

Report of the Commission on Ending Childhood Obesity: implementation plan

Report by the Secretariat

1. The prevalence of infant and young child obesity is increasing in all countries, with the most rapid rises occurring in low- and middle-income countries. The number of overweight or obese young children globally increased from 31 million in 1990 to 42 million in 2015. In the African Region alone over the same period, the number of overweight or obese children under 5 years of age increased from 4 million to 10 million. Childhood obesity is associated with several health complications, premature onset of illnesses such as diabetes and heart disease, continued obesity into adulthood and an increased risk of noncommunicable diseases.

2. In an effort to provide a comprehensive response to childhood obesity, the Director-General established in 2014 a high-level Commission on Ending Childhood Obesity, comprising 15 accomplished and eminent individuals from a variety of relevant backgrounds.¹ The Commission was tasked with preparing a report specifying the approaches and combinations of interventions that are likely to be most effective in tackling childhood and adolescent obesity in different country contexts around the world. It reviewed the scientific evidence, consulted more than 100 Member States and considered nearly 180 online comments before submitting its report to the Director-General in January 2016.²

3. In decision WHA69(12) (2016), the Sixty-ninth World Health Assembly decided to request the Director-General to develop, in consultation with Member States³ and relevant stakeholders, an implementation plan guiding further action on the recommendations included in the Report of the Commission on Ending Childhood Obesity to be submitted, through the Executive Board at its 140th session, for consideration by the Seventieth World Health Assembly.

¹ The biographies of the commissioners are available at: <http://www.who.int/end-childhood-obesity/about/en/> (accessed 6 March 2017).

² http://apps.who.int/iris/bitstream/10665/204176/1/9789241510066_eng.pdf?ua=1 (accessed 6 March 2017).

³ And, where applicable, regional economic integration organizations.

4. A draft implementation plan was made available for online consultation in September/October 2016 and comments were received from 106 entities, including 16 Member States.¹ The Secretariat has used the feedback given through this public consultation to prepare the annexed draft implementation plan to guide further action on the recommendations of the Commission on Ending Childhood Obesity.

5. In January 2017 the Executive Board, at its 140th session, considered an earlier version of this report² and broad support was expressed for the draft implementation plan.³

ACTION BY THE HEALTH ASSEMBLY

6. The Health Assembly is invited to consider the draft implementation plan.

¹ <http://www.who.int/end-childhood-obesity/implementation-plan/en/> (accessed 6 March 2017).

² Document EB140/30.

³ See the summary records of the Executive Board at its 140th session, fourteenth meeting.

ANNEX

**DRAFT IMPLEMENTATION PLAN TO GUIDE FURTHER ACTION ON THE
RECOMMENDATIONS INCLUDED IN THE REPORT OF THE
COMMISSION ON ENDING CHILDHOOD OBESITY**

1. The Sustainable Development Goals,¹ adopted by the United Nations General Assembly in 2015, identify prevention and control of noncommunicable diseases as one of the health challenges in the 2030 Agenda for Sustainable Development. Among the risk factors for noncommunicable disease, overweight and obesity are particularly concerning and have 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 2013–2020² calls for a halt in the rise in obesity among adolescents, and the comprehensive implementation plan on maternal, infant and young child nutrition³ sets a target of no increase in childhood overweight by 2025. Yet the prevalence of obesity in infants, children and adolescents⁴ is rising around the world and many children who are not yet obese are overweight and on the pathway to obesity. Renewed action is therefore urgently needed if these targets are to be met.

2. Almost three quarters of the 42 million children under 5 years of age who are overweight and obese live in Asia and Africa.⁵ In countries where prevalence of overweight and obesity is plateauing, there are growing economic and health inequities, and rates of obesity continue to increase among people with low socioeconomic status 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 so as adults and are at risk of developing serious noncommunicable diseases. Despite the rising global prevalence of overweight and obesity, awareness of the magnitude and consequences of childhood obesity is still lacking in many settings, particularly in countries where undernutrition is common and prevention of childhood obesity may not be seen as a public health priority. As countries undergo rapid socioeconomic and/or nutrition transition, they face a double burden, in which inadequate nutrition and excessive weight gain may coexist, in the same household and even in the same individuals. Children who have been undernourished, either in utero or in early childhood, are at particular risk of becoming overweight and obese if then faced with an obesogenic environment, that

¹ <https://sustainabledevelopment.un.org/sdgs> (accessed 6 March 2017).

² Endorsed by the Health Assembly in resolution WHA66.10 (2013) on Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases; see document WHA66/2013/REC/1, Annex 4 for the text of the action plan.

³ Endorsed by the Health Assembly in resolution WHA65.6 (2012) on Comprehensive implementation plan on maternal, infant and young child nutrition; see document WHA65/2012/REC/1, Annex 2 for the text of the implementation plan.

⁴ The Convention on the Rights of the Child defines children as those below the age of 18 years. WHO defines adolescents as those between 10 and 19 years of age. In global surveys, overweight and obesity in persons aged 18 years and over is reported as adult data. Therefore, in this context, childhood obesity refers to all children under 19 years of age, including adolescents, with body mass index-for-age more than 3 standard deviations above the WHO child growth median for children less than 5 years of age, and more than 2 standard deviations above the WHO growth reference median for children aged 5–19 years.

⁵ UNICEF, WHO, The World Bank Group. Levels and trends in child malnutrition: UNICEF-WHO-World Bank joint child malnutrition estimates (2016 edition), available at: <http://www.who.int/nutgrowthdb/estimates2015/en/> (accessed 6 March 2017).

is, one that promotes high energy intake and sedentary behaviour. An individual's biological and behavioural responses to such an environment can be strongly influenced by developmental or life course factors from before conception and across generations, as well as by peer pressure and social norms.

3. Recognizing that progress in tackling obesity in infants, children and adolescents has been slow and inconsistent, the Director-General established the Commission on Ending Childhood Obesity 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. The aim is to reduce the risk of morbidity and mortality due to noncommunicable diseases, lessen the negative psychosocial effects of obesity in both childhood and adulthood, and reduce the risk of the next generation developing obesity.

4. Having reviewed the scientific evidence,¹ consulted with more than 100 Member States and considered nearly 180 online comments, the Commission finalized its report, which contained a comprehensive, integrated package of recommendations to address childhood obesity.² The report presents the rationale for these recommendations and provides the background for this draft implementation plan. The Commission called 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 by recognizing the importance of remedying obesogenic environments, taking a life course approach and improving or addressing the treatment of children who are already obese.

5. In 2016, the Sixty-ninth World Health Assembly adopted decision WHA69(12) in which it requested the Director-General to develop, in consultation with Member States,³ an implementation plan guiding further action on the recommendations included in the report of the Commission.

6. The resulting draft plan comprises two sections. The first sets out the aim, scope and guiding principles of the implementation plan. The second defines the actions needed to end childhood obesity in the specific areas of (I) leadership; (II) the set of six recommendations of the Commission; (III) monitoring and accountability; (IV) key elements for successful implementation; and (V) roles and responsibilities of stakeholders.

DRAFT IMPLEMENTATION PLAN

Aim and scope

7. This draft implementation plan builds on the recommendations and accompanying rationales in the report of the Commission on Ending Childhood Obesity and aims to guide Member States and other partners on the actions needed to implement these recommendations. It recognizes that Member States face different challenges with respect to all forms of malnutrition. The draft plan acknowledges variations in constitutional frameworks among Member States, differences in the sharing of

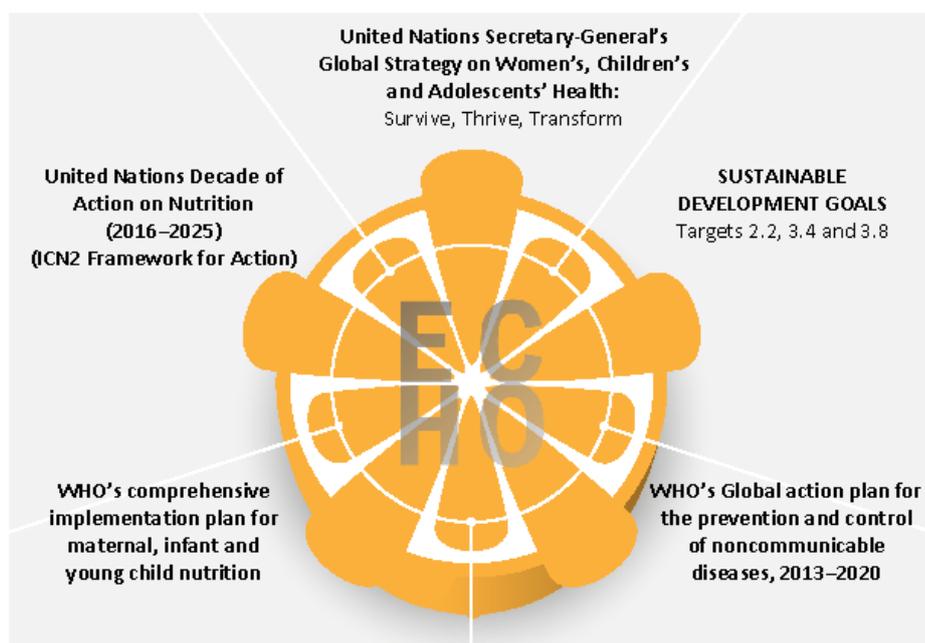
¹ WHO. Consideration of the evidence on childhood obesity for the Commission on Ending Childhood Obesity: Report of the ad hoc working group on science and evidence for ending childhood obesity. Geneva: World Health Organization; 2016.

² Commission on Ending Childhood Obesity. Report of the Commission on Ending Childhood Obesity. Geneva: World Health Organization; 2016, available at: http://apps.who.int/iris/bitstream/10665/204176/1/9789241510066_eng.pdf?ua=1 (accessed 6 March 2017).

³ And, where applicable, regional economic integration organizations.

responsibility between levels of government, and variance in the public health policies already in place in different countries. Actions to end childhood obesity should be integrated into existing policies and programmes across diverse domains at all levels. The goal to end childhood obesity aligns with the objectives of the 2030 Agenda for Sustainable Development, such as the targets of the Sustainable Development Goals that call for an end to malnutrition in all its forms (target 2.2), a reduction in premature mortality from noncommunicable diseases (target 3.4), ensuring universal health coverage (target 3.8), as well as contributing to quality education (Goal 4) and reduced inequalities within and among countries (Goal 10). If Member States take prompt and comprehensive action to prevent and treat childhood obesity, then other health initiatives, including those to improve maternal, child and adolescent health, nutrition and physical activity, will be further strengthened, thus contributing to broader targets for health and well-being. This synergy provides an additional focus for concentrating efforts for long-term impact. Figure 1 depicts 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 Adolescents’ Health, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and the United Nations Decade of Action on Nutrition (2016–2025), and so contribute to improving the health and well-being of this and the next generation of children.

Figure 1. Ending childhood obesity contributes to several other strategies



Guiding principles

8. In its report the Commission on Ending Childhood Obesity identified the following guiding principles, which underpin this draft implementation plan.

- (a) **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 by protecting children's rights to health and food. 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 on the Rights of the Child.¹

(b) **Government commitment and leadership.** Governments need to accept primary responsibility for taking action and implementing effective policies on behalf of the children they are ethically bound to protect. A failure to act will have major health, well-being, social and economic consequences.

(c) **A whole-of-government approach.** Prevention and treatment of obesity require a whole-of-government approach in which policies across all sectors systematically consider health outcomes. Avoiding harmful health impacts can help all sectors to achieve their goals. Current approaches are clearly insufficient and additional coordinated intervention is needed if the targets to halt the rise in obesity in children, adolescents and adults are to be achieved.² For example, the education sector plays a crucial role in providing education about nutrition and health, increasing the opportunities for physical activity and promoting healthy school environments. Agriculture and trade policies and the globalization of the food system affect food affordability, availability and quality at national and local levels. Urban planning and design, and transport planning, all have direct consequences on opportunities for physical activity and access to healthy foods. Intersectoral governmental structures, such as a high-level inter-ministerial task force for child and adolescent health that includes childhood obesity as one of its tasks, can identify mutual interests and facilitate coordination, collaboration and exchange of information through coordinating mechanisms.

(d) **A whole-of-society approach.** The complexity of obesity calls for a comprehensive approach that involves, in addition to all levels of government, other actors, such as parents, carers, 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 active engagement of all sectors of society at the local, national, regional and global levels, with appropriate attention to conflicts of interest. Joint ownership and shared responsibility are essential for effective interventions to have reach and impact.

(e) **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. Obesity and its associated morbidities erode potential improvements in social and health capital, and increase inequity and inequality. The social determinants of health mean that these population groups often have poor access to healthy foods, safe places for physical activity and preventive health services and support. Attention needs to be given to ensuring that interventions are developed in ways that are acceptable and culturally sensitive.

¹ United Nations Convention on the Rights of the Child, 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; document CRC/C/GC/15.

² Resolution WHA66.10 (2013) on Follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and resolution WHA65.6 (2012) on Comprehensive implementation plan on maternal, infant and young child nutrition.

(f) **Aligning with the global development agenda.** The Sustainable Development Goals call for an end to malnutrition in all its forms (target 2.2) and a reduction in premature mortality from noncommunicable diseases (target 3.4). Reducing childhood obesity will also contribute to universal health coverage (target 3.8), quality education (Goal 4) and reduced inequalities (Goal 10). Integrating ending childhood obesity into national development and financing frameworks for the Sustainable Development Goals will ensure a response from all sectors.\$

(g) **Integration into a life course approach.** The Commission has highlighted the need to reduce the risk of childhood obesity by action even before conception. Integrating interventions to prevent and treat childhood obesity into 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 Adolescents' Health, the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, the Rome Declaration on Nutrition adopted at the Second International Conference on Nutrition (Rome, 19–21 November 2014) and the United Nations Decade of Action on Nutrition (2016–2025). Several other strategies and implementation plans of WHO and other bodies in the United Nations system related to optimizing maternal, infant, young child and adolescent nutrition and health exist that are highly relevant to key elements of a comprehensive approach to prevention of obesity. Relevant principles and recommendations can be found in related documents providing guidance throughout the life-course. Initiatives to address childhood obesity should be integrated within these existing areas of work and build upon them to help children to realize their fundamental right to health and, improve their well-being, while reducing the burden on the health system.

(h) **Accountability.** Political and financial commitment is imperative in combating childhood obesity. A robust mechanism and framework are needed to monitor policy development, implementation and outcomes, thus facilitating the accountability of governments and non-State actors for the commitments they make.

(i) **Universal health coverage.** 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.² As such, access to and coverage of interventions for the prevention of overweight and obesity and the treatment of children already obese and those who are overweight and 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, available at: http://www.euro.who.int/__data/assets/pdf_file/0009/289962/The-Minsk-Declaration-EN-rev1.pdf?ua=1 (accessed 6 March 2017).

² As also expressed in United Nations General Assembly resolution 69/132 on Global health and foreign policy.

ACTIONS NEEDED TO END CHILDHOOD OBESITY

9. The Commission proposed six sets of recommendations to tackle the obesogenic environment and interventions at critical time points in the life course for the prevention of obesity and the treatment of children who are already obese.

10. Effective implementation of the recommendations will require political commitment and leadership as well as capacities to deliver the required interventions and effective monitoring of accountabilities of different stakeholders. The framework is illustrated in Figure 2.

Figure 2. Action framework for ending childhood obesity



11. In advance of a global strategy, WHO's regional offices developed several strategies and action plans that address some aspects of the recommendations below.¹ These instruments can be integrated and further strengthened, where necessary, by alignment with the recommendations of the Commission on Ending Childhood Obesity.

12. A multisectoral approach will be essential for sustained progress. The following sections provide guidance on the necessary actions that Member States must consider, and the supportive actions by other stakeholders, in order to achieve the aims of this implementation plan. In recognition of the policies already in place in some Member States, and the differing prevalence rates of malnutrition in all its forms, Member States are encouraged to prioritize actions in a step-wise approach according to local context, drivers of obesity and opportunities to intervene.

¹ WHO Regional Office for Europe. European food and nutrition action plan 2015–2020. Copenhagen: WHO Regional Office for Europe; 2015; WHO Regional Office for South-East Asia. Strategic action plan to reduce the double burden of malnutrition in the south-east asia region 2016–2025. Delhi: WHO Regional Office for South-East Asia; 2016; PAHO. Plan of action for prevention of obesity in children and adolescents. Washington DC: Pan American Health Organization; 2014; WHO Regional Office for the Western Pacific. Action plan to reduce the double burden of malnutrition in the Western Pacific Region (2015–2020). Manila: WHO Regional Office for the Western Pacific; 2015.

I. PROVIDE LEADERSHIP FOR COMPREHENSIVE, INTEGRATED, MULTISECTORAL ACTION

Rationale

13. Governments bear the ultimate responsibility for ensuring their citizens have a healthy start in life. Preventing childhood obesity requires the coordinated contributions of all governmental sectors and institutions contributing to policy development and implementation. 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. Resources need to be dedicated to 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, in order to successfully implement, monitor and evaluate the impact of programmes, activities and investments.

14. Table 1 proposes actions to be taken by Member States to implement the recommendation of the Commission on the roles and responsibilities of Member States. Some countries may already have implemented some of these policies and can build upon and strengthen these.

Table 1. Recommended roles and responsibilities and proposed actions for Member States

Recommended roles and responsibilities outlined by the Commission	Steps to be taken by Member States
(a) Take ownership, provide leadership and engage political commitment to tackle childhood obesity over the long term.	<p>Ensure regular contact with parliamentarians to consolidate high-level commitment to prevention of childhood obesity.</p> <p>Conduct regular high-level policy dialogues on childhood obesity.</p> <p>Mobilize sustainable resources to tackle childhood obesity.</p> <p>Prepare a budget and legislation or regulatory instrument to implement key interventions to reduce childhood obesity.</p>
(b) Coordinate contributions of all government sectors and institutions responsible for policies, including, but not limited to: education; food and 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 an existing multisectoral group, comprising relevant government agencies, to coordinate policy development, implementation of interventions, monitoring and evaluation across the whole of government, including accountability systems.
(c) Ensure data collection on body mass index-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 reductions in childhood obesity and monitoring mechanisms that include body mass index-for-age in addition to other appropriate measures , disaggregated by age, sex and socioeconomic status.

Recommended roles and responsibilities outlined by the Commission	Steps to be taken by Member States
(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.	Establish mechanisms to coordinate the engagement of non-State actors and hold them to account in the implementation of interventions. Establish clear mechanisms/policies for the management of conflicts of interest.

II. RECOMMENDATIONS OF THE COMMISSION

Rationale

15. No single intervention can halt the advance of the epidemic of obesity. To challenge childhood obesity successfully requires countering the obesogenic environment and addressing vital elements in the life course through coordinated, multisectoral action that is held to account.

16. Member States already have some 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 highlight the urgent need to add additional elements for prevention and treatment of obesity that will contribute to the achievement of a range of targets for maternal, infant, young child and adolescent health.

17. The prevalence of childhood obesity, the risk factors that contribute to this issue, and the political and economic situations differ between Member States. The actions recommended below are designed to allow countries to assess which package of integrated interventions may best be implemented in their particular settings. Section IV details how to prioritize actions and develop a step-wise approach to implementation in order to support governments in realizing these actions. Some tools and resources are available at both global and regional levels to support Member States in developing policies and interventions and implementing, monitoring and evaluating them. A page on the WHO website will be created to list tools and resources currently available and others as they are developed.¹

18. The tables below outline examples of actions that Member States may consider taking in order to implement the six recommendations of the Commission. Interventions to tackle childhood obesity can be integrated into and build upon existing national plans, policies and programmes.

¹ This will appear on the WHO webpage at: <http://www.who.int/end-childhood-obesity/en/>.

1. Actions to implement comprehensive programmes that promote the intake of healthy foods and reduce the intake of unhealthy foods and sugar-sweetened beverages by children and adolescents (Table 2)

Rationale

19. An obesogenic environment is one that promotes high-energy intake and physical inactivity, including sedentary behaviour. This includes foods and opportunities for physical activity that are available, affordable, accessible and marketed, and 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 underlying choices of healthy food and physical activity will be undermined if there are conflicting messages, both through marketing in the media and in settings where children gather. Voluntary measures or self-regulation commonly have limited value unless there is active government involvement in establishing the standards and the time frame for achievement, and in determining sanctions for non-compliance. Voluntary approaches and self-regulation can also impede progress if they are used to defer effective regulation. Enabling the choice of a healthy lifestyle needs healthy foods and opportunities for physical activity to be readily available and affordable to all members of society; it also requires that less advantaged children, who are at particular risk of obesity, are fully engaged in the intervention.

Table 2. Recommendation 1 of the Commission and steps to be taken by Member States

Recommendations of the Commission	Steps to be taken by Member States
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.	<p>Inform the population about childhood overweight and obesity and consequences for health and well-being.</p> <p>Update, as necessary, guidance on the prevention of childhood obesity through the consumption of a healthy diet throughout the life course.</p> <p>Ensure that food-based dietary guidance is disseminated in an accessible manner for children, carers, school staff and health professionals.</p> <p>Develop and implement evidence-based, public education campaigns about what constitutes a healthy diet and the need for it and for physical activity, which are appropriately funded and sustained over time.</p>
1.2 Implement an effective tax on sugar-sweetened beverages.	<p>Analyse the administration and impact of a tax on sugar-sweetened beverages.</p> <p>Levy an effective tax on sugar-sweetened beverages according to WHO's guidance.</p>
1.3 Implement the set of recommendations on the marketing of foods and non-alcoholic beverages to children ¹ to reduce the exposure of children and adolescents to, and the power of, the marketing of unhealthy foods.	<p>Assess the impact of legislation, regulation and guidelines to tackle the marketing of unhealthy foods and non-alcoholic beverages to children, where required.</p> <p>Adopt, and implement effective measures, such as legislation or regulation, to restrict the marketing of foods and non-alcoholic beverages to children and thereby reduce the exposure of children and adolescents to such marketing.</p>

¹ Endorsed by the Health Assembly in resolution WHA63.14 (2010) on Marketing of food and non-alcoholic beverages to children; see also document WHA61/2008/REC/1, Annex 3.

Recommendations of the Commission	Steps to be taken by Member States
	Establish mechanisms to effectively enforce implementation of legislation or regulation on the marketing of foods and non-alcoholic beverages to children.
1.4 Develop nutrient profiles to identify unhealthy foods and beverages.	Establish a national nutrient-profiling model to regulate marketing, taxation, labelling and provision in public institutions, based on WHO's regional or global nutrient-profile models. ¹
1.5 Establish cooperation between Member States to reduce the impact of cross-border marketing of unhealthy foods and beverages.	Engage in intercountry discussions on policies and proposals for regulating cross-border marketing of unhealthy foods and non-alcoholic beverages to children through WHO regional committees and other relevant regional mechanisms.
1.6 Implement a standardized global nutrient-labelling system.	At the international level, work through the Codex Alimentarius Commission to develop a standardized system of food labelling, to support health literacy education efforts through mandatory labelling for all pre-packaged foods and beverages. At the domestic level, adopt mandatory laws and regulations for nutrition labelling.
1.7 Implement interpretive front-of-pack labelling, supported by public education of both adults and children for nutrition literacy.	Consider undertaking pre-market/consumer testing of interpretive front-of-pack labelling, based on a nutrient-profile model. Adopt, or develop as necessary, a mandatory interpretive front-of-pack labelling system based on the best available evidence to identify the healthfulness of foods and beverages.
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 at events (see also recommendations 4.9 and 5.1) based on a national nutrient-profile model. Apply such food laws, regulations and standards in catering services for existing school, child-care and other relevant settings.
1.9 Increase access to healthy foods in disadvantaged communities.	Involve actors and resources outside the health system to improve access, availability and affordability of nutritious foods at a sustained scale in disadvantaged communities (for instance, through incentives to retailers and zoning policies). Establish regulations and standards for social support programmes based on national and international dietary guidelines. Incentivize local production of fruit and vegetables, such as urban agriculture.

¹ See: PAHO nutrient profile model, available at: <http://iris.paho.org/xmlui/handle/123456789/18621>; WHO Regional Office for Europe nutrient profile model, available at: http://www.euro.who.int/__data/assets/pdf_file/0005/270716/Europe-nutrient-profile-model-2015-en.pdf?ua=1; Technical Meeting on the Regional Adaptation of the WHO Nutrient Profile Model to the Western Pacific Region, available at: <http://iris.wpro.who.int/bitstream/handle/10665.1/13410/RS-2015-GE-52-PHL-eng.pdf>; Nutrient profiling: report of a technical meeting, 2010, available at: http://www.who.int/nutrition/publications/profiling/WHO_IASO_report2010.pdf?ua=1 (all accessed 6 March 2017).

2. Actions to implement comprehensive programmes that promote physical activity and reduce sedentary behaviours in children and adolescents (Table 3)

Rationale

20. Physical activity declines from the age of school entry and low physical activity is rapidly becoming a social norm. Yet, physical activity is known to reduce the risk of diabetes, cardiovascular disease and cancers and to improve children's ability to learn, their mental health and well-being. Moreover, childhood experience can influence lifelong physical activity behaviours.

Table 3. Recommendation 2 of the Commission and steps to be taken by Member States

Recommendations of the Commission	Steps to be taken by Member States
2.1 Provide guidance to children and adolescents, their parents, carers, teachers and health professionals on healthy body size, physical activity, sleep behaviours and appropriate use of screen-based entertainment.	<p>Develop and implement evidence-based, targeted and appropriately funded, public education campaigns on the importance of physical activity.</p> <p>Update existing materials, as necessary, to include guidance on physical activity throughout the life course.</p> <p>Disseminate guidance on physical activity to children, carers, school staff and health professionals in an accessible manner.</p> <p>Use peer education and whole-of-school initiatives to influence the physical activity behaviours of children and social norms.</p>
2.2 Ensure that adequate facilities are available on school premises and in public spaces for physical activity during recreational time for all children (including those with disabilities), with the provision of gender-friendly spaces where appropriate.	Provide, in collaboration with other sectors (such as urban planning and transportation) and stakeholders, safe facilities, resources and opportunities for all children to be physically active during recreational time.

3. Actions to integrate and strengthen guidance for noncommunicable disease prevention with current guidance for preconception and antenatal care, to reduce the risk of childhood obesity (Table 4)

Rationale

21. 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 exposures to obesogenic environments, guidelines are needed that address malnutrition in all its forms (including excessive energy intake) and the risk of subsequent development of obesity in the offspring. Interventions to tackle childhood obesity risk

factors also prevent other adverse pregnancy outcomes¹ and so contribute to improving maternal and newborn health.

Table 4. Recommendation 3 of the Commission and steps to be taken by Member States

Recommendations of the Commission	Steps to be taken by Member States
3.1 Diagnose and manage hyperglycaemia and gestational hypertension.	Ensure that screening for hypertension and hyperglycaemia are included in antenatal care.
3.2 Monitor and manage appropriate gestational weight gain.	Ensure that measurement of weight and gestational weight gain are included in antenatal care.
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.	Ensure that diet and nutrition counselling is included in antenatal care. Include information on the association between prospective parents' diet, physical activity and health behaviours and the risk of childhood obesity in the curriculum of health care providers. Disseminate guidance and provide support for healthy diet and physical activity to prospective parents whom preconception or antenatal care may not reach.

4. Actions to provide guidance on, and support for, healthy diet, sleep and physical activity in early childhood to ensure children grow appropriately and develop healthy habits (Table 5)

Rationale

22. 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.

¹ Temel S, van Voorst SF, Jack BW, Denktas S, Steegers EA. Evidence-based preconceptional lifestyle interventions. *Epidemiol Rev.* 2014;36:19-30.

Table 5. Recommendation 4 of the Commission and steps to be taken by Member States

Recommendations of the Commission	Steps to be taken by Member States
4.1 Enforce regulatory measures such as the International Code of Marketing of Breast-milk Substitutes and subsequent World Health Assembly resolutions.	Ensure that legislation and regulations on the marketing of breast-milk substitutes adhere to all the provisions in the International Code of Marketing of Breast-milk Substitutes and subsequent related Health Assembly resolutions.
4.2 Ensure all maternity facilities fully practice the Ten Steps to Successful Breastfeeding.	Establish regulations for all maternity facilities to practice the Ten Steps to Successful Breastfeeding. Build or enhance assessment systems to regularly verify maternity facilities' adherence.
4.3 Promote the benefits of breastfeeding for both mother and child through broad-based education to parents and the community at large.	Include information on the benefits of breastfeeding for promoting appropriate infant growth, health and reducing the risk of childhood obesity in guidance for parents and public communications.
4.4 Support mothers to breastfeed, through regulatory measures such as maternity leave, facilities and time for breastfeeding in the work place.	Ratify ILO Convention 183 and enact legislation mandating all the provisions of ILO Recommendation 191 on maternity leave and provision of time and facilities in the work place for breastfeeding.
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.	<p>Assess the impact of legislation, regulations and guidelines to address the marketing of complementary foods for infants and young children, where required.</p> <p>Adopt and implement effective measures, such as legislation or regulation, to restrict the inappropriate marketing of complementary foods for infants and young children.</p> <p>Establish mechanisms to enforce effectively and monitor implementation of legislation or regulation on the marketing of complementary foods for infants and young children.</p>
<p>4.6 Provide clear guidance and support to carers 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.</p> <p>4.7 Provide clear guidance and support to caregivers to encourage the consumption of a wide variety of healthy foods.</p> <p>4.8 Provide guidance to caregivers on appropriate nutrition, diet and portion size for this age group.</p>	<p>Include the following in guidance on infant and young child feeding:</p> <p>(1) the introduction of appropriate complementary foods, avoiding the use of added sugar or sweeteners; (2) responsive feeding to encourage infants and young children to eat a wide variety of healthy foods; (3) which foods and beverages high in sugar, fat and salt should not be given to infants and young children; (4) appropriate portion sizes for children of different ages.</p> <p>Train community health workers or peer support groups to support appropriate complementary feeding.</p>

Recommendations of the Commission	Steps to be taken by Member States
4.9 Ensure only healthy foods, beverages and snacks are served in formal child-care settings or institutions.	Set mandatory nutrition standards for foods and beverages provided (including meals) or sold (including vending machines and school shops) in public and private child-care settings or institutions. Implement such food laws, regulations and standards into catering services for existing child-care and other relevant settings.
4.10 Ensure food education and understanding are incorporated into the curriculum in formal child-care settings or institutions.	Develop nutrition, food and health education curricula jointly between education and health sectors. Train teachers in curriculum delivery. Integrate nutrition and health education components, including practical skills, developed in collaboration with the education sector, into the core curriculum.
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 child-care settings. Provide guidance to carers on the provision of safe and developmentally-appropriate physical activity, active play and active recreation for all children.
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, including age-appropriate activities and ideas to support and encourage participation in physical activity at home and in the community all year round. Develop guidelines on appropriate sleep time and use of screen-based entertainment by children and adolescents (see recommendation 2.1) and ideas to avoid sedentary activities, including avoiding excessive screen-time, and to model regular physical activities for families.
4.13 Engage whole-of-community support for carers and child-care settings to promote healthy lifestyles for young children.	Conduct public awareness campaigns and disseminate information to increase awareness of the consequences of childhood obesity. Promote the benefits of physical activity for both carers and children through broad-based education to carers and the community at large. Promote communication and community participation to raise awareness and create an 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.

5. Actions to implement comprehensive programmes that promote healthy school environments, health and nutrition literacy and physical activity among school-age children and adolescents (Table 6)

Rationale

23. Children and adolescents are highly susceptible to the marketing of unhealthy foods and beverages and the need to protect children from such marketing has been recognized.¹ Peer pressure and perceptions of ideal body image also influence children's attitudes to diet and physical activity. Adolescents in particular are exposed to influences and market forces different from those bearing on younger children and families. It is unfortunate that a significant number of school-age children are not in formal education, as the compulsory school years provide an easy entry point to engage this age group and embed healthy eating and physical activity habits for lifetime prevention of obesity. To be successful, programmes to improve the nutrition and physical activity of children and adolescents need to engage various stakeholders and ensure that conflicts of interest, such as those that can arise when the food and beverage industry is involved in such programmes, do not undermine progress. The active engagement of the education sector and integration of activities into health-promoting school initiatives, will help to ensure the success of such programmes and improve school attainment. Older children and adolescents, as well as their community, need to be engaged in the development and implementation of interventions to reduce childhood obesity.²

Table 6. Recommendation 5 of the Commission and steps to be taken by Member States

Recommendations of the Commission	Steps to be taken by Member States
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 (including vending machines and school shops) in the public and private school environment. Implement such food laws, regulations and standards into catering services for existing school and other relevant settings.
5.3 Ensure access to potable water in schools and sports facilities.	Ensure all school and sports facilities provide free access to safe drinking water.
5.4 Require inclusion of nutrition and health education within the core curriculum of schools.	Develop nutrition, food and health education curricula jointly between education and health sectors. Train teachers in curriculum delivery. Integrate nutrition and health education components, including practical skills, developed in collaboration with education sector, into the core curriculum.

¹ United Nations 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), 17 April 2013, document CRC/C/GC/15.

² School policy framework. Implementation of the WHO global strategy on diet, physical activity and health. Geneva: World Health Organization; 2008.

Recommendations of the Commission	Steps to be taken by Member States
5.5 Improve the nutrition literacy and skills of parents and carers. 5.6 Make food preparation classes available to children, their parents and carers.	Work with schools and communities to deliver skills through community classes/groups.
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.

6. Actions to provide family-based, multicomponent services on lifestyle weight management for children and young people who are obese (Table 7)

Rationale

24. When children are already overweight or obese, weight management to reduce body mass index-for-age and to reduce or prevent obesity-related morbidities 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 becoming obese. The mental health needs of children who are overweight or obese, including issues of stigmatization and bullying, need to be given special attention.

Table 7. Recommendation 6 of the Commission and steps to be taken by Member States

Recommendations of the Commission	Steps to be taken by Member States
6.1 Develop and support appropriate weight management services for children and adolescents who are overweight or obese that are family-based, multicomponent (including nutrition, physical activity and psychosocial support) and delivered by multiprofessional teams with appropriate training and resources, as part of universal health coverage.	Implement a context-appropriate multicomponent weight management protocol that covers diet, physical activity and psychosocial support services tailored to children and families. Align services with existing clinical guidelines and clearly configure the roles of primary health care providers for effective multidisciplinary work. Educate and train concerned primary health care providers in identification and management of childhood obesity and associated stigmatization. Include childhood weight management services as part of universal health coverage.

III. MONITORING AND ACCOUNTABILITY FOR EFFECTIVE PROGRESS (TABLE 8)

25. Monitoring can serve to sustain awareness of the problem of childhood obesity 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. Several monitoring mechanisms currently exist that countries could draw upon and integrate into a comprehensive national monitoring framework for childhood obesity. These include the Indicators and a Monitoring Framework for the Sustainable Development Goals, the United Nations Secretary-General's Independent Accountability Panel for the updated Global Strategy for Women's, Children's and Adolescents' Health, the Global Monitoring Framework for Noncommunicable Diseases, the Global Monitoring Framework for Maternal, Infant and Young Child Nutrition¹ and the Framework to Monitor and Evaluate Implementation of the Global Strategy on Diet, Physical Activity and Health.²

26. Member States do not want unnecessarily to increase the reporting burden. Thus, a second phase of work is required to identify all relevant existing indicators and reporting mechanisms that can be harnessed for monitoring implementation and to develop technical advice and tools for monitoring and accountability that take this into consideration. The Secretariat will develop a framework for evaluating progress on the implementation plan, which will define baselines, indicators and responsible sectors. It should also provide specific examples of the roles of different sectors/ministries in supporting a whole-of-government response to prevention and treatment of childhood obesity.

Table 8. Recommendations of the Commission on monitoring and accountability and steps to be taken by Member States

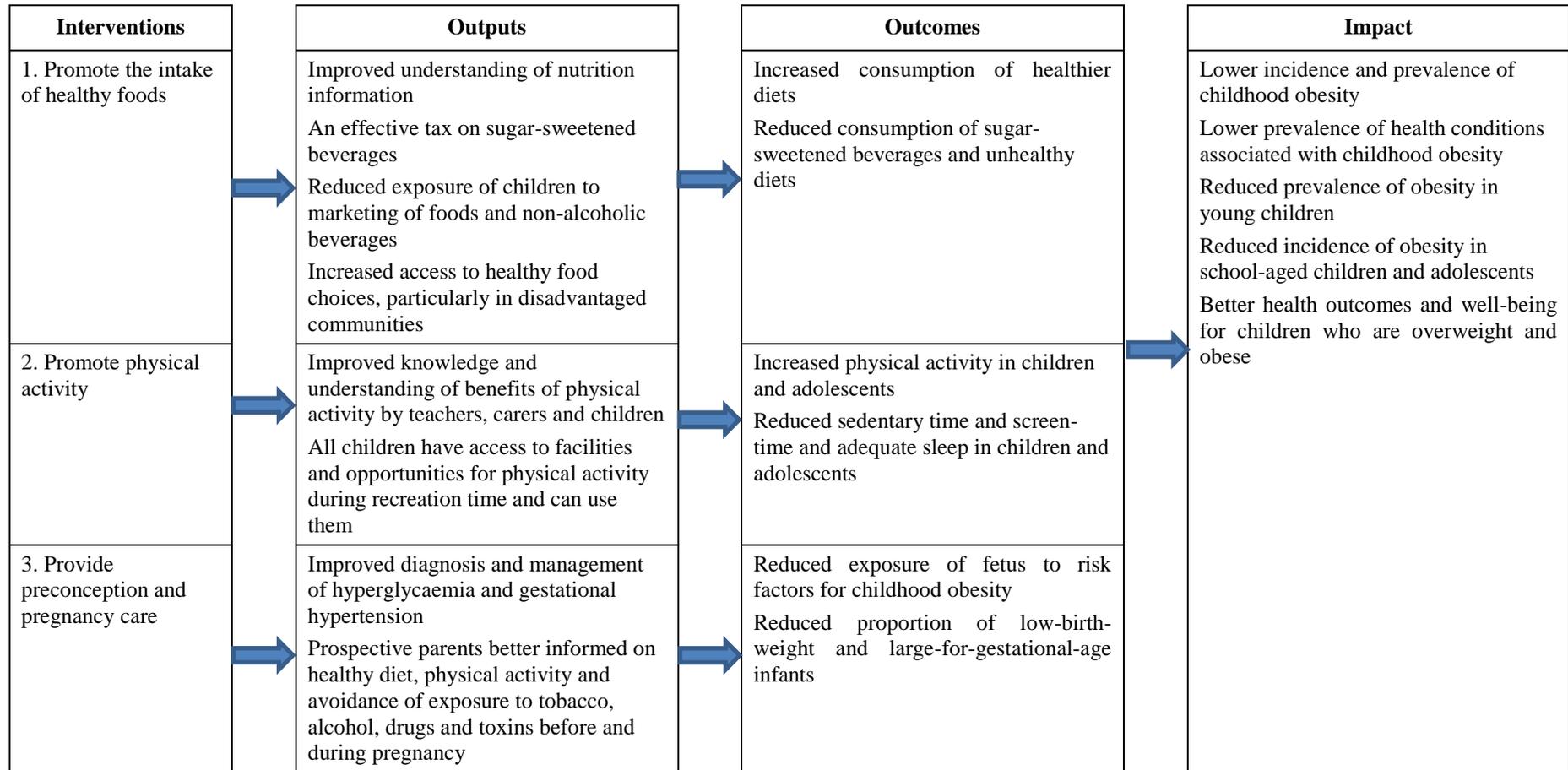
Recommendations of the Commission	Steps to be taken by Member States
Establish monitoring systems to provide evidence of the impact and effectiveness of interventions in reducing the prevalence of childhood obesity and use data for policy and implementation improvement.	Ensure weight and height of children are regularly measured in all primary care settings with adequate quality control. Establish monitoring systems to provide evidence of the impact and effectiveness of interventions in achieving their policy goals and use data for policy and implementation improvement.
Develop an accountability mechanism that encourages participation of nongovernmental organizations and academic institutions in accountability activities.	Establish coordinating mechanisms for the 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's, Children's and Adolescents' Health, the United Nations Decade of Action on Nutrition (2016–2025), Global Monitoring Framework on the Prevention and Control of Noncommunicable Diseases and the associated set of progress indicators.

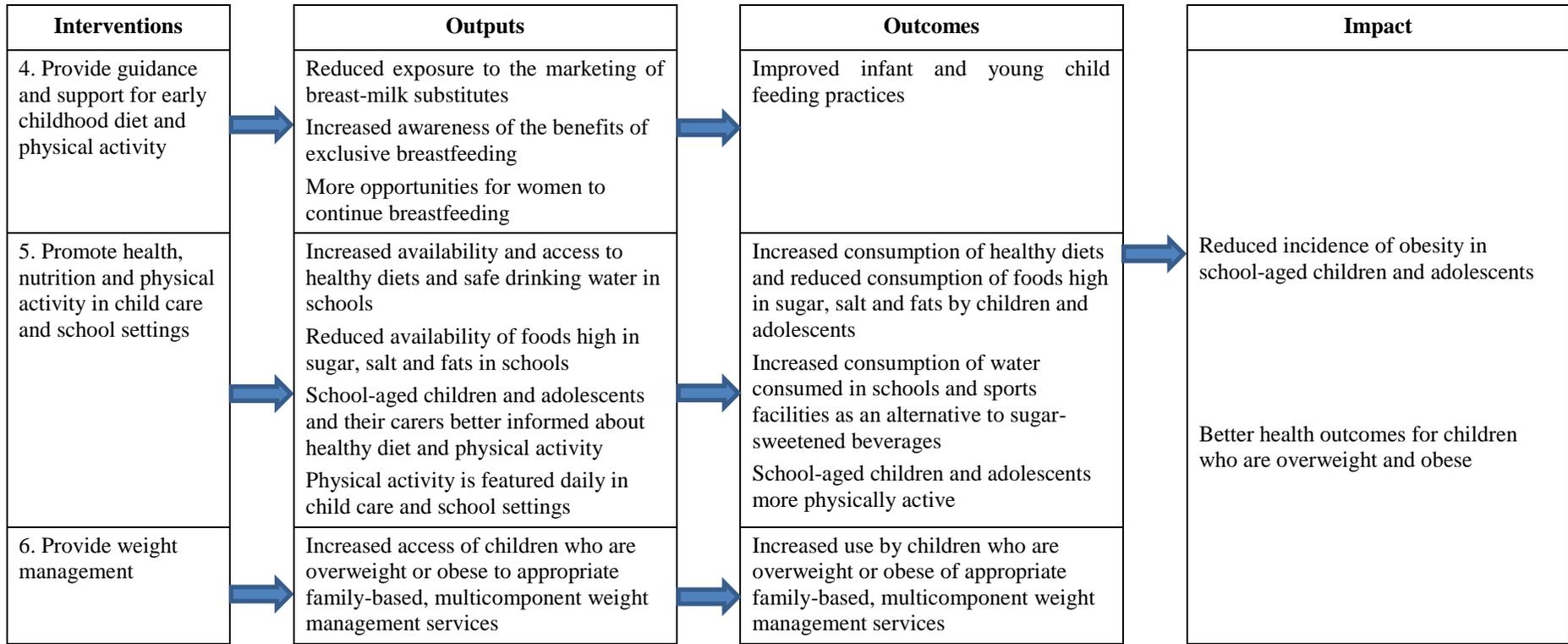
27. The logic model presented in Figure 3 provides guidance to Member States in identifying short- and medium-term outcomes in order to define specific indicators to measure determinants in a standardized manner.

¹ See decision WHA68(14) (2015) on Maternal, infant and young child nutrition: development of the core set of indicators and document WHA68/2015/REC/1, Annex 7.

² WHO global strategy on diet, physical activity and health: a framework to monitor and evaluate implementation. Geneva: World Health Organization; 2008.

Figure 3. Logic model for childhood obesity prevention interventions





28. 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 tackling childhood obesity. Both governments and other actors, notably, civil society, can hold each other and private-sector entities to account in order to ensure that they adopt policies and comply with standards.¹

29. 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 (see Figure 4) could serve as a tool for ensuring a whole-of-government accountability, through a clear delineation of the actions, the actors, the tasks, outputs or outcomes that an actor is accountable for, monitoring of the actions, and processes for holding parties to account. Government entities also have a broad range of tools and processes for holding external actors to account, including legal processes, regulatory arrangements, economic incentives, and market-based and media-based approaches.

30. Civil society can play a critical role in bringing social, moral and political pressure on governments to fulfil their commitments.² Ending childhood obesity should form part of civil society's agenda for advocacy and accountability. Improving coordination of civil society organizations and strengthening their capacity to monitor effectively and ensure accountability for commitments made is vitally important. Governments may consider providing opportunities for formal participation by civil society in the policy-making, implementation and evaluation process, as well as ensuring mutual accountability and transparency.

31. The private sector can play a role in tackling childhood obesity, with appropriate consideration of their core business, but additional accountability strategies are often necessary. Risks of conflicts of interest 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.

¹ Swinburn B, Kraak V, Rutter H, Vandevijvere S, Lobstein T, Sacks G, et al. Strengthening of accountability systems to create healthy food environments and reduce global obesity. *Lancet*. 2015;385:2534-45.

² Huang TTK, Cawley JH, Ashe M, Costa SA, Frerichs LM, Zwicker L, et al. Mobilisation of public support for policy actions to prevent obesity. *Lancet*. 2015;385:2422-31.

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

Actions (recommendations of the Commission)	Identify specific actions/sets of actions to be addressed ↓
Actors	Who will formulate the policy or action for implementation? Who will implement the policy/action? [separate question] Are there other relevant actors, and, if so, who are they? ↓
Allocation of responsibility for tasks and outcomes	What will each of the relevant actors be held accountable for? For example: formulating a policy/programme implementing a policy/programme complying with the policy achieving measurable progress towards the ultimate (or an appropriate intermediate) policy objective collecting and analysing data disaggregated by key determinants such as sex, age, socioeconomic level and education ↓
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 (that is, 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 and 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

32. In implementing actions for ending childhood obesity, consideration should be given to certain elements, as highlighted by the Commission in its report.

Prioritization

33. Regions, countries and national subregions may have differing childhood obesity prevalence and socioeconomic distribution, as well as different economic and health service capacity. They may also have a mix of nutrition conditions that have to be simultaneously addressed, including overweight, undernutrition and micronutrient deficiencies. An analysis that takes into account prevalence data by key determinants of health, such as gender, age, socioeconomic level and ethnicity, combined with a prioritization exercise, can help governments to choose combinations and the order of implementation of interventions that will effectively redress childhood obesity. Interventions that

have the capacity to generate revenue, such as taxation of sugar-sweetened beverages, may assist governments in meeting the cost of implementation. Various prioritization tools exist that can guide this process.¹ 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 all 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 conflicts of interest, is also important. All countries are invited to take action to prevent and control childhood overweight, even at very low prevalence levels, as the epidemic is quickly evolving.

Awareness, communication and education

34. Values and norms influence the perception of healthy or desirable body weight, especially for children. Communication to improve knowledge, correct misperceptions and ensure that communities support and participate in policies and interventions that encourage behaviour change is vital. Peer education and whole-of-community initiatives can engage children, adolescents, families and individuals in designing together new approaches to preventing and tackling obesity, empowering them to act but more importantly creating a demand and support for services and interventions. Capacity-building programmes to teach health care providers and community health workers additional skills in communications and education are also critical for effective programme implementation.

35. Evidence-based mass-media campaigns based on integrated marketing principles, and implemented at appropriate scale and with suitable frequency, should be conducted in order to justify and gain support for a wider programme of action. Such approaches have been shown to be important for changing perceptions, attitudes and intentions, and for promoting community discussions about obesity, physical activity and healthy diets. Such campaigns and programmes can also be targeted, for example, at parents and carers.

Mobilization of resources

36. Governments and stakeholders need resources to implement actions and to find innovative approaches for domestic and international financing. Taxation of sugar-sweetened beverages could generate revenue for programmes against childhood obesity, although due regard must be given to avoiding or managing conflicts of interest.

37. To ensure long-term impact, sustainable domestic and international resources are needed for implementing the recommendations of the Commission.

Capacity-building

38. Strengthening institutional capacity and providing appropriate training to health care workers, child-care and school staff are also essential for the successful implementation of the recommendations of the Commission. In addition, both capacity and capability are also needed to support the design, implementation, evaluation and enforcement of population-based policies, such as

¹ Prioritizing areas for action in the field of population-based prevention of childhood obesity: a set of tools for Member States to determine and identify priority areas for action. Geneva: World Health Organization; 2012.

taxation of sugar-sweetened beverages and restriction of the marketing of foods and non-alcoholic beverages to children.

39. Networks can provide support for countries committed to implementing specific activities as well as building capacity through platforms for sharing experience and exchanging policies between Member States.

V. ROLES AND RESPONSIBILITIES OF STAKEHOLDERS

40. Successful implementation of further action on the recommendations of the Commission requires the committed input, focus and support of numerous agencies besides Member States (see section II). The Commission identified the following stakeholder groups with specific roles and responsibilities.

WHO Secretariat

41. Momentum must be maintained. The Secretariat will lead and convene high-level dialogue within the United Nations system and with and between Member States. Its aim will be to fulfil the commitments made in the 2030 Agenda for Sustainable Development, 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 on Nutrition and other relevant global and regional policy frameworks through the actions detailed by the Commission on Ending Childhood Obesity in its report.

42. 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 in order to put the recommendations of the Commission and other relevant WHO mandates into effect at country level. The Secretariat can disseminate guidance for implementation, monitoring and accountability, and monitor and report on progress to end childhood obesity.

Actions

- (a) Collaborate with other bodies in the United Nations system whose mandates encompass nutrition and childhood obesity, in particular FAO, UNDP, UN Habitat, UNICEF and WFP.
- (b) Institutionalize a cross-cutting and life course approach to ending childhood obesity across all relevant technical areas in WHO headquarters, regional and country offices.
- (c) Develop, in consultation with Member States, guidelines for engaging constructively with the private sector for the prevention of childhood obesity.
- (d) Strengthen capacity to provide technical support for action to end childhood obesity at global, regional and national levels, by for example:
 - (i) building legal and regulatory capacity, by means including workshops and courses in collaboration with other government sectors;

- (ii) developing guidelines on obesity risk prevention during antenatal care, on physical activity for pregnant women and young children, and on appropriate sleep time and screen use by children and adolescents;
 - (iii) providing technical support and tools to Member States, as requested, through the establishment of multisectoral committees or task forces, for instance, in order to support the implementation of the recommendations of the Commission;
 - (iv) offering a platform to enable cooperation between Member States with similar priorities for implementation of the recommendations.
- (e) Support international agencies, national governments and relevant stakeholders in turning existing commitments into relevant actions to end childhood obesity at global, regional and national levels.
 - (f) Promote collaborative research on ending childhood obesity with a focus on the life course approach.
 - (g) Encourage innovative means of financing implementation of strategies for prevention of childhood obesity, with due attention to conflicts of interest.
 - (h) Report on global progress in ending childhood obesity.

International organizations

43. Cooperation between international organizations including entities in the United Nations system can promote global and regional partnerships and networks for advocacy, resource mobilization, capacity-building and collaborative research. The United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases can support Member States in tackling childhood obesity.

Actions

- (a) Cooperate to build capacity and support respective Member States in tackling childhood obesity.
- (b) Incorporate prevention of childhood obesity into country-level programmes in the United Nations Development Assistance Framework.
- (c) Provide support for the development and dissemination of guidance on healthy diet and physical activity.
- (d) Collaborate with organizations in the United Nations system dealing with nutrition to review current practices on the delivery of food and nutrition programmes and ensure that the programmes contribute to the prevention of childhood obesity.
- (e) Partner with governments to implement interventions to end childhood obesity, through for example the United Nations Inter-agency Task Force on the Prevention and Control of Non-communicable Diseases, the United Nations Network for Scaling Up Nutrition and the WHO-

UNDP Global Joint Programme to activate National Responses to Noncommunicable Diseases, which can support implementation of the recommendations of the Commission.

Nongovernmental organizations

44. Although governments build policy frameworks, in some countries the tasks of developing nutrition information and education campaigns, implementing programmes, and monitoring and holding actors to account for commitments made may be 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 prevention of childhood obesity through advocacy and 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 beverages to children.
- (c) Call on governments to create the legal and regulatory frameworks needed to implement recommendations to end childhood obesity.
- (d) Contribute to the development and implementation of a mechanism for monitoring and accountability.

The private sector

45. The private sector is not a homogeneous entity and includes the agricultural food production sector, the food and 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 governmental engagement with entities in the private sector whose activities could have a positive or negative impact on childhood obesity. Governments need to engage constructively with the private sector to encourage implementation of government-determined and government-led policies and interventions.

46. Some private sector initiatives exist that have the potential to reduce childhood obesity. These need to be encouraged where they are supported by an evidence base and do not have coincident negative impacts, such as delaying more effective regulation. As many companies operate globally, international collaboration between their different arms is vital. However, attention must also be given to local and regional entities and artisans. Although some cooperative relationships with industry have led to some encouraging outcomes related to diet and physical activity, others have been seen to shift responsibility from the food and beverage industry to the consumer and to be intended to improve the company's image in the community. Initiatives by the food manufacturing industry to reduce the content of fat, sugar and salt 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. Multinational companies should apply consistent approaches to labelling and marketing across their entire global portfolios so as to ensure that actions are global and do not differ between countries. In doing so, multinational companies should apply the highest standards to which their products are subjected. However, engagement between governments and the private sector needs to be health-goal

oriented, transparent and accountable and to pay particular attention to managing potential conflicts of interest.¹

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

47. 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 with long-term consequences and thus address this important issue.
- (b) Mobilize funds to support research, capacity-building, service delivery, and monitoring and accountability.

Academic institutions and health professional associations

48. Academic institutions can contribute to prevention and control of childhood obesity through studies on biological, behavioural and environmental risk factors and determinants, and the effectiveness of interventions on each of these. Associations of health professionals have an important role in raising public awareness of the immediate and long-term consequences of childhood obesity to health and well-being and advocate implementation of effective interventions. They can also provide support for health professional training and contribute to monitoring and accountability.

Actions

- (a) Raise the profile of prevention and treatment of childhood obesity through the dissemination of relevant information and its incorporation into appropriate curricula at all levels (pre- and post-graduate).
- (b) Fill gaps in knowledge through research that is free from commercial interests in order to provide evidence to support policy implementation.
- (c) Support and evaluate monitoring and accountability activities.

¹ Addressing and managing conflicts of interest in the planning and delivery of nutrition programmes at country level, available at: http://www.who.int/nutrition/events/2015_conflictsofinterest_nut_programmes/en/ (accessed 6 March 2017).

CONCLUSIONS

49. 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 and the next generation of children. 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 knowledge and skills related to health and nutrition. These responses require 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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