MAKING LIFE BETTER

Department of Health
An Roinn Sláinte
Männystrie O Poustie
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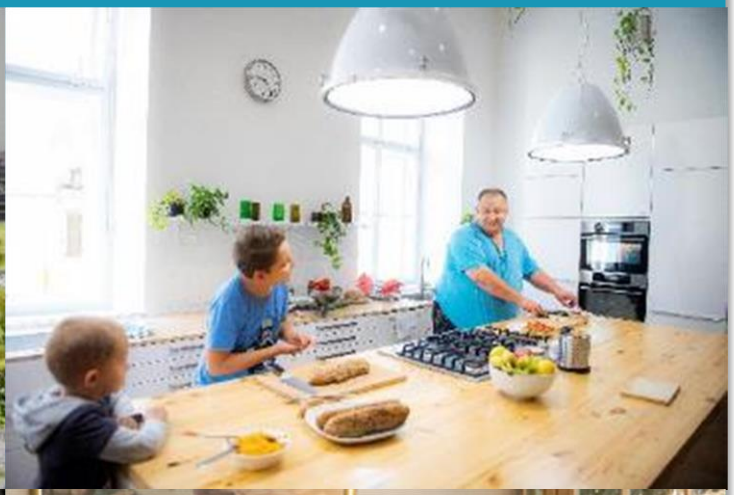
Healthy Futures

A Systematic Strategic Framework to Prevent the Harm caused by Obesity in Northern Ireland

November 2025

Ministerial Foreword

I am pleased to present the newly developed 'Healthy Futures' obesity strategic framework for Northern Ireland. A primary objective of my Department is to support and empower individuals in enhancing their health and well-being. This obesity strategic framework not only aims to improve the overall health of our population, thereby enhancing well-being and ensuring a better quality of life for our citizens, but it also seeks to alleviate the increasing demand on our health and social care services, which are currently under significant pressure.

Addressing health inequalities is a critical focus for me. The consequences of these inequalities are evident in the health outcomes we observe; for example, the rates of childhood obesity are consistently higher in the most deprived areas, with Year 1 obesity rates being 1.5 times greater among children from these areas compared to those from the least deprived areas, and over twice as high in Year 8 during the 2018/19 academic year. Thus, it is imperative to address the broader social and economic determinants of health that are linked to deprivation and opportunity, particularly concerning obesity and other population health outcomes.

The World Health Organisation has recognised obesity as a critical global health challenge, with its prevalence nearly tripling since 1975. In response to these challenges, my Department initiated a co-production process to refresh the strategic direction for obesity prevention. This process involved collaboration with a diverse array of stakeholders, including individuals with lived experiences of overweight and obesity, health professionals, academics, and community representatives, to formulate a new strategy that comprehensively addresses the complexities of obesity and its social determinants. The consultation process has engaged a wide range of participants, ensuring that diverse perspectives inform the development of effective health policies.

The findings from the consultation revealed overwhelming support for the proposed vision, principles, thematic approach, and overarching population-level priorities of the

new strategic framework. There is a strong emphasis on the necessity to intensify efforts to prevent overweight and obesity, alongside a call for a holistic, patient-centred approach to obesity management. Respondents underscored the importance of tackling health inequalities, fostering community engagement, and ensuring equitable access to resources and support for marginalised populations.

As we progress, it is essential to develop and implement a comprehensive strategy that integrates health policies, community initiatives, and collaborative efforts across various sectors. This approach will not only address the immediate challenges posed by obesity but also establish a foundation for a healthier future for all. By prioritising prevention, education, and support, we can create a sustainable framework that promotes well-being and resilience within our communities.

I would like to express my gratitude to all those who have contributed to this work over the past several years, and I look forward to collaborating with partners to realise the benefits of this new strategic framework.

MIKE NESBITT MLA
MINISTER FOR HEALTH

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1. EXECUTIVE SUMMARY

Introduction

1.1. The Healthy Futures strategic framework outlines the significant public health challenge of overweight and obesity in Northern Ireland, emphasising the need for a comprehensive approach to improve population health and reduce health inequalities. The Department for Health prioritises health improvement and prevention, aligning with the World Health Organisation's recognition of obesity as a global health challenge. Key statistics indicate a high prevalence of overweight and obesity among adults and children, particularly in disadvantaged communities, highlighting the urgency for effective interventions.

Background

1.2. Physical inactivity is identified as a leading risk factor for non-communicable diseases, necessitating regular physical activity and a healthy diet. The document discusses the multifaceted causes of obesity, including genetic, socio-economic, cultural, and environmental factors, and calls for a cross-sectoral approach to address these issues collaboratively.

1.3. The A Fitter Future For All (AFFFA) obesity prevention strategic framework aimed to combat obesity, with targets for reducing adult and childhood obesity by 2022. Despite achieving 82% of short-term outcomes, the strategic framework faced challenges, particularly due to the COVID-19 pandemic.

Way forward

1.4. This new strategic framework has been developed to enhance obesity prevention efforts, informed by research and stakeholder consultations. This framework emphasises a whole system approach, targeting specific groups and addressing health inequalities. It aims to prevent and manage obesity through education, treatment services, and a person-centred approach.

Vision, outcomes, principles, and thematic approach

1.5. The overall vision for this new strategic framework is:

To work collectively to create the wider social and environmental conditions in Northern Ireland that enable and support people to improve their diet and participate in more physical activity, and that reduces the risk of related harm for those living with overweight and obesity.

1.6. It has been developed and will be implemented through the following principles:

- The new strategic framework will take a **whole system approach** to addressing obesity and supporting people to achieve a healthy weight, it will be **health led but not solely health owned**.
- Recognising that overweight and obesity can cause harm at any stage, and that there is an intergenerational dimension, the new framework will take **a life course approach**, but it may specifically **target or prioritise certain groups**.
- Given the disparities that exist in this area, the framework will have a focus on reducing **inequalities** relating to; food, physical activity and overweight and obesity – which can be geographic, socio-economic, or at-risk inclusion health groups.
- Acknowledging the **alignment with other policy areas**, the new framework will seek to add value to existing strategic frameworks (such as the cancer, diabetes, food and the sport and physical activity strategies, and the breastfeeding action plan) and will not seek to duplicate activities or reporting arrangements.
- The framework will take a **population health approach** and be **outcome-based**, focused on how we improve life for people not just the activities and initiatives we undertake.
- The framework will provide an **umbrella for actions to prevent and address overweight and obesity**, from education and prevention through to weight management and treatment services. Previous obesity strategies focused solely on prevention.

- Finally, the Framework will take a **Person-centred approach**, working with those with lived and living experience and acknowledging and addressing weight stigma.

1.7. Delivery of this strategic framework will be taken forward through a thematic approach, across four key themes:

- **Healthy Policies**: the strategies, policies, regulations and stakeholders that influence our ability to eat a healthy diet, participate in physical activity, and to maintain a weight that is good for our health.
- **Healthy Places and Settings**: places and settings that influence our ability to eat healthily, be physically active and to manage our weight.
- **Healthy People**: supporting people to be healthy across a range of settings; provide early interventions and appropriate treatment which seek to reduce the harm to those who may be living with overweight and obesity.
- **Collaboration and a Whole System Approach**: regularly updating this strategic framework in line with the latest research and evidence; to work collectively across the UK and Ireland to find solutions and take a systematic approach to achieving goals.

1.8. The strategic framework focuses on four main long-term population level outcomes across the life course:

- Reducing the prevalence of overweight and obesity related Non-Communicable Diseases (NCDs).
- Halting the growth in the prevalence of obesity, and moving in the longer term to reducing the percentage of people in Northern Ireland who are a living with overweight and/or obesity;
- Improving the population's diet and nutrition; and
- Increasing the percentage of the population who participate in regular physical activity.

1.9. The document also highlights the importance of healthy policies related to food and physical environments, addressing the influence of external factors on dietary habits. Proposed actions include restricting unhealthy food advertising, enhancing food labelling, and promoting accessible environments for physical activity.

1.10. Furthermore, the strategic framework aims to create supportive environments for health across various settings, including schools and workplaces, to promote healthy eating and physical activity. It recognises the role of early interventions in establishing healthy habits and reducing health inequalities.

Next steps

1.11. The strategic framework aims to address obesity in Northern Ireland through actions delivered collaboratively across sectors, ongoing evaluation, and adaptation to ensure effective implementation of evidence-based actions. While acknowledging the financial challenges that come with delivery of this ambition, the framework sets out the potential for better alignment of existing programs to achieve improved outcomes and cost savings in health and social care services. A list of priority actions have been developed that allow for us to focus on the key issues we can shape in the short term and deliver primarily within existing resources. However, there is a clear invest to save rationale for this strategy, with the potential to support the wider prevention and health inequalities agenda, and reduce the substantial costs the harm from living with overweight and obesity (estimated at £500m per year), and related conditions like type II diabetes, has on Northern Ireland. As part of the development of the governance and implementation structures for this new strategy a fully costed plan setting out investments to deliver improved outcomes will be developed.

1.12. The strategic framework is expected to be in place for at least ten years, it will be updated as the required in light of new evidence or the availability of resources.

2. BACKGROUND AND THE CASE FOR CHANGE

Introduction:

2.1 This chapter outlines what we know about the impact of food, physical activity, and overweight and obesity, on health outcomes.

Context

2.2. Improving the health of the population of Northern Ireland, and preventing poor health and related outcomes, is a key focus of the Department of Health and for the wider Northern Ireland Executive. In support of this, the Programme for Government 2024-2027 'Our Plan: Doing What Matters Most'[1] sets out the overall goal of improving the wellbeing of everyone and contains a priority to cut health waiting times. The PfG specifically references the impact of obesity under the People theme of the Shaping a Better Tomorrow section of the document. Supporting and enabling people to improve their health and wellbeing, and preventing ill-health, will help to make the population of Northern Ireland healthier, will reduce the demand on our health and social care services, will make us economically more productive, and will help make our population more resilient to future crises, like pandemics.

2.3. In particular, the harms related to living with overweight and obesity, having poor diets or not being physically active, are recognised by the World Health Organisation (WHO) as one of the most serious global health challenges we face. The WHO European Regional Obesity Report 2022 states the "Recent estimates suggest that overweight and obesity is the fourth most common risk factor for non-communicable diseases, after high blood pressure, wider dietary risks and tobacco".[2]

2.4. It is also important to note that this issue is not specific to Northern Ireland, the worldwide prevalence of obesity nearly tripled between 1975 and 2016

[1] https://www.northernireland.gov.uk/sites/default/files/consultations/newnigov/draft-programme-for-government-our-plan-doing-what-matters-most.pdf
[2] https://apps.who.int/iris/bitstream/handle/10665/353747/9789289057738-eng.pdf

and it is estimated that by 2030 over 1 billion people globally will be living with obesity[3].

Defining Overweight and Obesity

2.5. Overweight is defined by the WHO[4] as a condition of excessive fat deposits. The WHO Health Service Delivery Framework for Prevention and Management of Obesity states that obesity is "… a chronic complex disease defined by excessive adiposity (having too much fatty tissue in the body) that can impair health. It is in most cases a multifactorial disease due to obesogenic environments, psycho-social factors and genetic variants"[5]. Overweight and Obesity is usually measured by Body Mass Index (BMI), which is calculated and is defined as the weight in kilograms divided by the square of the height in metres (kg/m^2). The BMI categories for defining obesity vary by age and gender in infants, children and adolescents. For adults, overweight is defined by a BMI greater than or equal to 25 kg/m² and obesity is defined by a BMI greater than or equal to 30 kg/m². There are three levels of severity of obesity – Class I BMI 30.0-34.9 kg/m^2, Class II BMI 35.0-39.9 kg/m^2, and Class III BMI greater than or equal to 40.0 kg/m^2 – in recognition of different management options[6].

2.6. However, BMI should only be considered as an approximate guide to categorising overweight and obesity for individuals. Differences in distribution of fat around the body, higher or lower than average amounts of muscle, and ethnic differences, may mean that people with the same BMI have different levels of fat, and this may affect the associated health risks.

2.7. There are some concerns about the validity of using BMI to measure obesity at the individual level, and there are alternatives such as waist to height ratio[7]. However, at the population level, BMI is generally accepted as a good

[3] https://s3-eu-west-1.amazonaws.com/wof-files/World_Obesity_Atlas_2022.pdf
[4] https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight
[5] https://www.who.int/publications/i/item/9789240073234
[6] https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/149403041
[7] https://www.nice.org.uk/guidance/cg189

measure of those living with overweight and obesity and can be compared across jurisdictions.

2.8. The situation for children is more complex because a child's BMI varies with age and gender. There are UK reference curves and an international classification of overweight and obesity[8] in children that can be used to calculate rates of overweight and obesity in children – with both producing slightly different results.

Statistics

2.9. According to the Health Survey Northern Ireland[9], 64% of adults are classified as living with overweight or obesity. More men (69%) than women (60%) are living with overweight or obesity and rates are also higher in the most disadvantaged communities (68%) compared to the least disadvantaged (62%). Detailed statistics and trends from 2010/2011 are set out at Annex A.

2.10. Just over one in four[10] children and young people in Northern Ireland are living with overweight (20%) or obesity (6%).

2.11. Around 55% of the population of Northern Ireland met the physical activity guidelines – with 27% reporting they were inactive.

2.12. 22% of the population were not aware of the guidance on consuming at least 5 portions of fruit and vegetables a day. 59% of the population consume less that the recommended portions with men (64%) less likely than women (55%) to reach the recommended level. The most disadvantaged communities have a lower proportion meeting the guidelines (38%) than the least disadvantaged (41%).

[8] https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight
[9] https://www.health-ni.gov.uk/topics/health-survey-northern-ireland
[10] Using the International Obesity task Force (IOTF) cut off points - https://onlinelibrary.wiley.com/doi/full/10.1111/j.2047-6310.2012.00064.x.

Summary:

2.13. The following charts, sourced from the Health Survey Northern Ireland[11] and the Young Persons Behaviour and Attitudes Survey[12], seek to summarise the position in relation to these issues in Northern Ireland:

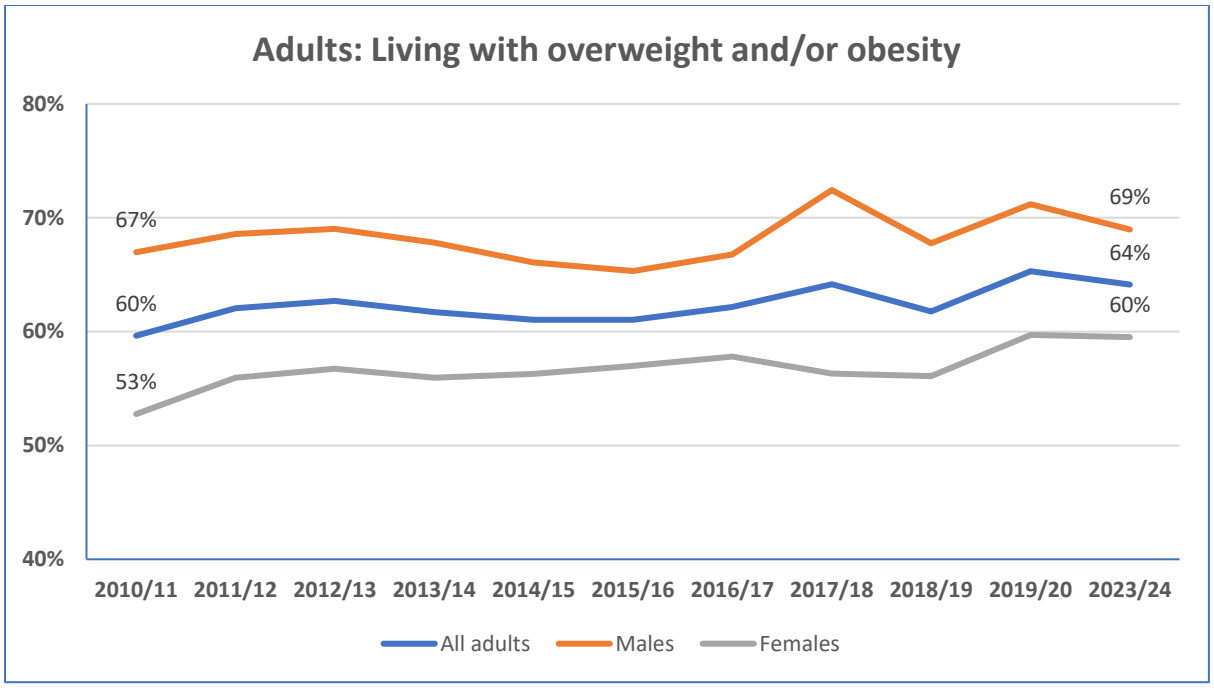

Figure 1: Adults living with overweight and/or obesity prevalence - 2010/11 to 2023/24

2.14. For all years, the proportion of males that were living with overweight or obesity was higher than for females and the overall trend has been increasing over the past 13 years.

[11] https://www.health-ni.gov.uk/topics/health-survey-northern-ireland
[12] https://www.nisra.gov.uk/statistics/find-your-survey/young-persons-behaviour-attitudes-survey

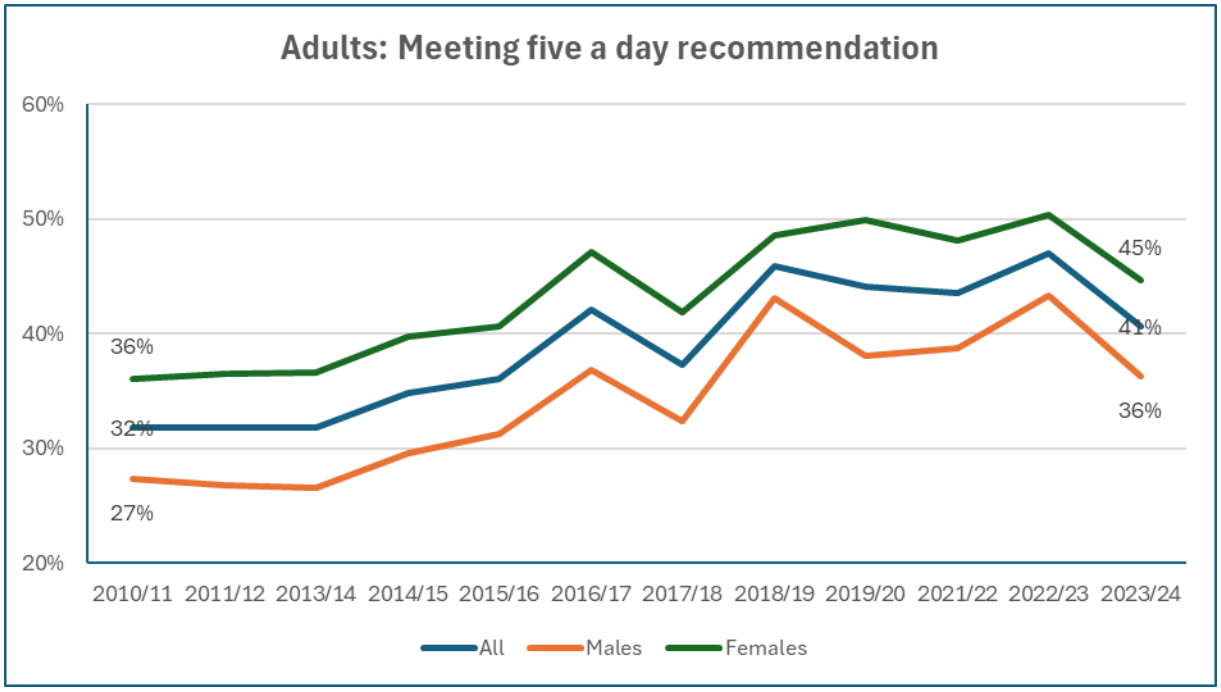

Figure 2: Adult rate of consuming '5-a-day' - 2010/11 to 2023/24

2.15. Consuming five a day increased from around a third (32%) in 2010/11 to 44% in 2021/22, but then dropped to 41% in 2023/24. Females (45%) were more likely than males (36%) to consume five a day

2.16. The latest Northern Ireland Food and You[13] report indicated that most people (74%) were aware that the UK Government recommend that people should eat 5 portions of fruit and vegetables every day.

2.17. Despite apparent knowledge of these guidelines, the National Diet and Nutrition Survey 2019 to 2023[14] reports that average adults aged 19 to 64 years consume 3.3 portions per day, adults aged 65 to 74 years consume 3.7 portions per day, and adults aged 75 and cover consume 3.6 portions per day. This meant only 17% of all adults met the 5 A Day recommendation

2.18. Children aged 11 to 18 years on average consume 2.8 portions of fruit and vegetables per day with only 9% meeting the 5 A Day recommendation.

[13] https://www.food.gov.uk/research/food-and-you-2
[14] https://www.gov.uk/government/collections/national-diet-and-nutrition-survey

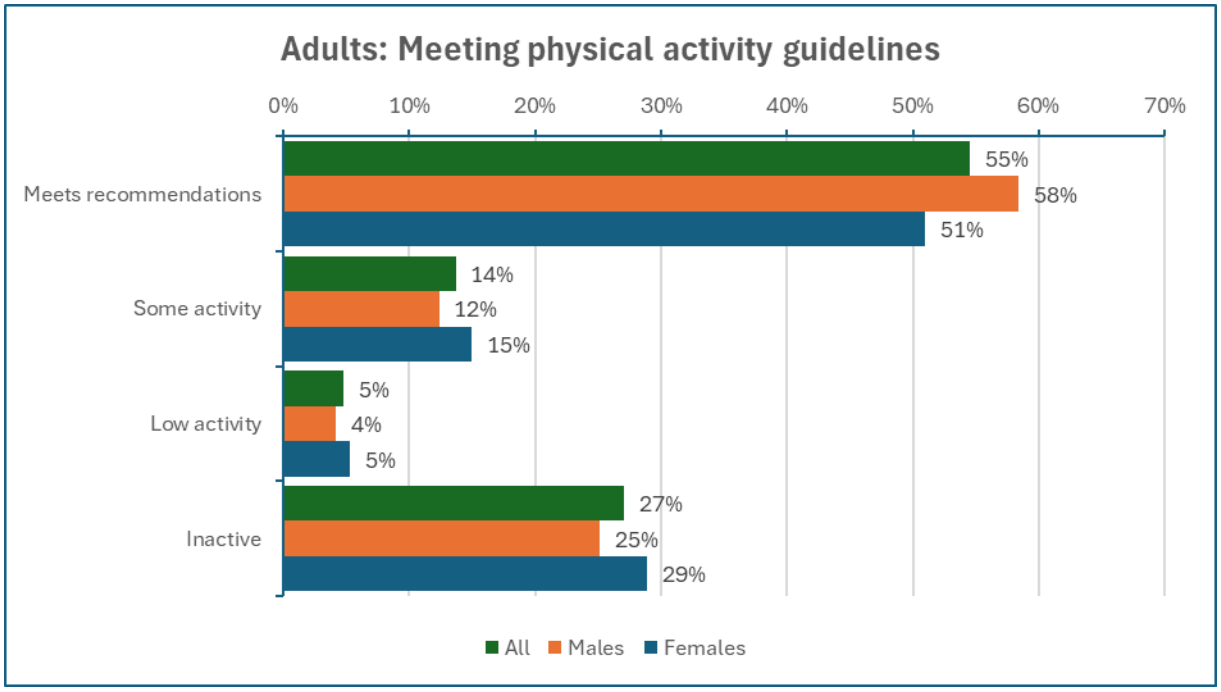

Figure 3: Adult rates of meeting Chief Medical Officers physical activity recommendations

2.19. 55% reported[15] meeting the Chief Medical Officer's physical activity recommendations, however females (51%) were less likely than males (58%) to meet the recommendations.

2.20. Children living with overweight and obesity[16] remained relatively stable between 2010/11 and 2019/20, with around a quarter of children in NI living with either overweight or obesity. In children aged 2 – 10, the rate changed from 27% in 2010/11 to 25% in 2019/20. For the same periods, for children aged 11 – 15 the rate changed from 27% to 26%.

[15] https://www.health-ni.gov.uk/topics/health-survey-northern-ireland
[16] Children in this context are aged between 2 and 15 years old.

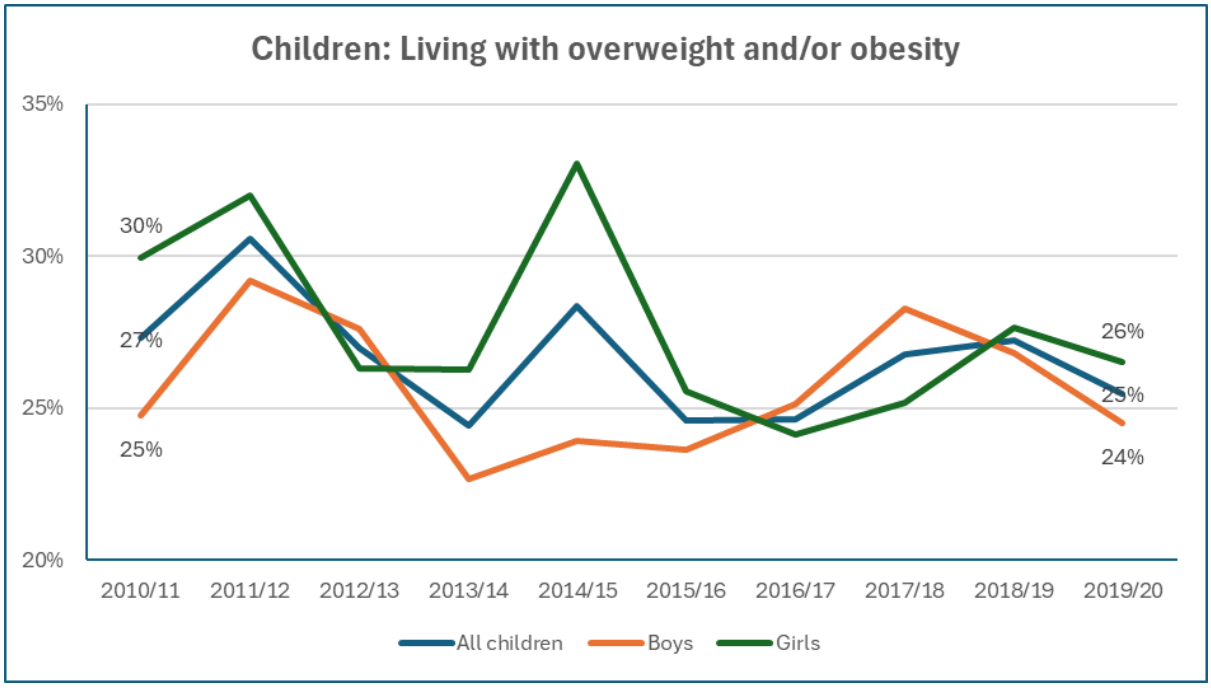

Figure 4:Children living with overweight and/or obesity, using IOTF cut-offs

2.21. Around a sixth (16%)[17] of children consumed five or more portions of fruit and vegetables each day. There was no difference between girls and boys. A higher proportion of those living in the least deprived areas (19%) stated that they consumed five or more a day than those in the most deprived areas (14%).

2.22. 62% of children thought you should eat five or more portions of fruit and vegetables each day to be healthy. The five a day message was known by a higher proportion of girls (than boys), those in Year 12 (compared with those in Year 8), and those living in the least deprived areas (compared with those in the most deprived areas).

[17] https://www.nisra.gov.uk/publications/young-persons-behaviour-and-attitude-survey-2022

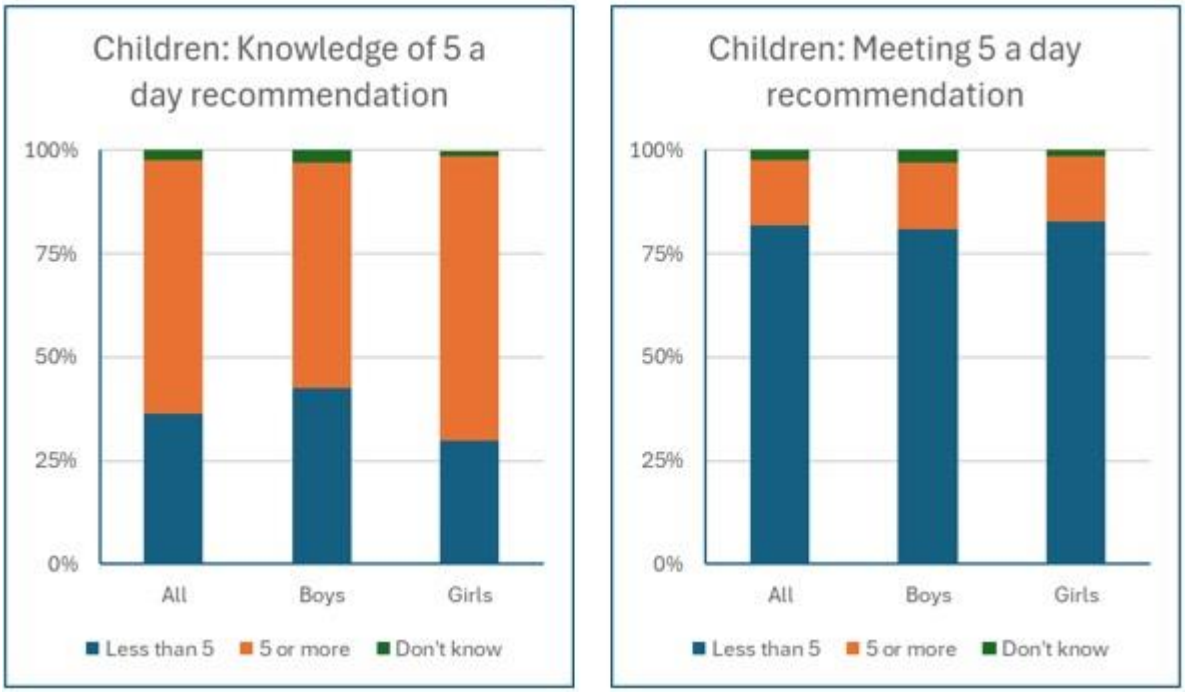

Figure 5: Children - 5 a Day Recommendations

2.23. In 2022, boys (28%) were twice as likely as girls (16%) to do more than 7 hours of moderate-to-vigorous physical activity per week. Those living in the least deprived areas (27%) were 50% more likely to state this than those living in the most deprived areas (19%). Young people that reported doing no hours of moderate-to-vigorous activity in a typical week were more likely to report spending more than 20 hours a week watching tv and more than 20 hours a week playing computer games.

2.24. A third (35%) of children described themselves as 'very active' and 'eat healthily' and 39% thought they were 'very active' but 'don't eat healthily'. Young people who did 60 minutes of moderate-to-vigorous physical activity each day were more likely to report consuming 5 or more portions of fruit and vegetables a day (29%) compared with 9% of those who reported no days.

2.25. Almost two thirds (62.4%) of children stated that they enjoyed doing sports or physical activity a lot, with a third (32.3%) saying they enjoyed it a little, and the remaining 5.3% stating that they didn't enjoy it at all.

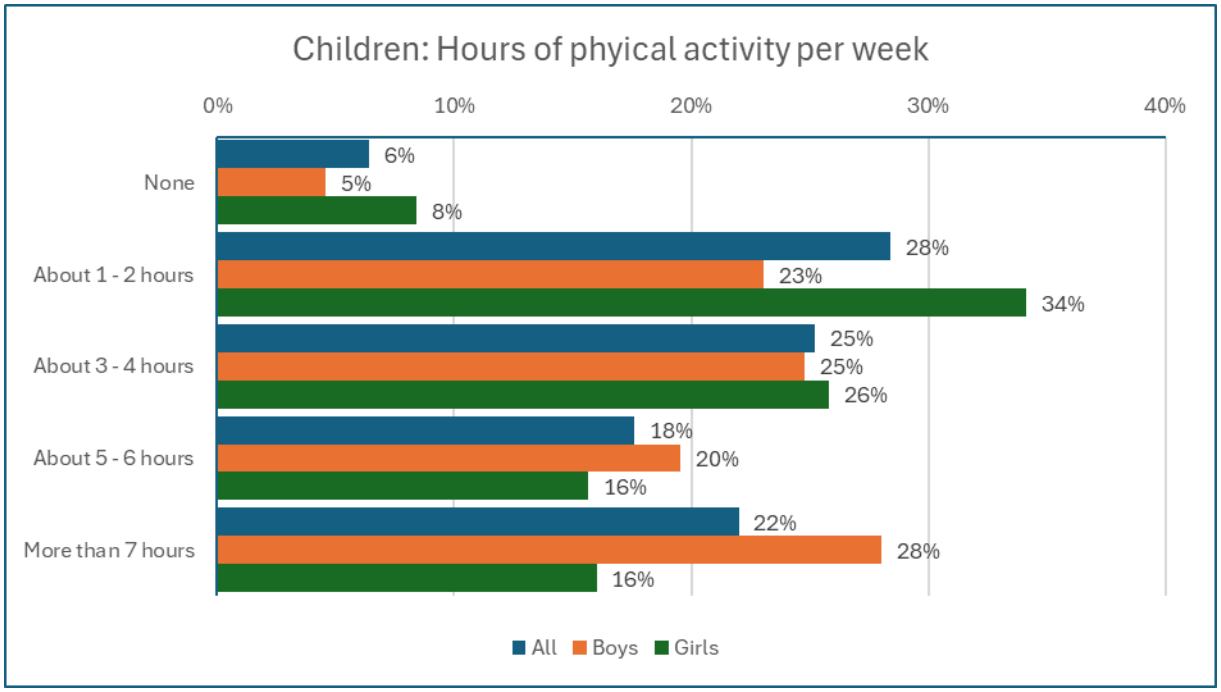

Figure 6: Child number of hours of physical activity per week 2019

Impact

2.26. The key issue is not the level of obesity in Northern Ireland, it is the impact this has on those living with overweight and obesity and on our wider population. For example, those living with overweight or obesity are at a higher risk of a range of major health conditions including heart disease and stroke; type II diabetes; some cancers, including postmenopausal breast cancer, orthopaedic problems, and complications in pregnancy. In addition, obesity can also impact negatively on disability in the wider population - restricting people's ability to engage in physical activity, potentially negatively impacting quality of life, and mental health.

2.27. In fact, estimates by Cancer Research UK[18] showed that obesity was the second main preventable cause of cancer, after smoking, and there are several other research reports on the links between body fat, weight gain and the risk of cancer[19].

[18] https://www.cancerresearchuk.org/sites/default/files/obesity_tobacco_cross_over_report_final.pdf?_gl=1*1clplp3*_ga*Nzg3OTk0OTIzLjE2MzU4NTg0ODk.*_ga_58736Z2GNN*MTY2MjM3NDU1Ny4yLjAuMTY2MjM3NDU1Ny42MC4wLjA.&_ga=2.108649159.493165658.1662374558-787994923.1635858489

[19] https://www.wcrf.org/wp-content/uploads/2021/01/Body-fatness-and-weight-gain_0.pdf

2.28. In addition, there are currently 108,000 people living with diabetes in Northern Ireland. Approximately 90% of people with diabetes will have type 2 diabetes. Diabetes diagnoses have almost doubled in the last 15 years[20], largely due to the number of cases of type 2 diabetes. While there are several risk factors for type 2 diabetes, including age and ethnicity, the biggest preventable risk factor is obesity, which accounts for as much as 85% of the overall risk of developing type 2 diabetes. It is also estimated that approximately 10% of Northern Ireland's HSC budget is spent on diabetes-related complications. Further estimates suggest that, without intervention, this could rise to 17% of HSC expenditure by 2035[21].

2.29. Overall, even low levels of excess weight can be associated with the loss of one in ten potentially disease-free years in middle and later adulthood (40-75 years old), and higher levels of obesity are associated with the loss of one in four disease-free years. There is an increasing loss of disease-free years as levels of obesity increase in both sexes, smokers and non-smokers, the physically active and inactive, and across socio-economic groups[22].

2.30. Children who live with overweight or obesity are at a greater risk of poor health in adolescence, as well as in adulthood. Indeed, a systemic review in 2016[23] showed that 80% of children who are living with obesity at 4/5 years old will continue to live with obesity into their adulthood.

2.31. Living with overweight and obesity can also impact on our body's resilience and ability to deal with other issues that can impact on our health. For example, evidence from the COVID-19 pandemic demonstrated that excess weight was associated with an increased risk of the following for COVID-19: a positive test, hospitalisation, advanced levels of treatment (including mechanical ventilation or admission to intensive or critical care) and death[24].

[20] https://www.health-ni.gov.uk/publications/200405-202021-raw-disease-prevalence-data-northern-ireland
[21] https://www.niauditoffice.gov.uk/files/niauditoffice/media-files/Type%202%20Diabetes%20Prevention%20and%20Care.pdf
[22] https://phw.nhs.wales/topics/overweight-and-obesity/the-case-for-action-on-obesity-in-wales/
[23] Predicting adult obesity from childhood obesity: a systematic review and meta-analysis - PubMed (nih.gov)
[24] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/907966/PHE_insight_Excess_weight_and_COVID-19__FINAL.pdf

2.32. Physical inactivity is one of the leading risk factors for noncommunicable diseases mortality. People who are insufficiently active have a 20% to 30% increased risk of death across the life course compared to people who are sufficiently active[25]. Increasing levels of physical activity, and reducing sedentary behaviour, can also help achieve the UN Sustainability Goals[26], which are a collection of seventeen interlinked objectives designed to serve as a "shared blueprint for peace and prosperity for people and the planet, now and into the future."

2.33. Regular physical activity can provide significant health benefits. Some physical activity is better than doing none. Being physically active on a regular basis can:

- improve muscular and cardiorespiratory fitness
- improve bone and functional health
- reduce the risk of hypertension, coronary heart disease, stroke, diabetes, various types of cancer (including breast cancer and colon cancer), and depression
- reduce the risk of falls as well as hip or vertebral fractures; and
- help maintain a healthy body weight.

2.34. Finally, consuming a healthy diet, across your life-course, helps to prevent malnutrition as well as a range of non-communicable diseases (NCDs) and conditions. However, many people are now consuming more foods high in energy, fats, free sugars and salt/sodium, and many people do not eat enough fruit, vegetables, and other dietary fibre such as whole grains leading to nutrient deficiencies. This can be exacerbated by issues with the accessibility and affordability of healthy foods, and thus there can be an interrelationship between food security, social and economic disadvantage, and the risk of obesity that can further drive and widen inequalities.

[25] https://www.who.int/news-room/fact-sheets/detail/physical-activity
[26] https://apps.who.int/iris/bitstream/handle/10665/272722/9789241514187-eng.pdf

Stigma

2.35. People living with obesity regularly face weight bias and stigma from a variety of sources, including education, workplace, healthcare settings. This is often the result of a lack of understanding about the complex drivers of obesity and lack of appreciation that addressing the issue of obesity is much more than simply 'eating less and moving more'. Experiencing weight stigma can directly and indirectly influence future weight gain, and negatively impact upon physical and mental health. It is therefore important that we recognise that obesity, and weight stigma, can also contribute to mental health issues such as depression, and vice versa.

Costs

2.36. The financial costs related to the harms caused by overweight and obesity are substantial. A study[27] focusing on estimating both the healthcare and productivity costs of overweight and obesity in Northern Ireland put this at £500m annually.

Causes and wider determinants

2.37. The causes of overweight and obesity are complex, and interrelated with wider genetic, socio-economic, cultural, and environmental factors.

2.38. The Foresight Report on Obesity published in 2007[28] outlined the causes of obesity as multiple, complex, and interlinked and reaching far beyond public health. The research that underpinned the report revealed that the causes of obesity are embedded in an extremely complex biological system, set within an equally complex societal framework. And while the report highlighted the contributions of a poor diet and physical inactivity as drivers of excess weight gain, it also brought an awareness that some individuals are biologically more susceptible to weight gain; recognised the impact of the environment on

[27] https://www.bhf.org.uk/-/media/files/what-we-do/in-your-area-northern-ireland-pages/ni-cost-to-society-figures-web.pdf?rev=febe531ce0ce495a932ca0613f760ed5&hash=D90EF4779523F69B25F854A512132837

[28] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/287937/07-1184x-tackling-obesities-future-choices-report.pdf

personal ‘choices’; and provided a much greater acknowledgement of the interactions between the environment and the individual.

2.39. Other research shows that there are also genetic and epigenetic factors at play, which can make it challenging for individuals, and means we need to ensure that we create a supportive environment and that we intervene at early stages of life, and even pre-conception. The WHO Health Service Delivery Framework for Prevention and Management of Obesity[29] also supports this and states that “... risk of obesity is influenced not only by genetic predispositions, biological factors and behaviours, but by upstream social, economic and commercial determinants such as poverty, employment, urbanization and food production and marketing that impact the environments in which eating and physical activity behaviours are learned and reinforced. These upstream determinants have the effect of limiting individual agency.”

2.40. In light of this, it is vital that we understand, while individual choices can play a role in overweight and obesity through decisions made around diet and nutrition and participation in physical activity, the physical, social, economic, and commercial environment in which people are born, grow, develop, live, work, and age plays a much greater role in shaping behaviours, opportunities and ability to make healthy choices. Therefore, these factors, along with ethnicity, genetics, poverty, and age, influence weight outcomes, and we need to think in these broad systemic ways if we are to address this issue.

Inequalities

2.41. The outcome of this is demonstrated in the inequalities we see in health outcomes, for example rates of childhood obesity are consistently higher in the most deprived areas – with the rates at Year 1 being 1.5 times higher among children from the most deprived areas than those from least deprived and over twice as high in Year 8 in 2018/19. Therefore, with obesity as with other population health outcomes, it is important to address the wider social and economic determinants of health linked to deprivation and opportunity.

[29] https://www.who.int/publications/i/item/9789240073234

The Case for Change

2.42. Obesity is one of the key risk factors for Non-Communicable Diseases (NCDs) such as type 2 diabetes, cardiovascular diseases, and certain types of cancer, as well as pulmonary, digestive, renal, endocrine, musculoskeletal, neurological, and mental health disorders. In 2019, there were an estimated 5 million obesity-related deaths from NCDs across the world, which corresponds to 12% of all NCD deaths[30]. This combination of rising prevalence and significance as a risk factor for other NCDs means that obesity now represents one of the major public health challenges of our time.

2.43. Given what we know about diet, nutrition, physical activity, and weight-related outcomes, it is clear that efforts to address these issues require a cross-sectoral and whole-of-Government approach. This means that it is not solely the responsibility of the health and social care sector or health services to address this issue. And, in fact, if this is seen as a health-only issue then we will not create the system change needed to see real and lasting improvements. Solutions are complex, and no single agency, sector or Government Department can deliver on them on their own. In addition, inequalities in economic and social circumstances are correlated with rates of obesity and therefore addressing these wider health determinants is an important aspect of any strategic approach to addressing obesity.

2.44. While there has been progress on implementing our current obesity prevention framework, A Fitter Future for All (see Chapter 3), it is clear that the strategy, for various reasons set out later, did not meet its overarching targets at the population level, and therefore any new approach to supporting improved diets, encouraging participation in physical activity, and reducing the prevalence of overweight and obesity at the population level, needs to take account of the most up-to-date evidence base and must be delivered at a scale and intensity that makes a difference at a population level.

[30] https://www.sciencedirect.com/science/article/pii/S2589537023000275?via%3Dihub

3. WHAT HAS HAPPENED TO DATE AND THE WAY FORWARD

Summary:

3.1. This chapter outlines the policy environment, as well as summarising the reports of progress of the previous strategy and the process to develop this strategic framework.

A Fitter Future for All

3.2. A Fitter Future For All 2012-2022[31] (AFFFA) was the former strategic framework to reduce the harm related to overweight and obesity, it aimed to "empower the population of Northern Ireland to make healthy choices, reduce the risk of overweight and obesity-related diseases and improve health and wellbeing, by creating an environment that supports and promotes a physically active lifestyle and a healthy diet".

3.3. AFFFA's overarching targets were:

- For adults, to reduce the level of obesity by 4% and overweight and obesity by 3% by 2022.
- For children, a 3% reduction of obesity and 2% reduction of overweight and obesity by 2022.

3.4. AFFFA has had a focus on outcomes across the life of the framework, with short, medium and long-term outcomes set and reviewed every 3 years – to align with anticipated budget periods. The latest set of short-term outcomes, covering 2019-2022 were agreed in October 2019. The framework, associated papers and progress reports are available at: https://www.health-ni.gov.uk/articles/obesity-prevention.

3.5. 82% of these latest short-term outcomes were either achieved or on track for achievement as of December 2023, while 18% were on track for achievement, but with some delay. Key delivery include:

[31] https://www.health-ni.gov.uk/publications/obesity-prevention-framework-and-reports

- The Weigh to a Healthy Pregnancy Programme being offered to all pregnant women with a BMI of 38+.
- All pregnant women receive the pregnancy book, which is updated yearly and contains information on healthy eating and physical activity.
- The 'Breastfeeding Welcome Here[32]' scheme continues to be promoted and any business open to the public is eligible to join the scheme.
- The HENRY Early Years Obesity Prevention Programme[33] (EYOPP) was procured in September 2019. EYOPP coordinators and child health assistants are in post in each trust to deliver the programme to families.
- Raise, Engage, Refer training has been delivered as part of EYOPP training package and informs Allied Healthcare Professionals and others working in health on how to constructively raise the issue of obesity, engage with parents/carers and to refer into the HENRY programme.
- An Eating Well, Choosing Better programme is being delivered to encourage the food industry to achieve sugar and calorie reduction by reduction in portion size, reduction in sugar and/or calories content per 100g of product or a shift in product portfolio towards lower sugar options.
- The development of the voluntary calorie labelling scheme, 'Calorie Wise' continues, in partnership with the eleven local councils in NI.
- Active Travel is supported in three settings, Schools (Active Schools Travel), workplaces (Leading the Way with Active Travel), and communities (Community Active Travel Programme in 12 disadvantaged communities in Belfast).
- The Daily Mile scheme is being promoted in primary schools and work is ongoing to expand this throughout NI.
- A regionally consistent Physical Activity Referral Scheme has been rolled out across all council areas in NI.

[32] https://www.publichealth.hscni.net/sites/default/files/Breastfeeding%20welcome%20here%20scheme%20booklet%202018.pdf

[33] https://www.henry.org.uk/crucialtime

3.6. Indicators used to measure these outcomes over the lifetime of AFFFA up to the latest available data, show that, for example:

- % mothers breastfeeding increased from 42% to 51% between 2012/13 and 2022.
- % of children in P1 living with overweight and obesity increased from 22.7%/5.7% to 23%/6.8% between 2010/11 and 2019/20.
- % of adults adopting the 5–a–day guidelines rose from 32% to 41% between 2010/11 and 2023/24.
- % of adults experiencing food poverty rose from 6% to 7% from 2013/14 to 2022/23.

3.7. There has therefore been good progress in implementing AFFFA, but it has not met its overarching targets at the population level. While individual interventions have proved successful, they have either not been delivered within a wider systematic approach needed to create a supportive environment, or they haven't been delivered at the scale required to have an impact. We also need to consider the impact on the pandemic on wider health behaviours and how this impacted obesity both during the pandemic and subsequently in terms of behavioural norms.

3.8. In addition, the current strategy has been taken forward within the constraints of the environment that exists in our society.

Project board and Pre-consultation process

3.9. To forward the development of a new obesity prevention framework, the Department of Health established an expert project board to advise on this work and to lead the co-production of a new strategy. The project board included input from health professionals, academics, the community and voluntary sector, those living with obesity, and a range of other Government Departments.

3.10. The project board developed and agreed the overarching process to develop the new strategic framework and helped inform the development of a range of

thematic co-production workshops to test the development of the strategy, advised on who should be involved, and developed a vision and principles for the work. The Department hosted seven virtual thematic workshops that had input from and engagement with all key sectors, and one overarching workshop on "whole system approaches".

Strategic Insight Lab and Systems Dynamic Modelling

3.11. The project board's work was informed by a 2-day Strategic Insight Lab in late 2019 on childhood obesity which was held to examine the challenge question 'how can we create a society in which children grow up a healthy weight?'

3.12. The Lab was supported by the development of a system dynamics model to get a better understanding of the wider determinants of obesity and how they interact with policy, society and communities. As part of the co-production of a new strategy, the Department brought back together those individuals and organisations involved in the Strategic Innovation Lab and the system's dynamic modelling to further revise and prioritise actions and include them in this new framework.

Research projects

3.13. The project board supported the design and commissioning two pieces of research that have helped to inform the development of this strategic framework. The first is "A whole systems approach to obesity prevention: a review of evidence to support Northern Ireland policy development"[34]. This co-produced briefing paper summarises the findings of an evidence review of what is known about using whole system approaches in relation to obesity, food and nutrition, and physical activity, and how this may operate in a Northern Ireland context.

3.14. The second research project involved the development of a policy options matrix. The matrix summarised the findings from a rapid review evidence

[34] https://publichealth.ie/report-evidence-is-building-to-support-a-whole-systems-approach-to-obesity-prevention-in-northern-ireland/

published in academic journals that related to international obesity prevention policies over the last 10 years. The project identified 51 review articles (48 systematic reviews, two scoping and one narrative review) which were summarised under the following categories: food labelling, food packaging, food reformulation, taxation/subsidies, advertising, marketing and sponsorship, food and physical activity environment, and target population policy measures including socially disadvantaged groups and indigenous groups.

NICE Guidelines

3.15. There are also a range of existing National Institute for Clinical Excellence[35] (NICE) guidelines related to diet and nutrition, physical activity, obesity prevention and management, and weight management. These have also been taken account of in the development of this work and also should be key to ensuring this strategic framework is delivered through an evidence-based and effective approach.

Consultation process and summary

3.16. The Department published a formal consultation document and undertook an engagement process to inform the finalisation of this strategic framework. The consultation ran for 14 weeks until 1 March 2024. The Department was specifically consulting on 18 questions covering the vision, principles, outcomes, and thematic approach for the new strategic framework, as well as on a draft Equality Screening and a draft Rural Needs Impact Assessment. The consultation documents are available online at https://www.health-ni.gov.uk/consultations/strategic-framework-prevent-harm-caused-obesity-and-improve-diets-and-levels-physical-activity.

3.17. A number of consultation events were held to support wider engagement and consultation with stakeholders. These events covered both the Healthy Futures consultation and a consultation on proposals for a Regional Obesity Management Service (ROMS), given the interlinkages between both

[35] https://www.nice.org.uk/

consultations. Events were scheduled for different times of the day, and the choice of attending virtual events or an in-person event gave stakeholders greater choice and flexibility. Each event included presentations on both Healthy Futures and ROMS. Attendees then had the opportunity to submit questions and comments to a panel of Departmental representatives for wider discussion.

3.18. Participants at the events represented a wide spectrum of interests including individuals with lived experience of obesity, health and social care professionals, policymakers, community and voluntary sector stakeholders and representatives from other organisations and groupings inclusive of professional bodies, political and private sector food industry representatives. Departmental representatives also met with individual stakeholders and groups on request to present on or discuss the Healthy Futures consultation.

3.19. A total of 111 responses were received, with the overwhelming majority of respondents agreeing with the vision, principles, themes, and population-level outcomes articulated in the consultation document. In their narrative responses, responders shared 280 separate sources of additional evidence and/research to support their arguments. This detailed evidence has taken some time to work through. At a very high level, the consultation analysis found that:

- 99% of respondents agreed or strongly agreed with the vision
- 99% agreed or strongly agreed with the principles
- 91% agreed or strongly agreed with the population-level outcomes
- 90% agreed or strongly agreed with the thematic approach
- 97% - 100% agreed or strongly agreed with each of the themes

3.20. The consultation report findings[36] emphasise the need to redouble efforts to prevent overweight and obesity, while also calling for a holistic, patient-centred approach to obesity management. Respondents highlighted the importance of addressing health inequalities, promoting community engagement, and

[36] https://www.health-ni.gov.uk/consultations/strategic-framework-prevent-harm-caused-obesity-and-improve-diets-and-levels-physical-activity

ensuring equitable access to resources and support for marginalised populations.

3.21. The responses demonstrated a belief that the focus for addressing obesity should shift from individual responsibility to systemic changes that foster healthier environments.

4. VISION, OUTCOMES, PRINCIPLES AND THEMATIC APPROACH

Introduction:

4.1 Based on the learning from the previous strategy, plus the consultation process and related evidence reviews, and a consideration of what has worked elsewhere, this chapter sets out the proposed overall vision for a new strategic framework, its outcomes, and the principles that should be at the heart of its implementation. It also sets out the thematic approach we propose to use to take this forward.

Vision

4.2. The overall vision for this new strategic framework is:

To work collectively to create the wider social and environmental conditions in Northern Ireland that enable and support people to improve their diet and participate in more physical activity, and that reduces the risk of related harm for those living with overweight and obesity.

Principles

4.3. The Strategic Framework has been developed and will be implemented through the following principles:

- The new strategic framework will take a **whole system approach** to addressing obesity and supporting people to achieve a healthy weight, it will be **health led but not solely health owned**.
- Recognising that overweight and obesity can cause harm at any stage, and that there is an intergenerational dimension, the new framework will take **a life course approach**, but it may specifically **target or prioritise certain groups**.
- Given the disparities that exist in this area, the framework will have a focus on reducing **inequalities** relating to; food, physical activity and overweight and obesity – which can be geographic, socio-economic, or at-risk inclusion health groups.
- Acknowledging the **alignment with other policy areas**, the new framework will seek to add value to existing strategic frameworks (such

as the cancer, diabetes, food and the sport and physical activity strategies, and the breastfeeding action plan) and will not seek to duplicate activities or reporting arrangements.

- The framework will take a **population health approach** and be **outcome-based**, focused on how we improve life for people not just the activities and initiatives we undertake.
- The framework will provide an **umbrella for actions to prevent and address overweight and obesity**, from education and prevention through to weight management and treatment services. Previous obesity strategies focused solely on prevention.
- Finally, the Framework will take a **Person-centred approach**, working with those with lived and living experience and acknowledging and addressing weight stigma.

Outcomes

4.4. We also recognise that, eating a healthy diet and being physically active have many health benefits beyond promotion of healthy weight. These are key components in living long, healthy lives, promoting good health and emotional wellbeing, and reducing the risk of injury and premature death and are therefore important in their own right.

4.5. This strategic framework therefore focuses on four main long-term population level outcomes across the life course:

- Reducing the prevalence of overweight and obesity related Non-Communicable Diseases (NCDs).
- Halting the growth in the prevalence of obesity, and moving in the longer term to reducing the percentage of people in Northern Ireland who are a living with overweight and/or obesity;
- Improving the population's diet and nutrition; and
- Increasing the percentage of the population who participate in regular physical activity.

Links to other strategies

4.6. Given the complexities involved and the existing policy across the NI Executive in relation to food and physical activity, this strategic framework cannot address all the wider causes of obesity-related harm and will therefore focus on where there are specific diet, nutrition, physical activity and healthy weight actions that can have a positive impact. However, we will work with others and play our part in addressing these issues through interaction with a range of strategies led by other NI Executive Departments. While further related strategies are mentioned under each theme in the chapters that follow, the following are particularly relevant:

a. Active Living - Sport and Physical Activity Strategy for Northern Ireland (https://www.communities-ni.gov.uk/publications/active-living-sport-and-physical-activity-strategy-northern-ireland).
b. The Northern Ireland Food Strategy Framework (https://www.daera-ni.gov.uk/publications/northern-ireland-food-strategy-framework).
c. Active travel - Sustainable transport policies, primarily focused on cycling and walking in Northern Ireland (https://www.infrastructure-ni.gov.uk/topics/active-travel).
d. A Cancer Strategy for Northern Ireland 2022-2032 (https://www.health-ni.gov.uk/publications/cancer-strategy-northern-ireland-2022-2032).
e. A Diabetes strategic framework (https://www.health-ni.gov.uk/publications/diabetes-strategic-framework)
f. Our Great Outdoors – The Outdoor Recreation Action Plan For Northern Ireland (https://www.outdoorrecreationni.com/publication/strategies/our-great-outdoors-the-outdoor-recreation-action-plan-for-northern-ireland/)
g. A Green Growth Strategy for Northern Ireland - A Green Growth Strategy for Northern Ireland - Balancing our climate, environment and economy | Department of Agriculture, Environment and Rural Affairs (daera-ni.gov.uk)
h. Breastfeeding Strategy - Breastfeeding - A Great Start: A Strategy for Northern Ireland 2013-2023 (health-ni.gov.uk) and Breastfeeding Action Plan (in development)

i. Healthy Child, Healthy Future A framework for the Universal Child Health Promotion Programme in Northern Ireland. [Healthy Child, Healthy Future (health-ni.gov.uk)]

Thematic approach

4.7. Delivery of this strategic framework will be taken forward through a thematic approach. This is set out in the following diagram, with further information contained in the following chapters:

Diagram – Thematic Approach

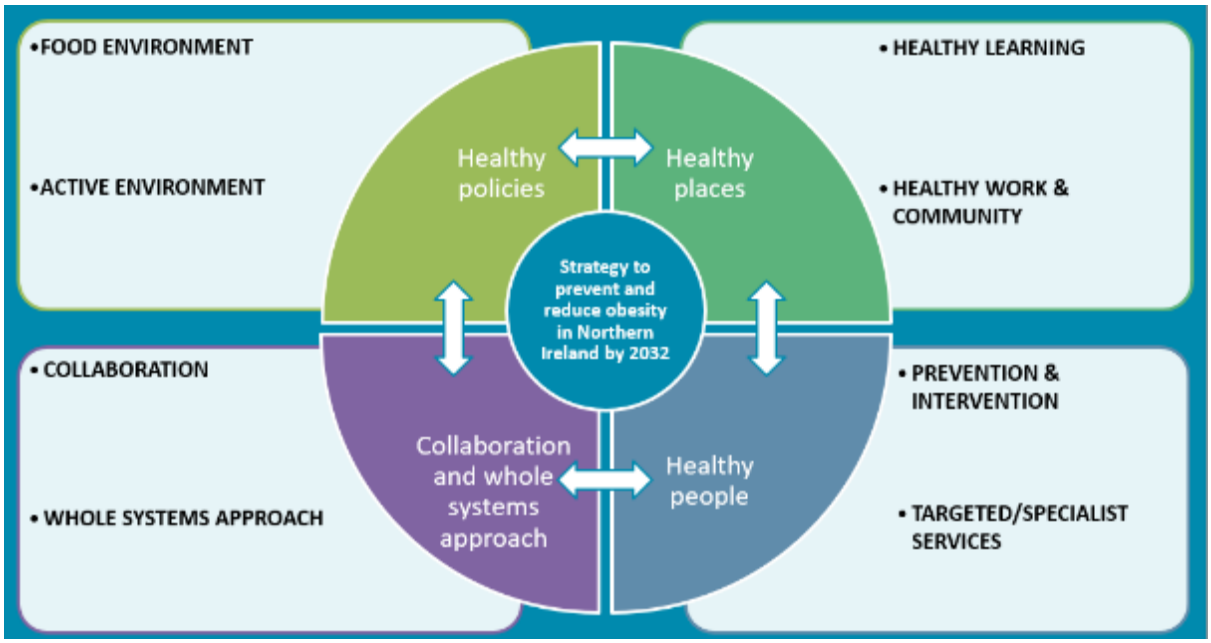

Figure 7: Thematic approach graphic, summarising project themes

5. THEME A – HEALTHY POLICIES

What is this and why is it important

5.1. **Our ability to eat a healthy diet, participate in physical activity, and to maintain a weight that is good for our health, is very much influenced by the wider environment in which we live our lives. The strategies, policies, regulations and stakeholders, such as the food industry, that control the wider food and physical environment therefore play a key role.**

Food environment

5.2. The food we eat and the drinks we consume have a direct impact on our physical and mental health. Over the past 50 years, the food environment, the commercial environment, wider regulations, and what and how we eat has continued to change.

5.3. The advertising and targeting or food marketing and promotions also plays a key role, in influencing the wider food environment and the choices we make. This has changed over time, with increasingly digital approaches allowing for much greater targeting of messages.

5.4. Eating out of home has become much more prevalent, as has ordering take-aways to eat on the move and at home. These meals can often be larger portion sizes and/or contain greater amounts of fat, salt and sugar than food we make ourselves. The planning system also plays a role, impacting the density and concentration of food outlets, particularly in areas of deprivation – which therefore impacts health inequalities.

5.5. Shopping has also changed, with more use of large retailers and home delivery or “click and collect” services. Ready meals and pre-prepared food are more available, and often the foods that are promoted and sold as lower cost deals are convenient, higher in fat, salt or sugar, and more energy dense

than healthier alternatives. If more of these unhealthy foods are eaten, over time this can create behavioural, psychological or dietary preferences.

5.6. There is also growing consideration being given to Ultra Processed Foods (UPFs). A rapid review of Ultra-Processed Food and Obesity[37] was completed in 2018 and it set out that these are products which are typically energy dense; have a high glycaemic load; are low in dietary fibre, micronutrients, and phytochemicals; and are high in unhealthy types of dietary fat[38], free sugars[39], and sodium[40]. When consumed in small amounts and with other healthy sources of calories, ultra-processed products are likely to be low risk; however, intense palatability, and the availability and the marketing of these foods makes their consumption more likely, and has the potential to displace fresh or minimally processed foods.

5.7. The Scientific Advisory Committee on Nutrition (SACN) carried out a scoping review of the evidence on processed foods and health, and published its position statement and report[41] in July 2023. This was followed by a rapid evidence update summary[42] in April 2025. Through the reports SACN state they have found consistent associations between higher consumption of UPF and adverse health outcomes. SACN continues to find the observed associations between higher consumption of (ultra) processed foods and adverse health outcomes concerning. They note there continues to be significant limitations in the evidence base. It remains unclear to what extent observed associations between UPFs and adverse health outcomes are explained by established relationships between nutritional factors and health outcomes on which SACN has undertaken risk assessments.

5.7 SACN report concerns and difficulties around the commonly used NOVA classification system. However, further subgroup analysis of foods classified

[37] https://phw.nhs.wales/topics/overweight-and-obesity/rapid-review-of-ultra-processed-food-and-obesity/
[38] https://www.nhs.uk/live-well/eat-well/food-types/different-fats-nutrition/
[39] https://www.nhs.uk/live-well/eat-well/food-types/how-does-sugar-in-our-diet-affect-our-health/
[40] https://www.nhs.uk/live-well/eat-well/food-types/salt-in-your-diet/
[41] https://www.gov.uk/government/publications/sacn-statement-on-processed-foods-and-health
[42] https://www.gov.uk/government/publications/processed-foods-and-health-sacns-rapid-evidence-update/processed-foods-and-health-sacns-rapid-evidence-update-summary

as UPF suggests there may be some potential to develop subcategories within the existing NOVA classification based on nutritional composition, in addition to processing. The update notes that subgroup analyses to date indicate increased risk of poor health outcomes for a number of food categories including meat and products and sweetened drinks. SACN has already made recommendations about these foods. They state the reasons for diverse findings for other subgroups remain unclear.

5.8 The UK's national food model the Eatwell Guide, which is based on SACN's recommendations, already indicates that many foods classified as ultra processed such as crisps, biscuits, cakes, confectionery and ice cream are not part of a healthy, balanced diet. It also emphasises a diet based on fruit, vegetables and wholegrain or higher fibre starchy carbohydrates, with less red and processed meat and less foods high in saturated fat, salt and free sugars. The update contains a range of recommendation which need to be considered by Government.

5.9. SACN have stated they will keep the topic under annual review and consider it again in 2026.

5.10. SACN issued a report[43] with a range of recommendation on non-sugar sweeteners in April 2025.

Physical Environment

5.11. The physical environment in which we live has also changed dramatically over the last 50 years. In general, our infrastructure is built around the car, rather than public transport, walking and cycling. And while there has been good progress in promoting and enabling active and sustainable transport, there can still be issues around perceived convenience and safety concerns that can influence us to take more sedentary options instead of active travel. This

[43] https://www.gov.uk/government/publications/sacn-statement-on-the-who-guideline-on-non-sugar-sweeteners/sacn-statement-on-the-who-guideline-on-non-sugar-sweeteners-summary

can be a particular issue in rural areas where access to active and public transport can be more of an issue leading to a greater reliance on cars[44].

5.12. There is also the opportunity to make greater use of the environment in which we live, for physical activity, recreation, and sport.

5.13. There is a strong link between childhood obesity and lack of access to quality green spaces and active travel opportunities. We therefore need to ensure that we use all the resources accessible to our population to provide high-quality, well-connected places and spaces, and that there are more opportunities for active recreation and play for families and children, particularly in the early years.

Thematic Outcomes

5.14. Over the lifetime of this new strategic framework, under this theme, we will seek to ensure that:

- healthier food and drink should be more accessible and affordable;
- consumers will be better informed and have clear information to enable them to make informed choices;
- there is greater consumption of healthier food in line with the Eatwell guide; and
- more people achieve the 4 UK Chief Medical Officer Physical Activity Guidelines;

5.15. Within all these areas we will focus on, and measure, reducing the inequalities that exist between the most deprived areas, the NI average and the least deprived areas.

5.16. It should be noted that there is also a clear overlap between progress on this agenda, and wider progress on climate change, net zero, green growth, air quality, food security, and the sustainability agenda. Delivering on this

[44] https://www.daera-ni.gov.uk/sites/default/files/publications/daera/Key%20Rural%20Issues%202022%20Infographic.pdf

strategic framework will also therefore very much support the delivery of 'A Green Growth Strategy for Northern Ireland - Balancing our climate, environment and economy'[45]. It will also align closely with the Northern Ireland Food Strategy Framework[46].

Thematic Delivery

5.17. Based on the research and evidence base of what works, the input and expertise of key stakeholders, the information from the consultation, and the developments in NI and across the UK and Ireland, we will undertake the following action to deliver on this theme:

[45] https://www.daera-ni.gov.uk/articles/green-growth-strategy-northern-ireland-balancing-our-climate-environment-and-economy
[46] https://www.daera-ni.gov.uk/publications/summary-responses-consultation-northern-ireland-food-strategy-framework

Theme: Healthy Policies		
Area: Food environment		
Actions	**Delivery Partners**	**Timescale[47]**
1. Work with the UK Government to further restrict the broadcast advertising of foods high in saturated fat, sugar and salt, including online.	DoH/UKG	Short
2. Consider what powers are in place within NI to reduce the promotion, and advertising of foods high in saturated fat, sugar and salt.	FSA/DoH	Medium
3. Scope the potential to bring forward legislation to restrict promotions on foods high in saturated fat, sugar and salt.	FSA/DoH	Medium
4. Deliver a communications campaign to raise awareness of the importance of the food environment	Safefood	Medium

[47] Short term = Year 1-year 2; Medium Term = Year 3-5; Long term = Year 5 onwards. Ongoing will be actions that have no natural start or end date but will run throughout the Framework's delivery

Area: Food labelling and information		
Priorities	**Delivery Partners**	**Timescale**
5. Work with UK Government to assess the best approach to front of pack nutritional labelling on pre-packed food	FSA/DoH	Medium
6. Consider and scope policy on calorie labelling at the point of choice for food eaten out of the home.	FSA/DoH	Medium
Area: Heathier food options		
Priorities	**Delivery Partners**	**Timescale**
7. Expand the use of nutritional standards to ensure that procurement and contracting in the public sector supports the purchasing and selling of healthier food and drink.	DAERA/DoH/FSA/DE/PHA/Safefood/All govt Departments	Medium
8. Promote and increase the awareness of nutritional standards among private sector employers.	FSA/Safefood/PHA	Longer term
9. Support food businesses to make the food environment healthier through reducing calories, saturated fat, sugar, and salt in the food they produce, sell or serve, reducing portion size and providing nutritional information.	FSA	Ongoing

Area: Physical activity and active travel		
Priorities	**Delivery Partners**	**Timescale**
10. Development of a holistic Active travel approach across communities, schools and workplaces.	DfI/PHA	Medium
11. Consider steps to develop a Walking for All programme with short, medium, and long term goals.	PHA/DfC/DfI/DAERA/C&V sector	Ongoing
12. Work with other government department, councils, and local communities to better promote, and provide more opportunities to access, local green spaces and safe paths for walking, cycling and recreation – particularly in areas of deprivation.	PHA/DfC/DfI/DAERA/C&V sector	Ongoing

6. THEME B – HEALTHY PLACES AND SETTINGS

Introduction

6.1. **At all ages, we can spend a significant portion of our lives in places and settings that influence our ability to eat healthily, be physically active and to manage our weight. Settings can play a positive role in supporting the health and wellbeing of the people who access them. Not just through providing healthy options, but also by promoting knowledge and awareness, and by understanding the impact that food and nutrition, physical activity and healthy weight play in promoting productivity, life-long health and longevity, supporting learning, and helping to address sustainability and climate change issues. But settings can also play a negative role by limiting access to opportunities, be barriers to participation and understanding the impacts noted above.**

Early years settings, schools, and further/higher education

6.2. Our children and young people can spend a significant proportion of their time in early years settings, schools, and further and higher education settings. These settings can therefore play a vital role in supporting the development of healthy habits that can support our young people through childhood, but also help establish this behaviour into adulthood.

6.3. We know that providing children with the appropriate foods and their participation in physical activity helps support their growth and development. But there is a growing body of research showing that what children eat and their physical activity levels, can affect not only their physical health but also their mood, mental health, and learning outcomes. It is therefore vital to recognise while these settings can support good health and wellbeing outcomes, good health and wellbeing is also a vital component and enabler of preparedness for school and the achievement of good learning outcomes both now and into the future. Research also shows that eating habits and healthy

behaviours are connected to academic achievement[48]. For example, in the USA, student participation in the School Breakfast Program is associated with better grades and standardised test scores, reduced absences, and improved memory[49].

6.4. The Children's Future Food Inquiry[50] set out that food insecurity, hunger and poor diets could lead to behavioural issues in class, alongside wider mental health and emotional wellbeing concerns. This will obviously impact on learning outcomes, not just for the individual but there are potential implications for the rest of the class.

6.5. Early years and education settings can play a key role in influencing healthy eating and physical activity habits, as students can consume on average 37% of their energy intake for the day during school hours and significant time can also be made available in these settings to undertake physical activity.

6.6. These settings can therefore promote and educate children, young people and their parents or carers about health. They can be used to deliver interventions which support regular physical activity and healthy eating, and can provide access to healthier food and drink. Staff in these settings can also benefit from this approach.

Workplace Settings

6.7. Even with the increase in hybrid and home working, as a nation we spend a significant amount of our lives in workplaces. It is important to acknowledge therefore that the places where we work play an important role in promoting positive health and wellbeing.

6.8. Not only can this be good for the health and wellbeing of employees, but there are strong social and economic reasons for workplaces in the private, public and third sectors to encourage and enable staff to be healthier as this can

[48] https://www.cdc.gov/healthyschools/health_and_academics/pdf/factsheetDietaryBehaviors.pdf
[49] https://pubmed.ncbi.nlm.nih.gov/30715390/
[50] https://foodfoundation.org.uk/publication/childrens-future-food-inquiry

increase productivity, job satisfaction and reduce sickness absence. Many workplaces already do just this, and we want to work to ensure this is the norm across Northern Ireland.

6.9. The types of initiatives that employers can take forward include increasing the availability and accessibility of healthier food and drink options in canteens and vending machines, where these are provided. They can also restrict promotions on unhealthy products and increasing promotion of healthier options. Many workplaces already provide schemes and support to promote good physical and mental health for staff such as offering health checks, programmes that provide advice and support on health issues, cycle to work schemes, gym access etc. In addition, workplaces can provide facilities and policies to support active travel and promoting peer support workplace initiatives, such as lunchtime walks or weight loss programmes.

6.10. There are also wider influences in respect of unemployment, under employment, job insecurity, shift patterns and health related behaviours[51].

Home, community, Health, and other settings

6.11. There are a number of other settings within our daily lives that play an integral role in creating healthy environments and can influence the daily opportunities available to us for eating well and physical activity. The key setting for most people, and in particular our children and young people, will be the home. Wider settings include health or care sites such as hospitals, GP surgeries or pharmacies, children's homes, hostels, and prisons, and places in the community such as leisure centres, cinemas or community centres.

6.12. These are also workplaces and have the ability to influence and support healthy behaviours for staff, as well as for the general public attending. But more than this they can all contribute to making healthy opportunities the norm across society as part of a whole system approach.

[51] https://diabetes-resources-production.s3.eu-west-1.amazonaws.com/resources-s3/public/2022-10/Preventing%20type%202%20and%20gestational%20diabetes%20position%20statement%20-%20October%202022.pdf

Thematic Outcomes

6.13. Over the lifetime of this new strategic framework, under this theme, we will seek to ensure that:

- more children start school a healthy weight and this is maintained;
- pupils leave education settings with the improved knowledge and skills in relation to food, drink and physical activity;
- there is increased offering and uptake of healthier food in educational settings, community settings, and workplaces in line with the Eatwell Guide;
- there are an increased number of children and young people meeting the Chief Medical Officer physical activity guidelines and a reduction in sedentary behaviours.
- there is an increase in those who are a healthy weight across the working population; and
- there is reduced sickness absence across workforces implementing interventions.

6.14. Within all these areas we will focus on, and measure, reducing the inequalities that exist between the most deprived areas, the NI average and the least deprived areas.

6.15. It should be noted that there is also an overlap between progress on this agenda, and wider progress to improve the productivity and economic outlook for Northern Ireland through the Economic Vision[52]. There are also clear overlaps between this agenda and work being taken forward through local community plans – and these can also support and reinforce each other.

Thematic Delivery

6.15. Based on the research and evidence base of what works, the input and expertise of key stakeholders, the information from the consultation, and the

[52] https://www.economy-ni.gov.uk/sites/default/files/2025-01/Delivering%20the%20Economic%20Vision%20-%20Year%20one%20progress%20report.pdf

developments in NI and across the UK and Ireland, we will undertake the following action the deliver on this theme:

Theme: Healthy Places and Settings		
Area: Early years settings:		
Priorities	**Delivery Partners**	**Timescale[53]**
1. Early Years Settings support young children to eat a healthy balanced diet and be physically active.	PHA/HSCTs/Providers	Ongoing
2. Support and scaling of interventions which promote a balanced diet, early childhood movement and the importance of play.	PHA/HSCTs/Providers Playboard	Ongoing
Area: School settings		
Priorities	**Delivery Partners**	**Timescale**
3. Implement all aspects of existing Food in Schools Policy	DE/DoH/PHA/ EA/FSA/CCEA/Safefood	Medium
4. Ensuring that children and young people are able to access appropriate PE and afterschool physical activity programmes, including active travel and safer routes to schools.	DE/EA//DE/DoH	Ongoing
5. Support the expansion of the Daily Mile programme.	QUB/ DE/DoH/PHA/ EA/C&V	Medium
6. School Inspection programmes include food, physical activity, and whole school approaches to health and wellbeing.	DE/CCEA/EA	Short

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[53] Timescale. Short term = Year 1-year 2; Medium Term = Year 3-5; Long term = Year 5 onwards. Ongoing will be actions that have no natural start or end date but will run throughout the Framework's delivery

Area: College, university, and workplace settings		
Priorities	**Delivery Partners**	**Timescale**
7. Further and Higher Education campuses and sites provide healthy food and drink options, and encourage active travel routes and a range of support for students to remain physically active and participate in sport for life.	DfE/Providers/PHA	Ongoing
8. Ongoing delivery of the Work Well and Live Well programme to support workplaces.	PHA	Ongoing
Area: Home, community, Health, and other settings		
Priorities	**Delivery Partners**	**Timescale**
9. Implement nutritional standards for catering and vending in health and social care and local government settings and expand to wider public sector settings. Continue to support local communities to improve access to healthy, safe food through funding Community Food Initiatives.	PHA / FSA / Safefood / All Government Departments / Local Government	Medium/Long term
10. Develop and deliver active travel plans for all HSC sites.	PHA/HSCTs	Short
11. HSC organisations deliver workplace health programmes to support health and activity within their workforces	PHA/HSCTs	Medium
12. Work through local government and community planning to promote increased update of healthy food and participation in physical activity.	PHA/LG – linked to WSA	Ongoing

7. THEME C – HEALTHY PEOPLE

Introduction

7.1. **People are at the heart of what we are trying to do. As well as creating a more supportive policy and legislative environment, and ensuring that a range of settings support people to be healthy, we also need to help, support, and enable people to prevent poor health and wellbeing, provide early interventions for those who may need additional help, and provide appropriate treatment and interventions which seek to reduce the harm to those who may be living with overweight and obesity.**

Prevention and Early Intervention

7.2. The best way to prevent the impact of poor diet and a lack of physical activity is to ensure that children get the best start in life and that from pre-conception and conception they are provided with the best opportunities to grow, develop and thrive. There is growing evidence in relation to the role of genetic and epigenetics in the development of obesity across the life course, and therefore intervening as early as possible is likely to provide a real opportunity to change and to break intergenerational cycles. In addition, establishing nutritional input and appropriate physical development in the lives of babies and young children greatly reduces their risk of poor physical and emotional health and wellbeing throughout childhood and the rest of their lives. Breastfeeding and weaning are also important to establishing healthy outcomes and behaviours from the early years throughout childhood[54].

7.3. Pregnancy and starting a family can be a key catalyst to encouraging people to make positive changes in their lives. Women with a BMI above 30 kg/m2 before conception are considered at higher risk of complications during pregnancy and delivery. In addition, early life exposures during pregnancy, such as maternal obesity, excessive gestational weight gain, high blood glucose levels, maternal smoking, stress and impaired foetal growth can

[54] https://www.health-ni.gov.uk/publications/breastfeeding-strategy

impact the weight at birth and the risk of obesity and related NCDs onward across the life course.

7.4. However, we have to recognise that not all people and families are starting in the same place, and this is demonstrated in the inequalities that exist in food, physical and weight-related indicators from an early age. People who live in areas of deprivation, or are part of at-risk groups, may live in environments that limit their choice or ability to live a healthy life.

7.5. In addition, many people will face challenges in maintaining good food and nutrition and physical activity habits across their life-course. There is a clear overlap between food, physical activity and mental health outcomes, and these can reinforce each other or act to exacerbate issues without support. This means that support and interventions may need to be tailored for the individual's needs, and may need to be flexible.

7.6. Our approach to prevention is based on the following model:

- **Primary** prevention: universal approaches focussing on **stopping problems before they emerge**, targets the **whole population** and interventions or solutions aim to promote good nutrition, physical activity and healthy weight outcomes are preferred;
- **Secondary** prevention: targeted approaches focussing on **people who are at risk** (e.g., due to social inequalities); solutions or interventions are referred to as selective or targeted; and
- **Tertiary** prevention: focussing on **people who require more intensive interventions or** solutions aimed at reducing symptoms, reducing the risk of recurrence and to support self-management. This type of prevention is an adjunct to treatment.

Weight Stigma

7.7. One issue that has come up strongly as part of our co-production and consultation on this new strategic framework is the issue of weight stigma, and

this is seen as a key issue, especially by those with lived or living experience of obesity.

7.8. Weight stigma can act as a barrier to people accessing services, can be reflected in people's experience of health and social care, and can also impact people's wider mental health and wellbeing.

7.9. We are keen that we don't add to those issues through this strategic framework. We recognise that weight in itself isn't a behaviour, it is the outcome of a range of complex interactions between people's genetic and biological factors, the environment they live in, and their wider mental and physical health. This new strategic framework will therefore take a person-centred approach to meet people where they are, recognising that this isn't just about behavioural change or making "healthy choices".

Treatment

7.10. Our previous strategy, A Fitter Future for All, was purely focussed on prevention and early interventions. One of the things we heard during the co-production of this new framework, particularly from those with lived or living experience of overweight and obesity, was that we can't completely separate prevention from treatment and other specialist services. People may require specialist support and help from highly skilled professionals to be able to manage their weight.

7.11. There are many people, children or families who may require access to specialist weight management services to provide intensive help and support. However, treatment services, particularly at hospital based or surgical, have been very limited in Northern Ireland, and it will be important that we develop and grow these services over time to meet the needs of those who require this level of support.

7.12. It is for that reason that in March 2019, the Department set up a multi-disciplinary Task and Finish group to explore options for the establishment of a Regional Obesity Management Service (ROMS) for Northern Ireland. The

key remit of the group was to develop a specification for a prototype ROMS model, to include: a surgical service for those individuals for whom surgical intervention is required to treat severe and complex obesity (Tier 4 service); and also a specialist weight management service, to support adults with severe and complex obesity to lose weight through a range of interventions, including psychological and dietetic support (Tier 3 service). This would also help to ensure that patients accessing Tier 4 surgical services would be supported sufficiently to deliver sustained results with weight loss.

7.13. Development of specialist weight management services will require additional resources, which is challenging at present given the continued pressures being faced across the HSC. However, it is very clear that there continues to be a real need for a ROMS in Northern Ireland. For this reason, the Department launched a public consultation in November 2023. The consultation closed on 1 March 2024, and a subsequently a consultation analysis report was developed. In April 2025, Minister Nesbitt approved a phased approach to establishing a ROMS. Phase 1 will initially focus on the development of a community-based service where patients will have access to lifestyle support and may have access to obesity medication. As work progresses, there may be further phases to this service development to include other interventions, such as bariatric (weight loss) surgery, subject to funding.

7.14. Overall, weight management services will need to be delivered based on an informed, respectful, non-judgemental and non-discriminatory approach to ensure the services effectively reach and support the people who require them.

Thematic Outcomes

7.15. Over the lifetime of this new strategic framework, under this theme, we will seek to ensure that:

- more people are a healthy weight in the pre-conception period and that healthy weight is maintained throughout pregnancy;

- more children start school a healthy weight and this is maintained;
- there is an increase in breastfeeding rates;
- there is an increase in people achieving the Chief Medical Officer Physical Activity Guidelines;
- there is a reduction in adults and children who are living with obesity; and
- there is reduction in chronic diseases, including Type 2 diabetes, linked to obesity.

7.16. Within all these areas we will focus on, and measure, reducing the inequalities that exist between the most deprived areas, the NI average and the least deprived areas.

7.17. It should be noted that there is also an overlap between progress on this agenda, and wider progress on the Mental Health Strategy[55].

Thematic Delivery

7.18. Based on the research and evidence base of what works, the input and expertise of key stakeholders, the information from the consultation, and the developments in NI and across the UK and Ireland, we will undertake the following action the deliver on this theme:

[55] https://www.health-ni.gov.uk/publications/mental-health-strategy-2021-2031

Theme: Healthy People		
Area: Pregnancy, postnatal period, and early years		
Priorities	**Delivery Partners**	**Timescale[56]**
1. Continued delivery of a healthy pregnancy programme and ensure that appropriate information is provided through the pregnancy book.	PHA	Ongoing
2. Continued promotion and support for breastfeeding and implementation of BFI Standards and evidence-based information on weaning, etc.	PHA/DoH	Ongoing
3. Scope specialist assessment for complicated pregnancy, obesity and complications/comorbidities.	PHA/HSCTs/SPPG	Long
4. Evaluate the current early years obesity prevention programme, with a view to wider roll out if successful	PHA	Short
Area: Prevention and awareness programmes		
Priorities	**Delivery Partners**	**Timescale**
5. Utilize the Multi-Disciplinary team model to better prevent issues in primary care and support those who need help.	SSPG/DoH	Ongoing
6. Promoting the awareness of the UK CMO Physical activity guidelines.	PHA	Ongoing

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[56] Timescale. Short term = Year 1-year 2; Medium Term = Year 3-5; Long term = Year 5 onwards. Ongoing will be actions that have no natural start or end date but will run throughout the Framework's delivery

7. Scope self-directed weight management interventions, including digital approaches, for those who could benefit	PHA	Medium
8. Deliver a communications campaign to include a fit for purpose public facing digital platform to source evidence-based nutrition and physical activity information and rebrand of "Choose to Live Better". This must be in line with person / people first language and non-weight stigmatising, and support behavioural science/change approaches.	PHA/DoH/Safefood	Ongoing
9. Increase the provision of engaging and enjoyable programmes to encourage eating well, sitting less and moving more. This will include targeted programmes in areas/inclusion health groups where there are greater health inequalities.	PHA/DoH	Short
10. Continued delivery of the Physical activity referral scheme and scope further options for expansion.	PHA	Ongoing
Area: Weight management services		
Priorities	**Delivery Partners**	**Timescale**
11. The development of a person-centred, flexible, clinical pathway, including pharmacological treatment and surgery.	SPPG/DoH	Medium
13. Scope the potential need for differential diagnosis of obesity types, such as those related to endocrine and genetic disorders, especially for children and young people.	SPPG	Medium
14. Access to specialist obesity management services for those who need them.	SPPG/DoH	Medium

8. THEME D – COLLABORATION AND A WHOLE SYSTEM APPROACH

Introduction

8.1. **We know that overweight and obesity are complex and interrelated with other issues and outcomes. It is vital therefore that this strategic framework is a living document, that our approach is regularly updated in line with the latest research and evidence, that we work collectively across the UK and Ireland, and that we enable people to come together to seek to find solutions and take a systematic approach to achieving our goals.**

Research and evaluation

8.2. The strategic framework will seek to support and build research on this issue to inform future practice, policy and implementation. This will include looking at the evidence base, and working with researchers locally and across the UK and Ireland to ensure that research can meet our policy needs.

8.3. Actions delivered under the new strategic framework will be monitored and where appropriate evaluated to ensure that we can demonstrate if they are working or that we learn from what isn't working and ensure that resources are used in the most effective way.

Collaboration

8.4. Issues that we need to address often sit across government, voluntary, and community sectors. Issues also cross borders – for example food production and retail is influenced by dynamics at the local, national, European and global levels. This means we need to ensure that we work with colleagues at different levels to ensure that, where appropriate, we take co-designed approaches to deliver at scale, or at least understand and work to mitigate wider changes in the policy context that can impact on the delivery of this strategic framework within Northern Ireland. We will work to set up mechanisms to support this collaborative approach.

Whole System Approach

8.5. A WSA approach incorporates a range of comprehensive initiatives targeted at system change by reaching government, policy makers, individuals, groups and community-level environments and drivers of human action[57]. A WSA to diet, and healthy weight shifts the focus from individuals and puts an emphasis on improving the 'systems' within which people are born, grow, live, work and age. A WSA focuses on multi-sectoral partnerships to leverage the strengths, and resources of a diverse range of actors (the collective) who have wide influence over and within the systems that influence diet and healthy weight.

8.6. A recent systematic review of WSAs applied to diet, healthy weight and obesity[58] showed WSAs have shown some success in positively impacting health outcomes including reducing Body Mass Index, reducing sugary food intake, and increasing physical activity. Importantly, this echoes findings in a rapid synthesis of evidence on systems approaches to obesity to inform policy in NI that was commissioned via the Institute of Public Health in Ireland (IPHI) and published in January 2023.[59] The IPHI's rapid review describes process evaluation of case studies where WSAs have been adopted and highlights barriers and facilitators to implementation, as well as setting out key considerations for taking a WSA to overweight and obesity in the Northern Ireland context[60].

[57] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820783/Whole_systems_approach_to_obesity_guide.pdf

[58] Breslin G, Fakoya O, Wills W, Lloyd N, Bontoft C, Wellings A, et al. (2024) Whole systems approaches to diet and healthy weight: A scoping review of reviews. PLoS ONE 19(3): e0292945.

[59] G Breslin, W Wills, L McGowan, JB Mack, CME Reynolds, H McAvoy (2023): A whole systems approach to obesity prevention: a rapid synthesis of evidence to inform the Northern Ireland Obesity Prevention Strategy Project Board. Dublin: Institute of Public Health. DOI: 10.14655/11971-1084903

[60] https://publichealth.ie/wp-content/uploads/2023/01/WSA-approach-to-obesity-prevention-final.pdf

A Whole System Approach to obesity prevention:

Figure 8: Illustration of a Whole System Approach to obesity prevention. © Institute of Public Health, 2023

8.7. Based on the IPHI rapid synthesis of evidence report[61] a workshop was held in October 2022 where the PHA with key partners established the basis on which WSA to obesity can be established in Northern Ireland. Work on the first early adopter site in Ards & North Down Borough Council area has commenced, as well as Belfast City Council, and Strabane and Derry City Council. Three further Council areas will be phased in over the next two years.

8.8. To ensure up to date evidence is guiding decisions on WSA implementation, research from the IPHI review and the National Institute for Health Research (NIHR) funded ongoing evaluations in other areas of the UK are being used to inform WSA workshop content, training and delivery in Northern Ireland. [62] [63] [64] [65] [66]

8.9. To empower public health leaders to utilise a WSA to tackle diet and unhealthy weight, Public Health England developed a guiding framework for WSA set-up, labelled the 'Leeds Beckett Model' (LBM).

[61] https://publichealth.ie/wp-content/uploads/2023/01/WSA-approach-to-obesity-prevention-final.pdf

[62] Breslin, G., Wills, W., Bontoft, C., Fakoya, O., Greco, H. A., Lloyd, N., ... & Brown, K. E. (2023). Whole systems approach to diet and healthy weight: a longitudinal process evaluation in East Scotland. Perspectives in Public Health, 143(6), 347-357.

[63] Breslin et al (In Prep) Implementing a Whole Systems Approach to Diet and Healthy Weight – A System Dynamic Modelling Perspective.

[64] https://phirst.nihr.ac.uk/wp-content/uploads/2024/01/Optimising-a-WSA-6.pdf

[65] https://phirst.nihr.ac.uk/wp-content/uploads/2023/09/WSA-WS23-briefing-10-1.pdf

[66] https://phirst.nihr.ac.uk/wp-content/uploads/2023/09/WSA-Review-of-Reviews-briefing-6-1.pdf

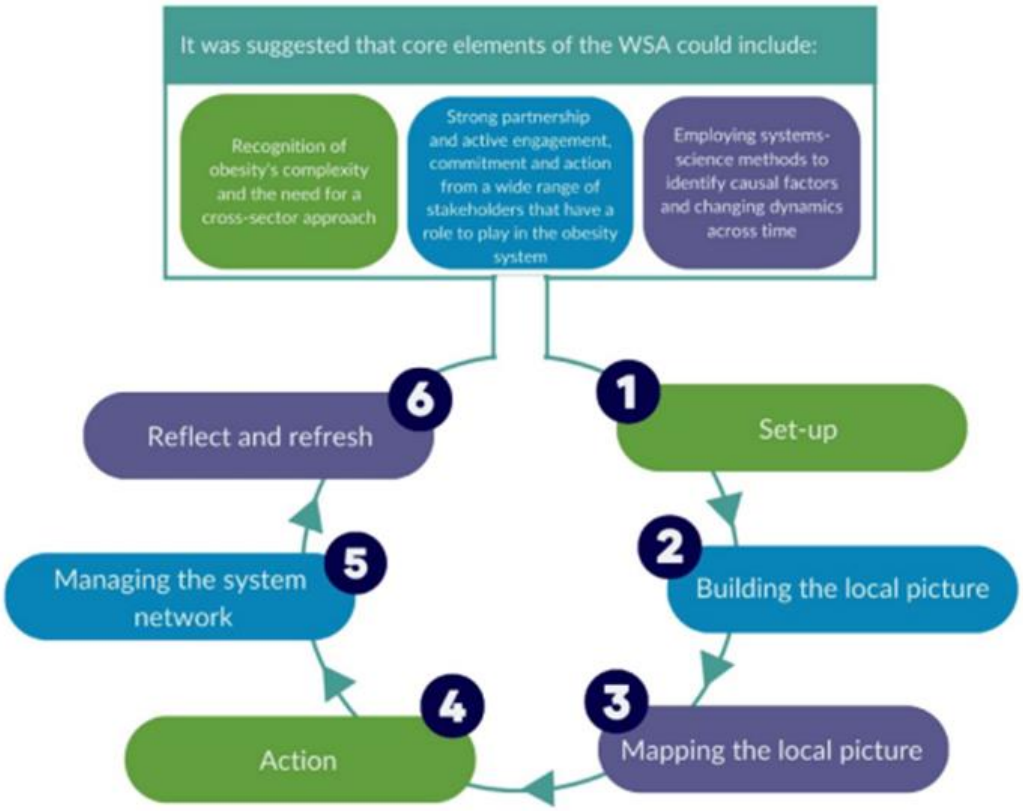

Figure 9: Illustration of a Whole System Approach to obesity prevention. © Institute of Publich Health, 2023

8.10. In 2019, Public Health Scotland launched a WSA pilot project in Scotland and provided funding to support local authority regions to set-up WSAs. Process evaluation of the pilots demonstrated how local systems can work more effectively to address complex public heath challenges.[67] In addition, WSA training has accelerated WSA interest. Areas adopting WSAs made progress in establishing new ways of working. In a one year longitudinal research study conducted in Scotland, two local authority (LA) areas receiving WSA funding, were selected for evaluation. This provided an opportunity to evaluate WSA implementation, including comparison of different implementation models (i.e. the untested LBM versus a hybrid model). This study assessed implementation of a WSA to diet and healthy weight and longitudinally explored enablers and barriers. Collected data also informed the range and extent of activity conducted by stakeholders in WSA delivery. Factors that

[67] Breslin, G., Wills, W., Bontoft, C., Fakoya, O., Greco, H. A., Lloyd, N., ... & Brown, K. E. (2023). Whole systems approach to diet and healthy weight: a longitudinal process evaluation in East Scotland. Perspectives in Public Health, 143(6), 347-357.

supported the two pilot sites in Scotland to progress with their WSAs included: stakeholders' belief in WSA effectiveness; positive relationships between key personnel; 'buy-in' by the public health authority at a national level; funding availability; WSA Working Groups comprising individuals with diverse expertise; effective communication; supportive existing governance structures; and community buy-in. Barriers included: appropriate funding; minimising staff turnover (or planning ways to mitigate its effects); and ensuring adequate training in WSA is available at all stages of implementation. The findings are summarised in the table below, where enablers and barriers to WSA implementation are outlined.[68]

Summary of enablers and barriers to WSA implementation	
Enablers	**Barriers**
• Personal interest in WSA	• COVID impacts
• Links and relationships with key person / people	• Previous experience of consultation without action
• Belief in approach	• Limited funding / constraints on us of funding
• Higher / strategic / national-level drive, change, and buy-in	• Daunting nature of workshops
• Sustained impetus in the WSA process	• Staff turnover
• Funding availability (appropriate and adequate)	• Tendency to revert to old ways of working
• 'Real', tangible action to encourage engagement	• Difficulty engaging community / stakeholders
• Engaging the 'right' people	• Lack of local leadership
• CWG comprising individuals with diverse expertise	• 'Taboo' nature of diet and healthy weight as a topic in community
• Communication and messaging of WSA work (e.g., in accessible / understandable language/terms)	• Publicity, marketing, framing of WSA
• Existing governance structures to build on	• Multiple competing messages about diet and healthy weight
• Community buy-in	
WSA: whole systems approach; CWG: core working group	

Table 1: Summary of enablers and barriers to WSA implementation

[68] https://phirst.nihr.ac.uk/wp-content/uploads/2023/09/WSA-WS23-briefing-10-1.pdf

Thematic Outcomes

8.11. Over the lifetime of this new strategic framework, under this theme, we will seek to ensure that:

- Research, modelling, and evidence continue to inform action;
- Delivery of the framework is monitored and evaluated on an outcomes basis as appropriate through the development of an overarching indicator set;
- Networks and collaboration exist to support local, national, and international work on key issues; and
- A framework is in place to allow the delivery of local action in a systematic way, with co-design and participant involvement at the core of the process.

Thematic Delivery

8.12. Based on the research and evidence base of what works, the co-design of the strategic framework with key stakeholders, the information from the consultation, and the developments in NI and across the UK and Ireland, we will undertake the following action the deliver on this theme:

Theme: Collaboration and a Whole System Approach		
Priorities	**Lead (and support)**	**Timescale[69]**
1. Establish research subgroup to inform, prioritise, and commission research to support the implementation of the Framework.	DoH with partners	Short
2. Monitor and report bi-annual on the delivery of the strategy	DoH with partners	Ongoing
3. Work across jurisdictions to deliver change at scale, where appropriate.	DoH with partners	Ongoing
4. Set up Whole System Approach early adopter sites to test the use of this approach to improve diet, physical activity and healthy weight outcomes in Northern Ireland.	PHA	Ongoing
5. Development of a Shared Learning Network for the WSA early adopter sites in NI where they can come together to reflect, showcase, share learning, collaborate implementation and provide feedback and critique on the development of a whole system approach to obesity prevention in Northern Ireland	PHA	Short

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[69] Timescale. Short term = Year 1-year 2; Medium Term = Year 3-5; Long term = Year 5 onwards. Ongoing will be actions that have no natural start or end date but will run throughout the Framework's delivery

9. DELIVERY

Introduction

This section of the framework sets out how it will be delivered and overseen.

Governance Structures

9.1 As set out earlier in this document, it is vital that we see addressing the harm from overweight and obesity, improving diets and increasing participation in physical activity within our wider approach to improving health and addressing health inequalities. It is therefore proposed that this strategy reports through the Making Life Better oversight and governance structures at the Executive level to ensure alignment

9.2 To support this a new cross-sectoral Programme Board will be established to drive forward and oversee the implementation of Healthy Futures. The membership of the Programme Board will cover Government Department, health professionals, academics, community/voluntary sector, local government, and experts by experience, and will build on the previous Obesity Prevention Steering Group, but will take on board the wider remit of this strategic framework. The Programme Board will establish policy advisory sub-committees on specific elements of the strategy as required. It will also link, as appropriate, to the governance structures for the new Food Strategy and the Sport and Physical Activity Strategy.

9.3 The Public Health Agency will establish a new Regional Implementation Board to oversee the delivery of the strategy and the Whole System Approach, and to align with key partners in other sectors

9.4 While the exact format of these structures will be agreed as part of the implementation of the strategic framework, we commit to having input from the community and voluntary sector and those with lived or living experience of overweight and obesity involved at all levels of programme delivery and oversight.

Resourcing

9.5 The financial position going into the future is likely to be challenging. However, it is also recognised that we can deliver additional value and capacity by better aligning existing programmes of work across related strategies and with other Government Departments. There may also be opportunities to reprofile existing public expenditure to achieve better outcomes. In addition, there are opportunities to jointly plan and commission interventions with partners, including local government, the community and voluntary sector and private sector to get better value for money and increase effectiveness. Finally, there may be opportunities to leverage funding from other sources and/or adopt innovative approaches that could help embed the finalised strategic framework.

9.6 Given this, the short term actions within the strategy will initially be scoped and taken forward within existing resources. During the initial year of the Framework's implementation we will develop a fully costed version of the action plan in the medium and longer term. This will allow time to consider the priority actions and take them forward in a co-ordinated way, and ensure that any additional funding requirements deliver positive outcomes and value for money. In the short term it would also allow us to focus on those actions which can be delivered within existing or limited resources, and start the process of longer term scoping and behavioural change against an agreed and supported policy framework.

9.7 There is a clear invest to save rational and mandate for the delivery of and investment in, in the strategic framework and its success in delivering better health outcomes has the potential to deliver substantial cost savings in future for the health and social care services and improve economic productivity, as well as improving the wellbeing of people right across Northern Ireland and addressing health inequalities. Overweight and obesity costs NI almost £500m every year, and in addition its impact on issues like type II diabetes is even more pronounced, so delivery in this area will clearly support the wider prevention and "shift left" agenda.

Timeframe

9.8 Given the long-term nature of the strategic framework, it is anticipated this will be in place for at least a ten-year period until 2035, but it may be extended further. However, since this is a rapidly developing sector, any reviews and updates will be conducted as required so that the latest developments in this policy area can be included in its implementation.

Equality and Rural Screening

9.9 As per the Department of Health's Equality Scheme and in order to comply with the Rural Needs Act (Northern Ireland) 2016, this policy has been screened for both Equality/Good Relations and Rural Needs impacts. The Equality screening will be published in the 'Policies screened and EQIAs' section on the DoH website at: https://www.health-ni.gov.uk/doh-equality.

9.10 These screenings have indicated that there is no significant negative impact from this strategy in terms of Equality of Opportunity, Good Relations or Rural Needs and thus no need for further Equality or Rural Impact Assessments. However, Equality Impact Assessments will be conducted on individual services as they are implemented whenever necessary.

Accessibility

9.11 Alternative formats of this strategy (such as other languages, large type, Braille, easy read and audio cassette) may be made available on request. Please contact the Department to discuss your requirements or if you have specific queries relating to this strategy. Please e-mail: hdpb@health-ni.gov.uk

Adult Data

All data sourced from Health Survey Northern Ireland trend tables[70]. Adult respondents aged 16+.

Survey questions asked annually from 2010/11 to 2019/20. Questions not asked in surveys in 2020/21 to 2022/23. Questions asked again in 2023/24, but sample size not sufficient to breakdown further to age groups, deprivations quintile, or by urban/rural differences.

BMI: Adults

All – weight category	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	2023 / 24	Significant difference?	
												2010/11 & 2023/24	2018/19 & 2023/24
Underweight	3%	2%	2%	1%	2%	1%	2%	2%	2%	1%	1%	↓	↔
Normal weight	38%	36%	36%	37%	37%	38%	36%	34%	37%	33%	35%	↔	↔
Living with overweight	36%	38%	38%	38%	36%	35%	35%	38%	37%	38%	37%	↔	↔
Living with obesity	22%	22%	23%	22%	22%	24%	24%	24%	23%	24%	24%	↔	↔
Living with severe obesity	2%	2%	2%	2%	3%	2%	3%	3%	2%	3%	4%	↑	↔
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
Unweighted base	*2603*	*3342*	*3280*	*3454*	*3172*	*2912*	*2729*	*2315*	*2723*	*3120*	*703*		

[70] https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland

BMI: Adults, by sex

Males – weight category	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	2023 / 24	Significant difference?	
												2010/11 & 2023/24	2018/19 & 2023/24
Underweight	2%	1%	1%	1%	1%	1%	1%	1%	1%	1%	2%	↔	↔
Normal weight	31%	30%	30%	31%	33%	34%	32%	26%	31%	28%	29%	↔	↔
Living with overweight	44%	43%	43%	43%	40%	37%	38%	46%	42%	43%	40%	↔	↔
Living with obesity	22%	24%	24%	23%	24%	26%	26%	24%	24%	26%	28%	↑	↔
Living with severe obesity	1%	2%	2%	2%	2%	2%	3%	2%	2%	2%	2%	↔	↔

Females	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	2023 / 24	Significant difference?	
												2010/11 & 2023/24	2018/19 & 2023/24
Underweight	3%	2%	2%	1%	3%	2%	2%	2%	2%	2%	1%	↓	↔
Normal weight	44%	42%	41%	43%	41%	41%	41%	42%	42%	38%	40%	↔	↔
Living with overweight	29%	34%	32%	33%	33%	32%	33%	30%	32%	33%	34%	↔	↔
Living with obesity	21%	20%	22%	20%	20%	22%	22%	23%	21%	23%	20%	↔	↔
Living with severe obesity	3%	3%	3%	3%	3%	2%	3%	3%	3%	4%	6%	↑	↔

Obesity: Adults, by age group.

Age group	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	Significant difference?	
											2010/11 & 2019/20	2018/19 & 2019/20
16-24	12%	8%	16%	10%	12%	14%	17%	9%	13%	14%	↔	↔
25-34	16%	20%	20%	19%	20%	22%	20%	22%	20%	25%	↑	↔
35-44	26%	26%	24%	22%	24%	29%	27%	29%	25%	27%	↔	↔
45-54	29%	30%	34%	30%	30%	32%	34%	32%	30%	34%	↔	↔
55-64	31%	34%	31%	33%	33%	33%	36%	37%	34%	30%	↔	↔
65-74	30%	30%	27%	31%	32%	29%	32%	32%	28%	35%	↔	↑
75+	24%	17%	21%	22%	26%	25%	25%	24%	22%	27%	↔	↔
Total %	**23%**	**24%**	**25%**	**24%**	**25%**	**26%**	**27%**	**26%**	**25%**	**27%**	↑	↑

Obesity: Adults, by deprivation quintile

Deprivation quintile	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	Significant difference?	
											2010/11 & 2019/20	2018/19 & 2019/20
Most deprived	25%	25%	31%	25%	28%	28%	27%	29%	28%	32%	↑	↔
Quintile 2	27%	25%	23%	27%	25%	28%	27%	28%	24%	28%	↔	↔
Quintile 3	23%	25%	25%	22%	26%	26%	29%	23%	26%	26%	↔	↔
Quintile 4	22%	23%	27%	22%	27%	26%	27%	28%	24%	27%	↑	↔
Least deprived	19%	20%	21%	22%	19%	24%	25%	24%	24%	25%	↑	↔
Total %	**23%**	**24%**	**25%**	**24%**	**25%**	**26%**	**27%**	**26%**	**25%**	**27%**	↑	↑

Obesity: Adults, by urban / rural

Urban / Rural	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	Significant difference?	
											2010/11 & 2019/20	2018/19 & 2019/20
Mixed Urban / Rural						19%	31%	27%	25%	24%		↔
Rural	24%	25%	24%	25%	26%	28%	27%	26%	24%	26%	↔	↔
Urban	23%	23%	26%	23%	24%	27%	26%	26%	25%	28%	↑	↑
Total %	**23%**	**24%**	**25%**	**24%**	**25%**	**26%**	**27%**	**26%**	**25%**	**27%**	↑	↑

Children data

All data sourced from Health Survey Northern Ireland trend tables[71]. Child respondents aged 2 – 15 years old. Figures here use the International (IOTF) Body Mass Index cut-offs for thinness, overweight and obesity in children[72]. Survey questions asked annually from 2010/11 to 2019/20. Questions not asked in surveys in 2020/21 to 2023/24.

BMI: Children – IOTF cut offs

All	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	Significant difference?	
											2010/11 & 2019/20	2018/19 & 2019/20
Underweight	7%	5%	4%	5%	5%	7%	6%	6%	6%	5%	↔	↔
Normal weight	65%	65%	69%	70%	66%	68%	69%	68%	67%	69%	↔	↔
Living with overweight	19%	21%	19%	17%	21%	16%	17%	18%	19%	20%	↔	↔
Living with obesity	8%	10%	8%	7%	7%	9%	7%	9%	8%	6%	↔	↔

[71] https://www.health-ni.gov.uk/publications/tables-health-survey-northern-ireland
[72] https://www.worldobesity.org/about/about-obesity/obesity-classification

BMI: Children, by sex

Boys	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	Significant difference?	
											2010/11 & 2019/20	2018/19 & 2019/20
Underweight	6%	4%	3%	4%	4%	6%	6%	5%	8%	7%	↔	↔
Normal weight	70%	67%	69%	73%	72%	70%	69%	67%	66%	69%	↔	↔
Living with overweight	17%	19%	20%	16%	18%	16%	17%	17%	17%	20%	↔	↔
Living with obesity	8%	10%	8%	7%	6%	8%	8%	11%	10%	5%	↔	↓

Girls	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	Significant difference?	
											2010/11 & 2019/20	2018/19 & 2019/20
Underweight	9%	6%	6%	6%	7%	8%	6%	6%	4%	4%	↓	↔
Normal weight	61%	62%	68%	67%	60%	66%	70%	69%	68%	70%	↑	↔
Living with overweight	22%	22%	19%	19%	24%	15%	18%	18%	21%	19%	↔	↔
Living with obesity	8%	10%	7%	8%	9%	10%	6%	7%	7%	7%	↔	↔

Obesity: Children, by age group

2 – 10 years old	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	Significant difference?	
											2010/11 & 2019/20	2018/19 & 2019/20
Underweight	7%	4%	5%	6%	5%	8%	5%	5%	7%	5%	↔	↔
Normal weight	65%	61%	71%	68%	69%	67%	73%	70%	67%	70%	↔	↔
Living with overweight	17%	22%	19%	18%	17%	16%	15%	16%	17%	18%	↔	↔
Living with obesity	10%	12%	6%	7%	9%	9%	7%	8%	9%	7%	↔	↔

11 – 15 years old	2010 / 2011	2011 / 2012	2012 / 2013	2013 / 2014	2014 / 2015	2015 / 2016	2016 / 2017	2017 / 2018	2018 / 2019	2019 / 2020	Significant difference?	
											2010/11 & 2019/20	2018/19 & 2019/20
Underweight	7%	6%	4%	3%	7%	6%	7%	7%	5%	6%	↔	↔
Normal weight	66%	71%	64%	74%	62%	71%	63%	62%	67%	68%	↔	↔
Living with overweight	23%	18%	20%	16%	28%	14%	22%	20%	22%	22%	↔	↔
Living with obesity	4%	6%	11%	7%	4%	9%	7%	11%	6%	4%	↔	↔

Obesity Prevention Strategy Project Board
Revised Terms of Reference

Chair: Gary Maxwell DoH

Background

To help reduce the harm related to overweight and obesity the Department developed the '**A Fitter Future for All 2012 – 2022**' strategic framework which addresses obesity prevention across the life course of the population. The Framework described the nature, scale and prevalence of obesity in Northern Ireland. It set out its causes and highlighted the inter-relatedness of those factors that have led to a rapid increase in obesity in recent years.

In this context, as we are nearing the end of the current strategy, the Department of Health considers that, for obesity and physical activity, a refreshed direction is required. Health Development Policy Branch is therefore instigating the co-production of a new 10 year Strategy

Role

The purpose of the Project Board is to provide procedural oversight of the project and they will report to the Obesity Prevention Steering Group. The Project Board is designed to be streamlined. As such it is not all encompassing of all areas of the health and social care system and the onus is therefore on the members of the Project Board to liaise, as appropriate and relevant, with others.

Secretariat: DoH Health Development Policy Branch

Functions

The project is divided into eight distinct areas:

1. **Preparatory work:** This work will create project structures centred on the principle of co-production which will explore methods for comprehensive stakeholder engagement through the use of stakeholder workshops.

It will also determine what baseline data should be gathered to ensure measurable outcomes and accessing relevant literature, reports, evidence based guidance, knowledge of services elsewhere and similar material.

2. **Develop themes via workshops** (these will probably be virtual). This will include engaging with stakeholders, including people with lived experience to co-produce the overarching themes of the Strategy.

3. **Undertake an assessment of the evidence** that has emerged since AFFFA was published, and review and benchmark against strategic plans in other countries.

4. **Analyse the results:** This work includes analysing the results from the workshops / Childhood Obesity SIL and the systems dynamic modelling to identify overarching themes of the Strategy.

5. **Develop outcomes / actions:** This will include engaging with stakeholders, including people with lived experience, to develop outcomes and actions within the themes identified in step 2 and 3.

6. **Draft Strategy:** This includes drafting the Strategy using the baseline data combined with the co-produced themes, outcomes and actions in the light of the strategic direction of the Department.

7. **Informal / formal consultation:** The draft plan must be shared with stakeholders and people with lived experience and their carers, either on a formal or informal basis before publication to ensure it meets the desired outcomes.

8. **Publish the Strategy**

Membership:

Membership of the Obesity Prevention Strategy Project Board will be limited but drawn from as wide a range of organisations as possible, including the statutory sector and voluntary/community organisations.

The Project Board will consist of the following members:

- persons with lived experience;
- representation from the community and voluntary sector;
- Health Development Policy Branch, Department of Health;
    - as required.
- professional representatives, Department of Health;
    - as required.
- representative(s) from the Public Health Agency;

    - Seamus Mullen, Colette Brolly and David Tumilty
- representative(s) from DE, DAERA, DfI and DfC
- representative(s) from the Food Standards Agency
- representatives from the academic sector