



Healthy Environments
for Healthy Children

Childhood obesity, lifestyle and the environment

Executive summary

Childhood obesity is a global public health problem, with an estimated 391 million school-aged and adolescent children being classified as overweight and 188 million being classified as obese (UNICEF, 2025a; World Health Organization, 2025a). Poor diet, lack of physical activity and sedentary behaviours, stress, prolonged screen time and behaviour–environment interactions (involving both the built and chemical environments, including exposure to endocrine-disrupting chemicals) all contribute to today's high rates of childhood obesity, with diet being the single biggest driver of the rise in childhood obesity. Obesity-related complications are also on the rise. These include hypertension, metabolic syndrome, type 2 diabetes, metabolic dysfunction-associated steatotic liver disease, asthma and mental health conditions, all of which are associated with an increased risk of obesity-related morbidity and mortality in adulthood. Notably, high body mass index (BMI) accounted for 3.7 million deaths in adults in 2021 due to, for example, cardiovascular disease, diabetes, cancer (Buechner, 2025). The associated economic costs of obesity are staggering, with projected global annual costs of over US\$2.47 trillion in 2025 and US\$4.32 trillion by 2035 and estimates of a 3 per cent obesity-associated loss

in gross domestic product. To tackle rapidly rising childhood obesity, countries at all income levels can adopt environmental policies in homes, schools and communities that prevent and reduce obesity.

Emerging research has enhanced our understanding of how the environment supports or acts as a barrier to healthy diets, physical activity and ultimately the healthy growth and development of all children. Actions endorsed by UNICEF, the World Health Organization and other organizations, such as academic and professional organizations, provide a multilevel road map for tackling childhood obesity. This has informed actions taken by low-, middle- and high-income countries on environmental strategies focused on the built environment, climate change and environmental obesogens (chemicals with endocrine-disrupting properties found in everyday products that can promote obesity) given their strong potential for population-level impacts on children's health. The global rise in childhood obesity rates requires urgent action, as it is anticipated that the current generation of children will be the first to have lower life expectancies than their parents. The time to act is now.

Box 1. School meals shaping lifelong healthy choices in Japan

School food policy in Japan is rooted in ‘Shokuiku’, using school meals as an opportunity to involve students in learning about the food they eat, including where the food comes from and how to prepare it, while introducing them to a variety of seasonal foods from Japan and beyond with the goal of encouraging lifelong healthy food choices. Students eat family style and are involved in preparing the meal and cleaning up after. Understanding food systems, including how to reduce the environmental impacts of food at school (e.g., by composting to reduce food waste and recycling packaging), is part of their learning. Providing this strong foundation for children early on has potential for lifelong benefits given the vital role of a healthy diet in preventing obesity and related complications.

Source: Asakura & Sasaki (2017); School Meals Coalition (2023).

Introduction



Childhood overweight and obesity are rising at alarming rates. Globally, 391 million school-aged and adolescent children are overweight (UNICEF, 2025a; World Health Organization, 2025a). In 5- to 19-year-olds, overweight is defined as a body mass index (BMI)-for-age of greater than 1 standard deviation above the World Health Organization (WHO) growth reference median (see Table 1). The majority (80 per cent) of children who are overweight live in low- or middle-income countries (LMICs), with 50 per cent living in Asia and 25 per cent in Africa (World Health Organization, 2025b).

Table 1. WHO definitions of childhood overweight and obesity

Children aged under 5 years	
Overweight	Weight-for-height greater than 2 standard deviations above the WHO Child Growth Standards median (World Health Organization, 2025a)
Obesity	Weight-for-height greater than 3 standard deviations above the WHO Child Growth Standards median
Children and adolescents aged 5–19 years	
Overweight	BMI-for-age greater than 1 standard deviation above the WHO growth reference median
Obesity	BMI-for-age greater than 2 standard deviations above the WHO growth reference median

Source: World Health Organization, (2006).

Childhood obesity, affecting 188 million children, is defined as a BMI-for-age of greater than 2 standard deviations above the WHO growth reference median (Pappachan et al., 2024; World Health Organization, 2025a). The rate of obesity is projected to double by 2035 compared with 2020 (Pappachan et al., 2024). Obesity has significant lifelong implications, and, as obesity rates rise throughout the life course, so too do the rates of obesity-related complications, notably hypertension, metabolic syndrome (cardiometabolic risk factors), type 2 diabetes and metabolic dysfunction-associated steatotic liver disease (MASLD) (see Table 2). Obesity also increases risk for and the severity of asthma, anxiety, depression, low self-esteem and social isolation (Reyes-Angel et al., 2022; Serebrisky & Wiznia, 2019). The pro-inflammatory state of obesity increases risk for cancer as an adult (Nuotio et al., 2022). This is a major global public health concern.

There were 830 million adults living with diabetes in 2022, with prevalence rates rising fastest in LMICs (World Health Organization, 2024a). Countries with the highest estimated prevalence of metabolic syndrome in children were Mexico (12 per cent), the Islamic Republic of Iran (9 per cent) and Nicaragua (5 per cent); and in adolescents were Spain and the United Arab Emirates (both 10 per cent) and the Islamic Republic of Iran (9 per cent). For MASLD, North America, South America and Asia were the continents with the highest prevalence (42–44 per cent) (Jia et al., 2025; Noubiap et al., 2022). In 2021, high BMI accounted for 3.7 million deaths due to cardiovascular disease, diabetes, cancer, neurological disorders, respiratory diseases and gastrointestinal disorders (G.B.D. 2021 Risk Factors Collaborators, 2024; World Health Organization, 2025a). The associated economic costs of obesity are staggering, with projected global annual costs of over US\$2.47 trillion in 2025 and \$4.32 trillion by 2035 along with estimates of a 3 per cent obesity-associated loss in gross domestic product (UNICEF, 2020; World Obesity Federation, 2023).

Table 2. Examples of obesity-related complications

Complication	Definition	Trends
Hypertension	Three elevated systolic or diastolic blood pressure readings over multiple visits for the child's age, height and sex (Thomas et al., 2022).	Global estimates of childhood hypertension from 2000 to 2020 (Zhou et al., 2026): - Boys: increased from 3 per cent to 6.5 per cent - Girls: increased from 3 per cent to 5.8 per cent
Metabolic syndrome (cardiometabolic risk factors)	Aged 10–16 years - Waist circumference: ≥ 90 percentile or adult cut-off if lower. - Plus two or more risk factors: - Triglycerides (TGs): ≥150 mg/dL - High-density lipoprotein (HDL): ≤40 mg/dL - Blood pressure (BP): systolic ≥130 mm Hg; diastolic >85 mm Hg - Glucose: ≥100 mg/dL (Zimmet et al., 2007) Aged >16 years (adult criteria can be used) - Waist circumference ≥94 cm for men and >80 cm for women (ethnicity-specific reference values available). - Plus two or more risk factors: - TGs, HDL, BP and glucose, as for children aged 10–16 years (Zimmet et al., 2007)	In 2020, about 3 per cent of children and 5 per cent of adolescents had metabolic syndrome, affecting an estimated 25.8 million children and 35.5 million adolescents globally (Noubiap et al., 2022).
Type 2 diabetes	Increase in blood sugar due to insulin resistance or insufficient insulin (Pappachan et al., 2024).	From 1990 to 2019, childhood diabetes increased by an estimated 39 per cent (Zhang et al., 2023).
MASLD	Deposition of fat in the liver due to obesity or diabetes, which can lead to inflammation, fibrosis and cirrhosis. It can also lead to liver cancer later in life (hepatocellular carcinoma).	An estimated 41 per cent of children and adolescents affected by overweight and/or obesity have MASLD (Jia et al., 2025).

Lifestyle risk factors for childhood obesity

Childhood has profoundly changed in the last several decades across the world, as children spend more time indoors, sedentary, on screens, eating high-calorie, high-fat, ultra-processed foods and consuming sugar-sweetened beverages. Poor diet, lack of physical activity and sedentary behaviours, stress and prolonged screen time all contribute to today's high rates of childhood obesity, with diet being the single biggest driver of the rise in childhood obesity. In the Health Behaviour in School-aged Children study of adolescents from 44 countries, 56 per cent of boys and 51 per cent of girls aged 15 years reported eating no fruits or vegetables (World Health Organization, 2024b). Children from low-income families are disproportionately likely to consume an unhealthy diet and drink sugar-sweetened beverages (18 per cent versus 15 per cent) and are less likely to consume fruits (32 per cent versus 46 per cent) and vegetables (32 per cent versus 54 per cent) daily. Consequently, lower-income families are at higher risk of developing associated adverse health outcomes. Exclusive breastfeeding in the first year of life is protective against childhood obesity, as is a balanced diet rich in protein and fibre and low in fat and sugar.

The effects of a poor diet are compounded by insufficient physical activity levels. WHO recommends 60 minutes of moderate to vigorous activity for

5- to 17-year-olds, with 60 minutes of vigorous activity per day on at least 3 days per week (Bull & Willumsen, 2020). In a survey of school children aged 11–17 years from 146 countries and territories (n=1.6 million), 81 per cent did not meet recommended levels of physical activity, with disparities seen between boys and girls (78 per cent of boys and 85 per cent of girls were inactive) (Guthold et al., 2020). WHO estimates that physical inactivity will cause 500 million new cases of obesity-related conditions, with associated health-care expenditure amounting to US\$300 billion, between 2020 and 2030 (Organisation for Economic Co-operation and Development, 2024).

Screen time across all ages in childhood has significantly increased over the years, worsened by the COVID-19 pandemic (Qi et al., 2023). Screen time adversely impacts sleep and is responsible in part for shortened sleep duration in childhood, an established risk factor for both an unhealthy diet and obesity. Insufficient sleep and high levels of stress in turn negatively affect diet and physical activity levels and contribute to increased sedentary behaviours and screen time. While low-income families are especially vulnerable with respect to obesity risk factors, these trends are seen across high-income countries as well as LMICs.

Box 2. Childhood obesity rates are rising in China

By 2030, China is predicted to have an estimated 62 million cases of childhood obesity (Lobstein & Brinsden, 2019).

“Cheap food is not healthy, and healthy food is not cheap.”

– Girl, 13, China (UNICEF, 2019)

In the Physical Activity and Fitness in China–The Youth Study (PAFCTYS) (n= 133,006, aged 9–17 years), it was found that 55 per cent of boys and 45 per cent of girls met the daily recommendation for 60 minutes of physical activity, with a decline in the percentage of children meeting this recommendation as children get older. Only 17 per cent of the children reported participation in organized sports or physical activity programmes in the past year (Liu et al., 2023).



Childhood obesity and the environment

It is important to consider the childhood obesity and obesity-related risk factors described above in the context of individual, family, community and societal risk factors, offering a framework for consideration of required public health programmes and policies. Considerations should include the broader environmental context of the child's life with regard to individual, family, community and societal characteristics, such as the child's family, home, school and community life, school lunch habits and extracurricular activities, family work hours, availability of parks and playgrounds, and access to transport networks, all of which affect a child's risk for childhood obesity.

The built environment, or the physical design of urban, suburban and rural communities, can either promote or act as a barrier to healthy behaviours including a healthy diet, regular physical activity, adequate sleep and limited screen time and stress. 'Food deserts' are areas where there is limited access to high-quality fresh foods, while access, marketing and industry sponsorship of low-cost high energy fast foods and ultra-processed foods are ubiquitous (UNICEF, 2025b). Access to parks, playgrounds, gyms, pavements and trails and the availability of public transport networks, all of which impact neighbourhood walkability, are

physical features of the built environment that influence neighborhood walkability and daily activity levels.

Gene-environment interactions influence obesity risk, with an estimated 40–70 per cent of obesity risk being attributed to genetic factors depending on the study (Littleton et al., 2020; Rhee et al., 2012). The dramatic increase in obesity across all ages in recent decades has shifted focus for public health intervention research from genes to the environment to better understand how the environment impacts obesity risk factors including socio-demographics, prenatal and early childhood periods, lifestyle and behaviour-environment interactions. Population attributable risks (PARs) for these factors vary by country, as shown by studies conducted in, for example, China, Germany, the Islamic Republic of Iran and the United States of America (Jiang et al., 2025; Saelens et al., 2012; Toorang et al., 2025; Varnaccia et al., 2017). In a study in China, for example, PARs varied for modifiable behavioural factors from 5.6 per cent for screen time to 15 per cent for insufficient sleep and 16.4 per cent for sugar-sweetened beverage consumption (Jiang et al., 2025). These environmental determinants of obesity require careful consideration, as they represent areas where policies can most readily be directed and where population-level impacts have been demonstrated.

Box 3. Population-wide monitoring to address childhood obesity and inform policy in Germany

"Childhood obesity is caused by a variety of individual and environmental factors that cannot be reduced to individual dietary habits and levels of physical activity. As such, providing healthy food in day-care centres can contribute as much to obesity prevention as the presence of spaces for sport in the local environment and parents acting as role models."

– Robert Koch Institut, (2021); World Obesity Federation, (2025)

To address obesity, the German Federal Ministry of Health convened experts to develop and implement a population-wide monitoring system (AdiMon) with the goal of identifying risk factors amenable to early-stage preventive measures to combat rising rates of childhood obesity and inform necessary policy change (von Philipsborn et al., 2022; World Obesity Federation, 2025).

Germany has committed to working towards the 17 United Nations Sustainable Development Goals (SDGs) by 2030. These include specific goals to address the increase in obesity among adults, children and adolescents (e.g., subsidizing healthy foods and imposing taxes on sugar-sweetened beverages). Germany's Federal Ministry of Education and Research, as part of the Joint Programming Initiative 'A Healthy Diet for a Healthy Life', also supported a comprehensive review of country-level nutritional policies led by multidisciplinary experts. The goal of this work was to assess the strengths and weakness of current nutritional policies and identify additional policy opportunities for this priority public health challenge.

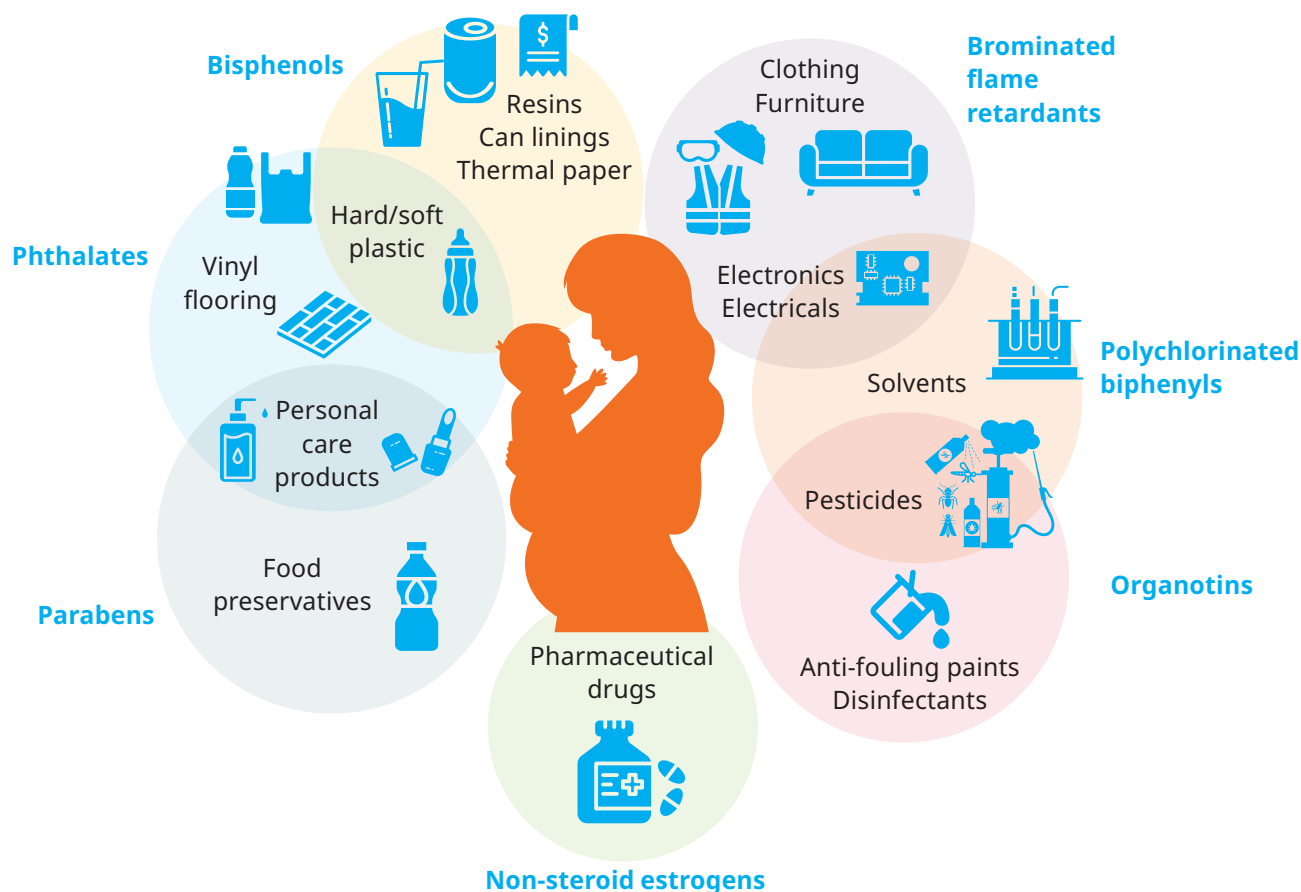
Environmental obesogens

Children are exposed to a range of environmental chemicals in the air they breathe, the food and beverages they consume, the personal care products they use and routine contact with everyday items in their homes, schools, workplaces and communities (see Figure 1). Advances in environmental research now allow better measurement of the risks these chemicals pose through environmental exposure assessments. There have also been major advances in biomonitoring (e.g., of blood, urine, hair), which have significantly enhanced the understanding of the impact of environmental chemicals on human health throughout the lifespan.

Endocrine-disrupting chemicals (EDCs) or endocrine disruptors are a family of chemicals that include

'obesogens', which can promote weight gain and increase risk for obesity and diabetes. Studies are examining potential critical windows of development that may be uniquely sensitive to EDC exposure. For example, studies have found associations between prenatal exposure and later risk of childhood obesity. Known and suspected obesogens include tributyltin, phthalates, per- and polyfluoroalkyl substances (PFAS), polychlorinated biphenyls (PCBs), bisphenol A (BPA), polybrominated diphenyl ethers (PBDEs), and diethylstilbestrol, according to WHO and the United Nations Environment Programme (United Nations Environment Programme, 2017a,b,c; World Health Organization and United Nations Environment Programme, 2012).

Figure 1. Sources of obesogens



Examples of how environmental obesogens can promote obesity and obesity-related complications:

- Alter adipose (fat cell) precursors and development of adipose tissue, induce adipose differentiation and adipogenesis, increase adipose cell size.
- Increase triglycerides in adipose tissue, stimulate fat production.
- Alter development of pancreatic tissue and alter insulin and leptin levels.
- Alter thyroid function.
- Perinatal exposure associated with overweight and obesity in later life.

EDCs can alter growth and development by disrupting how glucose and lipids are metabolized, fat cell formation and thyroid function. Cross-sectional studies primarily among adults have shown associations between EDCs and obesity, diabetes and heart disease. For example, studies of phthalates (e.g., plasticizers used in certain consumer products and personal care products) found associations with obesity among Chinese and non-Hispanic black children. While findings from studies are inconsistent, findings in animal studies support a link between EDCs and obesity. Population-based studies of obesogens demonstrate associations with obesity-related complications such as metabolic syndrome, cardiovascular disease, diabetes and MASLD.

Exposure to obesogenic chemicals has the potential to magnify existing health disparities. The same neighbourhoods that have a high prevalence of chronic childhood conditions (e.g., asthma, obesity) often are the neighbourhoods that carry a disproportionate burden of environmental exposure (e.g., higher exposure to obesogenic air pollutants due to siting of diesel bus depots and/or higher exposure to tobacco smoke in certain urban neighbourhoods). Ongoing research is examining interactions between complex mixtures of daily exposure to EDCs and other environmental, genetic and lifestyle factors throughout a child's lifespan on a range of human health outcomes (rather than studying a single exposure and a single outcome).

Foods that are heavily processed, referred to as ultra-processed foods (UPFs), are high in calories as well as added sugar, fat and salt. They offer little nutritional value and can lead to overeating. One way of identifying UPFs, other than by reading ingredient labels, is by looking at the packaging: snacks

packaged in boxes and bags designed for long shelf life are often UPFs. The industrial manufacturing and packaging processes used for UPFs can also result in exposure to environmental obesogens including plasticizers like phthalates and BPA. UPFs are associated with obesity, diabetes and other obesity-related complications.

Climate change is a global public health threat that has significant implications for obesity. As temperatures rise, or extreme heat-related events such as floods and wildfires worsen air quality, children stay indoors. Climate change directly impacts access to parks, playgrounds and natural resources, all of which are vital public health resources. Wildfires can increase exposure to both indoor and outdoor air pollutants including obesogens (e.g., polycyclic aromatic hydrocarbons, flame retardants), which is a concern given that air pollution has been linked to obesity. Extreme heat has direct impacts on the food supply, both directly by impacting crops/food production and indirectly, through, for example, extreme temperatures promoting the leaching of plasticizers in food and drink packaging.



Addressing childhood obesity through policy

Early prevention and treatment are key factors in promoting healthy lifestyles for children. It is recommended that clinicians regularly assess whether children and adolescents have a healthy weight or are overweight or obese; discuss recommendations for healthy diet and increased activity; and offer treatment at annual clinical visits or more frequently as needed. Public health initiatives are critical in combating obesity by improving access to healthy and affordable foods while also reducing consumption of unhealthy foods (e.g., through sugar-sweetened beverage taxes, restrictions on marketing of unhealthy foods, front-of-pack nutrition labels), combined with increasing opportunities for physical activity and addressing mental health (UNICEF, 2025b). Advancing health policy initiatives that promote healthy homes, schools, workplaces and communities with respect to the food and physical activity environment requires bringing together diverse stakeholders. Clinicians are trusted messengers whose voices are critical in advocating for policies that promote the health of all children.

Even if the contribution of environmental factors to obesity is small, the benefits of interventions aimed at reducing environmental exposure in the context of healthy environments and healthy communities are likely to be considerable given the high prevalence of obesity and its significant medical, social and economic costs. The cost of childhood overweight and obesity is expected to exceed US\$4 trillion globally per year by 2035.

Environmental public health policies that are adequately protective of children's health are the most important clinical intervention. Careful consideration is needed as to how to ensure ample opportunities for physical activity in the face of climate change. Climate initiatives – including promoting the use of sustainable energy and food sources, public transport and mixed-use neighbourhoods that encourage active transport and time in nature while reducing carbon footprints – mutually benefit the health of communities and the environment.

Strong environmental public health policy is highly effective in reducing children's exposure to environmental factors linked to obesity.

Box 4. Advances in chemical regulatory policy in Thailand

Thailand has severely restricted or banned persistent organic pollutants (POPs) for agricultural and public health uses and in foods, cosmetics and household products. These include the following environmental obesogens listed under the Stockholm Convention on Persistent Organic Pollutants: chlordane, dichlorodiphenyltrichloroethane (DDT), and PCBs (Government of the Kingdom of Thailand, 2023). Efforts since signing the Stockholm Convention have focused on needs assessment and capacity-building to comply with targets along with enhanced regulatory actions. This includes identifying needs such as development of a database and POPs inventory, source monitoring for POPs and increasing public awareness and education. Regulatory actions taken include issuing notifications that govern emissions standards, identifying pollution point sources and addressing hazardous substance and waste handling management.





EDC-related interventions proposed at the population level include regulating EDC use in industry, requiring thorough study of novel compounds and restricting product licensing, product labelling and import controls (Lobstein, 2024). Globally, the United Nations SDGs include targets on chemical pollutants' effects on health. For example, SDG 12 on responsible consumption and production includes managing chemicals safely. The Stockholm Convention on Persistent Organic Pollutants is a global treaty to protect human health and the environment from chemicals that remain wide spread throughout the environment and have harmful impacts on human health or on the environment. Over 180 countries have committed to take measures to eliminate or reduce the release of POPs into the environment. Of note, these measures include developing national implementation plans, undertaken by LMICs to phase out use of EDCs, including PCBs, dioxins/furans and certain pesticides. Some examples of environmental and other interventions that could be implemented through programmes and policies aimed at tackling obesity are summarized in Table 3.

Disparities in the rates of childhood obesity stem from structural inequities rooted in the social determinants of health including neighbourhood, community and social factors that can be improved when clinicians connect families to resources and advocate for effective policy changes. This includes targeting resources to communities where there will be the greatest public health impact. The recently released *WHO Technical Package to Stop Obesity* provides a detailed framework

for developing a response to the obesity epidemic (World Health Organization, 2025c). This package is rooted in adapting environments to enable healthy lifestyles; creating knowledge, motivation and skills for healthy behaviour; and transforming health systems. The 2025 *Guide to Creating Urban Public SPACES for Children* highlights design principles that can inform the creation of safe, inclusive outdoor places for children to play and gather around the world, to support children and their families' overall well-being (World Health Organization, UNICEF, UN-Habitat, 2026).

SPACES guidance covers:

- Safety and protection
- Play and developmental needs
- Access where need is greatest
- Child health and well-being
- Equity and inclusion
- Sustainability and resilience



Prioritizing governmental efforts to increase access to spaces for outdoor play is an effective way of combating sedentary behaviours and reducing time spent indoors and using screens.

Table 3. Target areas for obesity programme and policy change: a six-pronged approach

Monitoring and reporting	
Obesity surveillance, clinical care and reporting	- Integrate culturally appropriate measures for obesity prevention, screening and management into primary care. - Ensure access to equitable, high-quality care for those at risk of or living with obesity. - Implement evidence-based clinical guidelines. - Strengthen data systems to track obesity prevalence, risk factors and health outcomes.
Environmental monitoring	- Monitor environmental determinants of obesity, including food and physical activity environments and exposure to marketing. - Improve monitoring of environmental exposures through air, water, food and consumer products. - Expand use of low-cost sensors (e.g., for fine particulate matter and other air pollutants) and biomonitoring (e.g., hair, urine) to improve exposure assessment data in LMICs. - Integrate environmental and health data to inform interventions and policy.
Prevention and control	
Primary care across the lifespan	- Expand access to perinatal, maternal and primary care across the lifespan. - Implement policies that support optimal nutrition and breastfeeding, and improve access to affordable, healthy foods. - Integrate routine screening and counselling on diet, physical activity, sleep, stress, screen time and tobacco use, and provide access to evidence-based interventions.
Environmental and regulatory controls	- Establish and enforce standards to reduce harmful environmental exposures (e.g., to pollutants, EDCs, tobacco smoke) including by reducing indoor and outdoor emissions (Ribisl et al., 2016). - Require screening of chemicals for endocrine-disrupting properties before approving their use in consumer products. - Establish an international clearing-house database of chemicals (Grandjean and Landrigan, 2014). - Avoid regrettable substitutions (e.g., replacing BPA with bisphenol S for which less is known about human health hazards).
Management, treatment and remediation	
Clinical care and treatment	- Provide early screening and diagnosis for obesity. - Expand access to evidence-based interventions and education (e.g., counselling on nutrition, physical activity, psychosocial support) for children and their families. - Train health-care professionals to provide counselling and resources on how environmental factors influence diet, physical activity, sedentary behaviours, screen time, sleep, stress and weight.
Environmental risk reduction	- Enforce quality control measures to eliminate presence of EDCs in consumer products. - Support workforce training in safe remediation and reducing environmental hazards in homes, workplaces and communities.
Training the environmental health workforce	Train clinicians and community health workers to: - Evaluate and counsel patients on environmental exposures. - Provide guidance to families on actions and policies to reduce harmful environmental exposure.
Public awareness and behaviour change	
Community education in environmental health	Utilize community engagement strategies and trusted messengers (e.g., faith-based organizations, peers, co-workers) to: - Provide environmental health resources via trained health professionals. - Conduct mass media campaigns to raise awareness about environmental factors that influence diet and physical activity. - Provide community-based programmes that empower individuals and families to adopt and sustain healthier lifestyles. - Offer tailored educational initiatives such as school-based health programmes, early childhood programmes and workplace wellness initiatives.
Healthy behaviour-environment interactions	- Regulate the marketing of unhealthy and highly processed foods and beverages, especially those targeting children. - Implement healthy food procurement policies, ensuring that schools, hospitals and institutions provide nutritious food options to increase access to healthy foods. - Promote active environments (create safe outdoor spaces for walking, cycling and other recreational activities) (World Health Organization, UNICEF, UN-Habitat, 2026).

Environmental legislation and policy

Healthy food systems and environments

- Improve food systems by increasing access to affordable, nutritious foods and safe drinking water.
- Reformulate food and beverage products to reduce salt, sugar, trans fats and chemicals that can enter the food supply from agriculture, food processing, manufacturing and packaging.
- Regulate the marketing and labelling of unhealthy foods and beverages, including breast-milk substitutes, with a focus on protecting children.
- Develop and enforce evidence-based policies that reduce harmful environmental exposures, especially for children.
- Implement workplace policies that prohibit child labour and mandate protections from environmental hazards for workers, especially those of childbearing age.

Global environmental action

Global food systems

- Strengthen global governance on food systems, taxation (e.g., on sugar-sweetened beverages), trade, marketing and industry conflicts of interest that contribute to obesity.

Environmental protections and partnerships

- Establish global standards to reduce harmful environmental exposures.
- Prohibit global shipping of hazardous waste products such as lead-acid batteries and electronics to unregulated facilities in LMICs.
- Support global partnerships, financing and capacity-building, particularly for LMICs, to address both obesity and environmental health risks.

Source: Adapted from UNICEF and Pure Earth (2020); UNICEF (2025b); World Health Organization (2025c).

The majority of the world's population lives in countries where over 30 per cent of people with type 2 diabetes do not receive treatment, and those in LMICs are much less likely to receive treatment. These are the same countries where the prevalence of diabetes is rising the fastest. The World Obesity Federation assesses countries' efforts to tackle obesity by looking at five key policy areas:

- 1) taxes on sugar-sweetened beverages;
- 2) taxes on foods high in fats, saturated fats, salts or sugars;

- 3) subsidies on healthier foods;
- 4) restrictions on marketing of unhealthy foods to children;
- 5) taxes to promote physical activity.

The World Obesity Federation found no country with all five policies in place, with 126 countries having no policies or only one policy in place to prevent obesity. Of note, however, are the LMICs that have four (India, Mexico, Seychelles and Tonga) or three (Brazil, Ecuador and Malaysia) policies in place.

Box 5. Reducing unhealthy, ultra-processed foods in Mexico

"...in Mexico... where sugary drinks and ultra-processed foods account for 40 per cent of children's daily calories, the government recently banned the sale and distribution of ultra-processed foods and items high in salt, sugar and fat in public schools – positively impacting food environments for over 34 million children."

– UNICEF, 2025a

Policy intervention: tax on sugar-sweetened beverages enacted in Mexico in 2014

In 2014, Mexico launched a sugar-sweetened beverage (SSB) tax on manufacturers that increased SSB prices, resulting in reduced purchasing and consumption. Of note, the SSB tax was associated with a significant decrease in the prevalence of adolescents at risk for overweight or obesity by almost 2 per cent. Revenue generated from SSB taxes can be used to support community-based policies and programmes that support healthy eating and physical activity, especially for those communities at highest risk of obesity.

Source: Falbe et al. (2022); Falbe & Madsen (2017); Krieger et al. (2021).

Conclusion and call to action

The alarming rise in global childhood obesity rates requires urgent action. It is anticipated that the current generation of children will be the first to have lower life expectancies than their parents (Olshansky et al., 2024). Climate change only magnifies this risk. The time to act is now. Actions endorsed by UNICEF, WHO and other organizations provide a multilevel road map for tackling childhood obesity. This includes supporting environmental policies in homes, schools and communities that promote healthy diets, physical activity and ultimately the healthy growth and development of all children.



It is anticipated that the current generation of children will be the first to have lower life expectancies than their parents.

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