Review, and if necessary strengthen, existing legislation and regulations to** **1. restrict the marketing of breast milk substitutes** **2. ensure all maternity facilities practice the Ten Steps to Successful Breastfeeding** **3. provide maternity leave and time and facilities in the work place for breastfeeding.** **Include information on the benefits of breastfeeding for promoting appropriate infant growth and reducing the risk of childhood obesity in guidance for parents and public communications.**	International Code on the Marketing of Breast Milk Substitutes Evidence for the ten steps to successful breastfeeding Marketing of breast-milk substitutes: National implementation of the international code Status Report 2016 Baby-friendly Hospital Initiative (2009)

4.5 Develop regulations on the marketing of complementary foods and beverages, in line with WHO recommendations, to limit the consumption of foods and beverages high in fat, sugar and salt by infants and young children.	**Regulate to end the inappropriate promotion of foods for infants and young children.**	Ending inappropriate promotion of foods for infants and young children Ending inappropriate promotion of foods for infants and young children: A primer on WHO guidance (WPRO)
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.	**Include advice in infant and young child feeding guidance on:** **1. how to encourage infants and young children to eat a wide variety of healthy foods;** **2. what foods and beverages high in sugar, fat and salt should not be given to infants and young children;** **3. what are appropriate portion sizes for children of different ages.**	Essential nutrition actions improving maternal, newborn, infant and young child health and nutrition Planning guide for national implementation of the global strategy for infant and young child feeding Healthy diet Pocket guide for a healthy diet (WPRO)
Actions for health, nutrition and physical activity in child care and school settings		
Recommendations of the Commission	**Steps to be taken by Member States**	Available tools
4.9 Ensure only healthy foods, beverages and snacks are served in formal child care settings or institutions. 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.	**Set mandatory nutrition standards for foods and beverages provided (including meals) or sold in the child-care and school environment.**	Development of a framework on Nutrition-friendly Schools Initiative (2006) Be smart, drink water (WPRO) Be smart drink water : a guide for school principals in restricting the sale and marketing of sugary drinks in and around schools School policy framework Health Promoting Schools Framework for Action (WPRO)

5.3 Ensure access to potable water in schools and sports facilities.	**Require all school and sports facilities to provide free access to safe drinking water.**	Be smart drink water : a guide for school principals in restricting the sale and marketing of sugary drinks in and around schools Water, sanitation and hygiene standards for schools in low-cost settings
4.10 Ensure food education and understanding are incorporated into the curriculum in formal child-care settings or institutions. 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.	**Integrate nutrition and health education components, developed in collaboration with education sector into the core curriculum.** **Develop nutrition, food and health education curriculum jointly between education and health sectors. Train teachers in curriculum delivery.** **Work with schools and communities to deliver skills through community classes/groups.**	Development of a framework on Nutrition-friendly Schools Initiative (2006) Nutrition Education in Primary Schools: a planning guide for curriculum development (FAO)
4.11 Ensure physical activity is incorporated into the daily routine and curriculum in formal child care settings or institutions.	**Set standards for physical activity in the child-care settings.**	Early child development: a powerful equalizer
5.7 Include Quality Physical Education in the school curriculum and provide adequate and appropriate staffing and facilities to support this.	**Set standards for quality physical education in the school curriculum.**	Quality physical education (UNESCO) Promoting physical activity in schools: an important element of a health-promoting school.
4.13 Engage whole-of-community support for caregivers and child care settings to promote healthy lifestyles for young children.	**Conduct advocacy campaigns and disseminate information to increase awareness of the consequences of childhood obesity.** **Promote communication and community participation to raise awareness and create an**	Development of a framework on Nutrition-friendly Schools Initiative (2006)

	enabling environment and social demand for policy action to improve diet and physical activity in children. **Identify community champions/leaders/civil society organizations to work with, and ensure community representation.**	

Recommendations from Commission	**Steps to be taken by WHO**	Available tools
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.	**Develop guidance on physical activity for children under 5 years of age** **Develop guidelines on sleep and use of screen-based entertainment by children and adolescents.(see 2.1)**	

3. Actions to improve the current and future health of children who are obese

Rationale

When children are already overweight or obese, weight management to reduce BMI-for-age and improve obesity-related comorbidities will improve current and future health outcomes. Primary health-care services are important for the early detection and management of obesity and its associated complications. Regular growth monitoring at the primary health-care facility or at school provides an opportunity to identify children at risk of developing obesity. The mental health needs of children who are overweight or obese, including issues of stigmatization and bullying, need to be given special attention.

The interventions below are those outlined in Recommendations 6 of the report of the Commission on Ending Childhood Obesity and detail next steps for countries to take.

Actions for weight management		
Recommendations of the Commission	**Steps to be taken by Member States**	Available tools
6.1 Develop and support appropriate weight management services for children and adolescents who are overweight or obese that	**Implement a context-appropriate multicomponent weight management protocol that covers diet and physical activity services tailored to**	WHO Child Growth Standards

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.	**children and families.** **Align services with existing clinical guidelines and clearly configure primary care provider roles for effective multidisciplinary work.** **Include weight management services as part of Universal Health Coverage.**	

III. Monitoring and accountability for effective progress

Monitoring can serve to both describe the issue and is necessary to track progress in the development, implementation and effectiveness of interventions. Governments are understandably wary of increasing the burden of reporting on their commitments. A number of monitoring mechanisms currently exist which countries could draw upon and integrate into a comprehensive national monitoring framework for childhood obesity. These include the Global Monitoring Framework for Noncommunicable Diseases[1] and the Global Monitoring Framework for Maternal, Infant and Young Child Nutrition.[2]

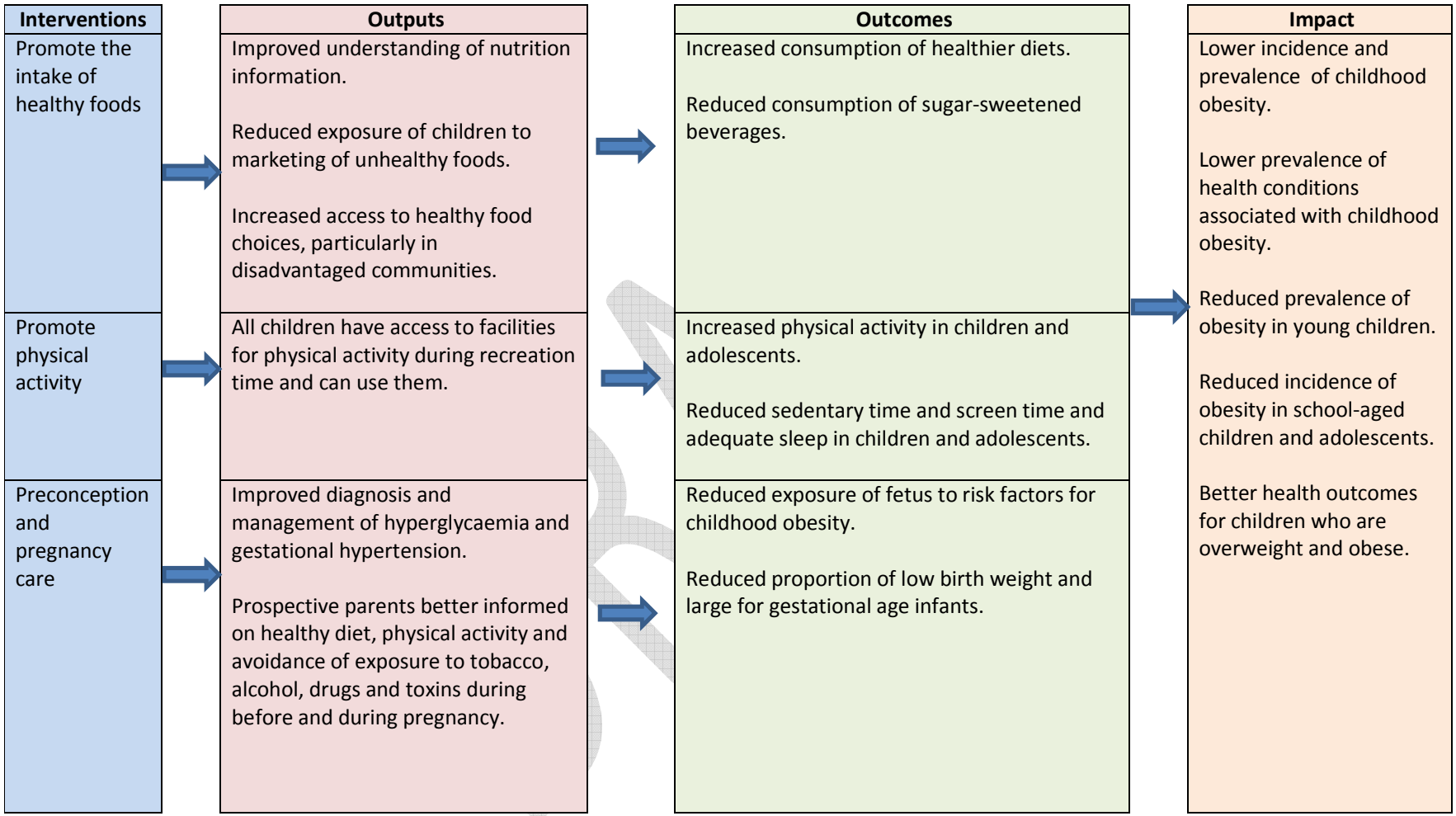
Actions for monitoring and accountability		
Recommendations of the Commission	**Steps to be taken by Member States**	Available tools
Establish monitoring systems to provide evidence of the impact and effectiveness of interventions in reducing the prevalence of childhood obesity and use data for policy and implementation improvement.	**Develop monitoring mechanisms and systems, with appropriate feedback mechanisms to ensure effective policy implementation.**	Global Monitoring Framework for Noncommunicable Diseases. Indicators for the Global Monitoring Framework for Maternal, Infant and Young Child Nutrition Childhood Obesity Surveillance Initiative (EURO)

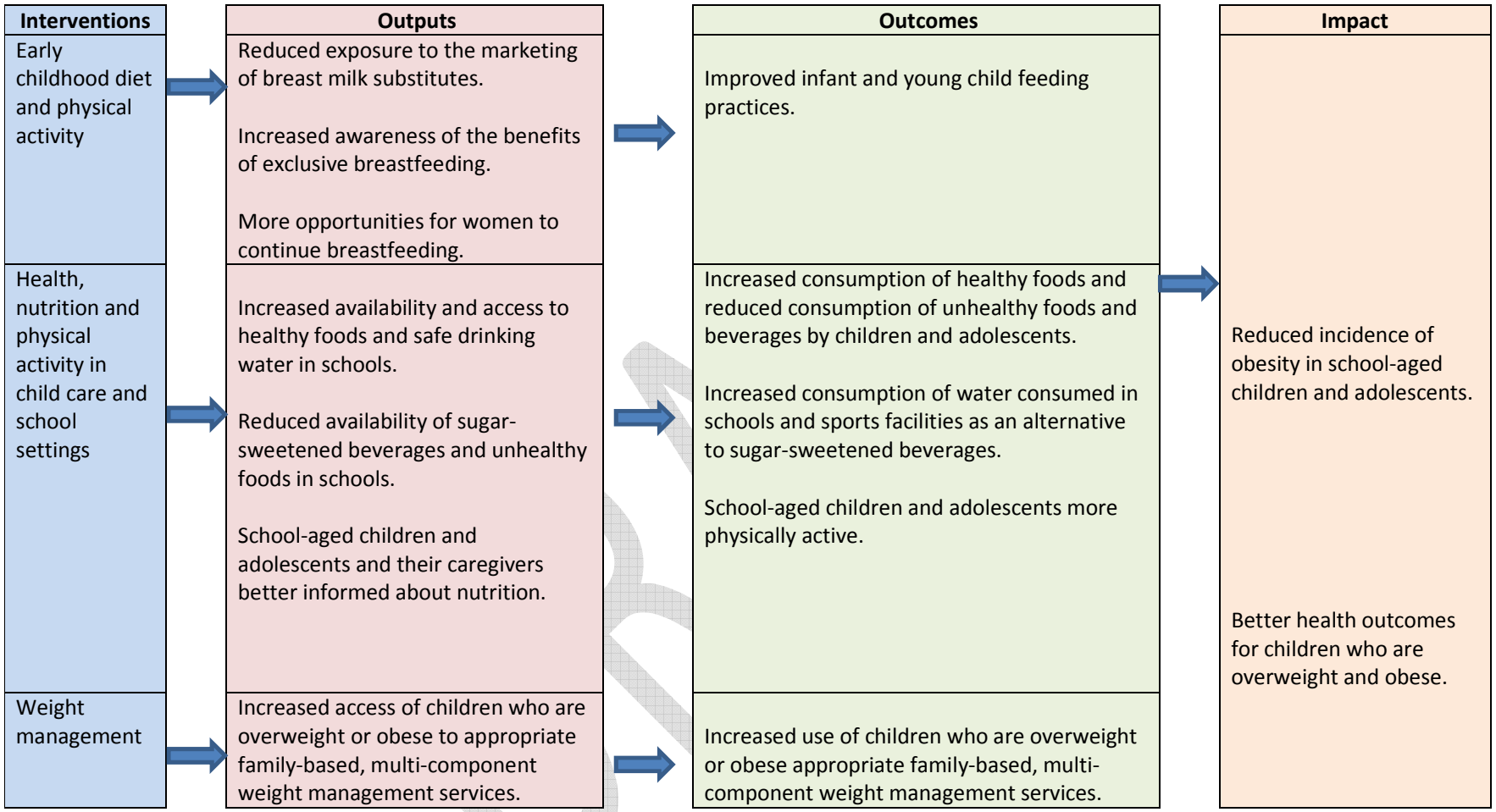
[1] WHA66.8 Global Monitoring Framework for Noncommunicable Diseases.
[2] WHA68.9 Indicators for the Global Monitoring Framework for Maternal, Infant and Young Child Nutrition.

Develop an accountability mechanism that encourages participation of nongovernmental organizations and academic institutions in accountability activities.	**Establish coordinating mechanism for involvement of non-State actors in monitoring and accountability activities aligned with the accountability mechanisms for the Sustainable Development Goals, The Global Strategy on Women, Children and Adolescent Health, the Decade of Action on Nutrition, Global Monitoring Framework and Progress Indicators.**	

The logic model presented in figure 3 below provides guidance to Member States in identifying short- and medium-term outcomes in order to identify specific indicators to measure determinants in a standardised manner.

Fig. 3: Logic model for childhood obesity prevention interventions




Interventions
Outputs
Outcomes
Impact
Early childhood diet and physical activity
Reduced exposure to the marketing of breast milk substitutes.
Increased awareness of the benefits of exclusive breastfeeding.
More opportunities for women to continue breastfeeding.
Improved infant and young child feeding practices.
Health, nutrition and physical activity in child care and school settings
Increased availability and access to healthy foods and safe drinking water in schools.
Reduced availability of sugar-sweetened beverages and unhealthy foods in schools.
School-aged children and adolescents and their caregivers better informed about nutrition.
Increased consumption of healthy foods and reduced consumption of unhealthy foods and beverages by children and adolescents.
Increased consumption of water consumed in schools and sports facilities as an alternative to sugar-sweetened beverages.
School-aged children and adolescents more physically active.
Reduced incidence of obesity in school-aged children and adolescents.
Better health outcomes for children who are overweight and obese.
Weight management
Increased access of children who are overweight or obese to appropriate family-based, multi-component weight management services.
Increased use of children who are overweight or obese appropriate family-based, multi-component weight management services.

Strong commitments must be accompanied by strong implementation systems and well-defined accountability mechanisms for effective progress in preventing childhood obesity. A whole of society approach offers the best opportunity for addressing childhood obesity. Both governments and other actors, notably, civil society can hold each other and private sector entities to account, to ensure they adopt policies and comply with standards.

Governments bear primary responsibility for setting the policy and regulatory framework for the prevention of childhood obesity at the country level. A whole-of-government approach requires that a clear chain of responsibility and accountability is established and that relevant institutions, tasked with developing or implementing interventions, are held accountable for the performance of those tasks. This can be facilitated through the development of a policy and action planning matrix. The matrix shown in figure 4 below could serve as a tool for ensuring a whole of government accountability, through a clear delineation of the actions, the actors, the task, outputs or outcomes that an actor is accountable for, monitoring of the actions and processes for holding to account. Government entities also have a broad range of tools and processes for holding external actors to account, including through legal processes, co-regulatory arrangements, economic incentives, market-based and media-based approaches.

Civil society can play a critical role in bringing social, moral and political pressure on governments to fulfil their commitments *(10)*. Ending childhood obesity should form part of civil society's agenda for advocacy and accountability. Improving coordination of civil society organisations and strengthening their capacity to effectively monitor and ensure accountability for commitments made is of critical importance. Governments may consider providing opportunities for formal participation by civil society in the policy-making, implementation and evaluation process.

The private sector can play a role in addressing childhood obesity, as part of their core business, but additional accountability strategies are often necessary. Conflict of interest risks need to be identified, assessed and managed in a transparent and appropriate manner when engaging with non-State actors. Codes of conduct and independently audited assessments of compliance with government oversight are therefore important.

Fig. 4. Policy and action planning matrix for monitoring and accountability

Actions (ECHO recommendations)	Identify specific actions/sets of actions embedded within the ECHO Commission recommendations ⇩
Actors	Who will formulate the policy or action for implementation? Who will implement the policy/action? [separate question] Are there other relevant actors? ⇩
Allocation of responsibility for tasks, outcomes	What will each of the relevant actors be held accountable for? E.g.: • Formulating a policy/program • Implementing a policy/program • Complying with the policy • Achieving measurable progress towards the ultimate (or an appropriate intermediate) policy objective ⇩
Monitoring	Who will monitor the tasks or actions which the actors are being held accountable for? ⇩
Holding to account (accountability relationships)	Who will hold the actors (i.e. those who formulate the policy and actions for implementation) to account? Who will hold the actors that implement the actions to account? Who will hold other relevant actors to account? ⇩
Monitoring indicators (process, outputs, outcomes)	What indicators provide measures of the actions for which actors are being held accountable? ⇩
Tools and processes for holding to account	How will the actors be held to account for their performance?

IV. Key elements for successful implementation

In implementing actions for ending childhood obesity, considerations should be given to certain elements, as highlighted in the report of the Commission on Ending Childhood Obesity.

Prioritization

Regions, countries and national sub-regions may have differing childhood obesity prevalence and socio-economic distribution, as well as different economic and health service capacity. A prioritization exercise can help governments choose which combinations of, and in what order to implement, interventions that will effectively address their particular childhood obesity situation. A number of prioritization tools exist that can guide this process *(11)*. Synergistic interventions and combinations that enable the healthy choice to become the easier choice, interventions that have

the benefit of stimulating population-wide discussion and education on childhood obesity can prove effective in raising public awareness and building support for legislation and regulation. Ensuring the involvement of relevant stakeholders in the prioritization exercise and policy development, with attention to potential conflict of interest is also important.

Awareness, Communication and Education

Values and norms influence the perception of healthy or desirable body weight, especially for children. Communication to improved knowledge and undo misperceptions are important to ensure communities engage with , support and participate in policies and interventions that encourage behaviour change. Capacity building programs to upskill workers on effective communications and education is also critical for effective programme implementation.

Mobilisation of Resources

Governments and stakeholders need resources to implement actions and innovative approaches for domestic and international financing are needed. Taxation of sugar sweetened beverages could leverage resources that could be used to address childhood obesity. In leveraging resources, due regard must be given to avoiding or managing conflicts of interest.

Capacity building

Strengthening institutional capacity and providing appropriate training to health care workers, child-care and school staff is essential for the successful implementation of the recommendations of the Commission. In addition, capacity is also needed to support the implementation , monitoring and enforcement of population-based policies, such as fiscal policies on sugar-sweetened beverages and restriction on the marketing of unhealthy foods and beverages to children.

Action networks are one example of ways that countries can share experience and build capacity. These networks provide support for countries committed to implementing specific activities through a platform for sharing experiences and exchanging policies between Member States.

V. Key roles and responsibilities of stakeholders

Successful implementation requires the committed input, focus and support of a number of agencies. The following stakeholder groups were identified in the Report of the Commission and specific roles and responsibilities were outlined.

WHO

It is essential that momentum is maintained to address this complex and critical issue. WHO will lead and convene high-level dialogue within the United Nations system and with and between Member States, to build upon the commitments made in the Sustainable Development Goals, the Political Declaration of the High-level meeting of United Nations General Assembly on the Prevention and Control of Non-communicable diseases, the Rome Declaration of the Second International Conference on Nutrition and other relevant global and regional policy frameworks, to address the actions detailed in the Report of the Commission on Ending Childhood Obesity.

Using its normative function, both globally and through its network of regional and country offices, WHO can provide technical assistance by developing or building on guidelines, tools and standards to support the recommendations of the Commission and other relevant WHO mandates at country level. WHO can disseminate guidance for implementation, monitoring and accountability, and monitor and report on progress to end childhood obesity.

<u>Actions</u>

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.

i. Develop legal and regulatory workshops, courses in collaboration with other entities for government officials;
ii. Provide technical support, develop guidelines and tools to support Member States, as needed.

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

Cooperation between international organizations including United Nations agencies can promote the establishment of global and regional partners and networks for advocacy, resource mobilization, capacity-building and collaborative research. The United Nations Inter-Agency Task Force on Non-communicable Diseases can support Member States in addressing childhood obesity.

Actions

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

i. Incorporate childhood obesity prevention into country level United Nations Development Assistance Frameworks.
ii. Provide support for the development and dissemination of guidance on healthy diet and physical activity.
iii. Partner with Member States to implement interventions to end childhood obesity.

Nongovernmental organizations

Although building the policy framework is undertaken by government, in some countries developing nutrition information and education campaigns, implementing programmes, and monitoring and holding actors to account for commitments made, may be tasks shared between government and civil society. Social movements can engage members of the community and provide a platform for advocacy and action.

Actions

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.

The private sector

The private sector is not a homogeneous entity and includes the agricultural food production sector, the food and non-alcoholic beverage industry, retailers, catering companies, sporting-goods manufacturers, advertising and recreation businesses, and the media among others. It is, therefore, important to consider the level of engagement with entities whose activities could impact positively or negatively on childhood obesity. Countries need to engage constructively with the private sector to encourage implementation of policies and interventions.

A number of private sector initiatives that have the potential to impact positively on childhood obesity exist. These need to be encouraged where they are supported by an evidence base. As many

companies operate globally, international collaboration is vital. However, attention must also be given to local and regional entities and artisans. Cooperative relationships with industry have already led to some encouraging outcomes related to diet and physical activity. Initiatives by the food manufacturing industry to reduce fat, sugar and salt content, and portion sizes of processed foods, and to increase the production of innovative, healthy and nutritious choices, could accelerate health gains worldwide if implemented widely. However, engagement with the private sector needs to be health-goal orientated, transparent and accountable and include particular attention to managing potential conflict of interest.

Actions

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

Philanthropic foundations are uniquely placed to make significant contributions to global public health and can also engage in monitoring and accountability activities.

Actions

a) Recognize childhood obesity as endangering child health and educational attainment and thus address this important issue.

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

Academic institutions and health professional associations

Academic institutions can contribute to addressing childhood obesity through studies on biological, behavioural and environmental risk factors and determinants, and the effectiveness of interventions in each of these. Health professionals associations can play an important role in raising public awareness of the immediate and long-term consequences of childhood obesity to health and wellbeing and advocate for implementation of effective interventions to address this important issue. They can also provide support for health professional training and contribute to the monitoring and accountability activities.

Actions

a) Raise the profile of childhood obesity prevention and treatment through the dissemination of information and incorporation into appropriate curricula at all levels (pre- and post graduate).

b) Address knowledge gaps with evidence to support policy implementation.

c) Support monitoring and accountability activities.

CONCLUSIONS

Childhood obesity undermines the physical, social and psychological well-being of children and is a known risk factor for adult obesity and noncommunicable diseases. There is an urgent need to act now to improve the health of this generation and the next. Overweight and obesity cannot be solved through individual action alone. Comprehensive responses are needed to create healthy environments that can support individuals in making healthy choices grounded on health and nutrition knowledge and skills. This requires government commitment and leadership, long-term investment and engagement of the whole of society to protect the rights of children to good health and well-being. Progress can be made if all actors remain committed to working together towards a collective goal of ending childhood obesity.

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