



REPORT OF THE COMMISSION ON

ENDING CHILDHOOD OBESITY

IMPLEMENTATION PLAN: EXECUTIVE SUMMARY

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GLOSSARY AND DEFINITIONS

BMI	Body mass index = weight (kg)/height (m ²).
BMI-FOR-AGE	BMI adjusted for age, standardized for children.
CHILDREN	Those less than 18 years of age. ¹
INFANTS	Those less than 12 months of age.
HEALTHY FOODS	Foods that contribute to healthy diets if consumed in appropriate amounts. ²
OBESITY	From birth to less than 5 years of age: weight-for-height more than 3 Standard Deviation (SD) above the WHO Child Growth Standards median. ³ From age 5 to less than 19 years: BMI-for-age more than 2 SD above the WHO growth reference median. ⁴
OBESOGENIC ENVIRONMENT	An environment that promotes high energy intake and sedentary behaviour. This includes the foods that are available, affordable, accessible and promoted; physical activity opportunities; and the social norms in relation to food and physical activity.
OVERWEIGHT	From birth to less than 5 years of age: weight-for-height more than 2 SD above WHO Child Growth Standards median. ³ From age 5 to less than 19 years: BMI-for-age more than 1 SD above WHO growth reference median. ⁴
UNHEALTHY FOODS	Foods high in saturated fats, trans-fatty acids, free sugars or salt (i.e. energy-dense, nutrient-poor foods).
YOUNG CHILDREN	Those less than 5 years of age.

1 Convention on the rights of the child, Treaty Series, 1577:3(1989): PART I, Article 1 defines a child as every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier. The World Health Organization (WHO) defines adolescents as those between 10 and 19 years of age. The majority of adolescents are, therefore, included in the age-based definition of "child", adopted by the Convention on the Rights of the Child, as a person under the age of 18 years.

2 <http://www.who.int/mediacentre/factsheets/fs394/en/>.

3 http://www.who.int/childgrowth/standards/technical_report/en/.

4 http://www.who.int/nutrition/publications/growthref_who_bulletin/en/. The new curves are closely aligned with the WHO Child Growth Standards at 5 years, and the recommended adult cut-offs for overweight and obesity at 19 years. They fill the gap in growth curves and provide an appropriate reference for the 5–19-year age group.

IMPLEMENTATION OF THE RECOMMENDATIONS OF THE COMMISSION ON ENDING CHILDHOOD OBESITY

The prevalence of obesity in infants, children and adolescents¹ is rising around the world and many children who are not yet obese are overweight and on the pathway to obesity. Bolder action is urgently needed if targets to halt the rise in childhood obesity and reduce mortality from noncommunicable diseases (NCDs) by one third are to be met.

In 2016 an estimated 42 million children under the age of 5 were overweight or obese.² Almost three quarters of these live in Asia and Africa. 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 obese as adults and are at risk of developing serious noncommunicable diseases.

Despite the rising 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. The double burden of malnutrition, whereby both under- and over-nutrition exist in the same community or even household, highlights the need for an integrated approach to address all forms of malnutrition.

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 report of the Commission presented a comprehensive, integrated package of recommendations to guide countries to address childhood obesity. Six key areas of action were identified, as summarized in figure 1³. These recommendations provide the background for this implementation plan⁴.

The Commission called for governments to provide leadership and for all stakeholders to recognize their responsibility to act on behalf of the child and reduce the risk of obesity. The recommendations call for all countries to remedy the obesogenic environments, take a life course approach in promoting obesity prevention and improve the treatment of children who are already obese.

AIM AND SCOPE

The Ending Childhood Obesity implementation plan guides Member States and other partners on the actions needed to implement the recommendations of the Commission on Ending Childhood Obesity.

It recognizes that the prevalence of childhood obesity, the risk factors that contribute to this issue, and the political and economic situations differ between Member States and provides relevant supporting information.

This document provides a summary of the recommended actions for policy makers. It can inform which package of integrated interventions may best be implemented in particular settings to achieve the target of halting the rise in childhood obesity.

1 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.

2 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/>.

3 Commission on Ending Childhood Obesity. Report of the Commission on Ending Childhood Obesity. Geneva: World Health Organization; 2016, available at: [HYPERLINK "http://apps.who.int/iris/bitstream/10665/204176/1/9789241510066_eng.pdf?ua=1"](http://apps.who.int/iris/bitstream/10665/204176/1/9789241510066_eng.pdf?ua=1)

4 http://apps.who.int/gb/ebwha/pdf_files/WHA70/A70_31-en.pdf?ua=1.

FIGURE 1. SIX KEY AREAS OF ACTION



LEADERSHIP FOR COMPREHENSIVE, INTEGRATED, MULTISECTORAL ACTION TO END CHILDHOOD OBESITY

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. Resources need to be dedicated to policy implementation and workforce capacity strengthening.

LEADERSHIP

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

- Ensure regular contact with parliamentarians to consolidate high-level commitment to prevention of childhood obesity.
- Conduct regular high-level policy dialogues on childhood obesity.
- Mobilize sustainable resources to tackle childhood obesity.
- Prepare a budget and legislation or regulatory instrument to implement key interventions to reduce childhood obesity.

JOINT ACTION

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.



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. Interventions to tackle childhood obesity can be integrated into and build upon existing national plans, policies and programmes.

DATA-FOR-ACTION

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.

GOOD GOVERNANCE

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.

ACTIONS

1



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

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.

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.

- Inform the population about childhood overweight and obesity and consequences for health and well-being.
- Update, as necessary, guidance on the prevention of childhood obesity through the consumption of a healthy diet throughout the life course.
- Ensure that food-based dietary guidance is disseminated in an accessible manner for children, carers, school staff and health professionals.
- 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.

1.2

Implement an effective tax on sugar-sweetened beverages.

- Analyse the administration and impact of a tax on sugar-sweetened beverages.
- Levy an effective tax on sugar-sweetened beverages according to WHO's guidance.

1.3

Implement the set of recommendations on the marketing of foods and non-alcoholic beverages to children¹ to reduce the exposure of children and adolescents to, and the power of, the marketing of unhealthy foods.

- Assess the impact of legislation, regulation and guidelines to tackle the marketing of unhealthy foods and non-alcoholic beverages to children, where required.
- 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.
- Establish mechanisms to effectively enforce implementation of legislation or regulation on the marketing of foods and non-alcoholic beverages to children.

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.



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.²

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.

² 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.





IMPLEMENT COMPREHENSIVE PROGRAMMES THAT PROMOTE PHYSICAL ACTIVITY AND REDUCE SEDENTARY BEHAVIOURS IN CHILDREN AND ADOLESCENTS

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.

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.

- **Develop and implement evidence-based, targeted and appropriately funded, public education campaigns on the importance of physical activity.**
- **Update existing materials, as necessary, to include guidance on physical activity throughout the life course.**
- **Disseminate guidance on physical activity to children, carers, school staff and health professionals in an accessible manner.**
- **Use peer education and whole-of-school initiatives to influence the physical activity behaviours of children and social norms.**

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



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

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. Interventions to tackle childhood obesity risk factors also prevent other adverse pregnancy outcomes¹ and so contribute to improving maternal and newborn health.

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.

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





4



PROVIDE GUIDANCE ON, AND SUPPORT FOR, HEALTHY DIET, SLEEP AND PHYSICAL ACTIVITY IN EARLY CHILDHOOD TO ENSURE CHILDREN GROW APPROPRIATELY AND DEVELOP HEALTHY HABITS

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.

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.

- Assess the impact of legislation, regulations and guidelines to address the marketing of complementary foods for infants and young children, where required.
- Adopt and implement effective measures, such as legislation or regulation, to restrict the inappropriate marketing of complementary foods for infants and young children.



- Establish mechanisms to enforce effectively and monitor implementation of legislation or regulation on the marketing of complementary foods for infants and young children.

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.

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 the following in guidance on infant and young child feeding:

- (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.
- Train community health workers or peer support groups to support appropriate complementary feeding.

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**IMPLEMENT COMPREHENSIVE PROGRAMMES THAT PROMOTE HEALTHY SCHOOL ENVIRONMENTS, HEALTH AND NUTRITION LITERACY AND PHYSICAL ACTIVITY AMONG SCHOOL-AGE CHILDREN AND ADOLESCENTS**

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. 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.¹

- 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.
- 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.

¹ School policy framework. Implementation of the WHO global strategy on diet, physical activity and health. Geneva: World Health Organization; 2008.



6



PROVIDE FAMILY-BASED, MULTICOMPONENT SERVICES ON LIFESTYLE WEIGHT MANAGEMENT FOR CHILDREN AND YOUNG PEOPLE WHO ARE OBESE

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.

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.**



KEY ELEMENTS FOR SUCCESSFUL IMPLEMENTATION

CAPACITY-BUILDING

Government, academic institutions, health professional associations and philanthropic foundations can all work together to strengthen institutional capacity and provide appropriate training to health care workers, child-care and school staff for the successful implementation of these recommendations. Both capacity and capability are also needed to support the design, implementation, evaluation and enforcement of population-based policies, such as taxation of sugar-sweetened beverages and restriction of the marketing of foods and non-alcoholic beverages to children.

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.

ADVOCACY

Social movements can raise the profile of prevention of childhood obesity through advocacy and dissemination of information.

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 can advocate for implementation of effective interventions.

Engaging members of the community and providing a platform for advocacy and action can create demand for governments to support healthy lifestyles and the food and non-alcoholic beverage industry to provide healthy products and not market unhealthy foods and beverages to children.

KNOWLEDGE BASE

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. Filling gaps in knowledge through research that is free from commercial interests will provide evidence to support policy implementation.

MOBILIZATION OF RESOURCES

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

Governments and stakeholders need resources to implement actions, and need 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.

Philanthropic foundations are uniquely placed to make significant contributions to global public health. They can mobilize funds to support research, capacity-building, service delivery, and can also engage in monitoring and accountability activities.

MONITORING AND ACCOUNTABILITY

Monitoring and evaluation can serve to sustain awareness of the problem of childhood obesity and are necessary to track progress in the development, implementation and effectiveness of interventions.

There is a need to monitor the body mass index of children, including at ages not currently monitored, in order to track progress in achieving national targets. Evaluation, with the support, for example, of academic institutions, NGOs and philanthropic foundations, can provide valuable data for improvement of programmes.

Governments are understandably wary of increasing the burden of reporting on their commitments. Several monitoring mechanisms currently exist that countries can draw upon and integrate into a comprehensive national monitoring framework for childhood obesity. Monitoring and holding actors to account for commitments made may be shared between government and civil society.

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 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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