KINGDOM OF ESWATINI

MINISTRY OF HEALTH

ESWATINI NATIONAL ACCELERATION PLAN TO STOP OBESITY

Eswatini Roadmap

2025-2030

World Health Organization

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NON COMMUNICABLE DISEASE DEPARTMENT

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FOREWORD

The escalating prevalence of overweight and obesity has become a critical public health challenge globally, affecting individuals across all ages, genders, and socioeconomic backgrounds. The World Health Organization (WHO) reports that global obesity rates have nearly tripled since 1975, with over 1.9 billion adults classified as overweight and 650 million as obese in 2022.

The health consequences of overweight and obesity are profound, contributing to the increasing burden of non-communicable diseases (NCDs) such as type 2 diabetes, cardiovascular diseases, hypertension, and certain cancers. Economically, the global cost of obesity is estimated at $2 trillion annually, placing a significant strain on healthcare systems and productivity losses. If these trends continue, it's projected that by 2028, over 2.2 billion adults will be overweight, and more than 750 million will be obese. The economic costs of obesity-related diseases could exceed $3 trillion annually. These projections underscore the urgent need for comprehensive strategies to address the root causes of overweight and obesity and mitigate their impact on individuals, communities, and economies.

Eswatini is also experiencing this rising tide of obesity. According to the Eswatini STEPS report, the prevalence of obesity among adults aged 18–69 years increased from 22.9% in 2014 to 24.7% in 2024. Obesity increases the risk of NCDs, which account for roughly 31% of all deaths in the region (WHO). The social and economic costs of obesity in Eswatini are substantial, including increased healthcare costs, reduced productivity, stigma and discrimination, reduced life expectancy, and diminished quality of life.

This roadmap outlines a comprehensive, multi-faceted approach to address the challenge of overweight and obesity in Eswatini. It acknowledges the complex interplay of factors driving obesity, including globalization and urbanization, unhealthy diets, food supply issues, and physical inactivity. It also details current initiatives in Eswatini, such as the National Multisectoral Nutrition Action Plan (2015-2020), healthy food initiatives, promotion of physical activity (Shukuma Eswatini), NCD strategies, education campaigns, school feeding programs, and the Neighbourhood Care Point (NCP) Strategy (2023-2028).

The roadmap sets forth a clear goal: to reduce the prevalence of overweight among the population from 27.4% in 2023 to 19.2% by 2030. It outlines specific targets for reducing overweight among children, adolescents, and adults, and details objectives focused on increasing the consumption of healthy foods and drinks, increasing physical activity, and introducing policies and taxation of sugar-sweetened beverages (SSBs). By addressing the root causes of obesity and implementing evidence-based interventions, Eswatini can work towards a healthier future for its population.

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We acknowledge the invaluable contributions of the Ministry of Health, including the Noncommunicable Diseases (NCD) Unit, the School Health Unit, and the Health Promotion Unit. Their technical guidance and commitment to addressing obesity as a public health priority have been instrumental in shaping this strategy.

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We sincerely thank all stakeholders, researchers, and policymakers who participated in consultations and provided valuable input to ensure a comprehensive and effective approach to obesity prevention in Eswatini.

The following professionals and country teams are appreciated for their input and review:

***Table 1**: List of Eswatini Roadmap technical team*

Name	Organization	Name	Organization
Ntombifuthi Ginindza	NCDIMH; MoH	Bongani Mdluli	Nutrition Council
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Lisa-Rufaro Marowa	CHAI	Dr Njeri Nyanja	NCDIMH; MoH
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Nonhlanhla Dlamini	Mangweni clinic	Melusi Kunene	WFP
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Thelma Fakudze	Lobamba clinic	Chiara Pierotti	UNICEF

ACRONYMS

***Table 2**: List of acronyms*

BMI	Body Mass Index
CHW	Community Health Worker
CMIS	Client Management Information System
CVDs	Cardiovascular Diseases
DALYs	Disability Adjusted Life Years
FBDGs	Food Based Dietary Guidelines
FOPL	Front Of Pack Labelling
HCW	Health Care Worker
M&E	Monitoring and Evaluation
NCP	Neighbourhood Care Point
OPD	Out-Patient Department
NCD	Non-Communicable Diseases
SBCC	Social Behaviour Change Communication
SSBs	Sugar Sweetened Beverages
SDGs	Sustainable Developmental Goals

EXECUTIVE SUMMARY

Obesity has emerged as one of the fastest-growing public health threats in Eswatini, contributing significantly to non-communicable diseases (NCDs) such as diabetes, hypertension, , and certain cancers. Current national data indicate a rising prevalence of overweight and obesity among the age group of 18 to 69 at 51.6% and 24.7 respectively (STEPS 2024). This trajectory poses a major challenge to the country's health system, economic productivity, and overall quality of life.

The Stop Obesity Acceleration Plan provides a comprehensive, multi-sectoral framework to halt and reverse the growing burden of obesity in Eswatini. Anchored in the National NCD Strategy and aligned with WHO's Global Action Plan on NCDs, the plan outlines evidence-based interventions targeting prevention, early detection, and supportive policy environments.

The Eswatini Plan is not only a health priority but also a socio-economic imperative. By tackling obesity, the country will reduce NCD-related health costs, enhance workforce productivity, and secure a healthier future for the next generation. Strong political commitment, coordinated partnerships, and active community participation will be the cornerstone of successful implementation.

CHAPTER 1: INTRODUCTION

1.1 Background

Obesity is a complex, multifactorial, chronic disease characterized by abnormal or excessive fat accumulation that presents a risk to health. Obesity and overweight are escalating problems globally, with epidemiological studies confirming that increased weight is associated with increased risk of death from all causes, most notably noncommunicable diseases. Its prevalence is rising globally, posing a significant challenge to public health systems worldwide. The consequences of obesity are far-reaching, increasing the risk of a range of non-communicable diseases (NCDs), including type 2 diabetes, cardiovascular diseases, hypertension, stroke, and certain cancers. These NCDs not only diminish the quality of life for affected individuals but also place a substantial burden on healthcare systems and hinder socioeconomic development.

Eswatini, like many nations, is experiencing a nutrition transition marked by shifts in dietary patterns and lifestyle behaviours. There is an increasing consumption of energy-dense, nutrient-poor foods, coupled with declining levels of physical activity. This transition, driven by factors such as urbanization, economic development, and globalization of food markets, has contributed to a growing prevalence of overweight and obesity across all age groups. The rise in obesity rates in Eswatini mirrors the trends observed in many countries in the African region and globally. Data indicates that Eswatini faces a significant challenge with increasing rates of overweight and obesity, particularly among women. This escalating prevalence not only poses serious health risks to individuals but also threatens to strain the nation's healthcare system and impede economic progress.

The impact of obesity extends beyond individual health. The associated NCDs place a significant strain on Eswatini's healthcare resources, diverting funds from other essential health programs. Furthermore, obesity can reduce productivity, increase absenteeism, and lower overall economic output, hindering the nation's development goals. Addressing the obesity epidemic is, therefore, a critical priority for Eswatini to safeguard the health of its population and ensure sustainable development.

1.2 Rationale for the Acceleration Plan

The Government of Eswatini recognizes the escalating threat of obesity and its profound impact on the health and well-being of its citizens, as well as its potential to undermine national development. This recognition has led to the development of this Eswatini Acceleration Plan to Stop Obesity as support by WHO. This plan represents a significant step towards a healthier future for all Eswatini residents. While efforts have been made to address various aspects of nutrition and related health issues, this Plan is the *first* comprehensive, multi-sectoral strategy specifically targeting the prevention and control of obesity in Eswatini.

The development of this Acceleration Plan is driven by several key factors:

- **The Growing Burden of Obesity:** The prevalence of overweight and obesity in Eswatini has reached alarming levels, demanding urgent and concerted action.
- **The Link to NCDs:** Obesity is a major risk factor for a range of NCDs, which are a leading cause of morbidity and mortality in Eswatini.
- **The Need for a Multi-Sectoral Response:** Addressing obesity requires a coordinated effort involving various sectors, including health, education, agriculture, trade, and urban planning.
- **Socioeconomic Impact:** The economic consequences of obesity, including increased healthcare costs and reduced productivity, necessitate a strategic and proactive approach.
- **Global Commitments:** Eswatini is committed to achieving global targets related to NCDs and sustainable development, which include addressing the obesity epidemic.

This Acceleration Plan provides a framework for a coordinated and comprehensive response to the obesity epidemic in Eswatini. It outlines evidence-based strategies and interventions aimed at creating an environment that promotes healthy eating and physical activity, and ultimately, reduces the prevalence of overweight and obesity across all age groups.

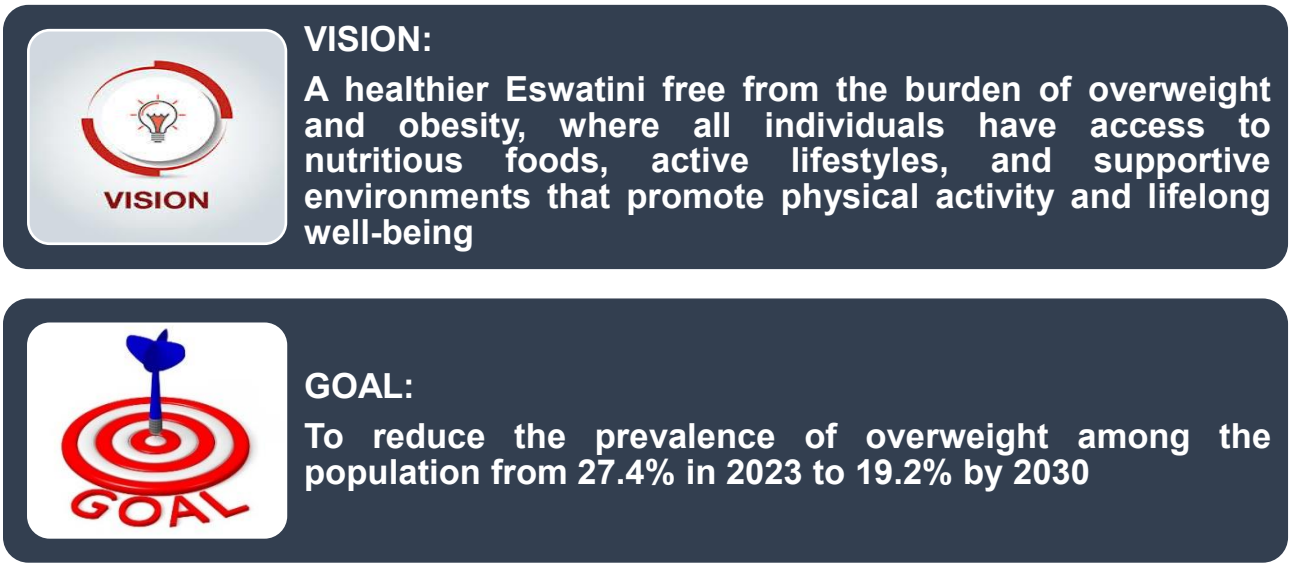
1.3 Guiding Principles

The development and implementation of this Acceleration Plan are guided by the following principles:

- **Health in All Policies:** Recognizing that health is influenced by a wide range of factors beyond the health sector, this plan promotes a "Health in All Policies" approach, ensuring that health considerations are integrated into decision-making across all sectors.
- **Multi-Sectoral Action:** Addressing obesity requires a coordinated effort involving government agencies, civil society organizations, the private sector, and communities.
- **Evidence-Based Interventions:** The strategies and interventions outlined in this plan are based on the best available scientific evidence and tailored to the local context of Eswatini.
- **Equity and Social Justice:** This plan prioritizes equity and social justice, aiming to reduce disparities in obesity prevalence across different population groups.
- **Sustainability:** The interventions proposed in this plan are designed to be sustainable in the long term, ensuring lasting impact.
- **Community Participation:** Engaging communities in the planning, implementation, and monitoring of interventions is crucial for their success and sustainability.
- **Life-Course Approach:** This plan recognizes that obesity can develop at any stage of life and adopts a life-course approach, addressing risk factors from early childhood through adulthood.

1.4 Vision, Goal, Objectives, and Targets

***Figure 1**: Goal and objectives to reduce obesity*



1.5 Strategy Approach

This Acceleration Plan adopts the WHO and SADAC strategy to stop Obesity comprehensive, multi-sectoral approach to address the complex issue of obesity. It recognizes that obesity is not solely an individual responsibility but is also shaped by the social, economic, and environmental contexts in which people live. Therefore, the plan emphasizes interventions that target multiple levels, including:

a) **Individual-level interventions:** Promoting healthy eating habits and physical activity through education, counselling, and behaviour change communication.

b) **Community-level interventions:** Creating supportive environments in schools, workplaces, and communities that make healthy choices easier.

c) **Policy-level interventions:** Implementing policies that promote healthy food systems, increase access to affordable healthy foods, and create environments that support physical activity.

The plan prioritizes preventive measures, aiming to address the root causes of obesity and prevent its development. It also includes strategies for the early detection and management of overweight and obesity in individuals who are already affected.

1.6 Structure of the Document

This Acceleration Plan is organized into five chapters, as follows:

a) **Chapter 1: Introduction:** Provides an overview of the obesity epidemic in Eswatini, the rationale for the plan, the guiding principles, and the overall goal and objectives.

b) **Chapter 2: Country Profile:** Presents a detailed profile of Eswatini, including its demographic, socioeconomic, and health context, with a specific focus on the prevalence of overweight and obesity and its associated risk factors.

c) **Chapter 3: Implementation Framework (Theory of Change):** Outlines the strategic priorities, interventions, and activities that will be implemented to achieve the plan's objectives. It also presents a Theory of Change, illustrating the causal pathways through which the interventions are expected to lead to the desired outcomes.

d) **Chapter 4: Monitoring and Evaluation Framework:** Describes the system for monitoring the implementation of the plan, evaluating its impact, and ensuring accountability. It includes a set of indicators, data sources, and evaluation methods.

e) **Chapter 5: Implementation Arrangements:** Details the roles and responsibilities of various stakeholders in the implementation of the plan, as well as the coordination mechanisms, resource mobilization strategies, and governance structure.

CHAPTER 2: COUNTRY PROFILE

2.1 Non- communicable disease burden

Overweight and obesity can significantly affect a person's life, impacting their overall health and well-being, including mental health as well as their social and economic prospects. The heightened risk of non-communicable diseases (NCDs) such as type 2 diabetes, cardiovascular diseases, and any various types of cancer, is a notable consequence of overweight and obesity. Non-communicable diseases continue to be an important public health problem globally, responsible for 41 million deaths each year, an equivalent of 71% of all deaths globally. Modifiable behaviour, such as tobacco use, sedentary lifestyle, unhealthy diet, and the harmful use of alcohol, all increase the risk of NCDs.

NCDs are among the top ten causes of out-patient visits in Eswatini. Key drivers of diabetes and hypertension include diets high in salt, trans-fat and low in fruits and vegetables, overweight and obesity, and physical inactivity. Consumption of fruits and vegetables is low, with 92% men and 91.7% women reporting to not regularly consume fruits and vegetables also a 15.3% of adults fail to meet the Global Recommendations on Physical Activity for Health amongst the 15-69 years age group. The Ministry of Health developed the NCD Communication Strategy (2022-2023) to address NCD risk factor prevention, stressing diets low in trans-fat and sugar and high in fruits and vegetables.

2.1.1 Drivers of Obesity in Eswatini

The rise in obesity in Eswatini is driven by a complex web of interrelated social, economic, environmental, and behavioural factors. Rapid urbanization and shifts in dietary patterns have led to increased consumption of processed foods high in sugar, salt, and unhealthy fats. Traditional diets rich in whole grains and vegetables are increasingly being replaced by energy-dense, nutrient-poor alternatives.

Physical inactivity has also become widespread, particularly in urban settings where sedentary lifestyles are more common due to motorized transport, office-based jobs, and limited recreational infrastructure. Children and adolescents spend more time on screen-based entertainment and less on physical play, especially in schools where physical education is not prioritized.

Socioeconomic factors such as poverty, food insecurity, and limited access to healthy food contribute to poor dietary choices. Additionally, cultural norms and perceptions linking body size with beauty or wealth may discourage weight control efforts. Weak regulatory frameworks on food marketing and labelling, and the limited integration of obesity services in the health system, further compound the problem.
Addressing these drivers requires a multisectoral, life-course approach that targets the root causes of obesity through coordinated action across health, education, agriculture, urban planning, and the private sector.

***Figure 2**: Common drivers of obesity*

2.2 Prevalence and burden of Overweight and Obesity

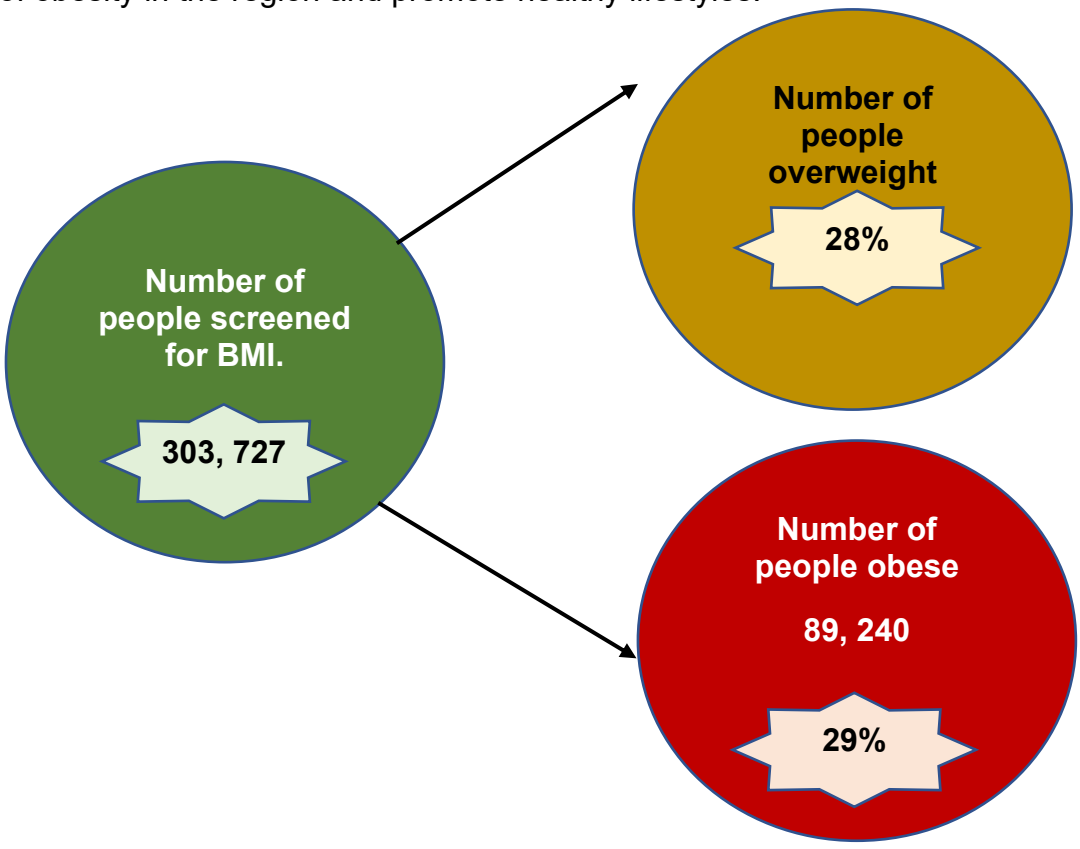
According to a 2016 report by the World Health Organization (WHO), the prevalence of obesity in Eswatini was estimated to be 16.5% in adults aged 18 years and above. Obesity is more prevalent in women, with 20.4% prevalence rate, compared to men at 12.4%. The 2023 SADC landscape analysis on overweight and obesity (4) also reveals that Eswatini is among the 16 countries in the SADC region that are affected by overweight and obesity, with variants in adult prevalence of 55% in South Africa, Botswana (45%), Namibia (42%), Lesotho (40%), Eswatini (39%), Zimbabwe (39%), and Seychelles (38%). The Eswatini 2024 STEP survey report further reveals a prevalence of 38.2% among adults. Overall, the obesity rates in Eswatini have been increasing steadily over the years, contributing to the burden of non-communicable diseases in the country.

Countries with high prevalence of Overweight and obesity in children and adolescents (aged 5-19) are South Africa (30%), Seychelles (25%), Botswana (20%), Eswatini (20%), Namibia (19%) and Lesotho (19%) according to the SADAC landscape analysis of 2023.

***Table 3**: Prevalence of overweight and obesity among adults, children and adolescents aged 5-19 years in SADC countries in 2019.*

	Adult (%)	Children and Adolescents aged 5- 19 yrs (%)	Children 0-4yrs (%)
South Africa	55	25	12.1
Botswana	45	18	10.1
Namibia	42	15	5.3
Lesotho	40	15	6.9
Eswatini	39	17	7.9
Zimbabwe	39	15	2.7
Seychelles	38	23	9.1

According to World Population Reviews, Eswatini is one of the countries with high prevalence of obesity although lower_compared to other sub-Saharan countries such as Ghana (21.5%), South Africa (28.3%) and Seychelles (29.7%). However, it is important to note that the prevalence in sub-Saharan Africa is generally lower compared to other regions such as North America and Europe. Nonetheless, efforts should still be made to combat the rise of obesity in the region and promote healthy lifestyles.



Source: CMIS-Daily morbidity, 2023

***Figure 3**: Proportion of NCD clients who are overweight and obese, 2023*

2.3 Impact of overweight and Obesity

Unhealthy weight gain starts early and increases with age. Children with overweight and obesity face various health problems and are at higher risk of obesity in adulthood. Targeted prevention actions at critical points over the life course-during pregnancy, the early years, adolescence-can help to reduce the risk of childhood and subsequent adult obesity. This is pivotal to avoid the high costs of treating obesity related illness that place a significant financial burden on individuals, families, and healthcare systems. The economic costs associated with overweight and obesity were estimated to be USD1.96 trillion globally in 2020, with a predicted increase to USD4 trillion in 2035 (World Obesity Federation Global Obesity Observatory, 2024)

The high prevalence of obesity in Eswatini, along with other sub-Saharan African countries, is linked to several health issues and is considered a leading cause of mortality and disability in the region. Firstly, obesity increases the risk of non-communicable diseases (NCDs) such as type 2 diabetes, hypertension, and cardiovascular diseases. These diseases are known to be major causes of mortality and disability in Eswatini and sub-Saharan Africa as a whole. According to the World Health Organization (WHO), NCDs account for roughly 31% of all deaths in the region. Secondly, obesity is linked to musculoskeletal disorders, particularly osteoarthritis, which can lead to chronic pain and disability. Thirdly, obesity is associated with an increased risk of some cancers such as breast and colon cancer, which are also leading causes of death in the region, additionally, obesity can diminish workforce productivity and increase absenteeism, exerting additional adverse effects on economic growth.

Obesity is a disease and a major risk factor for diabetes, respiratory diseases such as asthma, cardiovascular diseases such as hypertension, stroke, and coronary artery diseases. According to Eswatini STEPS 2024, hypertension was 21.7% and diabetes was at 3.8%. Furthermore, the cardiovascular risk among the age group 40-69 years with a 10-year CVD risk ≥ 30%, or with existing CVD was 14.1% in both sexes.

Therefore, the high prevalence of obesity can exacerbate the health burden in Eswatini and contribute to the leading causes of mortality and disability in the region. It underscores the importance of promoting healthy lifestyles and implementing policies to prevent and manage obesity and other NCDs in the country.

Obesity is not only a burden on the health of individuals but also has significant social and economic costs in Eswatini. Here are some examples:

a) **Increased healthcare costs:** Obese individuals are more likely to suffer from chronic diseases such as hypertension, diabetes, and heart disease, leading to increased healthcare costs as these conditions require regular and specialised medical care.
b) **Reduced productivity**: Obesity can result in reduced productivity due to increased absenteeism, decreased work capacity, and increased sick days. This, in turn, can negatively affect the economy of the country.
c) **Stigma and discrimination:** Weight bias and discrimination can result in social exclusion and job discrimination, limiting opportunities for people who are living with obesity.

d) **Reduced life expectancy:** Obesity reduces life expectancy and can lead to premature death, resulting in a significant loss of potential for individuals and the economy.
e) **Reduced quality of life:** Obesity can lead to reduced quality of life, as individuals may experience negative psychological effects such as depression, anxiety, and low self-esteem.

Therefore, addressing obesity in Eswatini should be a priority for policymakers to improve health outcomes, reduce healthcare costs, increase productivity, and promote social inclusion and well-being.

2.4 Current initiatives

Eswatini has taken some initiatives to reduce obesity in recent years as illustrated in table 4 below. While these initiatives are a positive start, there is still more that needs to be done to address the high rates of obesity in the country. For example, the government could consider more comprehensive policies that address the underlying social and economic determinants of obesity, increase access to healthy food options and recreational facilities, and prioritize health education in schools and communities. Below is a table detailing the problem statement and major contributors of Obesity in Eswatini

***Table 3**: Initiatives to reduce obesity*

Initiative/Policy	Target group	Success/ Enablers	Challenges
National Multisectoral Nutrition Action Plan (2015-2020)	Children, adolescents, and adults (across the lifespan)	It was launched in 2015 and some activities were implemented based on it: • Maternal Nutrition • Integrated Management of Acute Malnutrition • Infant and Young Children Feeding • Growth Monitoring • Integrated Community Based Growth Monitoring and Promotion • Baby friendly hospital initiatives • Nutrition Education and Promotion	• The action plan needs updating • Poor integration of the action plan with other sectoral programmes • No policy to support the implementation (Nutrition Policy still in draft) • No existence of nutrition program (nutrition council plays dual roles)
Initiative/Policy	**Target group**	**Success/ Enablers**	**Challenges**
NCD Strategy	Overall population	• The existence of the current NCD strategy 2024-2028 • It has a clear target for overweight and obesity • Aligned to National Health Sector Strategic Plan 2024 – 2028	• Limited resources for the prevention and management of NCD

Initiative/Policy	Target group	Success/ Enablers	Challenges
Education campaigns	Overall population	• Health radio programmes • Know Your Numbers campaign • Walk the talk campaign • health facility-based trainings • Community and clinic health days • Use of Community Health Volunteers on information dissemination on NCD	• Lack of consistency in the information dissemination • Lack of funding to sustain education campaigns
School Feeding Programme	School going children	• Promotion of school vegetable gardens • Ongoing school feeding programme supported by government for sustainability • Availability of Nutrition Inspectors	• Constrained fiscal budget by government which has resulted to untimely food supply • Lack of nutritional adequacy in schools' meals
Neighbourhood Care Point (NCP) Strategy (2023 - 2028)	Children and adolescents	• Provides meals to orphaned and vulnerable children in communities • NCP in custodianship of the Deputy Prime Minister's Office (DPMO) for sustainability • Availability of support from NGOs	• Lack of sustainability since they are mainly funded by NGOs • Lack of nutrition adequacy in NCP meals

2.5 SWOT Analysis

The following table summarises the strengths, weaknesses, opportunities, and threats to stop obesity in Eswatini.

***Table 4**: SWOT Analysis*

Strengths	Weaknesses
• Health policies that include obesity prevention • NCD Strategy that includes risk factors including physical activity and overweight and obesity • School feeding program which focuses on nutrition among school going children • Inclusion of nutrition assessments in the electronic system and screening module (CMIS) • Promotion of physical activity (Shukuma Eswatini) • Know your numbers of campaigns • Education campaigns and media slots • NCP Strategy clearly stipulates the roles of all players and stakeholders. • Nutrition component with the school health program which focuses on nutrition education and risk factors • Existing micronutrient supplementation for under 5s	• Poor multisectoral collaboration among ministries and stakeholders • Limited resources
Opportunities	**Threats**
• Tax on sugary drinks • STEP survey 2024 report • Integration with services from other ministries & stakeholders • NCD prevention in school curriculum (primary, secondary & tertiary) • Availability of life skills education in schools to integrate the NCDs education • Existing social responsibility from corporate companies • Availability of regional development team (RDT) and regional education officers standing meetings	• Constrained government funding • Outbreaks/epidemics that competes with funding and implementation of obesity reduction initiatives • Cultural norms that support overweight and obesity

CHAPTER 3: STRATEGIC PLAN FRAMEWORK

3.1 Vision

A healthier Eswatini free from the burden of overweight and obesity, where all individuals have access to nutritious foods, active lifestyles, and supportive environments that promote physical activity and lifelong well-being

3.2 Goal

To reduce the prevalence of overweight among the population from 27.4% in 2023 to 19.2% by 2030[1]

Specific Targets

a) To reduce the prevalence of overweight among children (0-9) from 7.6% to 5.9% by 2030
b) To reduce the prevalence of overweight among adolescents (10-19) from 20.6% to 17.9% by 2030
c) To reduce the prevalence of overweight among adults (20 and above) from 5.3% to 30.8% by 2030

3.3 Objectives

Eswatini will reduce the prevalence of overweight and obesity among children, adolescents, and adults from 27.4% in 2023 to 19.2% by 2030 by addressing the following objectives:

Objective 1: To increase the consumption of healthy foods and healthy drinks through the life course by 2030

Objective 2: To increase physical activity of school going children, adolescent and adults'

- Objective 2a**:** Reduce the prevalence of insufficient physical activity amongst children, adolescents, and adults
- Objective 2b**:** Reduce the prevalence of adults undertaking no physical activity

Objective 3: To introduce policies and taxation of Sweetened and Sugar Beverages (SSB).

[1] Source: GHO data

3.4 Theory of Change

The main principle for a theory of change is to outline the specific components or activities of the solution(s), with their intended influence on improving outcomes in the short, medium and long term to achieve the desired impact.

The table below provides the theory of change for the three objectives.

***Table 5**: Theory of Change*

GOAL: To reduce the prevalence of overweight and obesity among children, adolescents, and adults from 27.4% to 19.2% by 2030					
OBJECTIVE 1: To increase the consumption of healthy food and drinks over the life course by 2030					
Solutions	**Input**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
Policies over the life course (FBDGs, Food procurement and marketing of unhealthy food)					
Finalise FBDGs to inform communication campaign (healthy diets)	Conference package	Food-Based Dietary Guidelines (FBDGs) developed for Eswatini	Increased awareness and enhanced knowledge on healthy diets across [all age groups]	Increased number of schools, prisons, hospitals, neighbourhood care points and households providing healthy diets	Increased consumption of healthy foods Increased number of people achieving normal/healthy BMI
Disseminate the FBDGs to stakeholders (i.e., HCWs, community leaders, schools, pharmacists, health facilities	Conference package, printing	FBDGs disseminated to relevant stakeholders			
Update the education curriculum with FBDGs and nutrition action and management of obesity	Conference package	National education curriculum updated with FBDGs and nutrition action and management of Obesity Increased number of schools /education institutions with curriculum updated with FBDGs and nutrition action and management of Obesity			

GOAL: To reduce the prevalence of overweight and obesity among children, adolescents, and adults from 27.4% to 19.2% by 2030					
OBJECTIVE 1: To increase the consumption of healthy food and drinks over the life course by 2030					
Solutions	**Input**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
Adapt the WHO Procurement framework of healthy diets to Eswatini's context (schools, prisons, hospitals, elderly homes, neighbourhood care points)	Conference package	Availability of standards and regulations for healthy food	Number of staff in schools, prisons, public setting etc, knowledgeable (having received training) on Procurement framework of healthy diets	Increased number of outlets providing healthy diets	
Update of public food procurement standards and regulations	Conference package	Government procurement policy amended/adjusted	Reduced advertising, promotion & sponsorship of unhealthy foods by the food and beverages industry	Increased number of people eating healthy diets from public institutions and schools	
Develop nutrient profile model for marketing and advertising of unhealthy foods including unhealthy baby complementary foods and non-alcoholic beverages including code of marketing for breast milk substitute (adaptation of AFRO model)	Conference package	Nutrient Profile model developed		Decreased sales of unhealthy food, non-alcoholic beverages and breast milk substitute	
Develop & endorse standard and regulation/policy on the marketing and advertising of unhealthy foods	Conference package	Policy developed and endorsed			

GOAL: To reduce the prevalence of overweight and obesity among children, adolescents, and adults from 27.4% to 19.2% by 2030					
OBJECTIVE 1: To increase the consumption of healthy food and drinks over the life course by 2030					
Solutions	**Input**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
and non-alcoholic beverages and code of marketing for breast milk substitute					
Enforce the regulation of marketing and advertising of unhealthy foods and non-alcoholic beverages	Human resources for coordination and facilitation	Food marketing and advertising of unhealthy food included in the food regulatory system (Eswatini Bureau of Standards)		Decreased sale of healthy food and non-alcoholic beverages	
Children & Breast-feeding mothers (Breastfeeding)					
Roll out a baby friendly initiative (criteria) into maternity wards and health facilities	Trainings, Guidelines, IEC materials	increased number of baby friendly maternity wards at select hospital and health facilities (12)	Increased adherence to exclusive breastfeeding practices by lactating mothers	Increase in children being exclusively breastfed for the first six months	Reduced obesity in exclusively breastfed infants
Establish peer support groups at health facilities - 'piggyback' on existing peer support group (create awareness on breastfeeding etc) Institutionalise BFHI	Conference package (trainings), Human resource	Peer support groups established at clinics (329)			
Enforce existing laws on workplace maternity protection act to apply across private and public sector and integrate into	Human resources for coordination and facilitation	Enforced maternity protection act on workplace policies	Increased number of workplaces instituting allocated time for maternity leave, breastfeeding breaks, designated space and safe storage		

GOAL: To reduce the prevalence of overweight and obesity among children, adolescents, and adults from 27.4% to 19.2% by 2030					
OBJECTIVE 1: To increase the consumption of healthy food and drinks over the life course by 2030					
Solutions	**Input**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
[Employment Act]			for expressed breast milk, Adoption of the workplace regulations by private and public organisations (Mechanism: A system will be put in place- Ministry of Labour)		

OBJECTIVE 2: To increase physical activity of school going children, adolescents, and adults'					
Solutions	**Inputs**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
School going children					
Develop and disseminate national physical activity guidelines (adapting WHO global guidelines)	Conference package, printing	Physical activity guidelines for all ages developed Disseminate guidelines to all educational institutions and communities through relevant structures	Increased number of physical education/sports teachers trained on guidelines Increased provision of physical activity programmes and actions in schools providing opportunities for Children in and out of school	Increased number of school going children physically active	Increased number of school going children with normal BMI
Train physical education/sports teachers on the updated guidelines	Conference package	Physical education/sports teachers trained on the updated guidelines			
Mandate physical activity education into the national education curriculum across all	Human resources for coordination and facilitation	Physical activity education incorporated in curriculum across all educational institutions	Increased number of schools that have incorporated in curriculum across all educational institutions		

OBJECTIVE 2: To increase physical activity of school going children, adolescents, and adults'					
Solutions	**Inputs**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
educational institutions					
Physical activity over the life course					
Incorporate physical activity and know your numbers screening into existing community-based campaigns plans	Conference package	physical activity and know your numbers screening incorporated into community-based Campaign plan	Increased knowledge on physical activity and 'know your numbers' screenings	Increased number of people engaging in physical activity	Increased number of people achieving normal/healthy BMI
Collaborate with RHMs and other community health workers to establish community physical activity groups and conduct community-physical activity campaigns (e.g. Shukuma)	Conference package	Community-based groups established	Number of physical activity community groups established	Increased number of people engaged in structured physical activities in the community	
Advocate for availability of spaces and infrastructure for physical activity with municipalities, workplaces, schools and other settings (Tinkhundla centres)	Advocacy meetings	Advocacy meetings held with municipalities, workplaces, schools and other settings on availability physical activity infrastructure	Number of spaces and infrastructure for physical activity with municipalities, workplaces, schools and other settings	Increased number of people engaging in physical activity	
Advocate with Ministries of Tinkhundla Administration and Development,	Advocacy meetings	New Development considerations on physical activity structures, walkable communities	Increased number of physical activity structures, walkable communities (zoning laws,		Increased number of people with normal BMI

OBJECTIVE 2: To increase physical activity of school going children, adolescents, and adults'					
Solutions	**Inputs**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
Housing and Urban Development and Public Works and Transport to ensure there are adequate structures to promote physical activity.		(zoning laws, bicycle lanes) by the Ministries	bicycle lanes, etc.)		
Encourage the utilisation of digital health intervention to promote physical activity	Advocacy meetings	Awareness creation sessions on the utilisation of digital health interventions conducted	Increased utilization of digital health tools	Increased number of people engaging in physical activity	

OBJECTIVE 3: Introduce policies and taxation of Sweetened and Sugar Beverages					
Solutions	**Inputs**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
Collaborate and obtain and analyse sales data on SSBs	Boardroom meeting	Data analysis report	Increased revenue generated from SSB tax Increased availability of less sugar and sweetened beverages	Decreased consumption of sugar and sweetened beverages	Decreased sale of sugar and sweetened beverages
Draft the SSB policy to guide on setting a minimum tax rate on all SSBs	Conference package	SSB policy drafted			
Endorse/ approve SSB policy		Parliament endorsed SSB policy			
Develop SSB regulation	Conference package	SSB law / regulation developed			
Enforce SSB law/ regulation (implementation of the policy)	Conference package	Enforced SSB law (to be decided after enactment of law)			

OBJECTIVE 3: Introduce policies and taxation of Sweetened and Sugar Beverages					
Solutions	**Inputs**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
Development of Obesity and NCD risk factor investment case	Conference package	Investment case developed	Increased Awareness and Advocacy	Increased Awareness and Advocacy	Policy Dialogue and Prioritization
Cross cutting Training and Communication solutions (All objectives)					
Train the ministry of education and the school health programme officers on updated educational curriculum with FBDGs and nutrition options for preventing obesity.	Conference package	Ministry of Education and school health officers trained	Linked to outcomes above	Linked to outcomes above	Linked to outcomes above
Train facility and community-based health care workers on infant and young child feeding practices (exclusive breastfeeding, safe weaning) and promotion of physical education.	Conference package	Facility and community health care workers trained on infant and young child feeding practices			
Train health professionals in essential nutrition action, prevention and management of obesity. AND On FBDGs	Conference package	Trained health professionals (on nutrition, prevention and management of obesity and FBDGs)			

OBJECTIVE 3: Introduce policies and taxation of Sweetened and Sugar Beverages					
Solutions	**Inputs**	**Outputs**	**Short Term Outcomes**	**Medium Term Outcome**	**Long Term outcome**
Develop SBCC and mass media plan on obesity prevention	Conference package	Campaign plan developed			
Roll out the SBCC and mass media campaigns for healthy diets and physical activity	Human resources for coordination and facilitation	SBCC and mass media campaigns conducted			
Create public awareness about the policy and regulation on SSBs	Human resources for coordination and facilitation	SSBs campaigns and media campaigns conducted	Linked to outcomes above	Linked to outcomes above	Linked to outcomes above

CHAPTER 4: MONITORING AND EVALUATION FRAMEWORK

4.1 Indicators, targets, and acceleration scenarios

In pursuit of Eswatini's goal to reduce the prevalence of overweight and obesity among children, adolescents, and adults from 27.4% (2023) to 19.2% by 2030, three targets have been set:

An acceleration scenario for the third target (prevalence of overweight among adults) has been developed to show the step change over time. The Acceleration scenario is a useful tool to gauge progress and to course correct when off target.

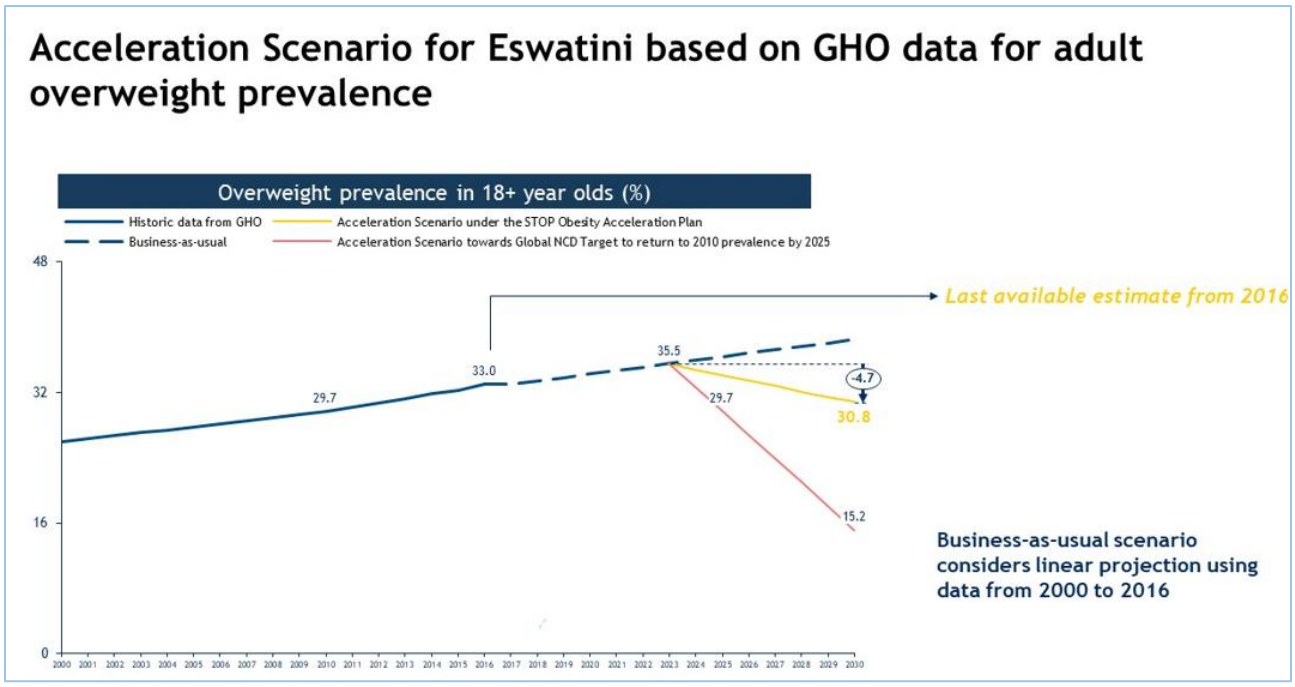


Figure 4: Acceleration scenario for Eswatini

Eswatini will also closely monitor the performance of the objective level indicators below to achieve the desired targets.

a) **Indicator 1:** Proportion of adults consuming an average of 5 servings of fruit and/or vegetables (2 servings of fruit and 3 servings of vegetables)
   - **Target:** Increase the consumption of fruit and vegetables among the population (children, adolescents, and adults) to an average of 5 servings per day from 8% to 20% by 2030
   -

b) **Indicator 2**: Proportion of exclusively breastfed infants for 6 months
   - **Target:** Increase the proportion of exclusively breastfed, for 6 months, infants from 63.8% to 70% by 2030

c) **Indicator 3:** Proportion of people engaging in physical activity for 150 minutes/week or 30 minutes/day for 5 days
   - **Target 1:** Reduce the prevalence of insufficient physical activity amongst children, adolescents, and adults from 46.9% to 31.9% by 2030
   - **Target 2:** Reduce the prevalence of adults undertaking no physical activity by at least 15% from the baseline by 2030

d) **Indicator 4:** Proportion of earmarked taxes on sweet and sugar beverages to NCD risk factors
   - **Target 1:** The government to increase sugar and sweetened beverages tax from 15% to 30% by 2030
   - **Target 2:** 15% of earmarked tax on Sugar and Sweetened Beverages (SSB) dedicated to NCD risk factors

e) **Indicator 5:** prevalence of overweight among children (0-9 years)
   - **Target 1:** reduced prevalence of overweight among children from 7.6% to 5.9% by 2030

f) **Indicator 6:** prevalence of overweight among adolescents (10-19 years) Target 1: reduced prevalence of overweight among adolescents from 20.6% to 17.9% by 2030

g) **Indicator 7:** prevalence of overweight among adults (>20 years)
   - Target 1: reduced prevalence of overweight among adults from 35.3% to 30.8% by 2030

The table below provides the full monitoring plan for the roadmap (output and outcome indicators)

***Table 6**: Monitoring plan*

MONITORING PLAN			
Outcome / Output	**Indicator**	**Target – where available**	**Data collection (Source, person responsible: where available)**
OBJECTIVE 1: To increase the consumption of healthy food and drinks over the life course by 2030			
Policies: over the life course (FBDGs, Food procurement, Marketing of unhealthy food)			
Output: FBDGs Finalised	FBGDs Finalised (yes/no)	August 2025	Source: Copy of FBDGs Responsible: Nutrition council
Output: FBDGs disseminated to relevant stakeholders	I) Number of stakeholders receiving FBDGs II) Number of printed FBDG packages	August 2025	Source: Distribution checklist Responsible: Nutrition council

MONITORING PLAN			
Outcome / Output	**Indicator**	**Target – where available**	**Data collection (Source, person responsible: where available)**
Output: National Curriculum updated with FBDGs and nutrition action & management of obesity	Existence of updated and approved National Curriculum	January 2026	Source: Copy of approved curriculum Responsible: NCDIMH, Ministry of Education
Short Term outcome: Increased number of public institutions and schools procuring healthy foods	Number of public schools/ hospitals/prisons compliant with procurement standards	January 2027	Source: Responsible: MoE, MoA, Ministry of Justice
Output: Availability of standards and regulations for healthy food	Standards and regulations for healthy food available	January 2027	Source: Copy of standards and regulations for healthy food Responsible: ESWASA, Nutrition Council
Output: Government procurement 'policy' amended/adjusted	Existence of government policy include standards and regulations for healthy food	January 2027	Source: Copy of amended/adjusted procurement policy Responsible: Ministry of Commerce, Justice
Short Term outcome: Reduced advertising, promotion, sponsorship of unhealthy foods (Billboards and media tracking are being done)	Proportion of children, adolescents and adults consuming unhealthy foods Proportion of children, adolescents and adults with a healthy BMI	January 2027	Source: CMIS, STEPS Responsible: MOH, Ministry of Commerce, Ministry of ICT
Medium Term outcome: Increased number of schools, prisons, hospitals, households, and neighbourhood care points providing healthy diets (related to the bulk procurement of food in public institutions)	Will be prioritised as Phase 2: Proportion of public institutions procuring and providing healthy food in line with FBDGs	January 2026	Source: assessments reports Responsible: MoH
Output: Nutrient profile model developed	Nutrient profile model available	March 2025	Source: Copy of Nutrient profile model Responsible: MoH, Nutrition Council

MONITORING PLAN			
Outcome / Output	**Indicator**	**Target – where available**	**Data collection (Source, person responsible: where available)**
Output: Policy developed on marketing of unhealthy foods and non-alcoholic beverages	Policy developed	January 2028	Source: Copy of marketing of healthy food and non-alcoholic beverages policy Responsible: MoH
Output: Food marketing regulation enacted	Availability of updated policy on marketing of unhealthy foods and non-alcoholic beverages within Eswatini Standards Authority	January 2027	Source: Food marketing regulation Responsible: MoH, ESWASA
Medium Term outcome: Decreased sales of unhealthy foods - all settings (following market restrictions)	Will be prioritised as Phase 2: Percentage of sales of unhealthy foods	January 2028	Source: Customs and excise sales report Responsible: Ministry of Commerce
Long Term outcome: Increased consumption of healthy foods (fruits & vegetables)	Proportion of adults consuming 2 servings of fruits and 3 servings of vegetables per day As a second phase: Eswatini to consider different data sources to measure different food types being consumed, sugar intake. More indicators to then be added	Target: 20% Baseline: 8%	Source: STEPS/ Dietary intake survey/household surveys. Consider UNICEF survey) Responsible: MoH
Long Term outcome: Increased number of people achieving normal/healthy BMI	Percentage of people with normal BMI between 18.5 and 24.9 (adults) Percentage of children and Adolescents (5-19) with Z-scores Children: BMI scores	Targets 19.2% Baseline: 27.4%	Source for adults: STEPS Source for adolescents: MICS Source for children: School Health Assessment tool – Services data tools Responsible: MoH

MONITORING PLAN			
Outcome / Output	**Indicator**	**Target – where available**	**Data collection (Source, person responsible: where available)**
Children and Breastfeeding-mothers			
Short Term outcome: Increased adherence to exclusive breastfeeding practices by lactating mothers	Percentage of mothers that have received counselling on breastfeeding practices	Target: 75% Baseline: 68%	Source: Routine data Assessments reports (MICS, VAC,) Responsible: Nutrition Council, MoH
Short Term outcome: Increased number of workplaces instituting allocated time for breastfeeding breaks	Percentage of workplaces instituting a breastfeeding hour	Target: 25% of workplaces implementing a breastfeeding hour policy Baseline: 0%	Responsible: Nutrition Council
Medium Term outcome: Increase in children being exclusively breastfed for the first six months	Percentage of infants 0–5 months of age who were fed exclusively with breast milk during the previous day.	Target: 70% Baseline: 63.8%	Source: MICS
Long Term outcome: Reduced obesity in exclusively breastfed infants	Weight and height measurement of infants under 5. More investigation of existing data is needed (work on this is underway)		Routine monitoring data from health facilities (CMIS)
Output: Baby friendly maternity wards at select hospital and health centres	Proportion of hospitals, health centres with baby friendly maternity wards	Target: 100% of facilities offering maternity service being baby-friendly Baseline: 0%	Responsible: SARA
Output: 329 Peer support groups for breastfeeding mothers in communities	Number of peer support groups for breastfeeding mothers in communities		Community RHM report
Output: Standardised workplace breastfeeding policy	Standardised workplace policy (yes/no)	January 2027	Copy of standardised workplace policy
Output: Amended Employment Act promulgated, and breastfeeding regulations developed	i)Promulgated Employment Act (yes/no) ii) Breastfeeding guidelines developed (yes/no)	January 2027	Copy of promulgated employment Act Copy of guidelines
Output: Workplaces adopting the regulations into own policy	Number of workplaces adopting regulations into own policy	January 2027	Tool: Nutrition Council report

MONITORING PLAN			
Outcome / Output	**Indicator**	**Target – where available**	**Data collection (Source, person responsible: where available)**
Output: Trained facilities and community-based health care workers on exclusive breastfeeding and safe weaning	Number of trained facilities and community-based health care workers on exclusive breastfeeding and safe weaning	Target: 80% of facility health care workers 70% of community-based health care workers Baseline: 0%	Training report

MONITORING PLAN			
Outcome / Output	**Indicator (Include baseline)**	**Target – where available**	**Data collection (Source, person responsible: where available)**
OBJECTIVE 2: To increase physical activity of school going children, adolescent and adults' and reduce their sedentary behaviour and enact policies by 2030 by creating an enabling policy environment			
School going children			
Medium Term outcome: School going children are more physically active	Percentage of schools' weekly schedule that reflects at least 1 hour of physical activity per day		Ministry of Health, and Schools Health (that liaise with Ministry of education)
Output: Physical activity guidelines for all educational institutions	Physical activity guidelines developed (Yes/no)	January 2026	
Output: Physical education/sports teachers trained on the updated guidelines	Number of physical education/sports teachers trained on guidelines	400 teachers trained	Training register
Output: Physical activity education incorporated in curriculum across all educational institutions	Number of schools with amended curriculum	830 schools with amended curriculum	Tool: MoE report
Physical Activity: Adults, adolescents			
Medium Term outcome: Increased physical activity among populations (18 and above)	Percentage of people engaging in physical activity (150 minutes per week)	Target: 30% Baseline: 15%	Tool: STEPS
Output: Community-based groups established	Number of community-based groups established	*January 2027* Target: 2 groups per community	Tool: *Community based group reports*

MONITORING PLAN			
Outcome / Output	**Indicator (Include baseline)**	**Target – where available**	**Data collection (Source, person responsible: where available)**
Output: Advocacy meetings held with municipalities, workplaces, schools and other settings on availability physical activity infrastructure	Number of advocacy meetings convened on physical infrastructure	Target: 4 advocacy meetings per year	Tool: Meeting minutes
Output Development considerations on walkable communities in urban areas (zoning laws, bicycle lanes) by the Ministries	Number of projects that support physical activities (pathways for walking/ cycling)	January 2028	Tool: Ministry of housing and development report, Ministry of Transport, City Council
OBJECTIVE 3: To reduce the consumption of SSBs by 2030			
Short Term outcome: Advocate for Increased revenue generated from SSB	Proposed indicator: Amount of tax revenue from SSB Refinement of SSB indicators to follow later	Target: TBC Baseline: TBC	Tool: Tax revenue report
Medium Term: Decreased sales of taxed SSBs	Proposed indicator: Volume of taxed SSB sold Refinement of SSB indicators to follow later	Target: TBC Baseline: TBC	Tool: Scanner data
Medium Term: Decreased consumption of sugar and sweetened beverages	Proposed indicator: Average daily consumption of SSBs (mL and calories) by beverage type Refinement of SSB indicators to follow later	Target: TBC Baseline: TBC	Tool: Intake survey (Note: if intake survey is not available, then purchases can be used as a proxy. Data source for this could be Household expenditure survey)
Output: SSB Data analysis report	SSB Data analysis report (Yes/no)	January 2027	Copy of SSB Data analysis report
Output: SSB policy drafted	SSB policy drafted	January 2028	Copy of SSB policy drafted
Output: Parliament endorsed SSB policy	Parliament endorsed SSB policy	January 2028	Copy of Parliament endorsed SSB policy

MONITORING PLAN			
Outcome / Output	**Indicator (Include baseline)**	**Target – where available**	**Data collection (Source, person responsible: where available)**
Cross cutting across objectives: Communications & Training Note: these activities feed into outcomes related to knowledge and awareness as recorded in this table			
Output: 43 school health workers trained on updated curriculum	Number of school health workers trained	January 2025	Attendance register
Train facility and community-based health care workers on: i) exclusive breastfeeding, supplementary feeding ii) promotion of physical education iii) essential nutrition action and prevention and management of obesity. iv) FBDGs	Number of facility and community health care workers trained	January 2026	Training report
Develop Physical Activity change communication and mass media plan	Campaign plan (yes/no)	January 2026	Tool: Mass media campaign reports
Roll out the behaviour change communication and mass media campaign for healthy diets & Physical Activity: i)Healthy learning campaign materials developed on healthy eating ii)Social media posts, TV, radio, and newspaper adverts	i) Campaign materials developed (yes/no) ii) Number of social media posts iii) Number of radio adverts iv) Number of newspaper adverts	July 2026	Copies of healthy learning material

CHAPTER 5: IMPLEMENTATION FRAMEWORK

5.1 Multisectoral Action Plan

The implementation plan of the Stop Obesity Acceleration plan is detailed in the theory of change in chapter 3.

The following delivery chain outlines the actors that are involved in the implementation of key identified in the objectives. While all interventions are aimed at beneficiaries, there are a series of actors that are involved in ensuring the success of any planned interventions as seen in table 5 below.

***Table 7**: Action Plan*

ACTION PLAN		
Actions	**Person/ Organisation responsible**	**Due Date**
OBJECTIVE 1: To increase the consumption of healthy food and drinks over the life course and decrease the consumption of unhealthy foods by 2030		
Policies over the life course (FBDS, food procurement and marketing of unhealthy food)		
Develop FBDGs to inform communication campaign (healthy diets)	MoH NCD program/ Nutrition council/FAO	April 2026
Disseminate the FBDGs to stakeholders (i.e. HCWs, community leaders, schools, pharmacists, health facilities	MoH NCD program/Health promotion	May 2026
Update the education curriculum with FBDGs and nutrition action and management of obesity	MoH School health/MoET	June 2026
Adapt the WHO Procurement framework of healthy diets for Eswatini's context (schools, prisons, public setting etc)	MoH NCD program	July 2027
Update of public food procurement standards and regulations	MoH NCD program/MoC	September 2027
Develop nutrient profile model for marketing of unhealthy foods and non-alcoholic beverages (adaptation of AFRO model)	MoH NCD program/Nutrition council	July 2026
Develop & endorse standard and regulation/policy on the marketing of unhealthy foods and non-alcoholic beverages	MoH NCD program	September 2026
Enforce the regulation of the marketing of unhealthy foods and non-alcoholic beverages	MoH NCD program/ MoC	January 2026
Children and Breast-feeding mothers		
Roll out a baby friendly initiative (criteria) into maternity wards and health centres	MoH SRH program/Nutrition council	January 2025
Establish peer support groups at health facilities - 'piggyback' on existing peer support group	MoH NCD program/ Nutrition council	January 2026
Develop a standardised workplace policy that applies across private and public sector and integrate into [Employment Act]	MoH NCD program	January 2026

ACTION PLAN		
Actions	**Person/ Organisation responsible**	**Due Date**
OBJECTIVE 1: To increase the consumption of healthy food and drinks over the life course and decrease the consumption of unhealthy foods by 2030		
Adopt/ promulgate law and develop workplace regulations	MoH NCD program	January 2027
Adoption of the workplace regulations by private and public organisations	MoH NCD program	January 2026

OBJECTIVE 2: To increase physical activity of school going children, adolescent and adults' and reduce their sedentary behaviour by 2030		
School going children		
Review and update physical activity guidelines for all educational institutions	MoH School health/ MoET/MoSports	March 2026
Train physical education/sports teachers on the updated guidelines	MoH School health	July 2026
Incorporate physical activity education into the national education curriculum across all educational institutions	MoH School health	January 2027
Physical activity over the life course: adults and adolescents		
Identify RHMs who will establish community physical activity groups and conduct community-physical activity campaigns (e.g. Shukuma)	MoH RHM program	January 2026
Advocate for availability of spaces and infrastructure for physical activity with municipalities, workplaces, schools and other settings (Tinkhundla centres)	MoH NCD program	January 2028
Advocate with Ministries of Housing and Urban Development and Public Works and Transport to ensure that all urban planning and new developments optimize physical activity opportunities and create walkable communities (zoning laws, bicycle lanes, etc.)	MoH NCD program	January 2028

ACTION PLAN		
Actions	**Person/ Organisation responsible**	**Due Date**
OBJECTIVE 3: To reduce the consumption of SSBs by 2030: To introduce a taxation policy of SSBs		
Identify and engage the government sectors responsible for SSBs taxation	MOH NCDs, Ministry of Finance	September 2025
Mobilise high level advocacy from MOH directorate and Health portfolio committee	MOH NCDs	April 2026
Obtain sale data on SSBs and analyse sales data to generate advocacy data	MOH NCDs, Ministry of Finance	September 2025

ACTION PLAN		
Actions	**Person/ Organisation responsible**	**Due Date**
OBJECTIVE 3: To reduce the consumption of SSBs by 2030: To introduce a taxation policy of SSBs		
Conduct a rapid assessment of feasibility and taxation options	MOH NCDs, Ministry of Finance	January 2025
Develop collaboration and accountability framework with the relevant government sectors	MoH NCD program, Ministry of Finance and Commerce	October 2026
Develop the SSB taxation policy	Ministry of MoH NCD program	January 2027
Endorse/ approve SSB policy	MoH directorate	January 2027
Enforce taxation SSB policy (implementation of the policy)	MoH NCD program/MoC	January 2028
Cross cutting training and communications (Applicable to all objectives)		
Train the school health programme workers on the educational curriculum content	MoH School Health program	July 2026
Train facility and community-based health care workers on exclusive breastfeeding, safe weaning and promotion of physical education.	MoH RHM program	July 2026
Train health professionals in essential nutrition action and prevention and management of obesity and FBDGs	MoH NCD program	January 2025
Develop Physical Activity change communication and mass media plan	MoH Health Promotion	July 2026
Roll out the behaviour change communication and mass media campaign for healthy diets	MoH Health Promotion	January 2025
Engage all government sectors, Private sector, NGOs and CSO in advocacy initiatives	MoH NCD Program	April 2026

5.2 Implementation Arrangements

The implementation of the Plan will be facilitated and coordinated by the NCD Program and Nutrition council. It will require technical assistance from International Partners (CHAI, WHO, UNICEF), hospitals, community clinics, NGOs and the private sector. The implementation of the Strategy will cover a period of 5 years from 2025 – 2030. At 5 years, there will be an end of term review to evaluate the changes, reassess the Obesity situation in Eswatini and produce recommendations considering this and new developments in this field.

5.3 Budget and Financial Plan

The costing of the operational plan will be activity-based and done on a yearly basis.

5.4 Resource Mobilisation Plan

Effective implementation of the Plan to Stop Obesity requires sustainable financing to support activities across all three objectives. In terms of financial support, special efforts from the Government will be required to ensure that all sectors have the capacity to play their role and assume there. Through adequate advocacy, Development Partners and the Private Sector will be expected to supplement Government efforts by providing both technical and financial support.

5.5 Conclusion

Oversight and accountability on the Acceleration Plan to Stop Obesity will be provided through the office of the Director of Health Services (DHS) through the multisectoral coordinating mechanism (MCM). Nominations will be requested from different government, private, non-government, development, academic, faith-based, and civil society partners. Guiding terms of reference will be developed to guide the operations of the MCM. The DHS will work closely with the department of Non-Communicable Diseases and the World Health Organization to convene quarterly meetings to monitor the progress of the implementation of the acceleration plan.

A well-defined national monitoring and evaluation framework with clear output and outcome indicators and timelines has been developed. For sustainability, the monitoring and evaluation tools will be updated and integrated into the existing health information system where they are currently not captured. The implementation plan will be monitored quarterly and adjusted as appropriate. The multisectoral coordinating mechanism will review the quarterly results and provide guidance on the next priority actions and areas for improvements. The last quarterly meeting will review the progress made in that year and agree on a road map for the following year's action plan.

Over the five-year period for the Acceleration Plan's implementation (2025 – 2030), special evaluations will be carried out in order to identify implementation outcomes, bottlenecks, and approaches to address them. These may take place at early, mid, and late implementation stages. Through quarterly reports, stakeholders' meetings and all other forms of evaluations, the purpose will be 1) to assess and improve the quality of the implementation process and (2) to determine the acceleration plan's effectiveness.

ANNEXURES

A. List of recommendations solutions to fight obesity

Action Domains	Specific Actions
Early Food environment	Implement Code of marketing of breast milk substitutes
	Protect, promote and support breastfeeding.
Physical activity in education	Mandate physical education in primary, lower, and upper high school.
Reformulation	Reformulate food for older infants and young children.
	Mandate limits on sodium and TFA, mandate sugar reformulation policies to bring sugar intake to recommended levels
Food marketing	Implement policies to protect children from the harmful impact of food marketing (including through digital media, and in settings where children gather)
	Implementation of the Code
Fiscal policies	Tax sugar-sweetened beverages, including all types of beverages containing free sugars[2]
Public food procurement and service	Implement standards and regulations for food served or sold in and around schools
	Implement standards for food served or sold in food outlets
	Implement standards for food served or sold in other public settings (e.g. government offices, workplaces, etc.).
Food labelling	Implement mandatory nutrient declaration in line with CODEX guidelines.
	Implement front of pack labelling
Public education and awareness	Conduct national public education communication campaigns on physical activity every two years.
	Conduct behavior changes communication and mass media campaigns for healthy diets
Integrated service delivery	Train health professionals in essential nutritional action and prevention and management of obesity.
	Include obesity management interventions in UHC and primary care benefit plan.
	Integration of obesity management health services in all service delivery points as appropriate across the health system and community
	Include physical activity education, counselling, and support as intervention of all service delivery packages.

[2] These include carbonated or non-carbonated soft drinks, fruit/vegetable juices and drinks, liquid and powder concentrates, flavoured water, energy and sports drinks, ready-to-drink tea, ready-to-drink coffee and flavoured milk drinks.

B. Problem statement and contributing factors of obesity

Obesity is a chronic health condition characterized by excessive accumulation of body fat, which can lead to significant health problems and increased risk of premature death. Obesity has become a major public health concern, with rising prevalence rates globally and in the country. The causes of obesity are complex and multifactorial, including genetic, environmental, and behavioural factors. Obesity is associated with a wide range of health problems, including heart disease, stroke, type 2 diabetes, certain types of cancer, and joint problems. The economic impact of obesity is also substantial, with healthcare costs and productivity losses associated with obesity accounting for a significant proportion of healthcare spending. Effective prevention and management of obesity are critical public health priorities, requiring a comprehensive, multifaceted approach that addresses the various factors influencing its development and progression.

Main Issue	Underlying Causes or Issues	Sub-Issues
Globalization and Urbanization	Social drivers	Rural to urban migration
		Sedentary lifestyles through increasing sedentary time in recreation, travel and work
		Competing priorities – work/life balance & school curriculum
	Unhealthy diet	Convergence of diets
		Affordability drives food choices
		Increased intake of fat, sugar and salt
		Market liberalisation & foreign direct investment making foods available across countries
		Increase in incomes leading to changes in taste preferences
	Food supply	Food production based on intensive farming
		Long product shelf-life
		Supermarkets replacing farmers markets
		Changes in food systems
	Physical inactivity	Sedentary lifestyles through increasing sedentary time in travel and work Increased use of digital technologies for entertainment and communications as well as learning and work Transport: shift / preference for motor vehicles Limited access to safe public open spaces Limited access to a safe and affordable sports and active recreation opportunities

C. Prioritisation matrix

<table>
<tr><th colspan="2">Priority Actions</th></tr>
<tr>
<td>No Brainer
School health policies (cafeteria, tuck shops, school feeding program)</td>
<td>Tough but worth it
Mandate limits on sodium, Trans Fats acids, sugary and sweetened beverages policies to bring sodium and sugar intake to recommended levels
Implement policies to protect children from the harmful impact of food marketing (including through digital media, and in settings where children gather)
Tax sugar-sweetened beverages, including all types of beverages containing free sugars
Implement standards for food served or sold in food outlets
Implement front of pack labelling
Implement mandatory nutrient declaration in line with CODEX guidelines.</td>
</tr>
<tr>
<td>Quick wins
Protect, promote, and support breastfeeding.
Mandate provision of quality health and physical education in, schools.
Formulate healthy complimentary food for infants and children.
Implement standards and regulations for food served or sold in and around schools
Implement standards for food served or sold in other public settings
Conduct national public education communication campaigns on physical activity
Conduct Social Behaviour Change Communication (SBCC) and mass media campaign for healthy diets
Train health professionals in physical activity
Provide physical activity education, counselling, and support to all clients Provide regular screening and counselling to the general population</td>
<td>Deprioritize
Include obesity management interventions in UHC and primary care benefit plan</td>
</tr>
</table>

D. Communication Plan

The communication plan is a vital component of the Obesity Roadmap. By leveraging on multiple communication approaches, the roadmap aims to create awareness, influence behaviour, and advocate for sustainable obesity prevention measures. Through collaboration and effective messaging, Eswatini can move towards a healthier future for all its citizens (see annex F for stakeholder engagement plan table). The stakeholder engagement plan how states activities to be conducted by stakeholders.

	Support obesity reduction activities	Energy to be Invested in stakeholder	Communications strategy
High influence; high stake	Yes	Support publicly/ vocally	• Provide them with information • Appreciate and acknowledge their contribution • Let them champion our cause
Low influence; High stake	Yes	Support Silently	• Educate, enable, inform, and motivate • Energise them by involving champions they admire
Low influence; low stake	No	Oppose silently	• Inform or ignore • Get critical mass of champions to influence them
High influence; low stake	No	Oppose loudly	• Ignore if they are not influential • Confront if their influence is significant • Counteract by giving facts and enlisting champions • Monitor what they say and who is listening to them

E. Stakeholder analysis

Stakeholders play a critical role in the likelihood of success in delivering a positive impact. Stakeholders will hold quarterly meetings to discuss policy changes for the prevention of Obesity. The following stakeholders are mapped according to their interest or potential role in stopping the rise in obesity in Eswatini. Each stakeholder has been classified as either Supporter [S], Neutral [N] or Opponent [O].

High influence, low stake	High influence, high stake
Fast Food Outlets [O]	UN entities: WHO, UNICEF, FAO, WFP, UNFPA [S]
Beverage company [O]	Ministry of Health - NCD [S]
Ministry of Public Works and Transport [N]	Clinton Health Access Initiative [S]
Ministry of Commerce, Industry, and Trade [N]	Taiwan International Cooperation Development Fund [S]
Ministry of Finance [S]	Nutrition council [S]
Eswatini Revenue Services [S]	Diabetes Eswatini [S]
School Vendors [O]	Ministry of Sport, Culture and Youth Affairs [S]
Market vendors [O]	World Vision [S]
Traditional leaders [N]	Save the children [S]
Town council [N]	Ministry of Education and Training [S]
Ministry of Justice and Constitutional Affairs [N]	School health program [S]
Deputy Prime Minister's Office PMs office [N]	Ministry of Agriculture [S]
	Eswatini Water and Agricultural Development Enterprise (ESWADE) [S]
	Health Promotion [S]
	Health Facilities [S]
	Eswatini Standards Authority (ESWASA) [S]
	Environmental Health [N]
	Rural Health Motivators and other Community Workers [S]
	Public Sector HIV/AIDS Coordinating Committee PSHACC [S]
	Sports and recreation facilities and service providers (e.g. gym facilities, running clubs, cycling clubs)

Low influence, Low stake	Low influence, high stake
Baylor Clinic [S]	Epilepsy Eswatini [S]
SRH program [S]	Autism Eswatini [S]
NERCHA [S]	Coordinated Assembly of Non-Governmental
EPI program [N]	Organisations (CANGO) [S]
Eswatini National Aids Program (ENAP) [S]	Hospice at Home [S]
PEPFAR [N]	Hope House [S]
Central Medical Stores (CMS) [S]	Cheshire Homes [S]
Tertiary institutions [S]	Eswatini business health and wellness [S]
National marketing and agricultural board [S]	

F. Stakeholder engagement plan

Engagement objectives	Engagement Activities
Building network of multisectoral stakeholders	• Develop terms of reference • Set and define clear rules of engagement and put in place mechanisms to prevent and manage conflicts of interests (e.g. disclosure of interest, transparency in all communications and in any engagement) • Mapping of multisectoral stakeholders • Presentation of the problem (obesity road map as an advocacy tool) • Establish multi sectoral coordination committee • Conduct regular multi sectoral coordination meetings
To create an enabling environment for healthy food policies	• Develop concept note to lobby for enactment of policies and legislations (School vending policy, Healthy public food policy, Front of pack labelling policy) • Revise and amend the 2016 food and nutrition policy • Develop policy for standardisation of salt, sweets and beverages products sold in the country • Develop an advocacy proposal for the allocation of a proportion of Sin taxes on all harmful products to the Ministry of Health to support in activities to reduce modifiable risk factors
Formulation of regulatory framework	• Conduct meetings with relevant stakeholders to formulate regulatory framework and progress monitoring tools • Conduct bi-annual performance assessments • Compile and disseminate annual progress reports

Engagement objectives	Engagement Activities
Develop an Investment Case for Obesity Control	• Develop an estimate budget for forecasting and planning • Engage an economist for the development of a costed investment case for obesity control • Conduct meeting to present costed investment case to all stakeholders for resource mobilisation and accountability
Map and engage the current physical activity stakeholders (involved in gyms, recreational parks)	• Engage Ministry of Sports and Culture to get buy in and support for physical activity initiatives • Engage municipalities in urban areas to expand physical activity parks • Engage corporates (companies) to ensure companies have access to physical activity centres • Engage primary schools to enforce inclusion of physical activity • Engage Ministry of Education to discuss mandatory inclusion of physical activity in high school curriculum

G. Service delivery chain

Who are the ultimate decision makers?	Who influences those who deliver?	Who delivers the actions at the frontline?	Who are the ultimate beneficiaries?
MoET	MoET, MoA, WFP, FAO	Teachers and Guardians	School going children
MoH	MoH, MoA (Home, commerce, Finance, economics), NGOs, Nutrition Council, Health care workers, Community health workers, WHO, UNICEF, UN Agencies	Breastfeeding mothers, caregivers	Infants and young children
DPMO	NGOs	Social workers, community volunteers, neighbourhood care point workers	Out of school children/youth
Government Ministries	MoH, UN Agencies, CBOS	Health care workers, community volunteers,	Adult populations

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