Royal College of Physicians

RCP view on maternal health and obesity

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Executive summary

Obesity is one of the most pressing public health challenges we face today in the UK. The Royal College of Physicians (RCP) recognises obesity as a chronic, systemic illness characterised by excess adiposity which, when associated with alterations in the function of tissues or organs, results in a disease state or 'clinical obesity'. It is exacerbated by, and is often a symptom of, health inequalities, genetic influences, social determinants, lifestyle, behavioural and psychological factors, stigma and our environments.

There are specific and significant impacts of obesity on maternal health. Maternal obesity is a major modifiable risk factor for adverse outcomes for women and children. The 2021–24 MBRRACE-UK *Confidential enquiry into maternal deaths* report (2025) showed that 64% of women who died in pregnancy or in the 6 weeks after giving birth were living with overweight or obesity.[1] In England, two-thirds of all adults and one-third of children leaving primary school are living with overweight or obesity.[2,3] A quarter of all pregnant women in England live with obesity, with significant disparities linked to deprivation, ethnicity and disability.[4]

Taking action to reduce maternal obesity would substantially reduce demand for complex maternity services, reduce infant death and improve life chances for thousands of babies. The RCP is calling for a coordinated, system-wide response to address maternal obesity through a life course approach to women's health, focusing on prevention, education and equitable access to holistic care and treatment.

This RCP view – developed with expertise from physicians, obstetricians, the Royal College of Paediatrics and Child Health (RCPCH), the Royal College of Midwives (RCM), the Royal College of Obstetricians and Gynaecologists (RCOG), the Royal College of General Practitioners (RCGP) and others – sets out the impact of the rapid rise in maternal obesity and overweight before examining seven key areas for action. It seeks to review the evidence available to best determine key recommendations for policymakers and the NHS.

Obesity is a multifaceted problem that requires multiple solutions. In the context of maternal health, we must improve education about the impacts of obesity on reproductive health, adopt non-stigmatising and inclusive approaches to treatment and support, enhance professional training and ensure alignment between women's health and maternity care with obesity. Prevention is also key: action on the social determinants of health including government intervention on food standards, advertising and taxation, as well as transforming the food system more broadly to tackle rates of obesity in the first place.

The RCP is calling for a coordinated, system-wide response, going beyond individual responsibility across seven priority areas:

- **Action on wider determinants:** transforming food systems, strengthening Healthy Start and implementing the Whole system approach to obesity.
- **Pre-pregnancy education:** universal, culturally competent programmes on nutrition, physical activity and reproductive health.
- **Professional education:** embedding obesity awareness and non-stigmatising communication in healthcare training.
- **Integrated, culturally competent services:** connecting maternity, weight management and community care.
- **Targeted interventions:** tackling inequalities through data-driven, locally co-designed strategies.
- **Data and insight:** robust surveillance and audit systems to monitor outcomes and drive improvement.
- **Research and evidence:** investment into clinical research of the long-term outcomes of weight loss drugs and clinical interventions, and their safety, on pregnant women and pregnant people or those wishing to conceive.

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The maternal health impacts of obesity

Obesity remains one of the most common medical conditions in women and people of childbearing age. It is associated with adverse outcomes for both women and children, yet the clinical approach lacks coherence and pace given the scale of the issue and its wide-ranging impacts.

During pregnancy, weight is measured in early pregnancy and the Body Mass Index (BMI) is calculated. The global prevalence of maternal obesity and overweight, determined by BMI, has risen rapidly.[5] In the UK, the proportion of women living with obesity in early pregnancy (determined by the first measurement of BMI after conception) was 26.2% in 2023–24.[6] The highest prevalence was in the Northeast of England (32.3%) and lowest in London (20%).[7] The proportion was highest in black women (36.3%) and in areas of high deprivation. These trends mirror the rise in obesity prevalence in general, with variation observed according to geography, areas of deprivation and in ethnic minority groups.

Obesity is a causative risk factor for serious and significant issues in both reproductive and maternal health.[8–12]

- Fertility in men and women is reduced, linked to impact on ovulation, sperm function and conception.
- Success of infertility treatment in women is reduced.
- Risk of gestational diabetes mellitus is 3 times higher.
- Risk of pre-eclampsia is 2.8 times higher.
- Caesarean-section is over twice as likely.
- Induction of labour is just under twice as likely.
- Postpartum haemorrhage is almost twice as likely.

Evidence shows that these obstetric conditions impact not only on the health of the pregnant woman or pregnant person but are also associated with negative outcomes for the health of their children too. Gestational diabetes mellitus and pre-eclampsia affect fetal growth, which is associated with adverse later life cardiometabolic risk in their children. Obesity-related long-term health conditions such as early-onset type 2 diabetes (under the age of 40 years) have increased by 39% between 2016–17 and 2022–23,[13] with corresponding higher rates of serious adverse outcomes for women and children in this cohort including fetal congenital abnormalities, stillbirths and neonatal death.[14,15]

Recent evidence also demonstrates an association between maternal obesity in the pre-pregnancy period and subsequent childhood obesity and rates of respiratory infections in children under the age of 5.[16] There is also emerging evidence showing an association between maternal obesity and increased health risks of offspring including cardiovascular disease, Metabolic Dysfunction-Associated Steatotic Liver Disease (MASLD), asthma, attention deficit hyperactivity disorder during childhood and higher risks of psychiatric disorders and colorectal cancer in adulthood.[17,18]

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Preventing overweight and obesity

The pre-pregnancy and interpregnancy periods are opportunities for weight management interventions and improving health. Indeed, maternal obesity is lower in first pregnancies (22%) compared with those having a subsequent pregnancy (28.7%), highlighting the importance of the interpregnancy interval as a key opportunity for public health prevention strategies. In the UK, RCOG and National Institute for Health and Care Excellence (NICE) recommend that women should optimise their weight before pregnancy and receive advice about managing their weight during pre-pregnancy counselling.

Prevention is key to reducing rates of obesity in the first place. We know that children from deprived groups in England are more than twice as likely to be living with obesity than their more affluent counterparts.[19] These inequalities are growing, as rates of children living with obesity are increasing significantly faster in communities with high, compared to low, deprivation levels. The prevention of obesity in the first place is a vital step in reducing the impact on pregnant women and pregnant people and their babies.

Tackling the root causes of obesity requires a multi-faceted approach that goes beyond individual responsibility and new treatments for weight loss. We need to address aggressive marketing and advertising tactics that make unhealthy choices the default. The government's announcement to mandate the auditing of supermarket product offerings with the aim of making the healthy choice the easy choice and the introduction of a junk food products advertising ban before the watershed are good first steps. Wider action on inequality is vital.

Inequalities in wealth and health must be tackled alongside clinical interventions to create an environment where healthier choices are possible for everyone to severely limit the impact on specific groups such as those seeking to have children. Education is essential to improve understanding of what a healthy, balanced diet looks like and to help people recognise when they are overweight, so action can be taken before obesity develops. Early recognition must also play a bigger role; data from early years should inform targeted interventions rather than remain purely indicative and clear signposting to support in the most affected communities is crucial.

Weight management

While the introduction of weight management medicines and interventions is welcomed, limitations and challenges remain. Access to in vitro fertilisation (IVF) in England is restricted to women with a BMI of less than 30 kg/m2. For this reason, access to weight loss drugs has been proposed as a priority for women needing to lose weight to access fertility treatment.[20] Benefits have also been demonstrated following bariatric surgery and weight loss associated with restoration of menstrual cycles and ovulation rates.[21]

Weight re-gain upon discontinuation of obesity medicines with corresponding increased risk of maternal complications during pregnancy is a concern.[22] As novel treatments for obesity become more readily available, it is imperative that full evaluation and research is conducted about potential deleterious effects and that women are aware of these. This includes unknown effects on the efficacy of contraception while on obesity medications, potentially resulting in unplanned pregnancies.

The Women's Health Strategy for England, launched in 2022, focused attention on key areas throughout the life course of a woman, including menstrual health, fertility, contraception, pregnancy, menopause, cardiovascular and bone health. In in the UK, 30% of deaths in women are due to cardiovascular disease, over twice as many deaths in women each year as all forms of cancer combined.[23] Given that obesity impacts such a wide range of multiple health conditions including cardiovascular disease, there is a clear opportunity to intervene at multiple stages within the life course of a woman with subsequent benefits for women and children.

Pre-pregnancy and postpartum lifestyle interventions (integrated delivery of healthcare, nutrition, water, sanitation and hygiene and psychosocial care interventions during the preconception period, or pregnancy and early childhood) are known to be effective in reducing health problems but there are challenges to their successful implementation.[24]

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Guiding principles

The RCP identifies seven principles to guide national and local action in relation to maternal health and obesity:

1. Non-stigmatising, holistic, person-centred approaches that empower women and families, recognising the complex contributors to obesity and avoiding a blame culture.
2. Equity and inclusion – identifying and addressing health disparities driven by deprivation, ethnicity and structural inequity within societies.
3. System and clinical readiness – ensuring services are resourced, integrated and, where applicable, digitally enabled.
4. Evidence-based, action-orientated recommendations supported by further research.
5. Includes co-production with patient representation, in design and mobilisation during intervention rollouts.
6. Education to inform public, policymakers and healthcare professionals in relation to women's health.
7. Overarching alignment with the RCP's position statement on obesity published in July 2025.

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Priority areas for action

Action on wider determinants of obesity

- **Department of Health and Social Care (DHSC) should continue to lead cross-government delivery of the ambitions of the NHS 10 Year Health Plan for England, ensuring policy commitments are implemented in full. Government should also work with arms-length agencies, such as the Food Standards Agency, to continue to accelerate action to address the wider food environment and its impact on the health of the population and fully implement the Whole system approach to obesity model.**[25]
- **The Department of Culture, Media and Sport (DCMS) and DHSC should work together with advertising and sponsorship sectors and regulators to address targeted marketing of foods and products with restrictions on unhealthy food advertising and instead promote healthy eating.**
- **DHSC should further strengthen the Healthy Start scheme, which is a vital nutritional safety net.**

The Whole system approach to obesity highlights the need for a broad set of actions rather than a narrow focus on weight management. This is particularly important in pregnancy.[26] A life-course approach recognises that the environments, services and policies influencing diet and physical activity start early – during pregnancy, infant feeding and in the first 1,000 days. Children growing up in the most deprived areas are more than twice as likely to live with obesity as those in the least deprived areas. To close this gap, the government must strengthen and coordinate action across health, education, local authorities and national government.

Transforming the food system is essential to protecting maternal health. The National Food Strategy, published in 2021, intended to help the most disadvantaged families.

Policy recommendations included the introduction of taxes on the most unhealthy foods, advertising restrictions and increased subsidies such as the Healthy Start vouchers and free school meals scheme.[27] Most recommendations remain unfulfilled, 5 years since the publication of this strategy.

The NHS 10 Year Plan also includes several important obesity-prevention measures that should be implemented in full, including extending access to healthy free school meals, nutritional breakfast clubs, introducing the new nutrient profile model, limiting new hot food takeaways and creating a Mandatory Healthy Food Standard requiring large food businesses to report on the healthfulness of sales with mandatory improvement targets.

DHSC should also move from voluntary guidelines for commercial baby foods to a mandatory, enforceable framework if progress stalls. Additionally, mandatory front-of-pack labelling, including clear sugar and salt warnings, should be extended to infant food products. The restrictions on less healthy food advertising on television (before 9pm) and online (at any time) came into force in January 2026; further steps should reduce exposure for women and people of reproductive age. In addition, we know that excessive alcohol consumption has many detrimental impacts on health, one of which is a significant contribution to overweight and obesity. The government should seek to take action on excessive alcohol consumption to tackle its health harms. Learning from previous national campaigns should be applied to encourage maternal health such as that related to breastfeeding and weight management.

Finally, the Healthy Start scheme is a proven, cost-effective way to support families with young children, yet its value and reach have eroded. To realise its potential, the government should expand eligibility (including all families on universal credit and those with no recourse to public funds), move to auto-enrolment and ensure payments keep pace with food-price inflation. Strengthened guidance and universal provision of multivitamins would better support nutritional needs in pregnancy and early childhood.

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Pre-pregnancy education

> **DHSC and the Department for Education (DfE) should develop and deliver an explicit and structured approach to universal and culturally competent pre-pregnancy education for all genders. This should consider impacts of obesity, diet and nutrition and physical activity on reproductive health across the life course, starting from primary school through higher education and supported by workplace health education.**

Health promotion should begin in infancy and childhood and continue throughout adulthood, making every contact count to discuss weight management and healthy weight conversations where appropriate, in line with existing NICE guidelines.[28] These contacts should promote understanding of overweight and obesity – including the impact it has on outcomes for pregnant women, pregnant people and their children. This should include citing evidence-based examples of where interventions can improve outcomes, including before and between pregnancies.

There should be integrated engagement with the science behind the health messages in school curricula, for both boys and girls, prioritising nutrition, physical activity, contraception, reproductive and postpartum health.[29] Educational approaches should capitalise on proven programmes[30] and involve key stakeholders such as the DfE and the PSHE Association. School-based programmes should be strengthened to promote healthy food and activity choices, and these programmes address the provision of school meals to reduce sugar, salt and fat alongside national campaigns advocating this.

These approaches should extend into higher education and workplace health initiatives building on existing models such as the approach to employer health toolkits and healthy university framework.[29,30] A range of culturally competent tools should be employed, including digital and AI-enabled tools to reach those with lower literacy or barriers to access.

Professional education

> **Professional healthcare bodies, approved educational institutions and healthcare regulators should embed understanding of obesity – and the skills to have compassionate, holistic and inclusive conversations around weight – across undergraduate and postgraduate education and training for all healthcare professionals.[31]**

In the UK, the RCOG and NICE recommend that women should optimise their weight before pregnancy and receive advice about managing their weight during pre-pregnancy counselling. In addition, women living with obesity should be advised about the risks of obesity and pregnancy outcomes. However, healthcare professionals (HCPs) are often reluctant to have these conversations for various reasons; including a belief that they lack sufficient knowledge and expertise to advise about weight and worries about offending the pregnant woman.[32,33]

Qualitative studies have shown that antenatal care in women living with obesity can vary significantly; women often feel judged about their weight and there is inconsistent advice and care provided.[34] Patient focus groups have highlighted that stigmatising language in medical literature can be interpreted as blaming women for poor pregnancy outcomes due to obesity. Health and care professionals must be equipped and trained to manage weight-related conversations sensitively and holistically to have the greatest impact on engagement with services.[35]

There is a clear need to expand diet, nutrition and physical activity teaching – and to train HCPs in obesity advocacy and communication.[36] This is particularly relevant to HCPs who have frequent touch points with women and pregnant people before, during and after pregnancy – such as doctors, midwives and health visitors. Contraception reviews are an ideal opportunity to discuss general health, including weight and weight management. These reviews should be incorporated in primary care and community settings, as well as among paediatric teams. Emphasis should be placed on 'preparation for parenthood' and interpregnancy periods as critical windows for intervention and promotion of breastfeeding.

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Promotion of breastfeeding and its impact on weight loss should be widely disseminated, particularly in areas of deprivation and higher rates of childhood obesity. The positive benefits of breastfeeding are evident; with studies showing a significant reduction in the prevalence of overweight and obesity in women and their children. The WHO Childhood Obesity Surveillance initiative studied 30,000 children across 12 countries in Europe, finding that children who were exclusively breastfed for 6 months were 25% less likely to develop obesity.[37] As a result, the WHO recommendation is to breastfeed for 6 months; despite this, UK breastfeeding rates are low. While 81% of postpartum women begin to breastfeed, by 6 weeks this falls to 24% in England, 17% in Wales and 13% in Northern Ireland. By 6 months, only 1% are exclusively breastfeeding.[38]

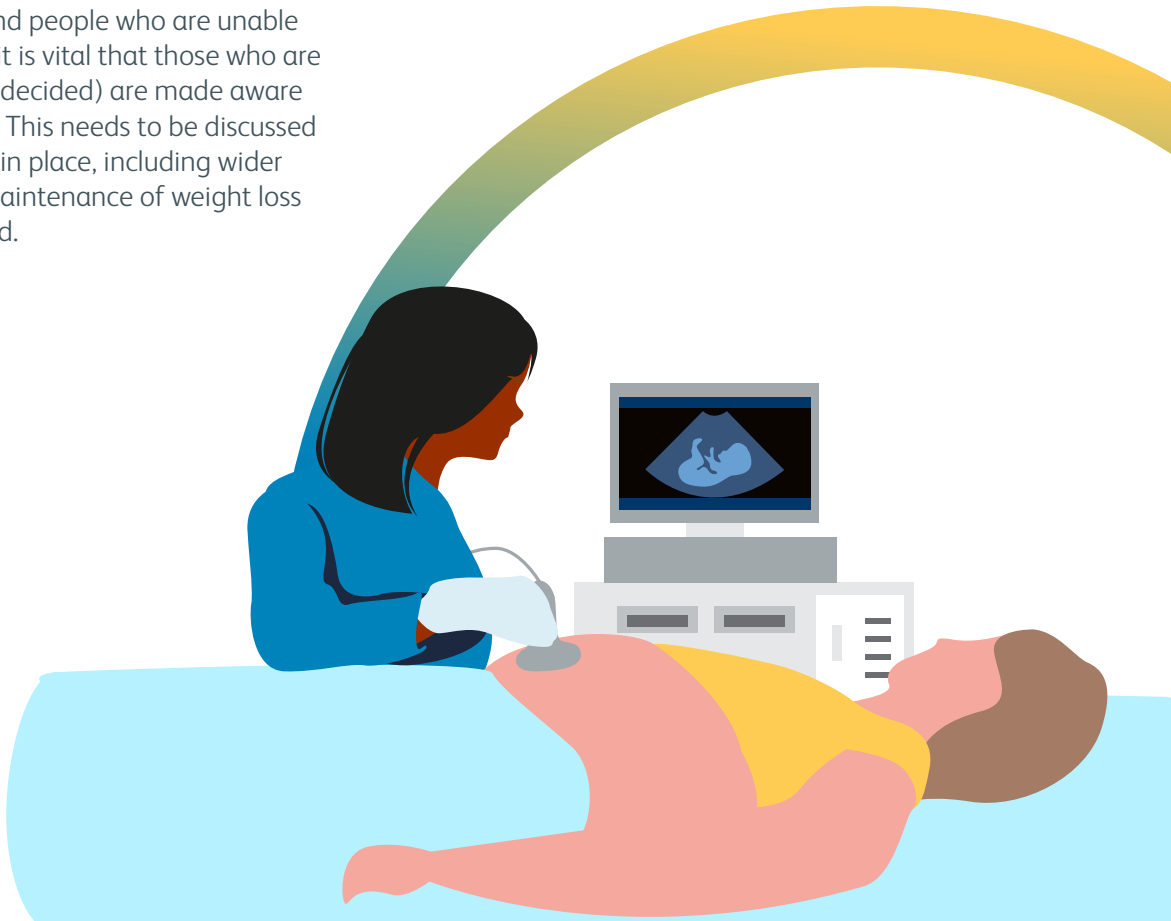
Ensuring that healthcare professionals are trained to deliver high-quality infant feeding support is essential. Furthermore, pregnant women and pregnant people should be advised of the importance of weight maintenance once breast feeding is discontinued. Long-term, ring-fenced funding for universal breastfeeding peer support – locally and via the National Breastfeeding Helpline – should be secured, alongside full implementation of the International Code of Marketing of Breastmilk Substitutes to protect families from commercial influence.

While there will be women and people who are unable or choose not to breastfeed, it is vital that those who are breastfeeding (or who are undecided) are made aware that it helps with weight loss. This needs to be discussed and appropriate support put in place, including wider lifestyle changes to ensure maintenance of weight loss once breastfeeding is stopped.

HCPs should also be aware that the postpartum period is a critical period in which depression and other mental health sequelae can manifest. These conditions must be identified early.

Untreated post-natal depression affects self-care, including meal preparation, physical activity and breastfeeding. A better understanding of psychological drivers of obesity is essential. Prescription of psychotropic medication in the postpartum period should make use of weight-neutral drugs to avoid iatrogenic causes of obesity.

Every HCP (throughout the life course of their patients) must understand the complex underlying causes of obesity. This includes the role of epigenetics and associated risks, including lowering thresholds of risk in some ethnicities. HCPs must be able to provide non-stigmatising, holistic and inclusive care, with training in cultural competence. Relevant educational institutions and organisations responsible for curriculum standards should ensure that training in obesity is included and disseminated through various means – including undergraduate and postgraduate teaching, conferences, online e-learning and webinars.



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Culturally competent community and patient-centred interconnected services

- **NHS and local government strategic commissioners should ensure coherent and connected pathways of care and support for women. Neighbourhood systems and maternity commissioning should incorporate reproductive health and obesity, drawing on links with cardiometabolic pathways and existing family and women's hubs. These services should explicitly consider cultural competency and the diversity of local populations; taking into account their needs and promoting dignity and respect of women living with obesity.**
- **Maternity services, weight management services and primary care should work together to ensure there is coherent communication to manage risk. They should ensure clear, interconnected support for women living with overweight and obesity, during their pregnancy and postpartum period.**

Clinicians and patients highlight the current disconnect between maternal pathways and weight management services. There should be a strengthening of joint working between the NHS, local authorities, education and the voluntary sector to align women's health and maternity care with obesity; ensuring community co-design that is in line with national and international best practice.[39,40] Maternal and obesity policy frameworks should have maternal health embedded. Systems should use digital tools and population data to identify those most in need, with collaborative efforts across the relevant stakeholders.

Identification of obesity and risk of excess weight in women should be embedded, with appropriate signposting to weight loss interventions. Where appropriate, alternative weight loss options and eligibility criteria, including medicines, bariatric surgery or endoscopic procedures, should be discussed. This allows patients to make an informed decision about the most suitable intervention for them and their families. There should be explicit, coherent pathways of joint care for women and people living with obesity during pregnancy to support weight management during pregnancy and in the postpartum period.

The emphasis should move away from maternal responsibility alone. Instead, shared parental and family responsibility should be promoted, acknowledging the influence of secondary care-giver health and the future health of children. Opportunities should be proactively sought at encouraging healthy living across the whole family, recognising the many contributors and challenges facing families particularly in areas of deprivation.

The 10 Year Health Plan clearly sets out moving more towards community-based care with the creation of neighbourhood health centres with services including weight management. Women and family hubs are now established in certain parts of England and provide an opportunity for weight management to be incorporated into routine care. This can be built on as an approach for integration in neighbourhood ways of working. With outcomes focused on improving health and reducing risk in women, there are key opportunities within these hubs; including screening for obesity-related multiple health conditions – such as cardiometabolic disease – and highlighting the importance of cancer screening, including for cervical and breast cancer.

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Targeted interventions to tackle inequalities

> **Local government public health leaders and NHS Integrated Care Boards (ICBs) and health boards in devolved nations should specifically focus action on geographical communities and communities of identity that experience higher risk of obesity, based on national and local data. These actions should be developed with communities and especially with people of reproductive age most affected by health inequalities.**

The 10 Year Health Plan set out the key importance of shifting from sickness to prevention. Tackling the issue of excess weight on reproductive health must be part of realising this. There needs to be a move from reactive care to proactive care using data-driven, digitally-enabled systems to identify unmet needs, track and address inequalities. Through population health management, strategic commissioners should be utilising population data to identify unmet needs and develop proactive care pathways for people of reproductive age living with obesity.[41]

Working through local neighbourhoods, there should be an emphasis on community, culturally sensitive co-design with people with lived experience, including explicit supported representation from underserved communities such as those with higher levels of deprivation, ethnically diverse and neurodiverse populations, and people with mental health conditions.[42]

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Data and insight

> **DHSC should develop data, surveillance and audit systems to monitor maternal and infant outcomes in relation to obesity, drawing on learning from MBRRACE-UK, the National Pregnancy in Diabetes (NPID) Audit and National Gestational Diabetes Mellitus (GDM) Audit.**

DHSC should develop data, surveillance and audit systems in maternal obesity – with a specific focus on maternal and infant outcomes – to monitor the impact of action, actively drive quality improvement and reduce the preventable mortality and health conditions linked to obesity.

These systems should capture information across the full maternity pathway; from pre-conception and early pregnancy, through birth and the postnatal period. This will enable timely identification of risks, variations in care and outcome disparities. In doing so, DHSC should draw on established methodologies, governance frameworks and quality-improvement approaches used in the MBRRACE-UK report, the National Pregnancy in Diabetes Audit, the National Gestational Diabetes Mellitus Audit and the National Diabetes Audit.[43]

Lessons from these programmes – such as standardised data collection, links across care settings, transparent reporting and the use of audits to drive clinical improvement – should inform system design.

Additionally, DHSC should incorporate the insights and recommendations of an expert reference group to ensure that indicators are clinically meaningful, equity-focused and aligned with wider national strategies on maternal health and obesity. Collectively, these actions would create a robust evidence base to guide service improvement, support personalised care and reduce obesity-related risks for women and infants.

Research and evidence

- **The National Institute for Health and Care Research (NIHR) and UK Research and Innovation (UKRI) should invest in research to strengthen the evidence base for what works effectively, to improve maternal and infant outcomes in the context of women living with overweight and obesity. Research participants need to be representative of the wider population – across race, ethnicity, socioeconomic status and other dimensions of diversity.**
- **The NIHR and UKRI should invest in research to specifically understand the evidence of risks and benefits of obesity treatments on maternal and fetal outcomes.**
- **The Medicines and Healthcare Products Regulatory Agency (MHRA) should issue specific guidance regarding the inclusion of pregnant and breastfeeding women in clinical trials, tackling the historical inequality faced by pregnant and breastfeeding women who have a right to participate in clinical research.**

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Summary

Maternal obesity must be recognised as an urgent and growing public health challenge in the UK, affecting one in four pregnancies and driving preventable risks for women and babies. It is linked to higher rates of gestational diabetes, pre-eclampsia, caesarean births and long-term health problems for children. These impacts are compounded by deep inequalities.

Every pregnant woman and pregnant person deserves the opportunity of good health throughout their life course. We must do more to ensure best possible outcomes from childhood. Reducing maternal obesity will improve life chances for thousands of babies, reduce demand on maternity services and deliver long-term benefits for families and the NHS.

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Contact: policy@rcp.ac.uk

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Members of the RCP short-term clinical reference group on obesity and maternal health:

Dr Kath McCullough, RCP special adviser on obesity

Dr Anita Banerjee, RCP censor; obstetric physician at Guy's and St Thomas' NHS Foundation Trust, London

Professor Keith Godfrey MBE, professor of epidemiology and human development at the NIHR Southampton Biomedical Research Centre and University Hospital Southampton NHS Foundation Trust; UK Preconception Partnership

Katharine Jenner, director of the Obesity Health Alliance

Dr Dita Aswani, RCPCH Health Improvement Committee and consultant paediatrician specialising in diabetes and weight management, North East and Yorkshire and Sheffield Children's NHS Foundation Trust

Sophie Russell, RCM president and head of midwifery

Dr Justin Varney-Bennett, DHSC regional director of public health (Southwest)

Professor Judith Stephenson, Margaret Pyke Chair of Sexual and Reproductive Health, University College London; UK Preconception Partnership

Atoshi George, patient representative

Dr Clare Hambling, national clinical director for diabetes and obesity, NHS England

Dr Kate Duhig, national specialty advisor for obstetrics and prevention, NHS England

Dr Smita Thakur, RCGP representative for obesity and weight management

Sarah Perman, director of public health, Hertfordshire County Council

Professor Hassan Shehata, RCOG vice president for global health (2022–25)

Dr Michael Mulholland, RCGP honorary secretary (2021–25)