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Public health responses to obesity in the United Kingdom: A critical evaluation of campaigns and policy directions (1990–2025)

Birleşik Krallık'ta obeziteye yönelik halk sağlığı yaklaşımları: 1990-2025 Kampanya ve politika yönelimlerinin eleştirel değerlendirmesi

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Abstract Obesity, defined by the World Health Organisation as excessive fat accumulation impairing health, has become a major global public health issue. By 2022, one in eight people worldwide were living with obesity, a figure projected to rise to one in four by 2035. The United Kingdom (UK) mirrors these trends, with obesity rates continuing to escalate, particularly among children. This ethnographic study explores obesity prevention strategies and health communication campaigns in the UK from 1990 to 2025, combining policy analysis with in-depth interviews with 35 adults across the UK. Findings indicate that the implemented campaigns have been effective in raising public awareness; however, their impact has neither been equitably distributed across different segments of society nor sustained over the long term. Although obesity prevention policies and campaigns implemented in the UK have, at times, demonstrated innovation and contributed to raising public awareness, these strategies have predominantly centred on behavioural change, while social policies and regulatory measures capable of addressing structural inequalities have been largely neglected. The study concludes that effective obesity prevention requires not only behavioural messaging but also long-term, equity-oriented policy reform that addresses social determinants and holds commercial actors accountable.

Öz Dünya Sağlık Örgütü tarafından sağlığı bozacak şekilde aşırı yağ birikimi olarak tanımlanan obezite, küresel ölçekte önemli bir halk sağlığı sorunu haline gelmiştir. 2022 itibarıyla dünya genelinde her sekiz kişiden biri obeziteyle yaşamaktadır ve bu oranın 2035 yılına kadar her dört kişiden birine yükselmesi öngörülmektedir. Birleşik Krallık da bu eğilimleri yansıtmakta; özellikle çocuklar arasında obezite oranları artmaya devam etmektedir. Bu etnografik çalışma, 1990'dan 2025'e kadar Birleşik Krallık'taki obeziteyi önleme stratejilerini ve (bu stratejiler doğrultusunda belirlenen hedeflere ulaşmak için yürütülen) sağlık iletişimi kampanyalarını incelemekte; politika analizini Birleşik Krallık genelinde 35 yetişkinle yapılan derinlemesine görüşmelerle birleştirmektedir. Bulgular, uygulanan kampanyaların kamu farkındalığını artırmada etkili olduğunu; ancak bu etkinin toplumun farklı kesimlerine eşit şekilde dağılmadığını ve uzun vadede sürdürülemediğini ortaya koymaktadır. Birleşik Krallık'ta uygulanan obeziteyle mücadele politikaları ve kampanyalar, belirli dönemlerde yenilikçi ve toplumsal farkındalığı artırıcı nitelikler taşısa da bu stratejiler genellikle davranışsal değişimi merkeze almış; yapısal eşitsizlikleri dönüştürecek sosyal politikalar ve düzenleyici önlemler geri planda bırakılmıştır. Çalışma, etkili obeziteyle mücadelenin yalnızca davranışsal mesajlarla sınırlı kalmayıp; sosyal belirleyicileri ele alan ve ticari aktörleri sorumlu tutan uzun vadeli, eşitlik odaklı politika reformlarını da gerektirdiği sonucuna varmaktadır.

Keywords Obesity · health strategies · policy · campaigns · UK

Anahtar Kelimeler Obezite · sağlık stratejileri · politikalar · kampanyalar · Birleşik Krallık

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Public health responses to obesity in the United Kingdom: A critical evaluation of campaigns and policy directions (1990–2025)

Obesity is defined by the World Health Organisation (WHO) as "an abnormal or excessive accumulation of fat that may impair health." Body mass index (BMI), a measurement based on the ratio of an individual's height to weight, is one of the most used indicators for diagnosing obesity. However, in recent years, BMI has come under increasing criticism for offering a one-dimensional assessment of an individual's health status. Over the past year, there has been a growing consensus that BMI should not be considered the sole criterion in evaluating obesity. According to WHO data from 2022, one in every eight people globally is living with obesity, and if current trends continue, by 2035, one in four individuals will fall into the obesity category by 2035 (World Health Organisation, 2023). A similar surge has been observed in childhood obesity. This rise constitutes not only a public health crisis that threatens individual well-being but also a multidimensional issue that places economic and structural strain on national health care systems.

The causes of obesity are multifactorial and involve genetic, hormonal, and environmental factors. Nevertheless, dominant public narratives often attribute obesity to a lack of willpower or personal choices. Such reductive perspectives foster stigma, social exclusion, and avoidance of health care services among individuals with obesity. Emphasis on personal responsibility also permeates public health policies, media discourse, and interpersonal interactions. Therefore, addressing obesity requires not only medical interventions but also a comprehensive approach that incorporates economic, social, and cultural dimensions.

The UK is among the countries in Europe with the highest obesity rates, and projections indicate that this trend will persist (World Obesity Federation, 2024). The UK has implemented several health policies, communication campaigns, and public health strategies over the past 35 years. These efforts aim to raise awareness across diverse segments of society and to promote behavioural change. However, gaps in policy implementation and the absence of regulatory frameworks in contributing sectors have hindered these initiatives' overall effectiveness.

This study examines obesity prevention strategies and health communication campaigns implemented in the UK between 1990 and 2025. The UK was selected as a case study for several reasons. The UK has some of the highest obesity rates in Europe and has developed various national campaigns, policy reforms, and regulatory interventions in response. The structure of the UK health care system, its media policies, and the influence of the food industry make it a particularly rich context for exploring both policy design and public engagement.

Despite the growing academic interest in obesity-related public health efforts, comprehensive ethnographic research that integrates policy analysis with the lived experiences and perceptions of citizens is still lacking. This study aims to fill that gap by providing a multidimensional perspective on how the public receives, interprets, and critiques obesity-related interventions.

The originality of the study lies in its effort to go beyond describing policies and campaigns. This study critically explores whether these interventions reinforce social inequalities, exclude vulnerable populations, or create lasting change. This research contributes to the growing literature on weight stigma, the structural determinants of health, and rights-based approaches to public health policy (Green & Thorogood, 2018; Ata & Thompson, 2010; Green & Thorogood, 2018; Finn & Nobles, 2018; Puhl & Heuer, 2009).

Obesity in the UK

In this study, the examination of obesity in the UK through the lens of social determinants and structural inequalities reflects the understanding that obesity is a complex public health issue and not merely an outcome of individual behaviour. Public health is concerned not only with the treatment of diseases but also with their prevention, protection of health, and promotion of overall well-being at the population level. Within this framework, obesity is shaped by several factors, including socioeconomic status, educational background, environmental conditions, media representations, policymaking processes, and access to health care services.

Therefore, the study conceptualises obesity as more than an individual risk factor; it is treated as a public health issue that both mirrors and reinforces social inequalities. As highlighted in the literature (Marmot, 2005; WHO, 2022), public health focuses not only on the biological origins of disease but also on the social determinants that contribute to their emergence. This conceptual approach has guided the research's theoretical and methodological orientation and defines its original contribution to the field.

When examining data on the prevalence of obesity in the UK, approximately 64% of adults fall within the overweight or obese category. The upward trajectory of these rates over time is a public health concern. The prevalence of overweight and obesity is highest among individuals living in the most deprived areas (71.5% and 35.9%, respectively) and lowest among those residing in the least deprived regions (59.6% and 20.5%, respectively). The steady increase in obesity rates and the growing financial burden on the national healthcare system have elevated the issue to the political agenda, necessitating the development of targeted public health policies (NHS Digital, 2023).

Adopting a comprehensive approach that considers the environmental, economic, and structural conditions that shape people's lives is crucial to understand obesity and enhance the effectiveness of interventions. In the UK, transformations in social structures over the past four decades have significantly influenced dietary behaviours, levels of physical activity, and access to health care services (Michalopoulou et al., 2024).

In this context, factors such as the quality of local food options, income level, educational attainment, and housing conditions are among the key determinants shaping health-related behaviours. Within the framework of modernisation and neoliberal economic policies, food supply and retail system commodification emerge as one of the most prominent external drivers of obesity. In recent years, the increasingly aggressive marketing of high-calorie, low-nutrient, and ultra-processed food products has steered individuals towards unhealthy dietary patterns. Geographic disparities in access to affordable, fresh, and nutritious foods are visibly pronounced across the UK, particularly in areas dominated by low-cost, ready-to-eat products (Collins et al., 2024).

Due to financial constraints, people living in low-income areas face significant barriers to accessing healthy food, especially fresh fruit and vegetables. Income level is a critical determinant that directly influences dietary choices and living conditions. A substantial body of research has shown that lower-income individuals tend to consume more energy-dense but nutrient-poor foods, thereby increasing the risk of obesity (Flint et al., 2015).

In the UK, the material hardship faced by families with children, especially single-parent households, has contributed to the class-based nature of childhood obesity. The high cost of healthy eating often forces families to rely on processed and convenience foods.

Cultural food practices, media influence, and obesity sociopolitical framing

Nutrition is not merely a means of fulfilling biological needs; it is also a multilayered social process that reflects the sense of belonging, cultural values, and identities of individuals. In societies with high levels of ethnic diversity, such as the UK, interactions between the country's traditional dietary patterns and migrant communities' eating habits have contributed to greater diversity in food preferences, mealtimes, and culinary rituals. Integration into the Western fast-paced consumption culture has led to increased consumption of fast food and packaged products, particularly among second- and third-generation individuals, thereby diminishing the protective effects of cultural dietary traditions on health. When viewed holistically, such evolving food practices can significantly contribute to the risk of obesity.

The role of media and marketing strategies in shaping dietary habits and sedentary lifestyles is undeniable. Children and adolescents in the UK are frequently exposed to advertisements for unhealthy foods through television, the internet, and social media platforms (Halford et al., 2024).

These advertisements often portray high-sugar, high-fat products as entertaining, educational, and appealing, effectively normalising unhealthy eating behaviours. While the media steer consumer behaviour, it also shapes body image and reproduces social norms. Ideals of thinness propagated through television programmes, fashion magazines, and social media channels contribute to eating disorders, low self-esteem, and appearance-based anxieties among young women and men. The frequent negative portrayals of individuals living with obesity in the media further exacerbate this situation. Such representations deepen societal stigma and serve as barriers to the adoption of healthy lifestyle practices. In this way, the media not only influences consumption patterns but also perpetuates structural discrimination in public health narratives.

In the context of cultural food practices, the influence of media representations and commercial marketing strategies on individuals' food consumption patterns and perceptions of the body has attracted increasing attention. The mass media often portrays people living with obesity in stigmatising ways, reinforcing narrow and exclusionary norms related to health, beauty, and moral responsibility (Ata & Thompson, 2010; Puthl & Heuer, 2009). Marketing activities frequently target low-income populations by promoting calorie-dense yet nutrient-poor food products, which intensifies existing health inequalities (Cairns et al., 2013). These structures, perpetuated through media and commercial actors, contribute to the social legitimisation of unhealthy dietary practices while placing the burden of responsibility on individuals, thereby obscuring structural inequities (Monteiro et al., 2013).

Historical evolution of obesity-related health policies in the UK

The development of health policies targeting obesity in the UK has extended far beyond managing a medical issue at the individual level; it has evolved into a multi-layered field of intervention addressing structural inequalities that affect public health more broadly. Since the 1990s, these policies have shifted from behaviour-focused individual strategies to broader environmental and systemic interventions since the 1990s. Obesity has become a central issue in public health discourse, requiring cross-sectoral approaches involving food policy, education equity, media regulation, and urban planning (Butland et al., 2007, p. 28). Initially, obesity was largely framed because of sedentary lifestyles and unhealthy diets, with a strong emphasis on personal responsibility and minimal public intervention (Department of Health, 1992, p. 14).

The UK government's 1992 *Health of the Nation* policy marked a strategic shift from a disease-focused model to one prioritising public health. It aimed to reduce obesity rates to 1980 levels (8%) and set national targets to prevent chronic diseases such as cardiovascular disease, stroke, and cancer (Main & Main, 1992, p. 362). Rooted in the WHO's *Health for All* vision, the policy underscored intergovernmental cooperation

and environmental changes to support healthy individual choices. While it acknowledged key social determinants such as poverty, unemployment, housing, and education, the implementation remained largely individualistic, with limited structural interventions to reduce inequalities (Michalopoulou et al., 2024).

In response to the limited impact of this strategy, the Labour government introduced a new policy in 1999 titled *Saving Lives: Our Healthier Nation*, which retained the 2010 targets but promoted a tri-partnership model involving government, communities, and individuals (Department of Health, 1999, p. 2–3). This policy explicitly acknowledges the influence of social determinants, such as housing, environment, and employment, on health. However, its application failed to achieve the desired holistic approach; obesity targets were removed, and the continued emphasis on behaviour change proved inadequate in reducing health inequalities (Public Accounts Committee, 2023a, p. 1–2; 2023b).

The 2000s marked a turning point in the UK approach to obesity. The 2004 policy paper *Choosing Health: Making Healthy Choices Easier* signalled a more proactive government role in promoting health. Instead of coercive measures, the focus shifted to modifying the environment to enable healthier choices, for instance, by displaying calorie counts on food labels and increasing access to recreational facilities (Department of Health, 2004, p. 39). Obesity was redefined not just as an aesthetic or quality of life issue but as a structural threat with profound implications for the national health system, directly linked to heart disease, type 2 diabetes, and certain cancers.

Although general practitioners were tasked with informing patients about obesity risks, limited time, training, and resources hindered widespread implementation. The Weight Management Services initiative, which aimed to expand obesity-related care within primary health services, was unevenly applied—ranging from multidisciplinary referrals in some regions to mere brochure distribution or app suggestions in others.

The 2007 Foresight report "Tackling Obesities: Future Choices" profoundly reshaped the obesity policy's strategic framework (Government Office for Science & Department of Health and Social Care. (2007–2011); Butland et al., 2007, p. 49). It emphasised the need for integrated strategies encompassing food industry regulation, urban planning, education systems, and media reform. By the 2010s, public health policies had adopted increasingly interventionist and regulatory characteristics. The 2016 "Childhood Obesity: A Plan for Action" introduced decisive measures, including the Soft Drinks Industry Levy, advertising restrictions on high-calorie foods, and structural reforms in school environments (HM Government, 2016, p. 11). The levy had a significant impact, prompting manufacturers to reformulate products by reducing sugar content (Cobiac et al., 2024; Teng et al., 2019). As a structural rather than behavioural intervention, this strategy marked a departure from previous models and focused on the supply-side determinants of obesity.

Policy efforts, such as front-of-pack labelling and store layout regulations were also prioritised during this period. Despite ambitious strategies, many interventions remained behavioural in nature, failing to adequately address structural inequities. For low-income individuals, making healthy choices is often not a realistic option—underscoring the need to ensure that policy interventions adhere to principles of access and equity. Another concern is the use of stigmatising language in policy documents. Over time, people living with obesity have been framed as societal threats to public health (Flint et al., 2018, p. 875). Flint et al. argue that the rhetoric within these documents often prioritises behavioural correction at the expense of human rights, ultimately undermining public trust.

Since 2020, particularly in the wake of the COVID-19 pandemic, the UK government has tried to implement more radical reforms. The *Better Health* campaign associated obesity with increased risks of COVID-19 complications, thus linking anti-obesity measures with public health security (HM Government, 2020, p. 9). While this strategy aimed to increase public awareness and impose tighter regulations on the food industry, uncertainty remains as to whether pandemic-era interventions will translate into a sustainable long-term

policy vision. Ultimately, the UK's approach has evolved from voluntary awareness-based campaigns to legal regulations targeting food supply and environmental factors. However, this evolution has lacked consistency due to cross-sector conflicts of interest, inadequate enforcement mechanisms, and social polarisation. A collaborative model that actively includes public authorities, industry stakeholders, media institutions, and civil society is required for effective, equitable, and ethically sound legal interventions.

In summary, the historical development of health policy in the UK reflects a complex shift from framing obesity as an individual failing to recognising it as a multi-sectoral public health issue. Nonetheless, the institutionalisation of equitable, participatory and holistic approaches remains insufficient. For future policy efforts to succeed, there is a need to learn from historical experience and prioritise structural justice within a strategic framework.

This study approaches obesity not merely as a medical or individual issue but rather focuses on the social, structural, and political dimensions of the problem approach, which is relatively rare in the international literature. It not only focuses on individual experiences but also critically examines public policies, health communication campaigns, and media representations**,** thereby integrating micro-level individual and macro-level societal analyses. This multi-layered analytical framework distinguishes the study from conventional qualitative research. Uniquely, participants in this study were not passive recipients of public health discourse; rather, many engaged in critical reflections on structural injustices and the role of industry in shaping obesogenic environments, revealing a form of grassroots policy literacy. Methodologically, the study stands out for its triangulated design, which combines critical policy analysis, ethnographic interviews, and media discourse evaluation to offer a multidimensional understanding that is rarely achieved in obesity-related research. This study contributes to the growing body of scholarship that calls for a shift from paternalistic health governance to rights-based, inclusive policymaking that resists stigmatising narratives and prioritises structural justice.

Aim and methodology

This study aims to examine obesity prevention policies and public health campaigns implemented in the UK between 1990 and 2025. The temporal scope of this research has been purposefully established as the period between 1990 and 2025 to encompass critical junctures in the evolution of obesity policies in the UK. The rationale for selecting these specific start and end dates is rooted in their significant historical and political context. The 1990s represent a pivotal era when obesity began to gain widespread academic and public recognition as a public health 'epidemic' in the UK, leading to the publication of the first national health reports and the emergence of early intervention strategies, which were primarily focused on individual behaviour. This starting point allows the study to offer a robust comparative analysis, observing the ideological and practical shift between initial approaches and contemporary strategies. This defined 35-year span comprehensively covers a radical transition in UK obesity interventions, moving from purely behavioural models to more structural and environmental regulations, such as fiscal measures and advertising restrictions. This process offers an opportunity for an in-depth examination of how successive governments have tackled obesity through various ideological lenses, revealing policy continuities and discontinuities. Finally, the end date of 2025 is a strategic choice to incorporate the most up-to-date policy and campaign outcomes available at the time of writing and to anticipate near-future policy trajectories. Consequently, the 1990–2025 range provides a meaningful and critical cross-section of the history of UK obesity policy, extending from its early recognition to its current complex structural strategies.

RQ1. What policies were developed in the UK to address obesity between 1990 and 2025?

RQ2. What campaigns have been initiated to prevent obesity and/or raise public awareness during this period?

RQ3. How are these obesity-related policies and campaigns perceived by the public?

RQ4. What do the public believe should be done to combat obesity?

The study population comprises all obesity prevention policies and campaigns developed within the specified time frame, while the sample focuses specifically on those implemented in the UK between 1990 and 2025.

This study employs an ethnographic research approach. Ethnography is a methodological framework that centres on direct engagement with everyday experiences of participants. It is grounded in field-derived knowledge and shaped by the researcher's active and immersive role as an observer. According to Hammersley and Atkinson (2007), ethnography involves observing the actions and discourse of individuals within their natural settings and interpreting the meanings attributed to them.

The research was conducted over a one-year period in the UK, during which the systemic dimensions of obesity were analysed in depth through expert interviews, field observations, field notes, and an extensive review of the relevant literature. The Ankara University Ethics Committee granted ethical approval for the study under decision number 56786525-050.04.04/10606 on February 10, 2020. Approval was also obtained for the semi-structured in-depth interview questions and informed consent form.

The set of ten open-ended interview questions employed in this study was developed to capture the multidimensional and socially embedded nature of obesity. A full list of interview questions is included in the Appendix. Rather than approaching obesity as a purely medical or behavioural issue, the questions were designed within a sociological and public health framework that conceptualises it as a phenomenon shaped by structural, cultural, and economic determinants (Marmot, 2005; WHO, 2022). The thematic framework guiding the design of the questions was established through an extensive review of the existing literature, which identified five recurrent domains: structural inequalities and social determinants of health, access to healthcare services, media representations and cultural narratives, policy interventions and institutional responsibility, and lived experiences of stigma and exclusion (Puhl & Heuer, 2009).

Each theme informed at least one interview question, ensuring a balance between individual experiences and broader social structures. The open-ended design allowed participants to freely articulate their perspectives, enabling new insights to emerge beyond predetermined categories. Methodologically, this approach aligns with qualitative inquiry principles that emphasise interpretive depth and theoretical grounding in lived experience (Charmaz, 2014; Creswell & Poth, 2018). Consequently, the interview framework ensured that data collection remained theoretically coherent, empirically grounded, and consistent with the study's aim of examining how obesity-related policies are interpreted and negotiated in everyday life.

Participants were selected based on the following inclusion criteria: age 18 years, residence in the UK, and BMI >30. Individuals who did not meet these inclusion criteria were excluded from the study. A total of 35 participants were interviewed using a semi-structured format.

The initial endpoint and data saturation target were set at 30 interviews. This decision aligns with Bernard's (2013) assertion that ethnographic research typically requires approximately 30 participants to gain a comprehensive understanding of complex social processes. Interviews continued as long as new conceptual insights emerged, and data collection was considered complete once thematic repetition became evident and interpretive diversity was adequately represented, indicating that saturation had been reached (Creswel & Poth, 2018).

In selecting participants, variables such as age, gender, socioeconomic status, ethnic background, geographic location, and immigration status were considered to ensure social diversity and representativeness. This approach enabled a deeper analytical understanding of how the lived experiences of people living with obesity are shaped not only at the individual level but also across diverse social contexts. Ethical principles, data protection policies, and cultural sensitivities in the UK context directly influenced participant access during the fieldwork process. During the interview process, several individuals declined participation or failed to attend scheduled interviews, while others expressed hesitations regarding the study's objectives. These dynamics reflect both structural and cultural barriers in participant recruitment. Therefore, throughout the data collection process, priority was given not only to the number of participants but also to the qualitative depth and diversity of interviews, ensuring robust interpretive representation. Legal frameworks such as the General Data Protection Regulation shaped the researcher's field access strategies in the UK context where this study was conducted. Despite these constraints, the 35 interviews yielded sufficient thematic convergence and meaningful variation, allowing the study to achieve thematic saturation (Creswel & Poth, 2018; Bernard, 2013; Morse, 1994). Consequently, the sample size provided adequate depth and representational capacity for the generation of qualitative data. The narratives of the participants offered a rich foundation for examining how health communication policies are experienced at the individual and societal levels. This approach is consistent with established practices in qualitative research addressing health communication, social inequality, and stigma.

All interviews were recorded, transcribed, and anonymized. Each interview lasted approximately 60 min, resulting in a cumulative interview duration of 35 h. The organisation of the interviews, including the provision of preliminary information to participants and the scheduling of appointments, proved to be more time-consuming than the interviews themselves.

Semi-structured interviews consisting of 10 questions were conducted with participants, focusing on six themes: personal experiences with obesity, obesity-related policies in the UK, media portrayals of obesity, public campaigns addressing obesity in the UK, proposed actions, and general reflections.

Of the 35 participants, 24 were women and 11 were men. The predominance of female participants can be attributed to their greater willingness to participate in in-depth interviews. Participants' ages ranged from 25 to 83 years. Educational backgrounds varied, with a focus on high school graduates, college attendees, and those holding bachelor's and master's degrees. Their professions included doctors, healthcare workers (laboratory staff, nurse assistants), office/white-collar workers (CEOs, managers, consultants, sales, and accounting), blue-collar workers (steel factory workers, fishermen, and restaurant chefs), retirees, and students.

The participants represented a diverse range of occupational backgrounds, including medical professionals, healthcare workers (e.g., lab technicians, nurse assistants), white-collar workers (e.g., CEOs, managers, consultants, salespeople, accountants), retirees, and students. Interview responses were analysed thematically. Special attention was paid to understanding how national health policies and obesity campaigns were perceived within the social context. Additionally, the study explored the influence of individual experiences, economic conditions, and media narratives on obesity perceptions.

The participants' insights were analysed alongside the researcher's field observations and personal reflections. In doing so, the study offers an interdisciplinary perspective that goes beyond biomedical approaches to obesity. It engages with broader dimensions, such as social justice, media responsibility, and structural inequalities, arguing for a more holistic and equity-oriented approach to tackling obesity.

Findings

The analysis begins with an examination of public health campaigns in the UK, tracing their trajectory from early media interventions to recent structural food policy reforms, and subsequently turns to the results of in-depth interviews with participants, which illuminate how these policies are perceived, challenged, and experienced in everyday life.

The Fighting Fat, Fighting Fit

The *BBC* launched the *Fighting Fat, Fighting Fit* campaign in January 1999, and it was considered one of the largest public health media initiatives ever conducted in the UK at the time. The campaign was supported by more than 30 programmes broadcast on *BBC One, BBC Two, Radio 2* and local radio stations. It was enriched through television series such as *Weight of the Nation*, *Fat Free*, *Fat Files* and *Body Spies*, along with a call centre and registration system (Wardle et al., 2002, p. 1300).

The core message of the campaign promoted sustainable lifestyle changes over quick-fix diets or radical transformations. The emphasis was on move more, eat better rather than calorie restriction alone (Wardle et al., 2002, p. 1299). The communication strategy drew on established behavioural change models, such as Bandura's social learning theory and the Health Belief Model.

A nationally representative survey conducted by the Office for National Statistics (n = 1.894) in March 1999 revealed that 57% of the public recalled the campaign. These findings demonstrated that a media organisation of the BBC's scale could leverage its influence for public health purposes. However, while recall was high among highly educated groups, it was significantly lower among ethnic minorities and those with lower educational attainment. To encourage participation, the campaign offered a sign-up package that included a booklet and self-monitoring cards to be returned over a five-month period. Yet, enrolment remained low (Wardle et al., 2002, p. 1301–346).

The *Fighting Fat, Fighting Fit* campaign marked a turning point in demonstrating how media can function as a public health intervention, particularly by highlighting the value of collaboration with media organisations. However, the promotion of behavioural changes through self-directed implementation models proved insufficient in generating long-term impact. Furthermore, the media can reproduce inequalities based on educational attainment and sociodemographic characteristics.

Although the *BBC's Fighting Fat, Fighting Fit* initiative showcased the potential of effectively leveraging media power for public health purposes, the television programme–centred model was ultimately limited in its ability to drive sustained behavioural change.

The Feed Me Better

Initiated in 2005 by British celebrity chef Jamie Oliver in 2005, the *Feed Me Better* campaign constitutes a pivotal case illustrating the potential of food policy as an effective societal lever in addressing childhood obesity. The campaign gained traction through the *BBC* television series *Jamie's School Dinners* and rapidly evolved into a nationwide public health movement. By exposing the poor nutritional standards of meals served in state schools, Oliver not only sought to influence public opinion on children's diets but also to catalyse policy reforms within the educational sector.

The principal aim of the initiative was to replace highly processed, fat- and sugar-laden meals with fresh, wholesome, and nutritionally balanced alternatives. Oliver advocated for a reduction in the reliance on ready-made foods in school kitchens, encouraged meal preparation from scratch, and promoted the provision of culinary training for school staff. Media campaigns and awareness-raising activities targeting pupils and their families further supported these objectives (Gibson & Dempsey, 2013, p. 46).

In response to the considerable public and political pressure generated by the campaign, the UK government allocated £280 million to reform school food provision. This funding was designated for staff development, kitchen infrastructure refurbishment, and food supply chain reassessment (Morgan & Sonnino, 2008, p. 91).

The campaign also engaged with broader issues of social equity. The study illuminated the disproportionate nutritional disadvantage experienced by children from low-income communities, exposing the structural nature of food insecurity. In doing so, it challenged the dominant individualistic narratives on dietary behaviour and foregrounded the need for systemic, policy-driven interventions to ensure equitable access to healthy nutrition.

Despite these achievements, *Feed Me Better* has been subject to critical scrutiny. Commentators have noted that Oliver's leadership approach was largely individualistic, with limited stakeholder consultation and participatory decision-making. Although the campaign achieved tangible improvements in certain school contexts, its long-term sustainability varied significantly depending on local authority support and financial constraints. In turn, this variability inhibited the uniform implementation of reforms across the country.

In sum, the *Feed Me Better* campaign offers a compelling example of how celebrity-led advocacy can drive change in public health discourse and policy. More fundamentally, it underscores that addressing obesity requires not merely individual behavioural change but also sustained institutional commitment and structural reform.

Launched in 2011 by Safefood[1] in Northern Ireland, the *Stop the Spread* campaign was a targeted awareness and intervention initiative addressing the rising obesity rates among adults. To promote public awareness of abdominal obesity and its associated health risks, the campaign employed tangible tools such as waist tape measures. The campaign emphasised that a waist circumference exceeding 94 and 80 cm in men and 80 cm in women significantly increases the risk of cardiometabolic diseases, including type 2 diabetes, stroke, and heart disease (Safefood, 2022).

The campaign garnered notable public attention with a multichannel communication strategy—encompassing television and radio advertisements, social media content, community outreach events, and political engagement. For example, members of the Northern Ireland Assembly publicly participated in the campaign by using the tape measures, thereby enhancing its legitimacy and visibility. According to Safefood reports, more than 400.000 measuring tapes were distributed within the first 12 months, and 56% of individuals who encountered campaign messages reported being motivated to measure their waist circumference. Half of the respondents also indicated revisiting their dietary and PA habits (Safefood, 2022, p. 5).

Despite its initial success in generating awareness, the campaign faced criticism regarding sustainability. Material-based interventions such as tape distribution may trigger short-term engagement, but long-term behavioural change necessitates integration with healthcare systems, individual counselling, and social support programmes (Flint et al., 2018, p. 873). Furthermore, the campaign was criticised for its emphasis on personal responsibility while inadequately addressing broader structural inequalities (Theis & White, 2021, p. 126).

Nevertheless, *Stop the Spread* remains a rare example of a regionally implemented public health campaign that successfully combined political endorsement, tangible visual tools, and community-level action. Its emphasis on waist circumference as a lay health indicator set a precedent for accessible, measurable risk communication and offers an adaptable model for local-level obesity interventions in other countries.

[1] Although tools such as measuring tapes might be perceived today as conventional or even clichéd, their use in public health communication at the time was an innovative approach.

Change4Life

Launched in 2009, the *Change4Life* campaign has been recognised as a milestone in the public health field in the UK. Developed under the leadership of Public Health England, it constituted the first nationwide, comprehensive public health communication initiative that specifically targeted the prevention of childhood obesity (Department of Health, 2009, p. 3). The primary objective of the campaign was to encourage the adoption of healthy lifestyle habits—particularly among children and their families—by promoting increased physical activity, reducing the consumption of unhealthy foods, and ultimately lowering obesity rates.

The campaign's messaging was carefully crafted using principles from behavioural science and delivered in accessible, straightforward language to reach a broad audience. With the slogan 'Eat well, move more, live longer,' the initiative sought to motivate individuals through a positive and non-stigmatising tone, encouraging incremental yet consistent behavioural changes across the three pillars of healthy living.

The key components of the campaign included multi-channel communication strategies (e.g., television advertisements, social media campaigns, public service announcements, billboards, and print materials); school- and community-based interventions (e.g., health education sessions, sports activities, and nutrition workshops in primary schools); family-oriented guidance (e.g., digital content for parents, recipe suggestions, daily planners, and activity recommendations); and collaborations with local authorities, including health services, municipalities, and civil society organisations (Department of Health, 2009, p. 12).

Change4Life achieved considerable visibility and awareness, particularly among its target audience of parents and children. Its child-focused messages were deemed particularly effective. In its first year, nearly one million families requested campaign materials, with 85% reporting that they found the resources useful (Croker et al., 2012). Some regions also reported reductions in the consumption of sugary drinks and the amount of time children spent in front of screens.

However, the long-term impact of the campaign has been subject to debate. Halford (2024) noted that while some degree of behavioural change was observed, these changes were disproportionately evident among middle-class families. According to his analysis, low-income groups were less likely to benefit due to the campaign's failure to sufficiently account for their socioeconomic realities.

On the other hand, Flint draws attention to a different concern. He argues that the visual and linguistic content of *Change4Life* often emphasised the idealised body, inadvertently reinforcing the notion that health equates to thinness (Flint et al., 2018, p. 875). Such representations, particularly during childhood, can negatively influence body image and result in psychological harm.

Further critiques have been directed towards the campaign's sustainability. While *Change4Life* was initially launched with significant public funding as a high-intensity, multi-platform media initiative, subsequent cuts in public spending led to a notable reduction in its scope and intensity. This underscores the fact that public health initiatives require not only strategic design but also sustained political and financial commitment. Campaigns operating with limited budgets are at risk of failing to reach high-risk populations or to reinforce behaviour change effectively. As a result, some regions continued to actively implement the campaign, while in others it almost entirely faded.

In conclusion, while *Change4Life* represents an innovative and wide-reaching public health communication strategy in the UK, its long-term effectiveness remains limited.

The One You

Launched by Public Health England in 2016, *the One You* campaign marked a comprehensive and integrative approach to change public health communication. Targeting adults aged 40–60, the campaign emphasised

that many chronic health conditions could be prevented and encouraged individuals to reassess their lifestyles (Public Health England, 2017). Unlike the *Change4Life* campaign, which primarily focused on children and their families, *One You* addressed the specific health risks of middle-aged individuals, positioning this cohort as a pivotal actor in preventive health behaviours.

The campaign sought to raise awareness around nutrition, physical activity, alcohol consumption, smoking cessation, stress management, sleep hygiene, and regular health check-ups (Public Health England, 2016, p. 8). It launched with an online self-assessment quiz titled How Are You?, which allowed participants to evaluate their health habits and receive personalised advice.

A key innovation of *One You* was its use of digital tools—apps that enabled users to track daily behaviours, set goals, and receive real-time feedback. The campaign also forged partnerships with supermarkets, pharmacies, and workplaces. For example, Tesco supported product labelling initiatives, while pharmacies offered free health screenings (Public Health England, 2017).

Nevertheless, access limitations due to digital illiteracy and socioeconomic constraints meant that the campaign benefited older adults and low-income groups less. Furthermore, the long-term efficacy of the behavioural changes promoted has not been rigorously evaluated (Fenton, 2016). Overall, *One You* represents an innovative shift in targeting and methodology, but its broader impact depends on addressing digital inequalities and investing in long-term behavioural monitoring systems.

The Better Health

In response to the coronavirus disease 2019 (COVID-19) pandemic, obesity emerged as an urgent public health priority. On July 27, 2020, the UK government launched the *Better Health* campaign, which was designed by Public Health England and delivered through the National Health Services (NHS) with digital reinforcement. The campaign framed obesity as a key comorbidity worsening COVID-19 complications and aimed to promote healthier lifestyles during a period marked by sedentary behaviours and weight gain (HM Government, 2020, p. 4).

The primary target groups included men over 40 years old, individuals from lower socioeconomic backgrounds, ethnic minorities, and those with chronic health conditions. The campaign promoted a range of behavioural tools focusing on healthy eating, regular exercise, digital weight management, and smoking cessation. At the campaign's core was the NHS-provided *Weight Loss Plan* mobile app, which allowed users to input demographic and biometric data (e.g., height, weight, age, ethnicity) to calculate BMI and set personalised calorie goals. The app also offered food tracking, activity monitoring, weekly motivational messages, and behavioural nudges.

The user data indicated that 81.5% of the users were women, 54.2% were over the age of 40, and 88.2% had a BMI of ≥25 kg/m²—aligning well with the intended demographic of the campaign. The ethnic distribution largely mirrored the UK population profile (assets.publishing.service.gov.uk), indicating a broad outreach. Reports noted clinically meaningful weight loss in some users and high app engagement, meeting key short-term goals (Department of Health and Social Care, 2020).

However, despite its initial success, the campaign faced significant criticism. Socioeconomically disadvantaged and culturally diverse groups reportedly struggled to access digital tools, limiting equitable participation. Critics argued that while the campaign was technologically robust, it lacked a holistic framework to address underlying structural inequalities. Its narrow emphasis on individual responsibility—without corresponding systemic support—was seen as a limiting factor in achieving enduring health equity.

In-depth interviews: Participant insights

While policy documents and campaign analyses reveal the strategic objectives of obesity prevention at an institutional level, individuals' experiences and perceptions must be closely examined to understand how such measures are translated into social reality. Through in-depth interviews, this section focuses on participants' insights, providing a nuanced exploration of everyday practices, perceptions, and structural critiques related to obesity.

Some participants reported being unfamiliar with specific policies or campaigns due to age. However, based on their knowledge and experience, a prevailing consensus emerged that the food industry plays a decisive role in the rise of obesity. The participants emphasised that rising food prices lead to a preference for cheaper, energy-dense products, which contribute significantly to weight gain because of their high sugar and fat content. Although environments suitable for physical activity exist, excessive calorie intake relative to expenditure was identified as a key driver of obesity and various comorbid health conditions.

Besides describing individual struggles, several participants articulated a broader awareness of how economic pressures, corporate lobbying, and the uneven distribution of public resources shape health behaviours. Such reflections highlight that individuals are active interpreters who situate their personal experiences within wider critiques of structural injustice and not merely passive recipients of health policies. This dimension of participant narratives underscores the importance of embedding lived experience in the design and evaluation of obesity prevention strategies.

Policy experience and inequitable access

Participants pointed to rising economic inequality as a significant barrier to accessing healthy foods in recent years. Most participants stated that cost outweighed nutritional considerations in their food choices, and affordable products typically had high caloric value and low nutritional quality—a point corroborated by the literature.

P14 remarked, "They say eating well is easy, but when I go to the store, the price of fresh food puts me off," indicating that current policies inadequately support access to nutritious options for low-income individuals.

Overall, the participants framed obesity less as a personal failure and more as a structurally driven issue. The financial cost of healthy living, lack of time, precarious employment, and aggressive food marketing strategies were identified as the primary structural barriers to weight management.

The perceptions of digital health interventions were mixed. While some participants found these tools useful, digital inequality emerged as a persistent obstacle. Individuals with low digital literacy or limited internet access were reportedly unable to benefit equally from such services.

P21 commented, "What difference does it make if I download the app? I don't have time to deal with it", highlighting the compounding effects of technological, temporal, and emotional inequalities.

Time constraints are a recurring theme. Working parents emphasised that long working hours and commute times made it difficult to prepare healthy meals at home, and they often resorted to cheaper, faster options. This indicates that healthy eating depends not only on knowledge but also on the availability of time, energy, and resources.

Participants were also critical of the stigmatising language found in policy documents. As P7 observed, "They talk as if we're lazy, but we don't have what it takes to be healthy," highlighting both economic and discursive inequities.

A key takeaway from the interviews was that policies focusing solely on individual motivation were inadequate. A truly effective approach would require social justice-based structural interventions.

Evaluation of the media and campaigns

Most participants described media portrayals of obesity as stigmatising, reductive, and one-dimensional. Only a few found them humorous or motivating. Headless body imagery frequently used in news and health content was perceived as dehumanising. Many expressed frustrations at being reduced to their physical appearance and portrayed as ridicule objects.

"They always show their bellies and hips." "No face, no personality," said P10. Others commented on the infantilizing or comical roles assigned to overweight characters in shows and advertisements. "They never give us lead roles—they are always dumb characters," added P17.

The participants felt that both media content and public campaigns exerted lifestyle pressure. Campaigns such as *Change4Life*, *Better Health*, and *One You* were cited as promoting idealised bodies and homogenised lifestyles. P18 noted, "All the posters show smiling, fit people. When I look in the mirror, I don't see that image," illustrating how such visuals induce internalised pressure. In particular, female participants shared memories of growing up surrounded by media glorifying thinness. "I used to see thin celebrities on TV after school and wished I looked like them," said P7.

Male participants, on the other hand, felt underrepresented or marginalised in campaigns. "The exercise tips always seem to be targeted at mothers. It would be nice if they thought of us, too" remarked P15.

Economic realities shape the applicability of media messages. Many reported that campaign suggestions clashed with their lived experiences. P29 stated, "The app says I have a smoothie every morning, but I don't even own a blender." P14 added, "Meal deals cost £3, but a healthy lunch is twice as much," underscoring economic disparities.

Regarding the *Feed Me Better* campaign, some participants acknowledged improvements in school meals but noted limited changes at home. "Thanks to Jamie Oliver, school food got a bit better, but we still eat frozen pizza at home," said P13.

Campaign slogans and messaging were perceived as judgmental by some. P6 shared, "The messages feel like 'You're lazy, get moving'—but people's circumstances are different." P4 added, "When the *BBC* said, 'obesity is a burden on the NHS,' I felt like I was the burden." P31 noted, "It's hard enough to accept your body, and then the media makes you feel ashamed of it too."

Nonetheless, there were positive views. Some participants felt that the messages directed at children were effective. "My kids started seeing that yellow character on TV and now think that eating vegetables is a game," said P5.

Participant narratives indicate that obesity strategies in the UK remain limited by their focus on individual behaviour change. These strategies do not adequately address the social determinants that shape health inequalities. Adopting healthy practices involves not only awareness or motivation but also access to financial resources, time, supportive environments, and digital infrastructure.

The interviews reveal a structural disconnect between the technical design of public health policies and the real-world barriers encountered during implementation. Digitally mediated interventions, such as *One You* and *Better Health*, often fail to consider key socio-technical factors, such as digital literacy, device access, and time availability, thereby limiting their reach.

Furthermore, dominant media narratives that circulate ideal body norms undermine public trust in health campaigns and damage body image, especially among vulnerable populations.

In summary, participants emphasised that obesity should not be framed as a failure of individual willpower but rather as a multi-dimensional social issue related to food environments, income inequality, employment security, and broader systemic conditions. Therefore, public health interventions must target not just the individual but also the structural context. These findings highlight how qualitative health research can serve not only as an evaluative tool for policies but also as a driver for redesigning equity and inclusive policy-making processes.

Discussion and conclusion

Since the 1990s, obesity prevention policies in the UK have undergone a significant transformation, both in terms of institutional public health approaches and broader societal perceptions. The policy documents and public health campaigns analysed in this study underscore that obesity is a multidimensional issue that cannot be explained solely through individual behaviours. When historical policy trajectories are considered alongside participant perspectives, obesity has increasingly been framed as a public health concern shaped by economic, cultural, and structural determinants. This aligns with the social determinants of health framework (Marmot, 2010), which suggests that upstream structural factors—such as income inequality, education, and food environments, play a crucial role in shaping health outcomes, including obesity. Similarly, the Foresight Report (Butland et al., 2007) emphasised the systemic and environmental nature of obesogenic conditions in the UK.

Public health campaigns, such as *Change4Life* and *One You*, succeeded in securing broad visibility and sought to reshape childhood behaviours and family-level practices. However, their predominant emphasis on personal agency and individual change attracted sustained critique for reproducing a moralising tone, normalising blame narratives, and minimising the role of structural constraints. Over the past decade, this behavioural emphasis has increasingly been balanced, although not entirely replaced, by policies such as *Better Health* and *the Tackling Obesity Strategy*, which incorporate structural interventions, such as advertising restrictions, fiscal measures, sugar taxes and calorie labelling. This progression represents an important conceptual evolution within the obesity strategy field in the UK. However, evaluation mechanisms remain limited despite these emerging systemic interventions, and the food and beverage industry's influential lobbying power continues to impede policy continuity and long-term reform. This dynamic reflects Lupton's (1995) critique of the moral regulation embedded in public health discourse and Evans et al.'s (2008) warning that behaviour-focused campaigns can reinforce stigma by obscuring the broader conditions shaping health.

The lived experiences of participants provide empirical grounding for these policy critiques. Their narratives revealed that health interventions and digital tools do not reach all segments of society equally. Rather, they intersect with existing social inequalities related to income, education, ethnicity, and work-life conditions. Digital divides, including disparities in technology access, digital literacy, and time availability, emerged as key mediators of who benefits from public health messaging. Participants also described how visual representations and language used in media and institutional communication undermine self-perception and sense of dignity, weakening the perceived legitimacy of public health messages. Although initiatives such as *Jamie Oliver's School Meals* Campaign briefly shifted public debate, their effects hinged on local authority resources, highlighting the uneven capacity of local institutions to sustain interventions. Similarly, campaigns such as *Stop the Spread*, which introduced tangible behavioural aids (e.g. measuring tapes), revealed innovative public engagement strategies but suffered from limited geographical and socioeconomic reach.

An important recurring theme in participant narratives was the manner in which obesity discourses emphasising personal responsibility erode empathy and narrow policy imagination. The participants stressed

that access to a healthy life should be seen as a fundamental social right and not a matter of personal virtue or economic capacity. This stance aligns with research demonstrating that individualising obesity contributes to stigma (Puhl & Heuer, 2009; Flint et al., 2015), undermines public support for structural reforms and intensifies health inequities. Thus, while informational campaigns remain necessary, they are insufficient without the structural transformation of food environments, social protection systems, and urban infrastructure.

The thematic convergence between the structural public health literature and participant perspectives underscores the relevance of the health framework's social determinants. Participants' accounts of health care access, body image pressures, nutritional decision-making, and stigma were deeply influenced by socioeconomic status, precarious employment, immigration history, and racialized identities. Economically marginalised participants reported reliance on low-cost, energy-dense processed foods as a constrained choice shaped by affordability and availability rather than a lifestyle preference (Darmon & Drewnowski, 2008). Racialized and migrant communities described intersecting forms of discrimination, reflecting wider scholarship on racialized health inequities (Bailey et al., 2017; Nazroo et al., 2020). Meanwhile, internalised weight-related stigma, driven by institutional and media discourses, resonates with Link and Phelan's (2001) conceptualisation of stigma as a mechanism that both reflects and reproduces social inequality.

Taken together, these findings illustrate that obesity cannot be understood isolated from broader sociopolitical inequities. They reinforce the need for multi-sectoral and equity-focused public health interventions, consistent with the WHO's (2010) framework emphasising the distribution of power, resources, and opportunities. The UK's policy trajectory signals movement towards systemic accountability. However, persistent gaps in cultural sensitivity, accessibility, and equity indicate that behavioural framings still dominate institutional narratives. A paradigm shifts from individual blame to structural responsibility remains essential.

A further contribution of this study is the demonstration of the value of qualitative and ethnographic approaches for evaluating public health interventions. Although epidemiological data provide insight into prevalence and risk, they cannot fully illuminate how policies are interpreted, mediated, and lived in everyday life. This research's qualitative findings reveal not only which interventions are implemented but also how they are enacted, who is empowered by them, and who remains marginalised**.** Qualitative evidence can challenge technocratic approaches and strengthen the legitimacy of equity-oriented policy reform by amplifying lived experience, echoing arguments by Popay et al. (2003) and Greenhalgh and Russell (2006) for incorporating lay knowledge into health policy processes.

In conclusion, the evolution of obesity policy in the UK reflects a meaningful movement towards structural recognition of health inequality; however, significant gaps remain in ensuring equitable access, cultural sensitivity, and long-term sustainability. Structural drivers, including socioeconomic inequality, food system dynamics, and urban environments, must remain central to future strategies, as emphasised by the Marmot Review and the Foresight Report. Therefore, public health communication and policy design should therefore continue shifting from behavioural framings towards structural responsibility and rights-based approaches. Qualitative and ethnographic evidence must be integrated into future policy frameworks to ensure that interventions are context-sensitive, socially grounded, and aligned with the everyday realities of people living with obesity. Only by balancing epidemiological metrics with lived experience and structural analysis can public health systems foster equitable, compassionate, and effective responses to obesity.

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Appendix | Ek

The interview questions

1. What does obesity mean to you personally? How would you define it?
2. How do you evaluate society's attitudes towards obesity?
   (Stigma, prejudice, social acceptance, and cultural perspectives)
3. Do you think that the shift in the UK's obesity policies towards more structural and environmental measures has created equal opportunities for everyone, or do some groups remain disadvantaged?
   (Economic Inequality, Digital Access, Social Class Considerations)
4. What are your opinions on obesity prevention policies and regulations?
   (e.g., sugar tax, food labelling, advertising restrictions, and urban planning)
5. Do you think that environmental conditions adequately support healthy living?
   (e.g., cost and accessibility of healthy foods, availability of physical activity spaces, neighbourhood environment, etc.)
6. How do you evaluate obesity-related public communication and awareness campaigns?
   (Supportive or blaming? Effective or not? What could be improved?
7. How do you think the media reflect the obesity issue?
   (e.g., images, language, headlines, content, and stereotyping)
8. What are your opinions about the roles portrayed by overweight characters in TV series and movies?
   (e.g., sloppy, overeating, blunt, comic relief roles)
9. Have you witnessed stigmatising or discriminatory discourse about people living with obesity in the media?
10. What changes would you recommend (in schools, workplaces, health care services, media, legal regulations, etc.) to better support people withliving with obesity?