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Preventing the Rising Tide of Childhood and Adolescent Overweight and Obesity in the Southern African Development Community – The Time to Act is Now

Joint Advocacy Brief by the SADC Secretariat and UNICEF
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The global and regional projections of overweight and obesity are alarming, with estimates predicting four billion people affected globally by 2035. Populations living in Southern African Development Community (SADC) Member States are not exempt from this problem. All Member States are experiencing increasing trends in overweight and obesity among children and adolescents, driven by urbanization, a growing youth population and the increasing influence of the unhealthy food and beverage industry. This problem is set to get increasingly and dramatically worse over time, depriving children in SADC of healthy and productive lives, and negatively impacting health systems and whole economies. However, with political will, commitment, and integrated policies, we can halt these trends. The SADC region and its children are not destined for prolonged unhealthy lives. This is preventable.

To inform a coordinated response, the SADC secretariat conducted a landscape analysis with technical support from UNICEF. Evidence was collated and analyzed to understand prevalence and trends in overweight and obesity across the 16 SADC Member States and multiple drivers of the problem.[1] Findings were used to inform the development of the SADC Strategy on Overweight and Obesity Prevention 2024-2030 that highlights the SADC Secretariat's commitment to support Member States to implement priority interventions over the next five years. This includes fiscal policies, front-of-package labeling systems, marketing restrictions, food product reformulation, public food procurement for healthy diets, and policies promoting physical activity. This report summarizes the key findings of the study and recommendations related to children and adolescents to inform the actions of Members States for this critical age group.

1 Childhood and adolescent overweight and obesity are rapidly increasing across the SADC region.

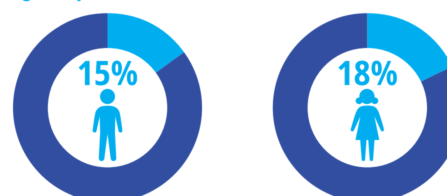
TABLE 1: Overweight and obesity prevalence in SADC Member States

	Overweight and Obesity (%)	
	0-4 years[a]	5-19 years[b]
Angola	4%	11%
Botswana	10%	18%
Comoros	8%	12%
DRC	4%	10%
Eswatini	8%	17%
Lesotho	7%	15%
Madagascar	2%	11%
Malawi	4%	11%
Mauritius	7%	15%
Mozambique	6%	13%
Namibia	5%	15%
Seychelles	9%	23%
South Africa	12%	25%
Tanzania	5%	12%
Zambia	5%	13%
Zimbabwe	3%	15%

a JME 2023
b SOWC 2023

Over the past two decades, the prevalence of overweight and obesity among children and adolescents in the SADC region have risen dramatically. By 2019, 15% of boys and 18% of girls aged 2 to 19 across the region were affected by overweight or obesity. The highest prevalence is among girls and children aged 5 to 19 years. This issue now affects all 16 Member States, most of which also face the challenge of persistent undernutrition and micronutrient deficiencies among their child and adolescent populations, representing a triple burden of malnutrition.

Overweight and obesity among children and adolescents has surged by **1.7 times** between 1990 and 2019 in SADC.



Most SADC countries are not on track to reach the World Health Assembly global targets aimed at halting the rise of childhood obesity by 2025 nor the Sustainable Development Goals aimed at reducing childhood overweight and obesity to under 3%.

Countries of particular concern in the SADC region are South Africa, Botswana, Eswatini, Lesotho, Mauritius, Namibia, Seychelles, and Zimbabwe, where overweight and obesity epidemics are escalating most rapidly (Table 1).

Currently, overweight prevalence is higher in wealthier socio-economic quintiles and urban areas, but this pattern is likely to shift, mirroring trends in other middle-income countries, where overweight and obesity eventually becomes more prevalent among the poorest groups.

2 The health and socioeconomic consequences of childhood and adolescent overweight and obesity are far-reaching and a major concern.

Childhood overweight and obesity are forms of malnutrition linked to excess body fat largely driven by over-consumption of ultra-processed foods high in fat, sugar and salt, low intake of healthy foods containing essential micronutrients, and insufficient physical activity. These conditions harm child health and wellbeing, increasing the risk of gastrointestinal, musculoskeletal, and cardiovascular problems, and type-2 diabetes in childhood. Children living with overweight and obesity also often face stigma, bullying, depression, and have poorer school performance. The negative impacts persist into adulthood, as individuals who were living with obesity and overweight as children have increased risk of obesity and non-communicable diseases (NCDs) throughout their lives. Shockingly, in 2019, obesity contributed to 37% of all deaths in the African region.

The negative impacts of overweight and obesity affect whole countries, due to the strain that NCDs put on already overburdened health systems, costing the region an estimated 1.39% of GDP annually, with projections of costs of USD 50 billion by 2035. There are also economic implications due to NCD-related loss of individual productivity and earnings.

3 Poor maternal and childhood nutrition and poor infant feeding practices drive childhood overweight.

Children born to poorly nourished mothers, including those living with overweight or obesity, are more likely to be born undernourished due to poor foetal growth, resulting in low birth weight. Undernourished children are more likely to experience overweight or obesity after a period of rapid growth compared to well-nourished children, making childhood undernutrition a risk factor for later overweight and obesity. In this way, overweight and obesity are an intergenerational problem.

How an infant is fed is also important. Not breastfeeding, non-exclusive breastfeeding, and inappropriate complementary feeding increase the risk of childhood overweight and obesity. Exclusive breastfeeding until six months of age, in contrast, significantly reduces this risk and related NCDs later in life.

In the SADC region, **10 countries remain below the global 2025 target of 50%** rate of **exclusive breastfeeding** in the first 6 months

Women of reproductive age in SADC

Overweight and Obesity **32%***

Anaemia: **33%***

Infants and children in SADC

Babies born with low birthweight <2.5kgs**:** **14%***

Children under 5 years of age stunted: **35%**

Breastfeeding and complementary feeding

Infants 0-6 months exclusively breastfed: **58%***

Child food poverty: **77%**

*Source: UNICEF. *Estimate for ESAR.*

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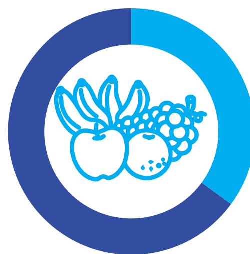
4 Regular consumption of unhealthy foods and lack of physical activity are major drivers of childhood overweight and obesity in SADC.

In SADC, children´s diets often lack diversity and are increasingly high in energy, fats, free sugars and salt. Home-cooked meals and fresh foods are being increasingly replaced with processed, ready to eat options, which typically have higher energy density. Additionally, fruit and vegetable intake are low across SADC. Fewer than half of children meet the daily recommended amount of fruit consumption in 11 out of 16 countries; that number is even lower – less than one in three – in Botswana, South Africa and Zimbabwe.

In Botswana[5],

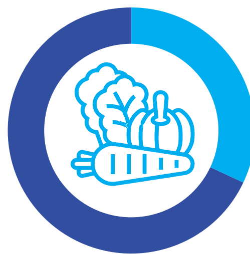
35%

of children **do not** consume fruits,



32%

do not consume vegetables at least once per day.



By contrast,

59%

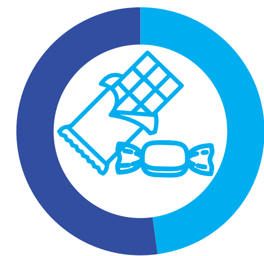
of children **consume** at least one sugar-sweetened beverage per day,

34%

consume cakes, biscuits, or donuts at least once per day,

48%

consume confectionary products at least once per day.



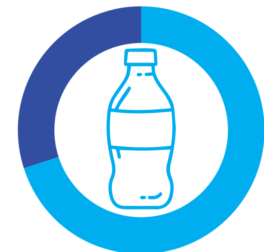
Children in Mozambique, Namibia, Seychelles, and Tanzania **have over one** carbonated soft drink **daily** and **eat fast food weekly**[6].

Unhealthy dietary patterns often begin before the age of two. This is a significant concern, as introducing sugary drinks and snacks at this early age is strongly linked to overweight and obesity by age six, dental caries, and micronutrient deficiencies due to the displacement of nutritious foods. Developing an early preference for unhealthy foods also negatively affects dietary choices later in life.

In Namibia[7],

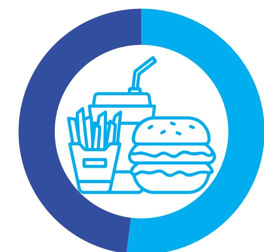
70%

of caregivers reported **children under 2 consuming sugary drinks**,



52%

of **children had unhealthy snacks**.



Insufficient physical activity (less than 60 minutes per day) also drives childhood overweight and obesity. In countries with available data (Botswana, Namibia, Mauritius, Mozambique, Seychelles, Tanzania, Zambia, and Zimbabwe), only one out of five children have sufficient physical activity.

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5 Children's environments in the SADC region are becoming characterized by unhealthy foods and sedentary lifestyles.

Overweight and obesity extend beyond the responsibility of individuals. Children are living, studying and playing in increasingly obesogenic environments that actively promote the consumption of unhealthy foods and sedentary behaviour. Simultaneously, it is getting harder to access affordable, nutritious food, even in schools. In Botswana, Eswatini, South Africa, and Zambia, school-age children struggle to access and afford healthy foods, while inexpensive, unhealthy options are widely available in and around schools through tuck shops and convenience stores.[8,9,10] This makes healthy food choices difficult if not impossible. These issues are particularly evident in urban areas, linking the overweight and obesity crisis to urbanization.

6 Multinational food corporations are major drivers of obesogenic environments by targeting children with misleading and appealing unhealthy foods advertisements.

The rising consumption of packaged, ultra-processed food in the SADC region is driven by their increased availability due to the increasing dominance of large, multinational food manufacturers that prioritize sales over population health.

In SADC, there was a notable increase of 76% in soft drink imports and 83% in processed snack food imports from 1995 to 2010. Evidence shows that these changes in diet since the 1990s correlate with trade liberalization.[11]

Such food manufacturers fuel unhealthy food environments through their use of aggressive marketing tactics that manipulate consumers to favour unhealthy food options over healthier alternatives. This includes the marketing of commercial infant formulas to mothers, and ultra processed products to children and adolescents. Children are exceptionally vulnerable to food marketing tactics, especially via social media and other digital marketing channels, where advertisements are often camouflaged as entertainment. While children living in urban areas are particularly vulnerable to marketing tactics, the influence of food companies extends to populations living even in remote, rural areas. This targeted marketing contributes significantly to childhood overweight and obesity and violates child rights to health, nutrition, privacy, and freedom from exploitation, as outlined in the Convention on the Rights of the Child.

Global fast-food industry spends over USD 5 million per day to market foods to children that do not meet nutritional guidelines.[12]

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7 Actions to address childhood overweight and obesity in SADC Member States are currently limited in scope and effectiveness.

Current strategies of SADC Member States to address overweight and obesity are predominantly built around actions to strengthen health systems, increase nutrition investment, and improve food and nutrition security. This is outlined in the SADC Regional Indicative Strategic Development Plan (RISDP) 2015-2030, the SADC Food and Nutrition Security Strategy 2015-2025, and SADC Vision 2050. Central to these initiatives are the promotion of healthy eating and physical exercise. While these are important components of an overweight and obesity prevention strategy, without the adoption and enforcement of robust legislation to address the drivers of obesogenic environments, they are unlikely to be effective.

The World Health Organization (WHO) recommends a comprehensive set of policy-level interventions to improve unhealthy food environments and mitigate overweight and obesity among children and adolescents (Box 1). Evidence from low- and middle-income countries, such as Mexico, shows that implementing a comprehensive package of policies offers a higher return on investment compared to siloed interventions.[13]

Governments in the SADC region have so far been slow to adopt the WHO recommendations. National strategies and policies for preventing NCDs and addressing overweight and obesity are in place in seven out of 16 SADC Member States. Health related taxes are implemented in only four countries (South Africa, Comoros, Zambia and Zimbabwe), and in all of these at a lower than recommended level (below 20%). Interpretive front-of-pack nutrition labelling (FOPNL) regulations are currently in draft form in South Africa only. Meanwhile, regulations to control the marketing of unhealthy foods and beverages are in place only in Botswana and South Africa, and even there fall short of the comprehensive standards recommended by WHO and UNICEF.

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8 SADC Member States must act now to prevent the rising tide of childhood overweight and obesity to safeguard the health and wellbeing of children and societies, and to protect regional economic development.

SADC Member State governments, partners and stakeholders must urgently develop country level roadmaps for the implementation of the SADC obesity strategy. Central to these should be the set of evidence-based, high impact policy-level interventions recommended by WHO (Box 1) to complement social and behaviour change strategies.

Effective regulation of the food environment necessitates mandatory measures, robust engagement across diverse sectors, and anticipation and mitigation of potential industry interference. Governments must establish conflict of interest mechanisms to remove 'Big Food' from the policy-making table, ensuring consultation without collaboration. These measures are essential for all SADC Member States, even where childhood overweight and obesity levels are still low, as critical prevention measures. Member states will also need to strengthen system capacities for a sustained, effective response, enhance data collection and monitoring, promote knowledge sharing and innovation, and advocate for ongoing communication and engagement.

Given the common challenges across SADC countries — socioeconomic fragility, a large and growing youth population, high undernutrition and anaemia rates, and aggressive marketing of unhealthy foods — a unified approach to addressing overweight and obesity is crucial. The SADC Strategy on the Prevention of Obesity represents a vital coordinated response to this pressing health issue. We call on governments and stakeholders across SADC Member States to use this strategy as an opportunity to galvanize a coordinated response to halt the rise of this critical problem.

BOX 1: A set of policy-level interventions recommended by WHO to address unhealthy food environments of children.

1. **Restriction on the marketing** of foods and non-alcoholic beverages to children.
2. **Front-of-pack labelling** that identify foods high in salt, sugar and fats.
3. **Health-related fiscal policies**, including taxes on unhealthy foods and subsidies on healthy food products.
4. **Policies and standards for improve food and physical activity environments** in preschools, primary and secondary schools, including regulating the sale and marketing of unhealthy foods and beverages in and around schools.
5. **Reformulation of processed foods** including portion sizes.

The Time to Act is Now!

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Endnotes

1 Landscape review of overweight and obesity in the SADC Region. Gaborone, Botswana, 2023: SADC.

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13 Brero et al. Investment case for the prevention and reduction of childhood and adolescent overweight and obesity in Mexico. Obesity Reviews. 2023; 24(9):e13595.

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