OBESITY IN THE WHO EUROPEAN REGION

World Health Organization
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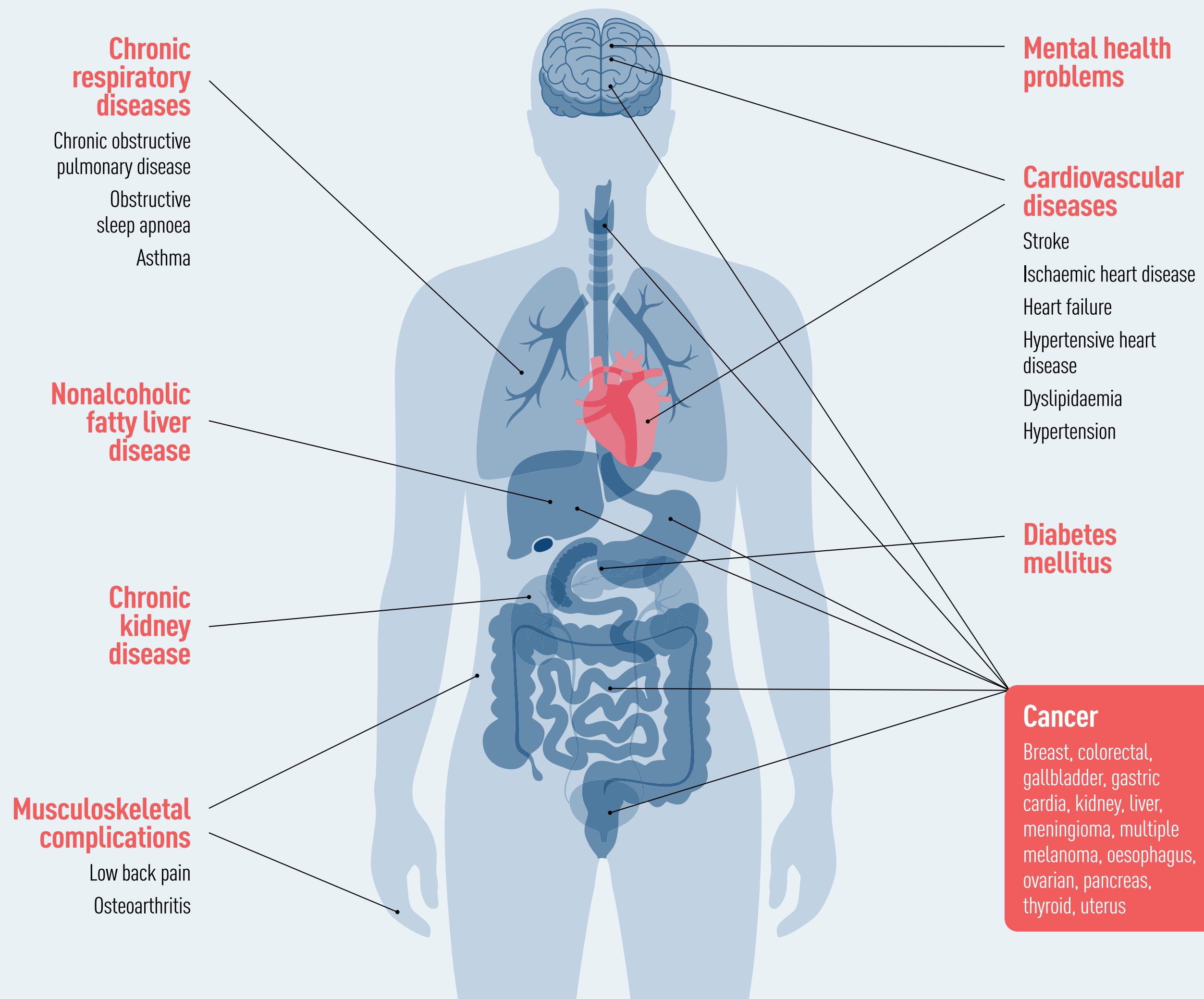
Health consequences of living with obesity



Note: These do not include all health consequences associated with obesity.
Sources: Malnick & Knobler, 2006 *(1)*; GBD 2015 Obesity Collaborators et al., 2017 *(2)*; Lauby-Secretan et al., 2016 *(3)*; Brock et al., 2020 *(4)*; Luppino et al. (2010) *(5)*.

This is a summary of the WHO European Regional Obesity Report 2022 *(6)*

- Obesity is a complex multifactorial disease defined by excessive adiposity that presents a risk to health *(7)*.
- Overweight and obesity are among the leading causes of disability and death in the WHO European Region *(8)*.
- In Europe, obesity is the highest risk factor for disability *(9)*.
- For some countries, obesity might overtake smoking as the the main risk factor for cancer in the coming decades *(10)*.
- People living with overweight and obesity have been disproportionately affected by the effects of COVID-19, with an increased risk of intensive care admissions and death *(11)*.

IN THE WHO EUROPEAN REGION

- Living with overweight or obesity has been identified as a serious public health challenge.
- Obesity is a major determinant of death and disability *(12)*.
- Almost 60% of adults live with overweight or obesity *(13)*.
- One in three school-aged children live with overweight or obesity *(14)*.

OBESITY IN THE WHO EUROPEAN REGION

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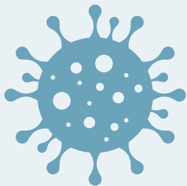
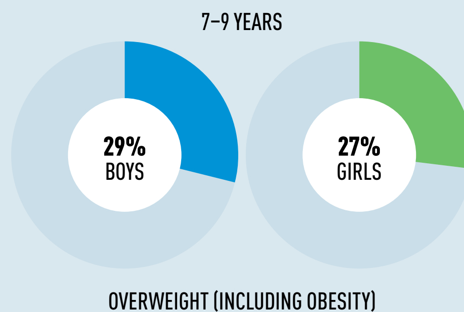
Prevalence and trends of living with overweight or obesity in the WHO European Region



Preliminary data suggests that obesity levels for children and adolescents are rising due to the COVID-19 pandemic *(15)*. This is particularly concerning as levels of overweight and obesity are already significant in children and adolescents.

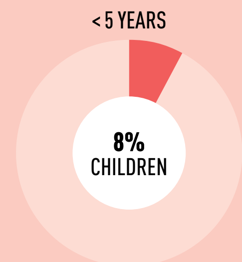
The WHO European Childhood Obesity Surveillance Initiative (COSI) shows that 29% of boys and 27% of girls aged 7–9 years are living with overweight or obesity *(14)*.

7–9 YEARS



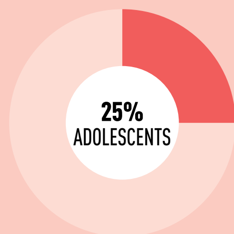
OVERWEIGHT (INCLUDING OBESITY)

< 5 YEARS



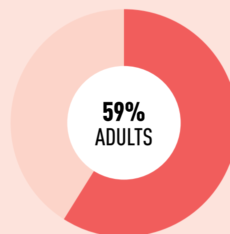
OVERWEIGHT (INCLUDING OBESITY)

In children below 5 years of age, 8% are living with overweight (including obesity) *(16)*. Prevalence is higher between 5 and 9 years, with 30% of children living with overweight (including obesity) *(13)*.



OVERWEIGHT (INCLUDING OBESITY)

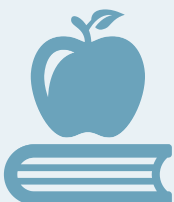
Prevalence decreases temporarily in adolescents, with one quarter living with overweight (including obesity) *(13,17)*.



OVERWEIGHT (INCLUDING OBESITY)

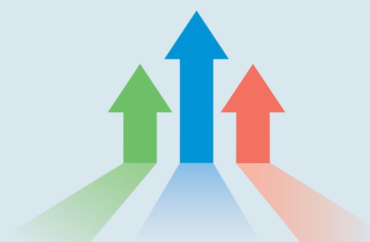
Almost two thirds of adults (59%) are living with overweight or obesity. Levels are higher among men (63%) than among women (54%) *(13)*.

Patterns in children vary by parental educational level. In many high-income countries, prevalence of overweight in children was higher when the parents had lower educational status. This pattern was reversed in several middle-income countries *(18)*.



Obesity prevalence is higher in adults with lower educational attainment *(19)*.

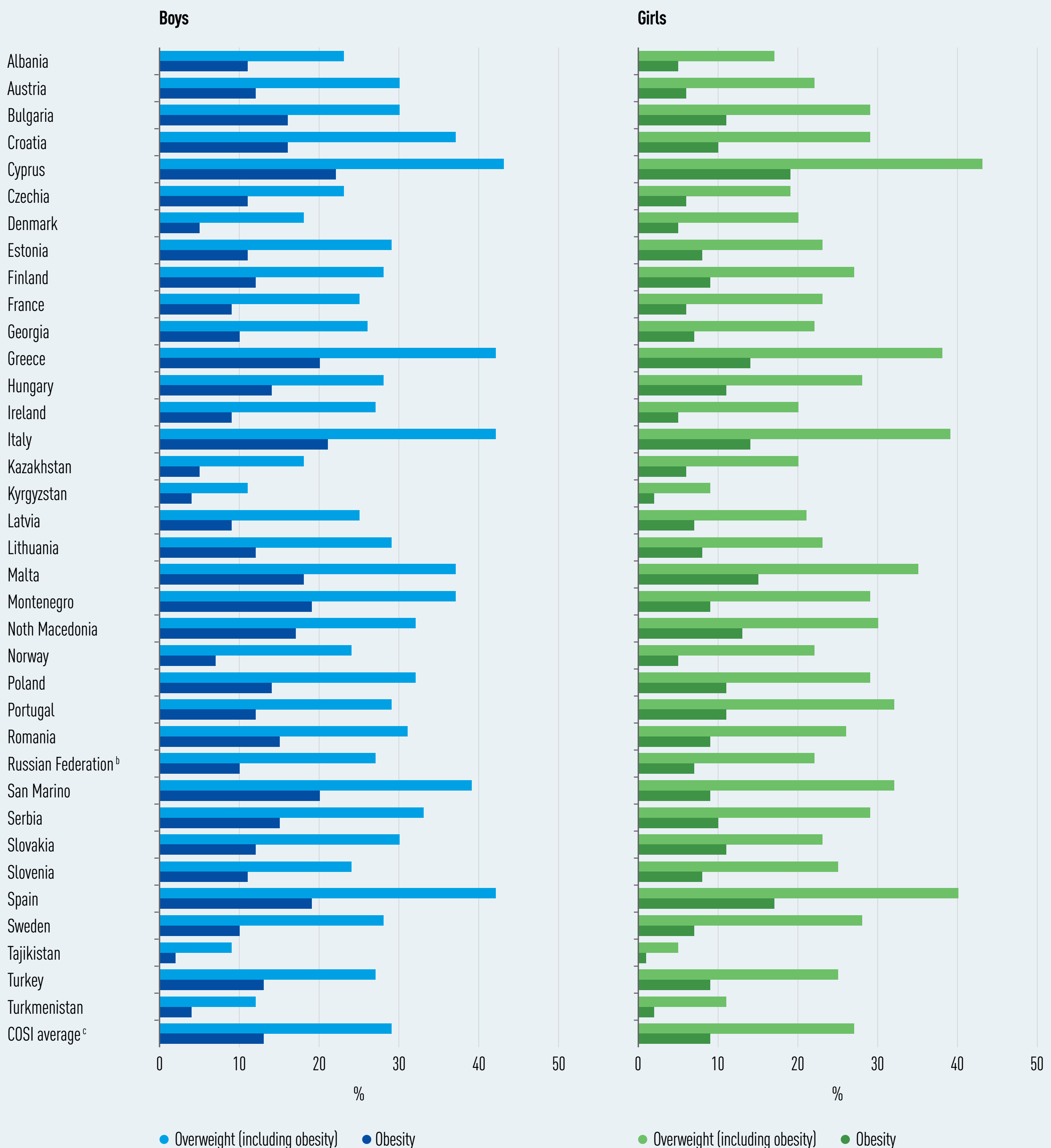
Between 1975 and 2016, prevalence of overweight and obesity amongst children aged 5 to 19 years increased nearly three-fold in boys, and more than doubled in girls.



Prevalence of adults living with obesity rose 138% between 1975 and 2016, with a 21% rise between 2006 and 2016.

No Member State in the WHO European Region is on track to reach the target of halting the rise in obesity by 2025 *(20)*.

Prevalence of overweight and obesity among children aged 7–9 years in 36 countries of the WHO European Region, by sex (2015–2017) [a]



a Data from COSI report on the fourth round of data collection, 2015–2017 *(14)*.
b Moscow only
c Represents the average value across the countries that provided relevant information.

Policy recommendations for all age groups

Diet

- Tax unhealthy food products.
- Restrict the sales, marketing and portion sizes of unhealthy foods.
- Provide subsidies to increase the consumption of fruits and vegetables.
- Have mandatory front-of-pack nutrition labelling on all foods.
- Run mass-media campaigns on healthy diets.
- Regulate where and how food outlets can operate.
- Implement healthy public food procurement and service policies; require that all foods and beverages served or sold in public settings contribute to the promotion of healthy diets.
- Control the clustering of unhealthy food outlets around secondary schools to support efforts within schools.

Physical activity

- Provide convenient and safe access to quality public open space.
- Encourage active travel by providing safe footpaths, local cycle lanes and creating walking buses for children attending local educational facilities.
- Ensure that urban design incorporates residential density, connected street networks that include sidewalks, easy access to a diversity of destinations and access to public transport.
- Run mass-media campaigns, community-based education and motivational and environmental programmes.
- Provide physical activity counselling and referral as part of routine primary health care services through brief interventions.

Surveillance

- Monitor obesity across the life course to help support policy efforts through systems such as COSI and the STEPwise Approach to NCD Risk Factor Surveillance (STEPS).
- Include other important indicators, such as socioeconomic status, to help inform and monitor policy action to address the social determinants of health.
- Continue monitoring food and physical activity environments (including digital environments) and policy actions at country level.

Obesity management

- Provide equitable access to integrated health-care services for management of overweight and obesity as part of universal health coverage.
- Provide equitable access to family-based, multicomponent, lifestyle weight management services for children and young people who are living with obesity.

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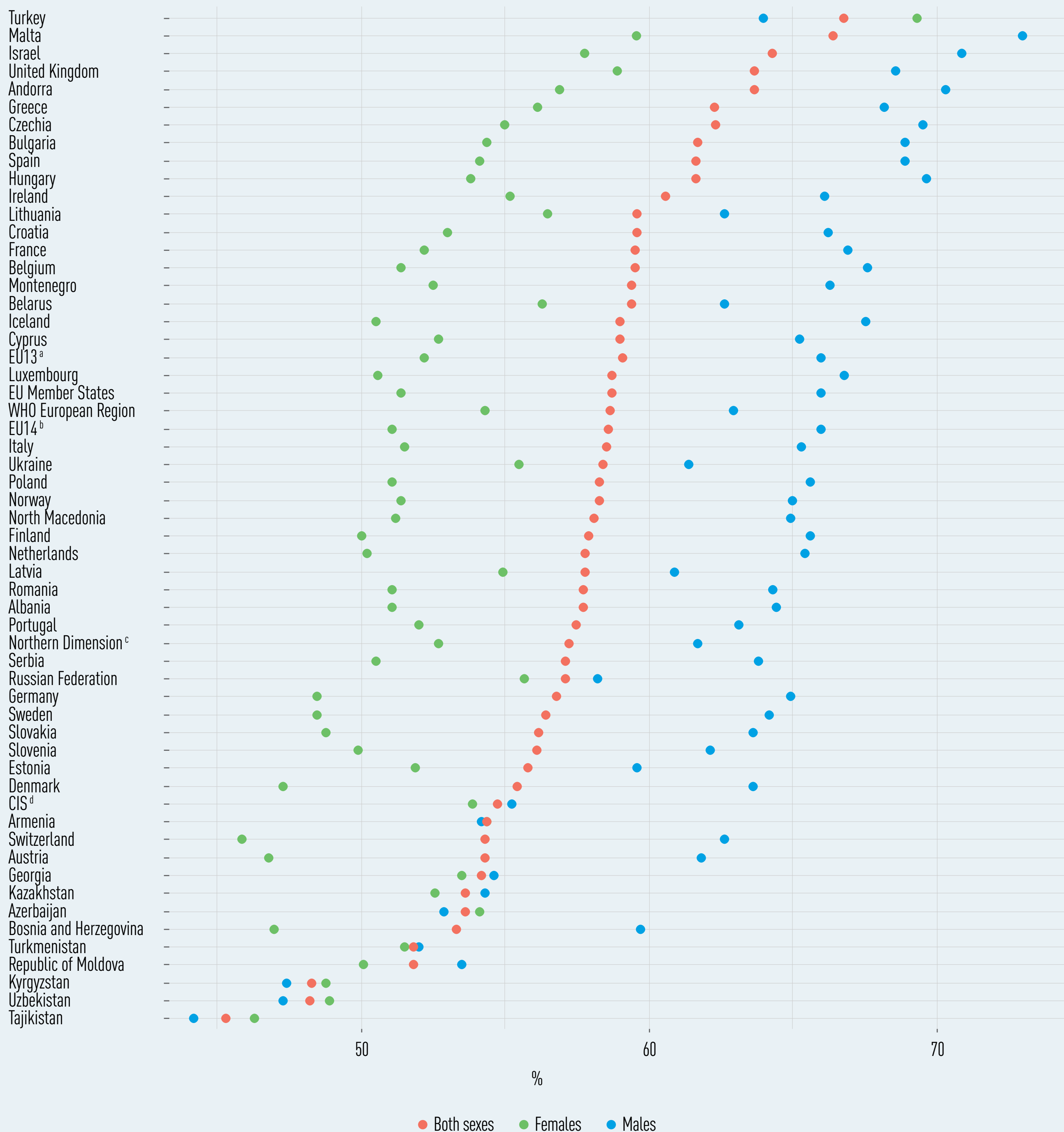
Prevalence of overweight (including obesity) among adults (age-standardized) in countries/country groups of the WHO European Region (2016)



a EU13: countries that became EU members after 2004 – Bulgaria, Croatia, Cyprus, Czechia, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia.
b EU14: countries that were part of the EU prior to 2004 – Austria, Belgium, Denmark, Finland, France, Germany, Greece, Italy, Ireland, Luxembourg, Netherlands, Portugal, Spain, Sweden.
c Northern Dimension: EU, Russian Federation, Norway, Iceland.
d CIS: members and associate members of the Commonwealth of Independent States – Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Uzbekistan.
Source: WHO estimates, 2016 *(13)*.

Policy recommendations for settings

Nurseries, kindergartens and schools

- Implement whole-of-school programmes that include quality physical education; ensure availability of adequate facilities and programmes to support physical activity for all children.
- Have health-promoting frameworks in nurseries and kindergartens.
- Provide free meals and clean drinking-water; particularly for early school years and children from low-income households.
- Implement mandatory national food standards for child-care settings, recreation facilities and schools.
- Have statutory nutrition education in educational curricula.
- Implement nutrition education and counselling in schools to increase the intake of fruits and vegetables.
- Make every school a health-promoting school through supporting implementation, maintenance and scaling-up of initiatives.

Local environments

- Reach out-of-work adults through community health promotion programmes.
- Develop age-friendly environments leading to cities and communities that enable people of all ages to realize their full potential of health in a sustainable and equitable way.

Digital environments

- Restrict online advertising for unhealthy foods, tobacco, alcohol and baby formula milk.
- Recognize the digital environment as a determinant of health.

Workplaces

- Implement multicomponent physical activity programmes in workplaces.
- Implement nutrition education and counselling in workplaces to increase the intake of fruits and vegetables.
- Promote healthy, safe and resilient places of employment through supporting workplace wellness programmes.

Health-care settings

- Implement nutrition education and counselling in hospitals to increase the intake of fruits and vegetables.

IMPLEMENTING POLICIES

POLICY APPROACHES TO PREVENT OBESITY REQUIRE LEAD FROM NATIONAL GOVERNMENTS THROUGH INVOLVEMENT AND INVESTMENT AT ALL LEVELS.

- A national strategy must provide clear definitions for the role of local government, which has an important part to play in creating supportive environments and tackling inequalities.
- The support of lower socioeconomic population groups should be a priority in any obesity prevention strategy, as these groups face more constraints and limitations on making healthy choices.
- Governments need to “build back better” after the COVID-19 pandemic, recognizing that human, animal and environmental health are all connected.

Policy recommendations for preconception and infancy

Why have policies for these life stages?

- A woman's nutritional status during preconception and in the prenatal period may influence her offspring's health and susceptibility to obesity and a range of noncommunicable diseases.
- Once born, the promotion and support of exclusive breastfeeding for the first 6 months of life is recommended.

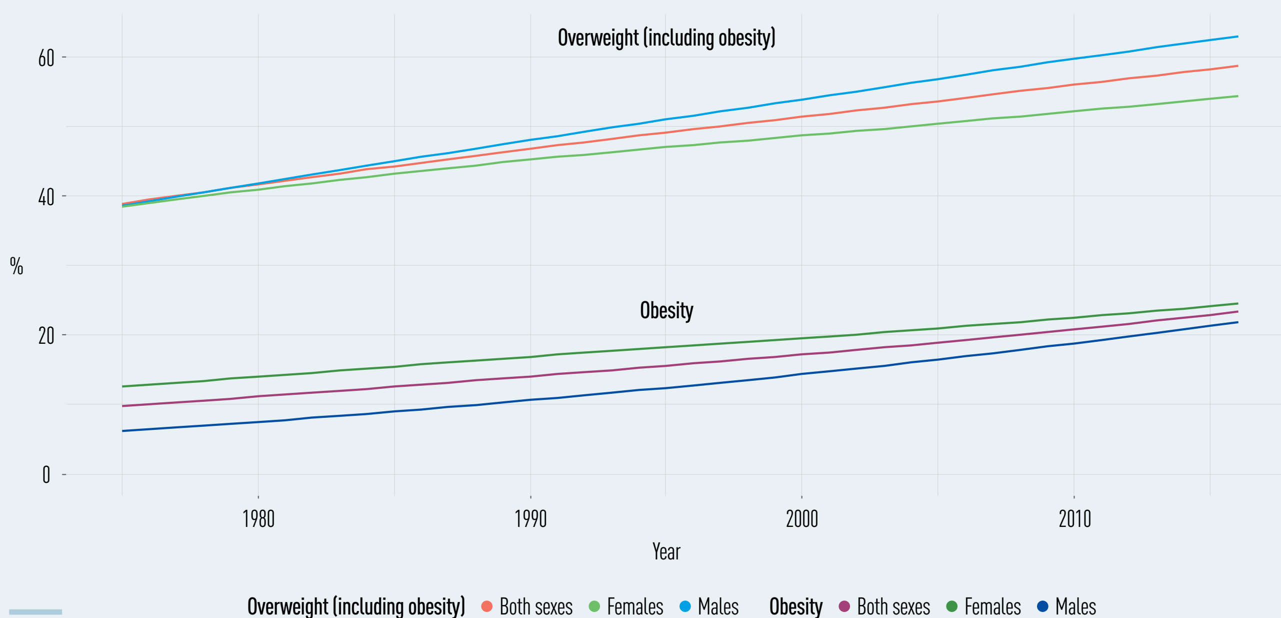
Supporting the health of the parents

- Monitor and provide counselling on nutrition and exercise before and during pregnancy.
- Provide food vouchers for new parents to subsidize the purchase of healthy foods.

Breastfeeding and early nutrition support

- Implement the WHO and UNICEF Baby-friendly Hospital Initiative to enable mothers to breastfeed infants, along with lactation support training for health professionals.
- Provide universal paid maternity leave, national labour policies and workplace support for breastfeeding, along with laws to protect breastfeeding in public.
- Restrict the inappropriate marketing of products that compete with breast milk, as detailed in the International Code of Marketing of Breast Milk Substitutes.
- Encourage a healthy introduction to solid food through reformulation of infant food to improve its nutritional profile, along with accurate labelling of these products.

Prevalence of overweight and obesity among adults in the WHO European Region, by sex (1975–2016)



Source: WHO estimates, 2016 *(13)*.

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Barriers to implementing obesity policy

WHO European Region conducted consultations with Member States to understand the barriers to implementing obesity policy, including WHO "best buys". These barriers include:

1. The continuing narrative that addressing obesity is the responsibility of the individual, and not the responsibility of wider society including governments.
2. The upstream determinants of obesity (including obesogenic digital environments) are not always prioritized for action.
3. Economic priorities often take precedence over health, including obesity policies.
4. Cross-sectoral engagement and impact delivery is challenging.
5. Interventions that impact the food industry face significant opposition and low political will. This is a key barrier for cross-sectoral engagement.
6. Lack of guidance on how to implement effective and integrated obesity treatment and management as part of universal health coverage.

Policy approaches must be:

- **comprehensive**
- **multisectoral**
- **reach individuals across the life course**
- **target inequalities**
- **move away from exclusively individualistic approaches**

- **A number of policy tools are available to Member States to prevent and manage obesity.**
- **No single intervention can halt the growth in the obesity epidemic on its own.**

To address the burden of overweight and obesity in the Region, it is important for countries to prioritize their areas of action. Currently, some of the policy areas which have gained attention are sugar-sweetened beverage taxation, marketing restrictions to children and strengthening health systems to better prevent and manage obesity and overweight.

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1 All URLs were accessed on 22 February 2022.

WHO European Office for the Prevention and Control of Noncommunicable Diseases

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