Return to State of the Union Report

Obesity

Information Retrieved from AI – To Be Verified

Section 1: Top 35 Countries with the Lowest Obesity Not Due to Health Reasons 2
Section 2: What Other Countries Have Done to Decrease Their Obesity Rate 4
Section 3: What the United States Can Do to Decrease Its Obesity Rate.................................... 11
Section 4: References.. 12
Section 5: Draft of a House Bill to Decrease Obesity in the United States 14

Section 1: Top 35 Countries with the Lowest Obesity Not Due to Health Reasons

Data Source: Gallup World Poll, NCD Risk Factor Collaboration (NCD-RisC), and World Health Organization Global Health Observatory. Data year: 2022.

Rank	Country	Obesity Rate
1	Việt Nam (Vietnam)	2.1%
2	বাংলাদেশ (Bangladesh)	3.6%
3	ኢትዮጵያ Ityop'iya (Ethiopia)	4.5%
4	भारत Bharat (India)	4.9%
5	កម្ពុជា Kampuchea (Cambodia)	5.0%
6	नेपाल (Nepal)	5.1%
7	မြန်မာ Myanma (Myanmar)	5.8%
8	Tanzania	6.4%
9	Uganda	6.5%
10	Rwanda	6.7%
11	Burkina Faso	7.0%
12	Moçambique (Mozambique)	7.2%
13	Pilipinas (Philippines)	7.4%
14	Indonesia	7.5%
15	Ghana	7.7%
16	Kenya	7.9%
17	中国 Zhongguo (China)	8.1%
18	Sénégal (Senegal)	8.3%
19	Mali	8.4%
20	Nigeria	8.9%
21	پاکستان (Pakistan)	9.1%
22	Madagasikara (Madagascar)	9.2%
23	Malawi	9.4%

Rank	Country	Obesity Rate
24	ශ්‍රී ලංකා (Sri Lanka)	9.5%
25	ประเทศไทย Prathet Thai (Thailand)	10.0%
26	日本 Nippon (Japan)	10.3%
27	한국 Hanguk (South Korea)	10.8%
28	Laos	11.0%
29	السودان As-Sudan (Sudan)	11.3%
30	Zambia	11.6%
31	Soomaaliya (Somalia)	11.8%
32	Haïti	12.1%
33	افغانستان (Afghanistan)	12.3%
34	ایران (Iran)	12.8%
35	Singapore	13.0%

Source: NCD Risk Factor Collaboration (NCD-RisC), Gallup World Poll (2022).

Rank of the United States and Explanation

The United States does not appear on the list of the Top 35 Countries with the Lowest Obesity Not Due to Health Reasons. **As of 2022, the United States has an adult obesity rate of approximately 36.2%**, placing it among the highest in the world.

This high rate is attributed primarily to behavioral, environmental, and socioeconomic factors rather than genetic or medical conditions alone. Key contributing factors include widespread consumption of ultra-processed foods high in sugar, fat, and sodium; sedentary lifestyles driven by car-dependent urban design and desk-based occupations; large portion sizes embedded in food culture; aggressive marketing of unhealthy foods; limited access to fresh produce in lower-income communities (food deserts); economic disparities that make calorie-dense processed foods more affordable than fresh alternatives; and insufficient physical activity among both children and adults.

The most recent data available (2023) indicates that the U.S. adult obesity rate has risen slightly to approximately 36.5%, reinforcing the need for systemic policy interventions.

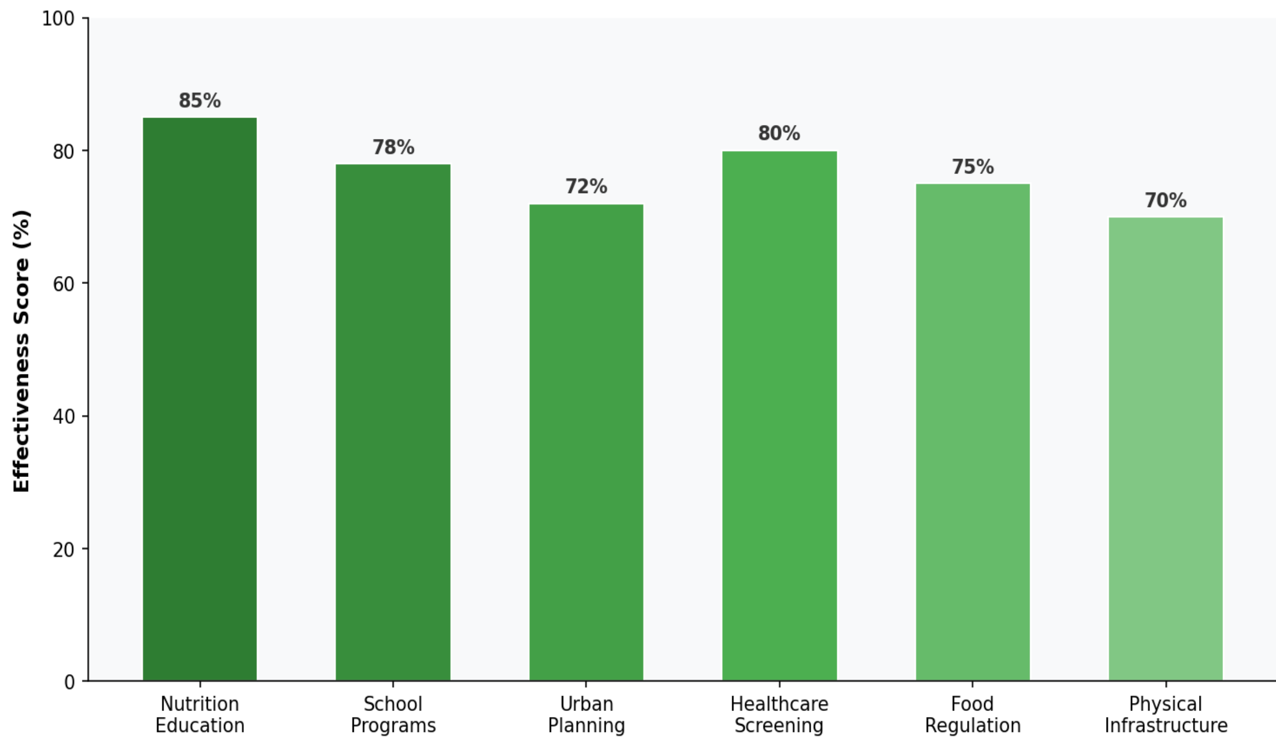
References for Section 1:

NCD Risk Factor Collaboration (NCD-RisC): https://ncdrisc.org
Gallup World Poll: https://www.gallup.com/analytics/318875/world-poll.aspx
World Health Organization Global Health Observatory: https://www.who.int/data/gho
Centers for Disease Control and Prevention (CDC) – U.S. Obesity Data: https://www.cdc.gov/obesity/data/adult.html

Section 2: What Other Countries Have Done to Decrease Their Obesity Rate

The 8 Top Rated Countries with the Lowest Obesity Values

Rank	Country	Obesity Rate
1	Việt Nam (Vietnam)	2.1%
2	বাংলাদেশ (Bangladesh)	3.6%
3	ኢትዮጵያ Ityop'iya (Ethiopia)	4.5%
4	भारत Bharat (India)	4.9%
5	កម្ពុជា Kampuchea (Cambodia)	5.0%
6	नेपाल (Nepal)	5.1%
7	မြန်မာ Myanma (Myanmar)	5.8%
8	Tanzania	6.4%



Việt Nam (Vietnam)

Việt Nam maintains one of the world's lowest obesity rates through a combination of deeply ingrained cultural food practices, active transportation habits, and targeted government programs.

The Vietnamese diet is traditionally built around rice, fresh vegetables, lean proteins such as fish and tofu, and herb-based broths, with minimal reliance on processed or fast foods.

Large municipal markets provide widespread access to fresh foods and limit dependence on packaged food supply chains.

The government, through the Ministry of Health (MOH) (https://moh.gov.vn), implemented the National Nutrition Strategy 2011-2020 and its successor plan, which set targets for reducing malnutrition and preventing the rise of obesity, particularly among urban populations. The Ministry of Health promotes traditional diets centered on vegetables, seafood, and rice rather than processed foods.

The Việt Nam Food Administration monitors food safety and labeling standards. School meal programs emphasize balanced nutrition, and physical education is mandatory at all levels of schooling.

The National Institute of Nutrition (NIN) (https://viendinhduong.vn) conducts ongoing population studies and advises on dietary guidelines.

Urban planning in Vietnamese cities continues to favor walking and cycling, and street food culture promotes smaller, vegetable-rich meals. Public parks and exercise spaces in major cities support physical activity across multiple age groups.

Private sector engagement has been limited but growing, with the Việt Nam Food and Foodstuff Association (VINAFOOD) beginning to address reformulation of packaged foods.

বাংলাদেশ (Bangladesh)

Bangladesh has maintained a low obesity rate largely due to economic factors, traditional dietary patterns, and active physical lifestyles among a largely rural population.

School health campaigns emphasize balanced diets and active lifestyles.

The typical Bangladeshi diet centers on rice, lentils (dal), fish, and vegetables, with limited consumption of saturated fats or highly processed foods.

Agricultural development strategies encourage local production of vegetables and fruits to improve dietary quality.

The Bangladesh National Nutrition Council (BNNC) (https://nnc.gov.bd) coordinates national nutrition policy and monitors the nutritional status of the population. The government's National Nutrition Services program, implemented through the Directorate General of Health Services (DGHS) (https://dghs.gov.bd), integrates nutrition counseling into primary health care.

Urban areas, particularly Dhaka, are beginning to see rising obesity rates as fast food consumption grows; however, this remains concentrated among higher-income groups.

The Institute of Public Health Nutrition (IPHN) (https://iphn.gov.bd) provides technical guidance on dietary practices.

Community health workers (known as BRAC health volunteers through BRAC, https://brac.net) play a significant role in disseminating nutrition education at the grassroots level. Community health workers conduct nutrition education programs in rural and urban communities.

Physical activity remains high due to reliance on walking and cycling for transportation, especially in rural areas.

Ityop'iya (Ethiopia)

Ityop'iya's low obesity rate is primarily associated with food scarcity and poverty, but the government and non-governmental organizations have also instituted genuine public health frameworks that promote healthy eating and physical activity.

The Ityop'iya Public Health Institute (EPHI) (https://ephi.gov.et) leads research on non-communicable diseases including obesity.

The Federal Ministry of Health (FMOH) (https://moh.gov.et) integrates nutrition into its Health Extension Program, which deploys health extension workers (HEWs) to rural communities to provide nutrition education and monitor child and adult health indicators.

Ityop'iya's traditional diet includes injera (fermented teff flatbread), lentils, chickpeas, and vegetables, with low consumption of animal fats or processed foods.

The government has partnered with UNICEF (https://www.unicef.org/ethiopia) and the World Food Programme (https://www.wfp.org/countries/ethiopia) to address both undernutrition and the nascent problem of urban overnutrition.

School feeding programs emphasize nutritional balance.

The government's National Nutrition Program (NNP) provides a multi-sectoral framework for dietary improvement and integrates health education with agricultural development.

Local agriculture programs improve access to nutrient rich foods.

Bharat (India)

Bharat maintains a relatively low national obesity average despite significant regional variation. The government has pursued multiple strategies to manage the double burden of undernutrition and rising obesity.

The Food Safety and Standards Authority of Bharat (FSSAI) (https://fssai.gov.in) regulates food labeling and has launched the 'Eat Right Bharat' campaign to promote healthy diets and reduce consumption of salt, sugar, and saturated fats.

Public awareness campaigns promote traditional diets based on grains legumes and vegetables

The Ministry of Health and Family Welfare (https://main.mohfw.gov.in) runs the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases & Stroke (NPCDCS), which includes obesity management.

The National Health Mission (NHM) (https://nhm.gov.in) integrates nutrition counseling into primary health care. The National Nutrition Mission coordinates federal nutrition policy across multiple ministries.

Taxes on sugar-sweetened beverages were introduced as part of the Goods and Services Tax (GST) structure.

The Indian Council of Medical Research (ICMR) (https://icmr.gov.in) issues dietary guidelines and conducts population health surveys.

School curricula include nutrition education, and the Mid-Day Meal Scheme (now PM POSHAN) provides nutritious lunches to millions of school children.

Private sector organizations such as the Confederation of Indian Industry (CII) (https://www.cii.in) have developed voluntary commitments to reduce unhealthy ingredients in food products.

Kampuchea (Cambodia)

Kampuchea has maintained low obesity rates through a traditional diet rich in rice, fish, fresh vegetables, and fermented foods, combined with active physical lifestyles among a predominantly rural population.

The Ministry of Health (MOH) (https://moh.gov.kh) developed the National Strategic Plan for Food and Nutrition 2019-2023, targeting both undernutrition and the prevention of non-communicable diseases including obesity.

The National Nutrition Program under the MOH coordinates nutrition surveillance and public education campaigns.

The Kampuchea Food and Drug Administration (CAMFDA) (https://www.fda.gov.kh) regulates food labeling and enforces restrictions on false nutritional claims.

International partners including the World Health Organization Kampuchea Country Office (https://www.who.int/cambodia) and Helen Keller International (https://www.hki.org) support community-based nutrition programs.

Physical education is incorporated into the national school curriculum.

Fast food consumption remains low, particularly in rural areas, and traditional cooking methods continue to dominate household food preparation.

नेपाल (Nepal)

Nepal low obesity rate reflects a traditional diet based on dal Bhat (lentils and rice), vegetables, and minimally processed foods, combined with high levels of physical activity among both rural farmers and urban residents who rely on walking for transportation.

The Ministry of Health and Population (MOHP) (https://mohp.gov.np) oversees the Multi-Sector Nutrition Plan (MSNP), which integrates nutrition goals across agriculture, education, water, and health sectors.

The Department of Food Technology and Quality Control (DFTQC) (https://dftqc.gov.np) enforces food safety and labeling regulations.

The Nepal Health Research Council (NHRC) (https://nhrc.gov.np) conducts surveillance of non-communicable disease risk factors including obesity. International organizations including USAID (https://www.usaid.gov/nepal) and the World Food Programme Nepal (https://www.wfp.org/countries/nepal) support community nutrition programs.

Community outreach programs promote physical activity and diet awareness.

School health programs include nutrition education, and the school meal program in targeted districts promotes consumption of locally grown, nutritious foods.

Myanma (Myanmar)

Myanma's traditionally low obesity rate is supported by a diet dominated by rice, vegetables, fish, and legumes, with limited consumption of processed foods and sweetened beverages.

The Ministry of Health and Sports (MOHS) (https://mohs.gov.mm) has developed national nutrition policies within its Five-Year National Health Plan.

The National Nutrition Center under the MOHS coordinates nutrition surveillance and public education. Myanma's Food and Drug Administration (FDA Myanma) (https://www.fda.gov.mm) regulates food products and enforces labeling requirements.

Physical activity levels remain high due to agricultural lifestyles and limited motorized transportation in rural areas.

The government, with support from UNICEF Myanma (https://www.unicef.org/myanmar) and WHO Myanma (https://www.who.int/myanmar), has implemented community-based programs targeting dietary practices in schools and health centers.

Physical education is included in the national school curriculum.

Tanzania

Tanzania maintains a low obesity rate through a combination of traditional dietary practices, physical activity, and government nutrition programs.

The Tanzanian diet is centered on ugali (maize porridge), beans, vegetables, and fish in coastal regions, with limited consumption of processed or high-fat foods.

The Ministry of Health (MOH Tanzania) (https://moh.go.tz) oversees the National Nutrition Strategy, which targets all forms of malnutrition including the growing prevalence of overweight and obesity in urban areas.

The Tanzania Food and Drugs Authority (TFDA) (https://www.tfda.go.tz) enforces food safety and labeling regulations.

The government has partnered with the World Bank (https://www.worldbank.org/en/country/tanzania) and USAID (https://www.usaid.gov/tanzania) on community nutrition interventions.

School health programs include nutrition education components, and physical education is incorporated in the national curriculum. Tanzania's ongoing urbanization and growing fast food sector present emerging challenges that the government is beginning to address through public awareness campaigns and food labeling reforms.

Other Countries that had Low Obesity Rates

Nippon (Japan)

Nippon enacted the Basic Law on Shokuiku which mandates nationwide nutrition education integrated throughout the school system.

Municipal governments coordinate daily school lunches prepared by trained nutritionists using nationally approved dietary standards.

Corporate health monitoring programs measure metabolic health indicators annually under the national health insurance framework.

Hanguk (South Korea)

Hanguk operates a universal health screening system that regularly measures body mass index and metabolic risk indicators.

The Ministry of Education regulates balanced nutritional content in school lunches served to millions of students each day.

Urban planning policies prioritize mass transit networks which require walking and increase routine daily activity.

Indonesia

The Healthy Living Community Movement promotes reduced sugar consumption and increased exercise.

Nutrition labeling reforms assist consumers in identifying healthier foods.

Municipal governments invest in sports facilities and public recreation areas.

Obesity Values by World Region (Approximate 2022 Data)

The following represents the approximate adult obesity prevalence rates by world region, based on data from the World Health Organization and NCD-RisC (2022). These figures illustrate the significant global disparities in obesity rates:

Region	Obesity Rate (approx.)
中国 Zhongguo (China)	8.1%
Asia (excl. 中国 Zhongguo (China))	9.5%
Africa	14.0%
Other Regions	16.0%
Western Europe (excl. Россия Rossiya (Russia))	21.0%
Россия Rossiya (Russia)	23.1%
South America	24.0%
Central America	25.0%
Middle East	26.5%
México	28.9%
Australia	29.0%
Canada	29.4%
United States	36.2%

References for Section 2:

World Health Organization – Obesity and Overweight: https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

NCD Risk Factor Collaboration: https://ncdrisc.org

Việt Nam Ministry of Health: https://moh.gov.vn

Section 3: What the United States Can Do to Decrease Its Obesity Rate

The United States faces one of the most severe obesity crises in the world, with approximately 36.5% of adults classified as obese as of 2023. Decreasing obesity at the national level requires a comprehensive, multi-sectoral approach that engages federal and state government agencies, the food and beverage industry, the healthcare system, educational institutions, urban planners, employers, and individual citizens. The following describes in general how the United States can reduce its obesity rate.

Federal Government Actions:

The U.S. Department of Health and Human Services (HHS), Centers for Disease Control and Prevention (CDC), and Food and Drug Administration (FDA) must work collaboratively to develop and enforce evidence-based nutrition standards, regulate food labeling, and fund public health campaigns.

The USDA must expand access to healthy foods through programs such as SNAP (Supplemental Nutrition Assistance Program) and WIC by incentivizing the purchase of fruits, vegetables, and whole grains while restricting subsidies for processed food ingredients.

The Federal Trade Commission (FTC) must regulate deceptive food marketing, particularly advertising targeting children. Congress must pass legislation establishing a national sugar-sweetened beverage tax, the proceeds of which fund community health initiatives.

State and Local Government Actions:

State health departments must implement policies requiring physical education in schools, establishing nutritional standards for school meals, and regulating the placement of fast food outlets near schools and low-income housing.

City and county governments must invest in walkable infrastructure, bicycle lanes, and public parks to encourage physical activity. Zoning laws should incentivize grocery stores in food deserts.

Food and Beverage Industry: Corporations must voluntarily and through regulation reformulate products to reduce sugar, sodium, and saturated fat content. Front-of-pack warning labels (similar to Chile's system) should be required on unhealthy products.

Restaurants must display calorie information prominently on menus, as required under the Affordable Care Act but inconsistently enforced. Advertising of ultra-processed foods to children under 13 should be prohibited.

Healthcare System: The Centers for Medicare and Medicaid Services (CMS) must expand reimbursement for obesity counseling, behavioral therapy, and evidence-based weight management programs. Primary care physicians must be trained and required to screen for obesity at every patient encounter and provide appropriate referrals. Obesity must be formally recognized and treated as a chronic disease with the same insurance coverage obligations as other conditions.

Educational Institutions: Schools must serve nutritious meals meeting updated USDA nutritional guidelines, limit the sale of competitive foods and beverages that fail to meet health standards, and incorporate nutrition education into core curricula from kindergarten through grade 12.

Physical education must be provided for a minimum of 150 minutes per week at the elementary level and 225 minutes per week at the secondary level.

Employers and the Private Sector: Employers with more than 50 employees must provide health insurance coverage that includes obesity screening, counseling, and treatment.

Workplace wellness programs must include evidence-based physical activity and nutritional components.

The business community should be incentivized through tax credits to create healthier workplace food environments.

Individual and Community Actions: Individuals should be supported with accessible nutrition education, culturally appropriate dietary guidance, and affordable healthy food options.

Community health workers must be deployed in underserved neighborhoods to provide one-on-one nutrition and lifestyle counseling.

Faith communities, nonprofit organizations, and social service agencies should be engaged as partners in delivering health promotion programs.

Section 4: References

References for Section 2 and Section 3:

World Health Organization (WHO) – Obesity and Overweight: https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

NCD Risk Factor Collaboration (NCD-RisC): https://ncdrisc.org

Centers for Disease Control and Prevention (CDC) – Overweight and Obesity: https://www.cdc.gov/obesity/index.html

U.S. Food and Drug Administration (FDA): https://www.fda.gov

U.S. Department of Agriculture (USDA) – Nutrition: https://www.usda.gov/topics/food-and-nutrition

Centers for Medicare and Medicaid Services (CMS): https://www.cms.gov

Federal Trade Commission (FTC) – Food Marketing: https://www.ftc.gov/reports/food-marketed-children-ages-2-17

Việt Nam National Institute of Nutrition: https://viendinhduong.vn

FSSAI – Eat Right Bharat: https://eatrightindia.gov.in

BRAC Health Program (বাংলাদেশ): https://brac.net/programme/health

Ethiopian Public Health Institute: https://ephi.gov.et

नेपाल Ministry of Health and Population: https://mohp.gov.np

Tanzania Food and Drugs Authority: https://www.tfda.go.tz

Section 5: Draft of a House Bill to Decrease Obesity in the United States

118th CONGRESS

2d Session

H.R. ____

A BILL

To establish a comprehensive national framework to prevent, reduce, and manage obesity in the United States, and for other purposes.

SHORT TITLE

This Act may be cited as the "National Obesity Prevention and Reduction Act of 2024."

SECTION 1. DEFINITIONS

As used in this Act:

(1) Obesity. The term 'obesity' means a body mass index (BMI) of 30 or greater, as defined by the Centers for Disease Control and Prevention.

(2) Overweight. The term 'overweight' means a body mass index (BMI) of 25 or greater but less than 30.

(3) Secretary. The term 'Secretary' means the Secretary of Health and Human Services.

(4) Covered Employer. The term 'covered employer' means any employer with 50 or more full-time equivalent employees operating in interstate commerce.

(5) Ultra-Processed Food. The term 'ultra-processed food' means a food product classified under Group 4 of the NOVA food classification system, including industrially formulated multi-ingredient products containing additives such as hydrogenated oils, modified starches, and artificial colorings.

(6) Sugar-Sweetened Beverage. The term 'sugar-sweetened beverage' means any non-alcoholic beverage containing caloric sweeteners, including sodas, fruit drinks with added sugar, sports drinks, and energy drinks.

(7) Food Desert. The term 'food desert' means a low-income census tract in which a substantial number or share of residents has low access to a supermarket or large grocery store, as defined by the USDA Economic Research Service.

(8) Physical Activity. The term 'physical activity' means any bodily movement produced by skeletal muscles that requires energy expenditure, consistent with guidelines established by the Department of Health and Human Services.

(9) Healthy Food. The term 'healthy food' means a food meeting the nutritional criteria established by the Food and Drug Administration, including limits on saturated fat, sodium, and added sugars, and minimum thresholds for beneficial nutrients.

(10) National Obesity Reduction Plan. The term 'National Obesity Reduction Plan' means the comprehensive plan described in Section 2 of this Act.

SECTION 2. ENACTING CLAUSE

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, that Congress hereby establishes a National Obesity Prevention and Reduction Program to address the public health crisis of obesity in the United States through a comprehensive, evidence-based, and equitable framework. Congress finds that:

(a) Obesity affects approximately 36.5% of adult Americans and 19.7% of children and adolescents aged 2 to 19 years, representing a significant and growing public health burden.

(b) Obesity is a major risk factor for type 2 diabetes, cardiovascular disease, certain cancers, sleep apnea, and other chronic conditions that reduce quality of life and impose enormous costs on the healthcare system.

(c) The economic costs of obesity in the United States exceed $170 billion annually in direct medical expenditures and substantially greater costs in lost productivity.

(d) Obesity disproportionately affects racial and ethnic minority communities, low-income populations, and communities with limited access to healthy foods and safe spaces for physical activity.

(e) Evidence from countries with low obesity rates demonstrates that comprehensive national policies addressing food environments, physical activity infrastructure, education, and healthcare can meaningfully reduce obesity prevalence.

SECTION 3. REQUIREMENTS BY GOVERNMENT AGENCIES

(a) DEPARTMENT OF HEALTH AND HUMAN SERVICES.

(1) The Secretary shall, within 180 days of enactment, develop and publish a National Obesity Reduction Plan establishing measurable targets for reducing adult and childhood obesity rates by 15% within 10 years.

(2) The Secretary shall establish an Interagency Council on Obesity Prevention comprising representatives from HHS, USDA, FTC, DOT, HUD, and DOE to coordinate federal anti-obesity initiatives.

(3) The Centers for Disease Control and Prevention shall expand its DNPAO (Division of Nutrition, Physical Activity, and Obesity) grant programs to all 50 states and territories.

(b) FOOD AND DRUG ADMINISTRATION.

(1) The FDA shall, within 1 year of enactment, promulgate rules requiring front-of-pack warning labels on foods and beverages that exceed thresholds for saturated fat, sodium, and added sugars.

(2) The FDA shall update the definition of ‘healthy’ on food labels and enforce compliance with the updated standard.

(3) The FDA shall require disclosure of added sugar content in all food products and limit added sugar in products marketed specifically to children.

(c) UNITED STATES DEPARTMENT OF AGRICULTURE.

(1) The USDA shall revise the National School Lunch Program and School Breakfast Program nutritional standards to increase fruit, vegetable, and whole grain requirements while eliminating products exceeding limits for added sugars and saturated fats.

(2) The USDA shall redesign the SNAP program to include incentive payments for the purchase of fresh fruits, vegetables, and whole grains, and shall restrict SNAP benefits from being used to purchase sugar-sweetened beverages.

(3) The USDA shall fund a Healthy Food Access Grant Program to establish grocery stores and community food hubs in food deserts.

(4) The USDA, in coordination with the DHHS, shall update and disseminate the Dietary Guidelines for Americans every 5 years to reflect current evidence on obesity prevention.

SECTION 4. REQUIREMENTS BY GOVERNMENT OFFICIALS

(a) SECRETARY OF HEALTH AND HUMAN SERVICES. The Secretary of Health and Human Services shall:

(1) Publish and update the National Obesity Reduction Plan annually and submit a biennial report to Congress on progress toward obesity reduction targets.

(2) Convene quarterly meetings of the Interagency Council on Obesity Prevention and publish meeting minutes and action items on the HHS website.

(3) Establish the Office of Obesity Policy and Prevention within HHS to coordinate all obesity-related programs and initiatives across federal agencies.

(b) SECRETARY OF AGRICULTURE. The Secretary of Agriculture shall:

(1) Ensure all USDA nutrition programs align with updated Dietary Guidelines and issue guidance to state agencies administering SNAP, WIC, and school meal programs within 90 days of Dietary Guidelines publication.

(2) Designate a Chief Nutrition Officer within the USDA responsible for monitoring and reporting on nutritional outcomes of all federal food assistance programs.

(c) ATTORNEY GENERAL. The Attorney General shall:

(1) Enforce penalties under this Act and promulgate regulations specifying enforcement procedures for all penalty provisions no later than 1 year after the date of enactment.

(d) SECRETARY OF EDUCATION. The Secretary of Education shall:

(1) Amend Title IV regulations to require recipient schools to implement physical education requirements of not less than 150 minutes per week for elementary students and not less than 225 minutes per week for secondary students.

SECTION 5. REQUIREMENTS BY CORPORATIONS

(a) FOOD AND BEVERAGE MANUFACTURERS.

(1) All food and beverage manufacturers with gross annual revenues exceeding $10,000,000 shall reduce the sodium content of their products by 20% within 5 years and reduce added sugar content by 15% within 3 years of enactment.

(2) All manufacturers shall comply with FDA-promulgated front-of-pack labeling rules and shall not use deceptive health claims on product packaging.

(3) Manufacturers shall not advertise ultra-processed foods or sugar-sweetened beverages to children under the age of 13 through any medium, including television, digital platforms, social media, and in-school marketing.

(b) RESTAURANTS AND FOOD SERVICE ESTABLISHMENTS.

(1) All restaurant chains and food service establishments with 20 or more locations shall display calorie counts and key nutritional information prominently on menus and menu boards, consistent with Section 4205 of the Affordable Care Act.

(2) All covered food service establishments shall offer at least one meal option for children meeting the healthy meal standards established by the Secretary.

(c) COVERED EMPLOYERS.

(1) All covered employers shall provide health insurance plans that cover, without cost-sharing, obesity screening, diagnosis, behavioral counseling, and treatment including pharmacotherapy and surgical intervention when medically indicated.

(2) All covered employers shall implement workplace wellness programs that include evidence-based physical activity components, healthy food options in workplace cafeterias, and annual health screenings.

(3) All covered employers operating in food deserts shall receive tax credits for establishing or subsidizing access to healthy food options for employees.

SECTION 6. REQUIREMENTS BY PRIVATE CITIZENS

(a) Nothing in this Act shall be construed to impose enforceable dietary or physical activity requirements upon private individuals. The provisions of this section are intended to be advisory, educational, and facilitative in nature.

(b) The Secretary is authorized to:

(1) Fund community health worker programs that provide voluntary nutrition counseling and healthy lifestyle coaching in underserved communities, with special focus on populations at highest risk of obesity.

(2) Develop and disseminate culturally and linguistically appropriate health education materials to support individuals in making informed dietary and physical activity choices.

(3) Partner with faith-based organizations, community health centers, and nonprofit agencies to deliver evidence-based obesity prevention programs at the local level.

(4) Establish a national physical activity campaign, modeled on Norge's and Nippon's national exercise programs, to encourage adults and children to engage in 150 minutes of moderate-intensity physical activity per week.

SECTION 7. PENALTY CLAUSES

(a) CIVIL PENALTIES.

(1) Any food or beverage manufacturer that fails to comply with front-of-pack labeling requirements shall be subject to a civil penalty of not more than $50,000 per day per violation.

(2) Any food or beverage manufacturer that markets ultra-processed foods or sugar-sweetened beverages to children in violation of Section 5(a)(3) shall be subject to a civil penalty of not more than $1,000,000 per violation.

(3) Any covered employer that fails to provide required health insurance coverage for obesity-related care shall be subject to a civil penalty of not more than $200 per employee per day of non-compliance.

(b) CRIMINAL PENALTIES.

(1) Any person who knowingly and willfully makes false or fraudulent statements in connection with the labeling of food products regulated under this Act shall be subject to criminal prosecution and, upon conviction, imprisonment for not more than 2 years, a fine not exceeding $250,000, or both.

(c) ENFORCEMENT AUTHORITY.

(1) The FDA, FTC, and USDA shall have joint enforcement authority over the provisions of this Act within their respective jurisdictions. The Attorney General may bring a civil action in any district court of the United States against any person who violates this Act.

SECTION 8. EFFECTIVE DATES AND IMPLEMENTATION

(a) EXCEPT AS OTHERWISE PROVIDED, this Act shall take effect on the date of enactment.

(b) IMPLEMENTATION SCHEDULE.

(1) Within 90 days of enactment: The Secretary shall establish the Interagency Council on Obesity Prevention and convene its first meeting.

(2) Within 180 days of enactment: The Secretary shall publish the National Obesity Reduction Plan. The FDA shall initiate rulemaking for front-of-pack labeling requirements.

(3) Within 1 year of enactment: All agency regulations required under this Act shall be proposed or finalized. Covered employers shall begin providing required health insurance coverage.

(4) Within 3 years of enactment: Food and beverage manufacturers shall meet initial product reformulation targets for added sugar reduction.

(5) Within 5 years of enactment: All remaining product reformulation targets shall be met. A full program evaluation shall be conducted and submitted to Congress.

SECTION 9. APPROPRIATIONS AND BUDGETARY NOTES

(a) AUTHORIZATION OF APPROPRIATIONS.

(1) There are authorized to be appropriated to the Secretary to carry out this Act:

(A) $500,000,000 for fiscal year 2025;

(B) $600,000,000 for fiscal year 2026;

(C) $700,000,000 for fiscal year 2027; and

(D) such sums as may be necessary for each fiscal year thereafter.

(b) SUGAR-SWEETENED BEVERAGE TAX FUND.

(1) The Secretary of the Treasury, in consultation with the Secretary, shall establish a Sugar-Sweetened Beverage Tax Fund comprising revenues from a federal excise tax of $0.01 per fluid ounce on all sugar-sweetened beverages, to be allocated as follows: 50% to community health worker programs, 25% to healthy food access grants, and 25% to school nutrition and physical education programs.

(c) BUDGETARY IMPACT.

(1) The Congressional Budget Office estimates that a 10% reduction in obesity prevalence would result in long-term federal savings exceeding $200,000,000,000 through reduced Medicare and Medicaid expenditures over a 20-year period.

Endnotes for Section 5:

1. Front-of-pack labeling systems modeled in part on Chile’s Law 20.606 and Australia’s Health Star Rating System: https://www.minsal.cl/ley-de-alimentos-nuevo-etiquetado-de-alimentos/

2. Sugar-sweetened beverage tax policies modeled on México’s IEPS tax and UK Soft Drinks Industry Levy: https://www.gov.uk/government/collections/soft-drinks-industry-levy

3. Norge national physical activity guidelines: https://www.helsedirektoratet.no/faglige-rad/fysisk-aktivitet-for-barn-unge-voksne-eldre-og-gravide

4. Nippon’s Metabo Law (waist circumference measurement mandate): https://www.mhlw.go.jp/english/wp/wp-hw3/dl/2-009.pdf

5. Sverige’s national nutrition and physical activity framework: https://www.folkhalsomyndigheten.se/the-public-health-agency-of-sweden/

6. Deutschland’s National Action Plan IN FORM: https://www.in-form.de/

7. République française’s Programme National Nutrition Santé (PNNS): https://www.mangerbouger.fr/

8. Australia’s National Preventive Health Strategy: https://www.health.gov.au/resources/publications/national-preventive-health-strategy-2021-2030