Obesity Facts

Editorial

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Accepting and Embracing Responsibilities

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On the 30th anniversary of the European Congress on Obesity it is my true honour to chair the congress on behalf of the European Association for the Study of Obesity and the Association for the Study of Obesity on the Island of Ireland.

We are at an impasse regarding obesity prevention and treatment, and the steps we take over the coming years will determine whether conscious action and accountability will be taken at the level of the individual citizen, our scientific communities, geographical regions and at wider economic and policy levels. We have abundant usable data to guide us in supporting prevention, treatment and care related to obesity and we must be steadfast in placing human dignity, respect and potential at the centre of our decisions. We must be courageous and accept that the complexity of obesity demands us to regularly review, reflect and interrogate our scientific understanding, personal beliefs and biases. Living, growing and working in complex human systems is influenced by upstream decisions that can potentially default to what is best for a few but detrimental to many. As such, we must be conscious of the responsibility that we bear in terms of advocating for and defending human rights and social justice for our patients, colleagues, neighbours, family members and friends. Such rights and general principles are described clearly in the United Nations Convention on the Rights of the Child (UNCRC) and though they address the survival-, development-, protection- and participation rights of children [1], by embracing and realising such rights we, in turn, invariably ensure and protect the rights of adults.

Sometimes we as adults, face confusion in our professional and personal lives regarding how to make the best decisions to optimise scientific rigour and impact in the field of obesity research, how to choose the most appropriate treatment in healthcare practice, how to follow and evaluate obesity treatment as a patient, how to invest in a new therapeutic approach or how to action and implement obesity policy. When making these decisions, our confusion, uncertainty and hesitancy could be bounded by key principles that place human health, development and equity at the core. Is it unreasonable to ensure that we as adults and as citizens with the capacity to vote, commit to adhering to the UNCRC in all that we do related to obesity prevention, treatment and care?

Specific examples for consideration and focus include Article 2 which addresses *non-discrimination* such that children must not be directly or indirectly discriminated against and requires us to recognise the cold face of social

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and health inequality where some but not all children in our communities have access to nutritious and affordable food that promotes their health and development while supporting disease prevention. In cases where obesity has developed, we must ensure that our health and education systems do not discriminate against children based on the shape, size or appearance of their body or that an evidence-sparse understanding of obesity is embraced by adult decision makers such that the environmental and commercial determinants and drivers of obesity are ignored or downplayed. For children and adolescents living with obesity who are subjected to teasing, bullying or isolation at school, the duty of care by the school must be appreciated, so that students fully understand their rights themselves and as they relate to others.

It is a harsh reality that we have ample evidence suggesting structural discrimination of our most vulnerable children living in deprivation. For those living with disability, additional protections under Article 23 behove adults to ensure the child's community is adapted to meet their *needs for social participation and play* rather than expecting a child to adapt to environments that promote disability and exclusion. Children, adolescents and adults living with obesity and who present with movement or breathing difficulties may not easily participate in typical play, games, physical activity or sport and we need to ensure any such disability and impairment is considered so they can be included when they choose to be, and so that the built environment and access to outdoor space is accessible by all.

Article 3 describes how adults and those in power must consider the *interests of children and young people* and ensure that they are protected and cared for. Though we might address this by adhering to statutory child protection obligations, as parents health professionals or educators, our understanding of 'care' related to health, development and obesity requires us to interrogate whether our policies and practices related to marketing, advertising, agriculture, universal healthcare, technology and privacy have the interests and care of children at their core. If not, then we must reflect and analyse whether such practice and policies directly prevent us from adhering to Article 6 which stipulates that children have the *right to grow and develop in conditions that do not impact negatively on their physical and mental wellbeing*. Such 'conditions' include child safety and privacy (offline and online), adequate housing, access to nutritious, affordable and developmentally appropriate food and water, and adequate protection from commercial coercion and environmental pollutants. In addition, ensuring access to safe, stimulating and inclusive places to play provides conditions that also meet their rights under Article 15 (*freedom of association*) and Article 31 (*to have fun and to rest*).

In our policy-related work or in the design and delivery of health and education services, we must strive to adhere to Article 12 by including the *voice of children and young people* and not only seeking but authentically listening to their opinions related to obesity management, social justice and how to optimise growth, development, health and wellbeing in our modern world. Keeping UNCRC central to our media-engagement and the provision of education and information to the public will facilitate Article 17 where children and young people should have *access to information* from all kinds of media. At a time when misinformation and myths around obesity abound, we as scientists, educators, health professionals and patient advocates have a duty to contribute evidence-based information and discussion so that our children do not have social media actors and monetizers as their main source of information regarding factors that influence their health, development, education and wellbeing. Similarly, as educated adults we must collaborate directly with media to demand respect and dignity in discussions and visual representation around obesity, inequality and stigma.

For those children seeking asylum, Article 22 sets out specific rights related to *medical treatment, education and shelter*. It requires us to consider how nutrition or access to nutritious food may be impacted by migration, temporary shelter or direct provision by states welcoming such vulnerable children. Provision of medical treatment and quality healthcare is also enshrined under Article 24 where the *right to access healthcare* and the right to be *physically and mentally fulfilled* are addressed. Our clinical communication with children and families around obesity, its drivers and related health complications should be optimal so that the right *to health information* is achieved in an evidence-informed, sensitive and respectful manner. Receiving a clinical diagnosis of obesity should not result in harm, judgement or further discrimination as is unfortunately sometimes the case. Similarly, children should be able to *reach their physical, mental and social potential* (Article 27) which implies access to nutritious food, safe housing, safe places to play and education.

Regardless of whether we work in healthcare with children, in a laboratory completing mechanistic studies or in a policy realm, we can no longer ignore the complexity of obesity. Nor can we ignore the significant impacts that the environmental and social conditions created by adults have on either supporting or arresting the development

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and health of children and adults alike. We must harness our research efforts to better understand the impact of the child's environment on their health.

There is a need for integrated research effort so that we can better appreciate when and how excessive or ectopic adipose tissue is a sign indicating a known physiological disease process or whether it is a sign of mechanisms less understood by our existing paradigm. Clearly, we must listen to those living with obesity so that we can better use outcome measures beyond that of body size and which reflect the health gains that can result from evidence-based treatments. Simple and low-cost outcomes like muscle strength, aerobic fitness and function can complement anthropometry and patient reported outcome measures to assist with improved objective evaluation and monitoring of prevention and treatment interventions. With the emergence of omics-based discovery, we should consider what we mean by precision-based healthcare or treatment. Do we need to consider asking the patient what is most concerning to them and base our personalised treatment plan around that in the first instance? Should we consider genomic and metabolomic profiling in order to estimate the most suitable treatment? How can we attempt to use such approaches to ensure equity and to reduce the impact of social or health inequalities? It becomes clear that regardless of what assessment is required in a clinical setting or what treatment might be planned, all roads lead to and from authentic, respectful and empathic communication. Without a strong and trusting therapeutic alliance, neither the patient, the health professional nor the health system will realise optimal outcomes. Neither can personalised healthcare or medicine be realised.

Our human physiology is impacted by modifiable and non-modifiable factors and as voting adults, we must use our ballot power to shape societies that minimise the negative impact of modifiable environmental, socioeconomic, agricultural and commercial drivers on human health. Our votes must count so that we can move with ease in communities where soil, air and water quality is protected, where active travel is supported for all, where there is equity and proportionate universalism in terms of access to primary- and secondary prevention and treatment for obesity, where agricultural practices and policies protect biodiversity, support supply of fresh produce and disincentivise proliferation and promotion of energy-dense, nutrient poor, highly profitable edible products and where marketing is regulated to support the provision of choice rather than the illusion of choice.

Understanding obesity as a chronic disease implies that we will need a clear EU-wide plan for sustainable long-term financing so that member states can address obesity across all sectors enhancing research efforts, strengthening health systems and implementing system-based approaches and interventions. The COVID-19 pandemic similar to other periods of immense challenge has taught us that with unified intention and effort, we are capable of incredible collaboration and can deliver major programmes of change in our society. We must tap into this ability as a community of committed adults and work together in order to improve quality of life and health status for all, through a concerted effort of accepting our responsibility to address obesity prevention, treatment and care. The road ahead is not certain, but our responsibility and accountability will have a more defined silhouette if we keep UN-CRC central to all that we do.

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1 UN General Assembly. Convention on the Rights of the Child. United Nations, Treaty Series. 1989 Nov 20;1577(3):1–23.