

Supplementary Appendix

This appendix has been provided by the authors to give readers additional information about their work.

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Health Effects of Overweight and Obesity in 195 Countries over 25 Years

Supplemental Materials

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Data Sources

We systematically searched Medline to identify studies providing nationally or subnationally representative estimates of overweight prevalence, obesity prevalence, or mean body-mass index (BMI) there were published between 1 January 2014 and 31 December 2015 to update the systematic literature search previously performed as part of GBD 2013.¹

The search for adults was conducted on 26 January 2016 using the following terms:

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((("Body Mass Index"[Mesh] OR "Overweight"[Mesh] OR "Obesity"[Mesh]) AND "Geographic Locations"[Mesh] NOT "United States"[Mesh]) AND ("humans"[Mesh] AND "adult"[MeSH]) AND ("Data Collection"[Mesh] OR "Health Services Research"[Mesh] OR "Population Surveillance"[Mesh] OR "Vital statistics"[Mesh] OR "Population"[Mesh] OR "Epidemiology"[Mesh] OR "surve*" [TiAb]) NOT Comment[ptyp] NOT Case Reports[ptyp] NOT "hospital"[TiAb] AND ("2014/01/01"[Date - Publication] : "2015/12/31"[Date - Publication])
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The search for children was conducted on 11 August 2016 using the following terms:

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((("Body Mass Index"[Mesh] OR "Overweight"[Mesh] OR "Obesity"[Mesh]) AND "Geographic Locations"[Mesh] NOT "United States"[Mesh]) AND ("humans"[Mesh] AND "child"[MeSH]) AND ("Data Collection"[Mesh] OR "Health Services Research"[Mesh] OR "Population Surveillance"[Mesh] OR "Vital statistics"[Mesh] OR "Population"[Mesh] OR "Epidemiology"[Mesh] OR "surve*" [TiAb]) NOT Comment[ptyp] NOT Case Reports[ptyp] NOT "hospital"[TiAb])) AND ("2014/01/01"[Date - Publication] : "2015/12/31"[Date - Publication])
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Our search for adult estimates identified 2,036 abstracts, of which 127 met inclusion criteria and were extracted. The search for children estimates identified 971 articles, of which 146 were extracted.

Including sources from the GBD 2013 search, a total of 10,627 articles were identified, of which 816 were included. Additionally, we searched the Global Health Data Exchange (GHDx) database for

individual-level data from major multinational survey series or country-specific surveys and identified 1,026 unique sources meeting the inclusion criteria. Figure S4 describes the study selection process.

Eligibility Criteria

We included nationally or subnationally representative studies providing data on mean BMI or prevalence of overweight or obesity among adults or children. For adults, studies were included if they defined overweight as $\text{BMI} \geq 25 \text{ kg/m}^2$ and obesity as $\text{BMI} \geq 30 \text{ kg/m}^2$, or if estimates using those cutoffs could be back-calculated from reported categories. For children (children ages 2-18), studies were included if they used International Obesity Task Force (IOTF) standards to define overweight and obesity thresholds. We only included studies reporting data collected between 1 January 1980 and 31 December 2015 in one of the 195 countries included in this analysis. Studies were excluded if using non-random samples (e.g., case-control studies or convenience samples); conducted among specific subpopulations (e.g., pregnant women, racial or ethnic minorities, immigrants, or individuals with specific diseases); using alternative methods to assess adiposity (e.g., waist-circumference, skin-fold thickness, or hydrodensitometry); having sample sizes of less than 20 per 5-year age-sex group; or providing inadequate information on any of the inclusion criteria. We also excluded review articles and non-English articles.

Data collection process

Where individual-level survey data were available, we computed mean BMI using weight and height and then used BMI to determine the prevalence of overweight and obesity. For individuals aged over 18 years, we considered them to be overweight if their BMI was greater than or equal to 25 kg/m^2 , and obese if their BMI was greater than or equal to 30 kg/m^2 . For individuals aged 2-18 years, we used monthly IOTF cutoffs² to determine overweight and obese status when age in months was available.

When only age in years was available, we used the cutoff for the 6 month of that year. We excluded studies using the World Health Organization (WHO) standards or country-specific cutoffs to define childhood overweight and obesity. At the individual-level, we considered BMI < 10 kg/m² and BMI > 70 kg/m² to be biologically implausible and excluded those observations.

The rationale for choosing to use the IOTF cutoffs over the WHO standards has been described elsewhere.¹ Briefly, the IOTF cutoffs provide consistent child-specific standards for ages 2-18 derived surveys covering multiple countries. On the other hand, the WHO growth standards apply to children under 5 and the WHO growth reference applies to children ages 5-19. The WHO growth reference for children ages 5-19 was derived from United States data which is less representative than the multinational data used by IOTF. Additionally, the switch between references at age 5 can produce artificial discontinuities.¹ Given that we estimate global childhood overweight and obesity for ages 2-19 (with ages 19 using standard adult cutoffs), the IOTF cutoffs were preferable. Additionally, we found that IOTF cutoffs were more commonly used in scientific literature covering childhood obesity.

From report and literature data, we extracted data on mean BMI, prevalence of overweight, and prevalence of obesity, measures of uncertainty for each, and sample size, by the most granular age and sex groups available.

In addition to the primary indicators described above, we extracted relevant survey-design variables, including primary sampling unit, strata, and survey weights, which were used to tabulate individual-level microdata and produce accurate measures of uncertainty. We extracted three study-level covariates: 1) whether height and weight data were measured or self-reported, 2) whether the study was predominantly conducted in an urban area, rural area, or both, and 3) the level of representativeness of the study (national or subnational). Finally, we extracted relevant demographic indicators, including location, year, age, and sex. We estimated the standard error of the mean from individual-level data where available and used the reported standard error of the mean for published data. When multiple

data sources were available for the same country, we included all of them in our analysis. If data from the same data source were available in multiple formats such individual-level data and tabulated data, we used individual-level data.

Self-report bias adjustment

We included both measured and self-reported data. Of 68,539,856 person-years of data, 16,944,472 (24.7%) were self-reported. We tested for bias in self-report data compared to measured data, which is considered to be the gold-standard. We found that there was no significant difference between measured and self-reported data for children ages 2-19. For adults, we adjusted self-reported data for overweight prevalence, obesity prevalence, and mean BMI using the following nested hierarchical mixed-effects regression models, fit using restricted maximum likelihood separately by sex:

$$\begin{aligned} \text{logit(overweight)}_{c,a,t} &= \beta_0 + \beta_1 m + \sum_{k=2}^{15} \beta_k I_{A[a]} + \sum_{l=16}^{41} \beta_l I_{A[a]} I_{M[m]} + \alpha_s + \alpha_s m + \alpha_r + \alpha_r m + \alpha_c + \alpha_c m + \alpha_t + \alpha_t m + \epsilon_{c,a,t} \\ \text{logit(obesity)}_{c,a,t} &= \beta_0 + \beta_1 m + \sum_{k=2}^{15} \beta_k I_{A[a]} + \sum_{l=16}^{41} \beta_l I_{A[a]} I_{M[m]} + \alpha_s + \alpha_s m + \alpha_r + \alpha_r m + \alpha_c + \alpha_c m + \alpha_t + \alpha_t m + \epsilon_{c,a,t} \\ \log(\text{BMI})_{c,a,t} &= \beta_0 + \beta_1 m + \sum_{k=2}^{15} \beta_k I_{A[a]} + \sum_{l=16}^{41} \beta_l I_{A[a]} I_{M[m]} + \alpha_s + \alpha_s m + \alpha_r + \alpha_r m + \alpha_c + \alpha_c m + \alpha_t + \alpha_t m + \epsilon_{c,a,t} \end{aligned}$$

Where m is a fixed effect on measurement (binary, either measured (1) or self-report (0)), $I_{A[a]}$ is an indicator variable for specific age group A , $I_{A[a]} I_{M[m]}$ is an interaction term between age and measurement, α_s , α_r , and α_c are random effects at the super region, region, and country, respectively, and α_t is a random effect by time-period (1980-1991, 1992-2003, 2004-2015). The models were run in Stata 13. Random effects at the country level and time-period level were used to fit the models, but were taken as noise and were not used in adjustment of self-reported data. We propagated the uncertainty in the self-report adjustment model by adding the variance of each of the regression coefficients used in adjustment to the data variance in delta-transformed space. After adjustment, regressions confirmed that self-

reported data was no longer significantly different from measured data. As an additional sensitivity analysis we ran a set of models for overweight and obesity using only measured data and compared the root-mean squared error (RMSE) of these model to the RMSE of the full models. RMSE was calculated comparing measured data to the predicted estimates. Differences in RMSE were minimal and are shown in Table S7.

Age and sex splitting

Any report or literature data provided in age groups wider than the standard 5-year age groups or as both sexes combined were split using the approach used by Ng et al.⁴ Briefly, age-sex patterns were identified using sources with data on multiple age-sex groups and these patterns were applied to split aggregated report and literature data. Uncertainty in the age-sex split was propagated by multiplying the standard error of the data by the square root of the number of splits performed. We did not propagate the uncertainty in the age pattern and sex pattern used to split the data as they seemed to have small effect.

Prevalence estimation for overweight and obesity

After adjusting for self-report bias and splitting aggregated data into 5-year age-sex groups, we used spatiotemporal Gaussian process regression (ST-GPR) to estimate the prevalence of overweight and obesity. Prevalence models for adults were restricted to using only adult data (ages 20+). Due to data scarcity in child data for some geographies and time periods, prevalence models for children included data for both children and adults, but only the childhood estimates were retained. This modeling approach has been described in detail elsewhere.^{3,4}

Briefly, we estimated the prevalence of overweight and obesity in country c , for age group a , and sex s at time t ($p_{c,a,s,t}$) using the equation below:

$$\text{logit}(p_{c,a,s,t}) = g_{c,a,s}(t) + \epsilon_{c,a,s,t}$$

where

$$g_{c,a,s}(t) \sim GP\left(m_{c,a,s}(t), \text{Cov}\left(g_{c,a,s}(t)\right)\right).$$

$$\epsilon_{c,a,s,t} \sim \text{Normal}(0, \sigma_p^2),$$

σ_p^2 represents the error variance, which is composed of the squared standard error of the observed data point as well as the prediction errors from the self-report adjustment, if applicable, ($m_{c,a,s}(t)$) is the mean prior input to GPR, and $\text{Cov}\left(g_{c,a,s}(t)\right)$ is the covariance function input to GPR.

We used an empirical mean prior ($m_{c,a,s}(t)$), which was the output of the first-stage linear model plus the smoothed residuals:

$$m_{c,a,s}(t) = X_{c,a,s}\beta + h(r_{c,a,s,t})$$

where $X\beta$ is the summation of the components from the following linear regressions, fit separately by sex, and $h(r_{c,a,s,t})$, is a smoothing function for the residuals, $r_{c,a,s,t}$, derived from the following linear models for adults only:

$$\text{logit}(\text{ow}_{c,a,t}) = \beta_0 + \beta_1 \text{energy}_{c,t} + \beta_2 \text{lat}_c + \beta_3 \text{urbanicity}_{c,t} + \sum_{k=4}^{16} \beta_k I_{A[a]} + \epsilon_{c,a,t}$$

$$\text{logit}\left(\left(\frac{\text{ob}}{\text{ow}}\right)_{c,a,t}\right) = \beta_0 + \beta_1 \text{energy}_{c,t} + \beta_2 \text{lat}_c + \beta_3 \text{urbanicity}_{c,t} + \sum_{k=4}^{16} \beta_k I_{A[a]} + \epsilon_{c,a,t}$$

and adults including children:

$$\text{logit}(\text{ow}_{c,a,t}) = \beta_0 + \beta_1 \text{energy}_{c,t} + \beta_2 \text{lat}_c + \beta_3 \text{urbanicity}_{c,t} + \sum_{k=4}^{20} \beta_k I_{A[a]} + \epsilon_{c,a,t}$$

$$\text{logit}\left(\left(\frac{\text{ob}}{\text{ow}}\right)_{c,a,t}\right) = \beta_0 + \beta_1 \text{energy}_{c,t} + \beta_2 \text{lat}_c + \beta_3 \text{urbanicity}_{c,t} + \sum_{k=4}^{20} \beta_k I_{A[a]} + \epsilon_{c,a,t}$$

where $\text{energy}_{c,t}$ is a 10-year lag distributed energy intake per capita in country c at year t , lat_c is the absolute latitude of country c , $\text{urbanicity}_{c,t}$ is the proportion of people living in urban areas in country c in time t , and $I_{A[a]}$ is an indicator variable for specific age group A that the overweight prevalence point ($\text{ow}_{c,a,t}$) or obese as a proportion of overweight point ($(\frac{\text{ob}}{\text{ow}})_{c,a,t}$) is capturing.

While the linear model component of the mean function captures the general trend in exposures over time, much of the data variability may still not be adequately accounted for. To address this, we fit a locally weighted polynomial regression (LOESS) function $h(r_{c,a,s,t})$ to systematically estimate this residual variability by borrowing strength across time, age, and space patterns. The time adjustment parameter (λ) borrows strength from neighboring time points. The age adjustment parameter (ω) borrows strength from data in neighboring age groups. The space adjustment parameter (ξ) borrows strength across the hierarchy of geographical locations.

To estimate the $w_{c,a,s,t}$ (the final weight assigned to observation $r_{c,a,s,t}$ with reference to a focal observation r_{c_0,a_0,s_0,t_0}), we first generated a preliminary weight $w'_{c,a,s,t}$ for smoothing over time, which was based on the scaled distance along the time dimension of the two observations:

$$w'_{c,a,s,t} = \left(1 - \left(\frac{|t - t_0|}{1 + \max |t - t_0|} \right)^\lambda \right)^3$$

Next, we calculated the weight $w''_{c,a,s,t}$ to smooth over age, which is based on a distance along the age dimension of two observations. For a point between the age a of the observation $r_{c,a,s,t}$ and a focal observation r_{c_0,a_0,s_0,t_0} , the weight, given an age adjustment parameter ω , is defined as follows:

$$w''_{c,a,s,t} = \frac{1}{e^{\omega|a-a_0|}}$$

Finally, these combined weights were multiplied and further adjusted to account for geographic patterns.

Specifically, we defined a geospatial relationship by categorizing data based on the GBD location hierarchy. We adapted the weighting strategy used in previous studies estimating time series of global indicators to be more flexible with respect to estimating subnational locations and to borrow strength from all levels.^{4,5} A vector of spatial weights corresponding to each level of the location hierarchy was derived as $[\xi, \xi * (1 - \xi)^{n_1-1}, \dots, \xi * (1 - \xi)^{n_i-1}, (1 - \xi)^{n_i}]$, where the vector is expanded to include the number, n_i , levels in the location hierarchy between the location being estimated and global, which receives a pre-rescaling weight of $(1 - \xi)^{n_i}$. For example, estimating a country would use the following weighting scheme:

- Country data: ξ
- Regional data not from the country being estimated: $\xi * (1 - \xi)$
- Data from other regions in the same super region: $\xi * (1 - \xi)^2$
- Global data from other super regions: $(1 - \xi)^3$

A full derivation of weights for each category, assuming the location being estimated was a country, follows:

- 1) If the observation $r_{c,t}$ belongs to the same country c_0 of the focal observation r_{c_0,t_0} :

$$w_{c,a,s,t} = \frac{\xi (w'_{c,a,s,t} w''_{c,a,s,t})}{\sum_{c=c_0} (w'_{c,a,s,t} w''_{c,a,s,t})} \quad \forall c = c_0$$

- 2) If the observation $r_{c,t}$ belongs to a different country than the focal observation r_{c_0,t_0} , but both belong to the same region R:

$$w_{c,a,s,t} = \frac{\xi * (1 - \xi) (w'_{c,a,s,t} w''_{c,a,s,t})}{\sum_{c \neq c_0} (w'_{c,a,s,t} w''_{c,a,s,t})} \quad \forall c \neq c_0 \cap R[c] = R[c_0]$$

- 3) If the observation $r_{c,t}$ belongs to the same super region SR but to a both different country c_0 and region $R[c_0]$ than the focal observation r_{c_0,t_0} :

$$w_{c,a,s,t} = \frac{\xi * (1 - \xi)^2 (w'_{c,a,s,t} w''_{c,a,s,t})}{\sum_{c \neq c_0} (w'_{c,a,s,t} w''_{c,a,s,t})} \quad \forall c \neq c_0 \cap R[c] \neq R[c_0] \cap SR[c] = SR[c_0]$$

- 4) If the observation $r_{c,t}$ is from a different super region than the focal observation r_{c_0,t_0} (ie. all other data currently not receiving a weight):

$$w_{c,a,s,t} = \frac{(1 - \xi)^3 (w'_{c,a,s,t} w''_{c,a,s,t})}{\sum_{c \neq c_0} (w'_{c,a,s,t} w''_{c,a,s,t})} \quad \forall c \neq c_0 \cap R[c] \neq R[c_0] \cap SR[c] \neq SR[c_0]$$

Selection of the parameters was determined based on the results of out-of-sample cross-validation performed by Ng et al. We used three different values for ξ depending on data-coverage. The highest ξ (0.99) was used in countries with high data coverage (≥ 15 years covered), whereas a mid-range ξ (0.8) and a low ξ (0.7) was used in countries with 5-14 and 1-4 years of data covered. To control the rate of decay in weight for points further away across the time and age dimensions, we used a single λ (0.9) and a single ω (1.5).

For the covariance function, we used the Matern covariance function:

$$M(t, t') = \sigma^2 \frac{2^{1-\nu}}{\Gamma(\nu)} \left(\frac{d(t, t')\sqrt{2\nu}}{l} \right)^\nu K_\nu \left(\frac{d(t, t')\sqrt{2\nu}}{l} \right)$$

where $d(\cdot)$ is a distance function; σ^2 , ν , l , and K_ν are hyperparameters of the covariance function—specifically σ^2 is the marginal variance, ν is the smoothness parameter that defines the differentiability of the function, l is the length scale, which roughly defines the distance between which two points become uncorrelated, and K_ν is the Bessel function. Based on previous analyses, we approximated σ^2 by $MADN(r'_{c,t})$, which is the normalized absolute deviation of the residuals from the smoothing step by region and used the parameter specifications $\nu = 2$ and $l = 15$.

Based on the specification above, to predict the time series of overweight prevalence p_{c,a,s,t_*} , for country c , age a , and sex s for time t_* , we integrated over $g_{c,a,s}(t_*)$ to obtain the following:

$$\text{logit}(p_{c,a,s,t_*}) \sim N\left(m_{c,a,s}(t_*), \sigma_p^2 I + \text{Cov}(g_{c,a,s}(t_*))\right)$$

From this derivation, we generated the prevalence estimates as well as the uncertainty intervals. The analysis was implemented through PyMC package in Python. Random draws of 1,000 samples were obtained from the distributions above for every country, age, and sex group. The final estimated prevalence for each country, age, and sex group was the mean of the draws. In addition, uncertainty intervals were obtained by taking the 2.5 and 97.5 percentiles of the samples.

Estimating mean BMI

To estimate the mean BMI for adults in each country, age, sex, and time period 1980-2015, we first used the following nested hierarchical mixed-effects model, fit using restricted maximum likelihood on data from sources containing estimates of all three indicators (prevalence of overweight, prevalence of obesity, and mean BMI), in order to characterize the relationship between overweight, obesity, and mean BMI:

$$\log(\text{BMI}_{c,a,s,t}) = \beta_0 + \beta_1 \text{ow}_{c,a,s,t} + \beta_2 \text{ob}_{c,a,s,t} + \beta_3 \text{sex} + \sum_{k=4}^{17} \beta_k I_{A[a]} + \alpha_s(1 + \text{ow}_{c,a,s,t} + \text{ob}_{c,a,s,t}) + \alpha_r(1 + \text{ow}_{c,a,s,t} + \text{ob}_{c,a,s,t}) + \alpha_c(1 + \text{ow}_{c,a,s,t} + \text{ob}_{c,a,s,t}) + \epsilon_{c,a,s,t}$$

where $\text{ow}_{c,a,s,t}$ is the prevalence of overweight in country c , age a , sex s , and year t , $\text{ob}_{c,a,s,t}$ is the prevalence of obesity in country c , age a , sex s , and year t , sex is a fixed effect on sex, $I_{A[a]}$ is an indicator variable for age, and α_s , α_r , and α_c are random effects at the super region, region, and country, respectively.

The model was run in Stata 13.

We applied the regression coefficients to the 1,000 draws of overweight prevalence and obesity prevalence produced through ST-GPR to estimate 1,000 draws of mean BMI for each country, year, age,

and sex. This approach ensured that overweight prevalence, obesity prevalence, and mean BMI were correlated at the draw level.

Assessment of risk-outcome pairs

Risk-outcome pairs were defined based on strength of available evidence supporting a causal effect.

Table S1 reports the results of our assessment for included risk-outcome pairs and Table S8 reports the supporting scientific literature.

Computing attributable burden

Flowchart

The process of estimating the disease burden of high BMI has been shown in Figure S5.

Exposure definition

Exposure to high BMI is defined using metrics related to national and subnational estimates of BMI. If a person has a BMI of 22.5 kg/m² or greater (midpoint of the optimal range of 20-25 kg/m²), he/she is considered at risk for a range of diseases including cardiovascular diseases, musculoskeletal disorders, and cancers.

Relative risk

The relative risk per 5-unit change in BMI for each disease endpoint was obtained from meta-analyses, and where available, pooled analyses of prospective observational studies. Relative risks for all 20 outcomes, by age and sex, are reported in Table S2.

Theoretical minimum risk exposure level

The theoretical minimum risk exposure level (TMREL) of BMI was determined based on the BMI level that was associated with the lowest risk of all-cause mortality in prospective cohort studies. In GBD 2015, based on the findings of the most recent pooled analysis of prospective cohorts,⁴ we changed the TMREL of BMI from 21-23 to 20-25 kg/m².

Population attributable fraction

Population attributable fractions (PAFs) are computed using the following equation:

$$PAF_{oasgt} = \frac{\int_{x=l}^u RR_{oasg}(x)P_{asgt}(x)dx - RR_{oasg}(TMREL)}{\int_{x=l}^u RR_{oasg}(x)P_{asgt}(x)dx}$$

Where PAF_{oasgt} is the population attributable fraction for cause o , age group a , sex s , geography g , and year t . $RR_{oasg}(x)$ is the relative risk as a function of exposure level x for cause o , age group a , sex s , and geography g with the lowest level of observed exposure as l and the highest as u ; $P_{asgt}(x)$ is the distribution of exposure at x for age group a , sex s , geography g , and year t ; $TMREL$ is the theoretical minimum risk exposure level.⁶

Attributable burden

Burden attributable to high BMI is computed using the following equation:

$$AB_{asgt} = \sum_{o=1}^w DALY_{oasgt} PAF_{oasgt}$$

where AB_{asgt} is the attributable burden for age group a , sex s , geography g , and year t ; $DALY_{oasgt}$ is total DALYs for cause o (of w relevant outcomes) for age group a , sex s , geography g , and year t ; PAF_{oasgt} is the population attributable fraction (PAF) for cause o , age group a , sex s , geography g , and year t . The proportion of attributable deaths can analogously be computed by sequentially substituting each metric in place of DALYs in the equation above.

Uncertainty of PAF estimates was calculated from 1,000 draws resulting from 1,000 PAF calculations using the 1,000 draws of exposure estimates, 1,000 draws of relative risk estimates, and 1,000 draws of the theoretical minimum risk exposure level. The 1,000 draws of PAF estimates were multiplied by 1,000 draws of deaths and DALYs to produce 1,000 draws of attributable burden. All components of the PAF calculation analysis were assumed to be independent of each other.

Socio-Demographic Index

Details on construction of the Socio-demographic index (SDI) are previously published.³ Briefly, SDI is a composite indicator (range 0-1), calculated using the Human Development Index methodology, that includes average educational attainment in the population over age 15, lag-distributed income per capita, and total fertility rate. The list of countries with their SDI level is provided in Table S3.

Decomposition

We applied the decomposition methods developed by Das Gupta to decompose changes in all-cause and cause-specific DALYs due to changes in population growth, population structure, exposure to risk, and background death and DALY rates. Details of the decomposition analysis are reported in elsewhere.³

Figure S1a. Age-standardized Relative Percent Change in Obesity Prevalence between 1980 and 2015 for Males (ages >= 20)

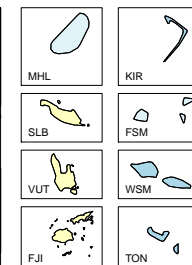
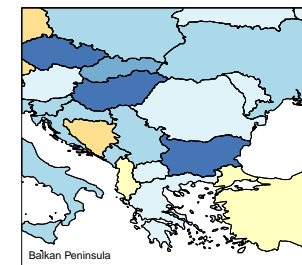
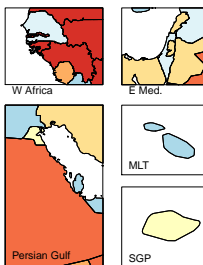
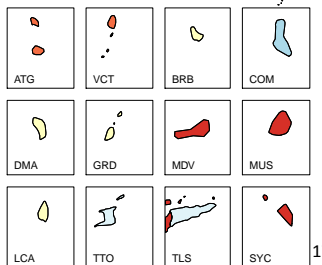
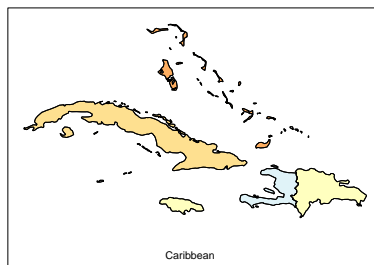
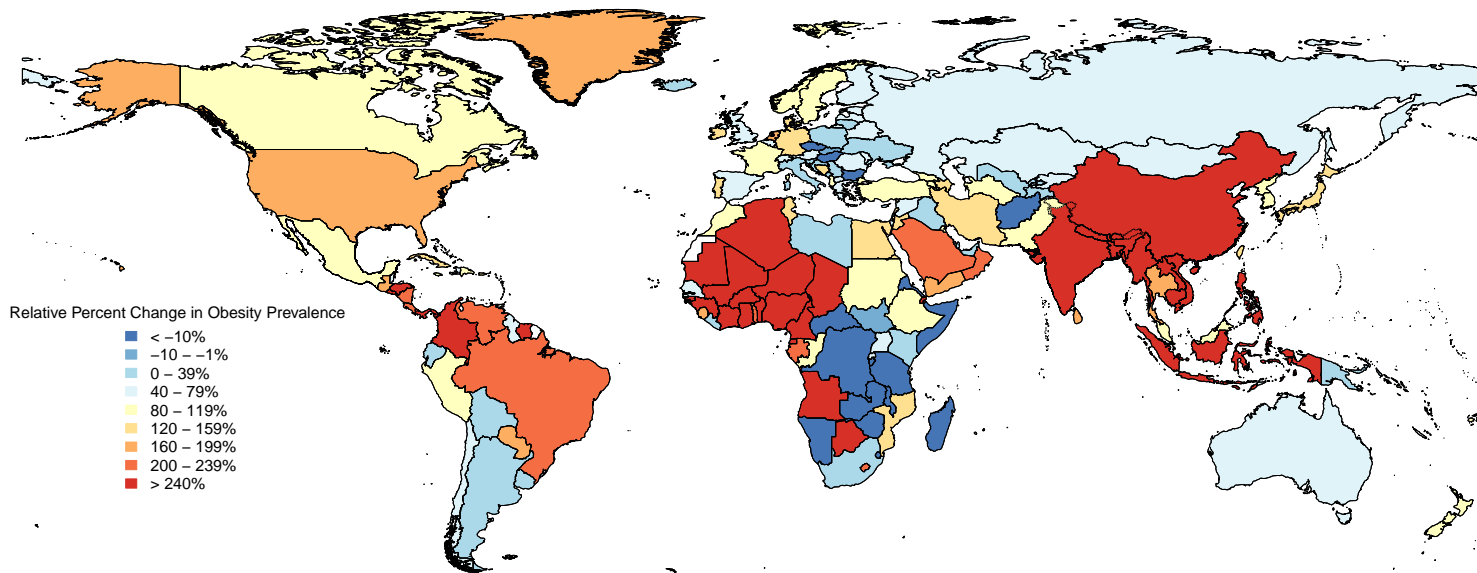
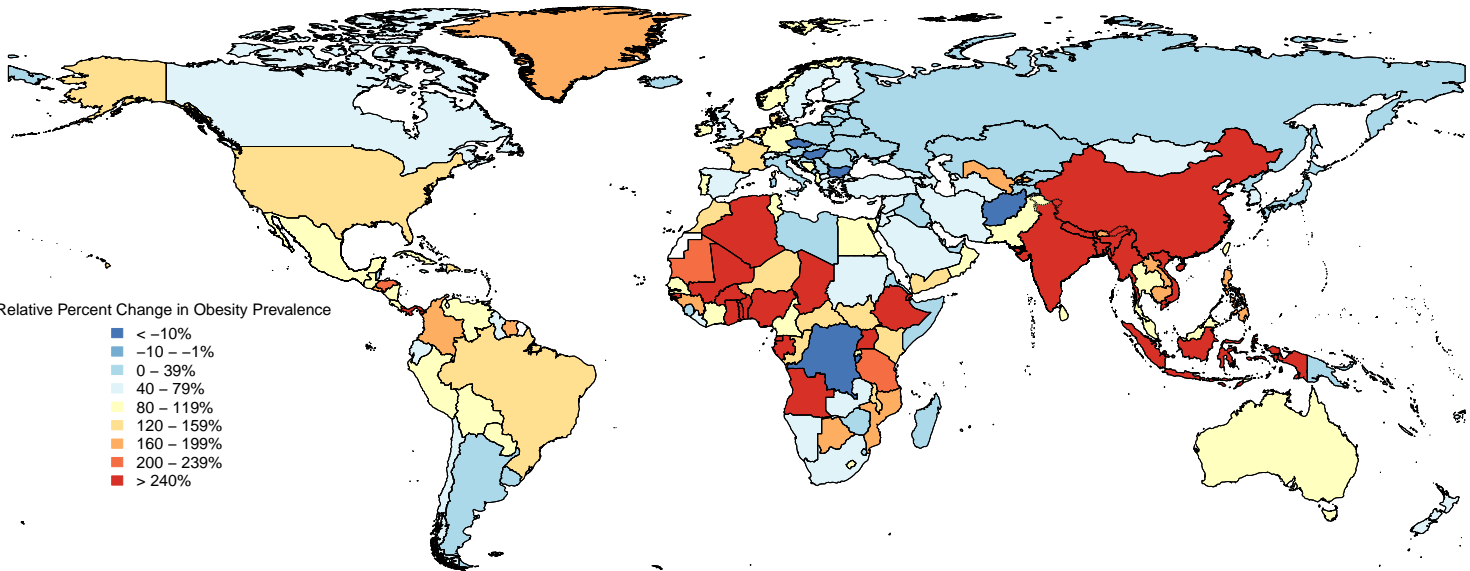


Figure S1b. Age-standardized Relative Percent

Change in Obesity Prevalence between 1980 and 2015 for Females (ages >= 20)



Relative Percent Change in Obesity Prevalence

- < -10%
- -10 - -1%
- 0 - 39%
- 40 - 79%
- 80 - 119%
- 120 - 159%
- 160 - 199%
- 200 - 239%
- > 240%

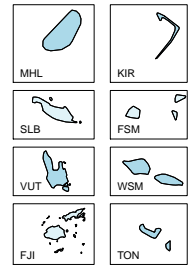
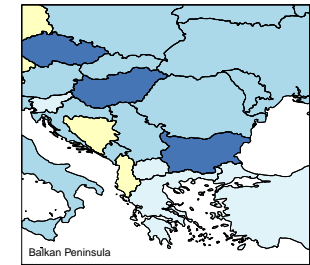
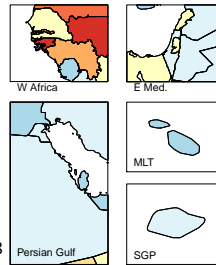
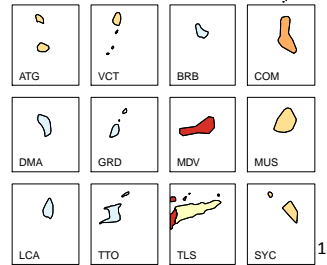
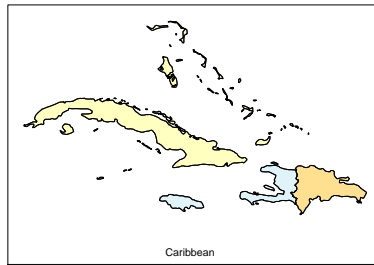


Figure S1c. Age-standardized standardized Relative Percent Change in Obesity Prevalence between 1980 and 2015 for Males (ages 2 – 19)

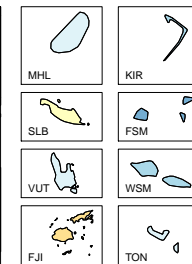
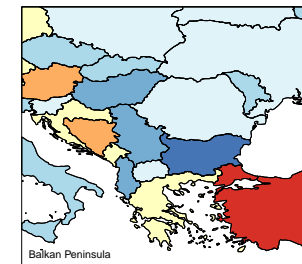
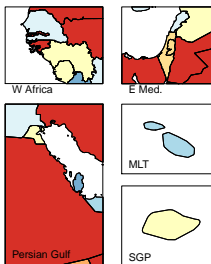
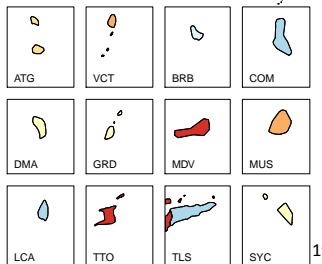
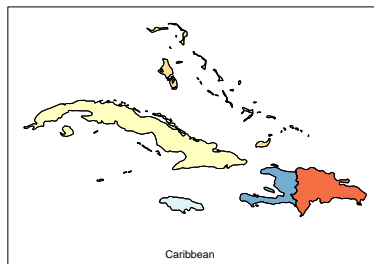
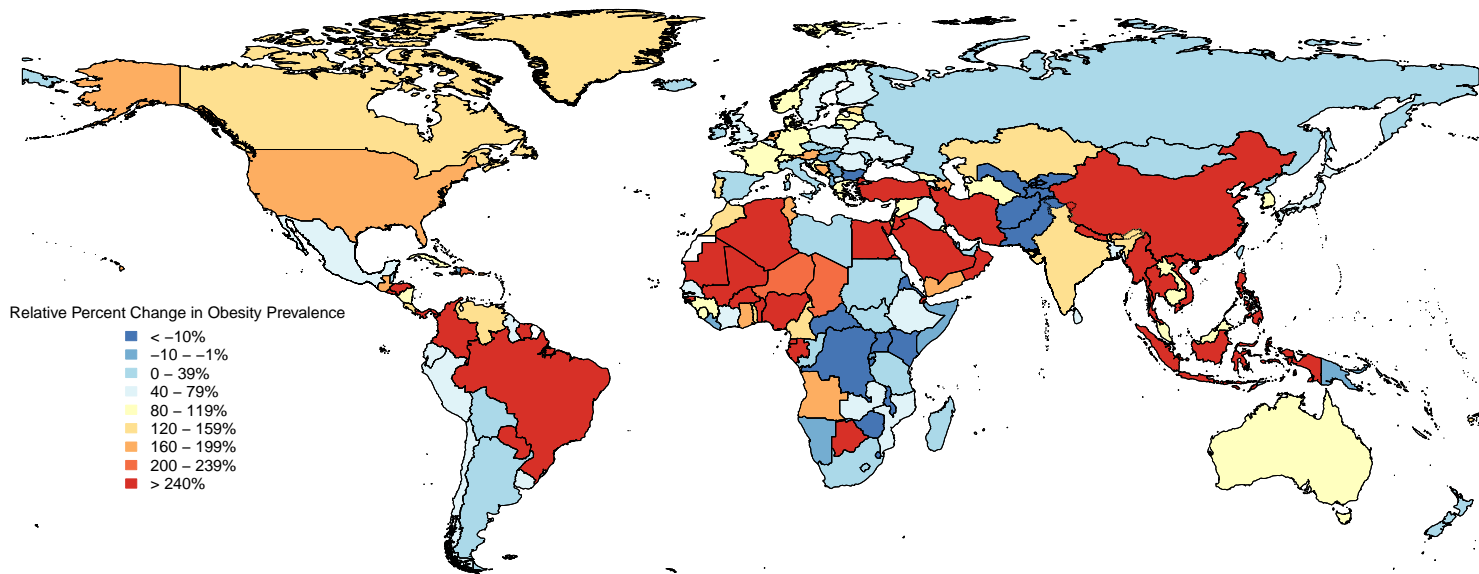
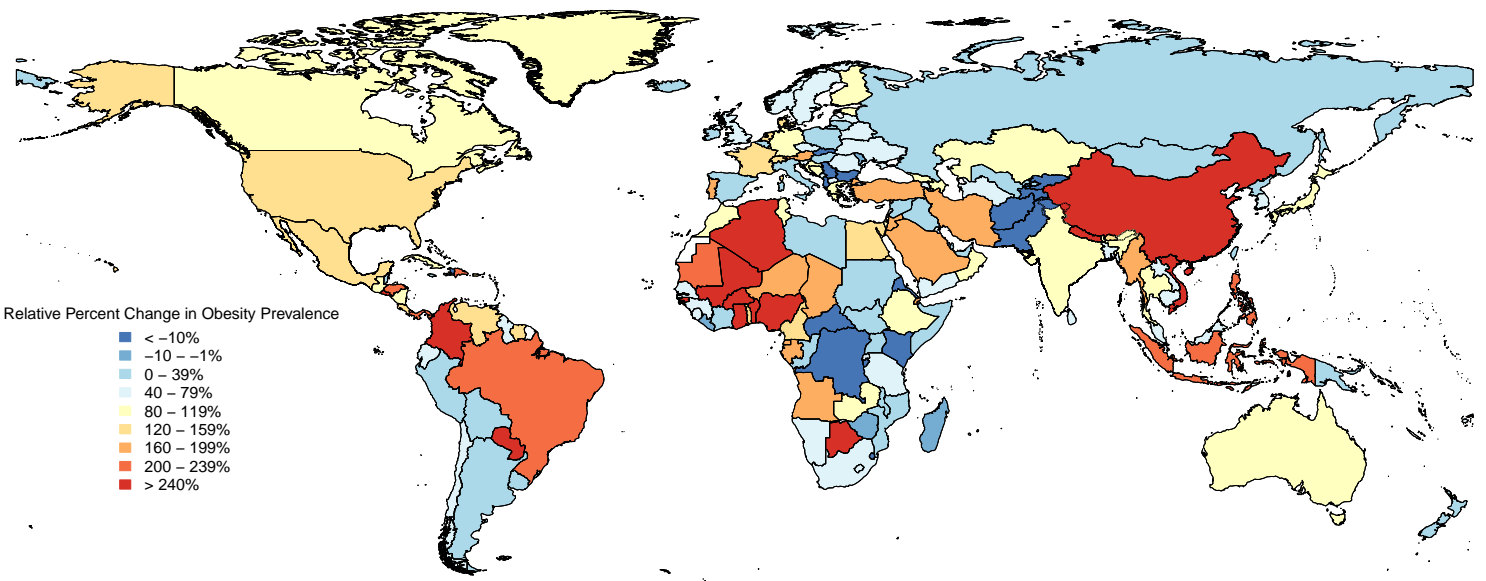


Figure S1d. Age-standardized Relative Percent

Change in Obesity Prevalence between 1980 and 2015 for Females (ages 2 – 19)



Relative Percent Change in Obesity Prevalence

- < -10%
- -10 – -1%
- 0 – 39%
- 40 – 79%
- 80 – 119%
- 120 – 159%
- 160 – 199%
- 200 – 239%
- > 240%

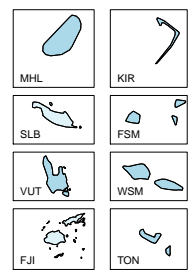
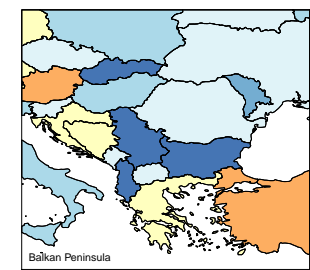
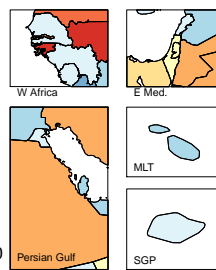
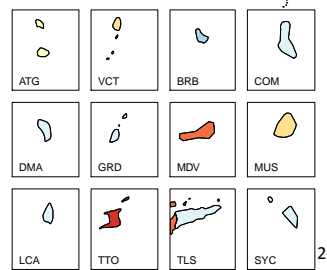
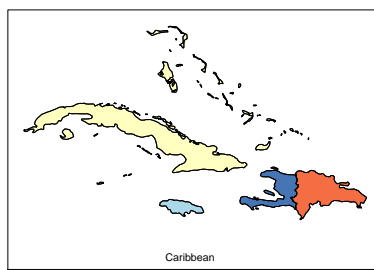
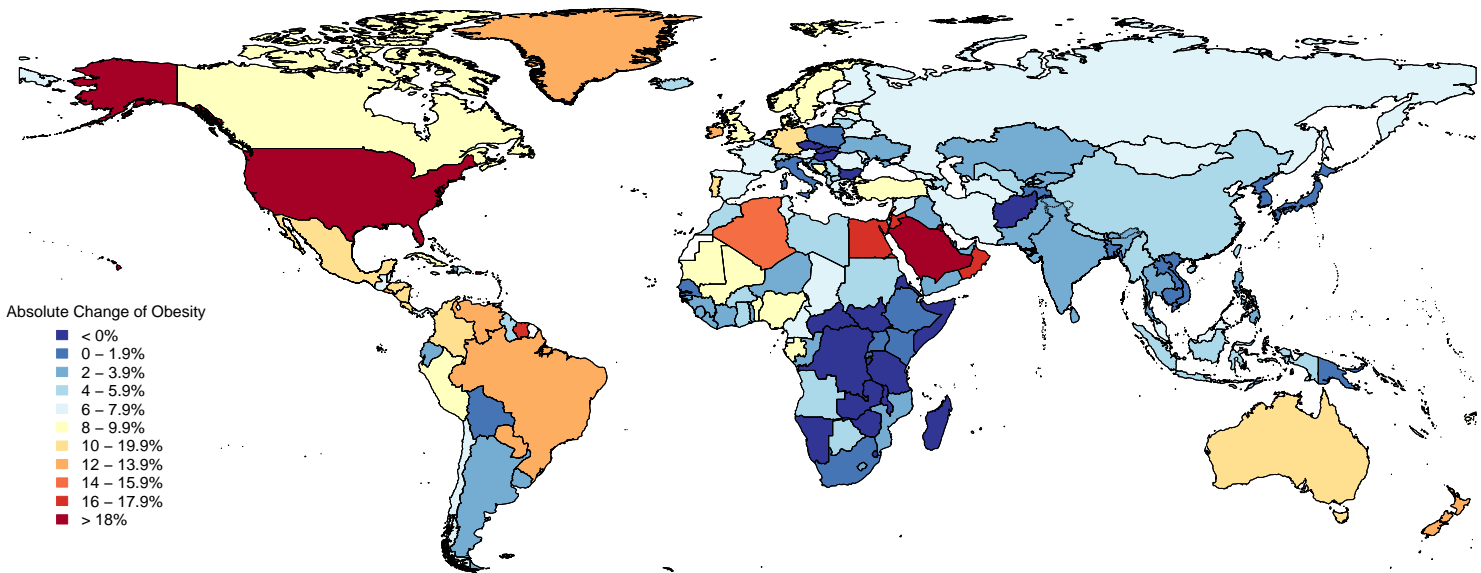


Figure S2a. Age-standardized Absolute Change of Prevalence of Obesity for Males (ages >= 20) in 2015



- Absolute Change of Obesity
- < 0%
 - 0 - 1.9%
 - 2 - 3.9%
 - 4 - 5.9%
 - 6 - 7.9%
 - 8 - 9.9%
 - 10 - 19.9%
 - 12 - 13.9%
 - 14 - 15.9%
 - 16 - 17.9%
 - > 18%

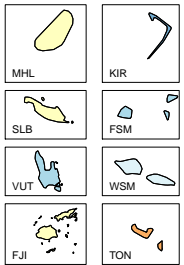
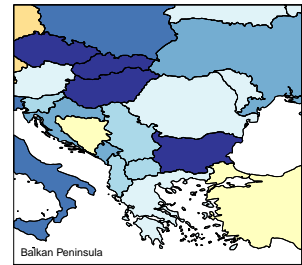
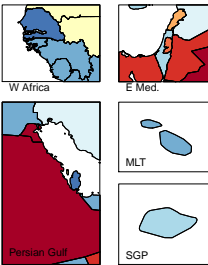
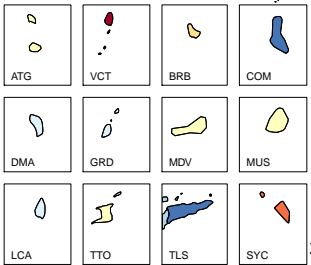
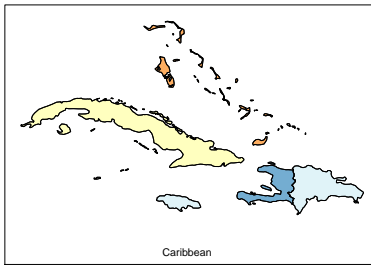
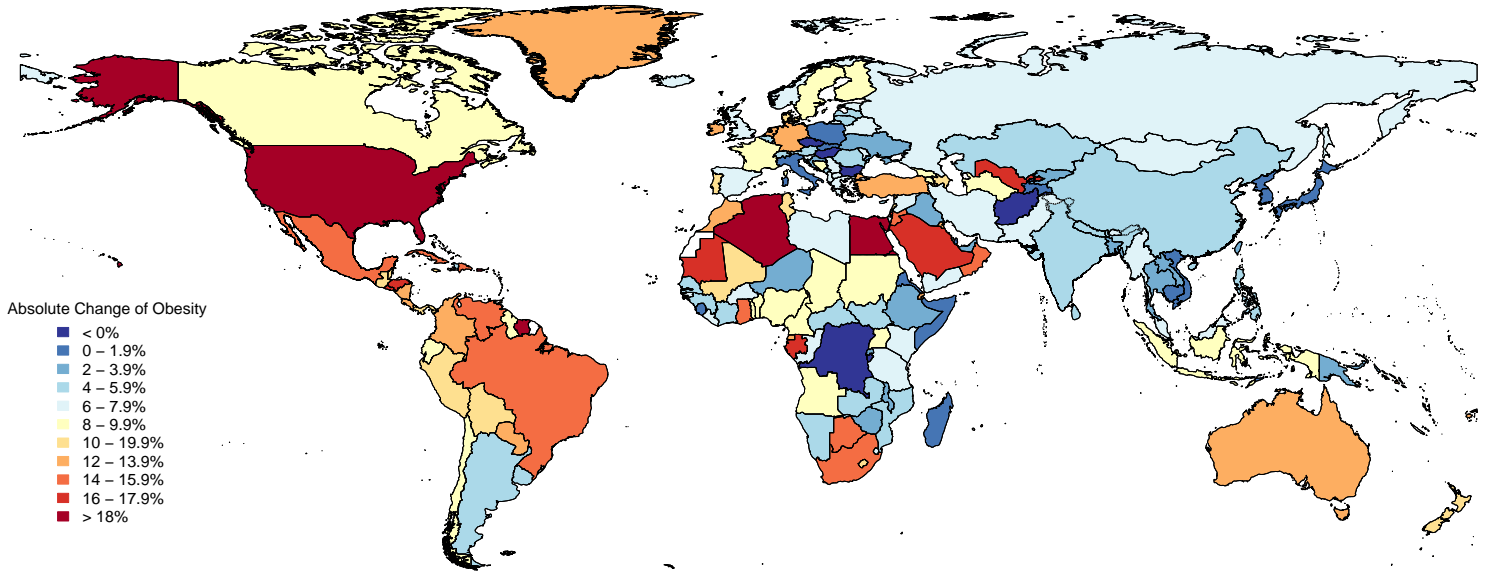


Figure S2b. Age-standardized Absolute Change of Prevalence of Obesity for Females (ages ≥ 20) in 2015



Absolute Change of Obesity

- < 0%
- 0 – 1.9%
- 2 – 3.9%
- 4 – 5.9%
- 6 – 7.9%
- 8 – 9.9%
- 10 – 19.9%
- 12 – 13.9%
- 14 – 15.9%
- 16 – 17.9%
- > 18%

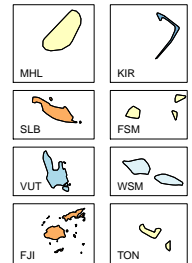
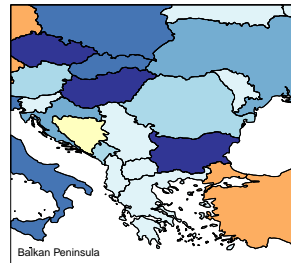
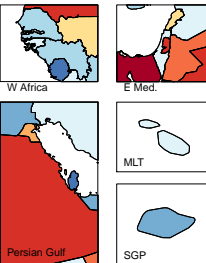
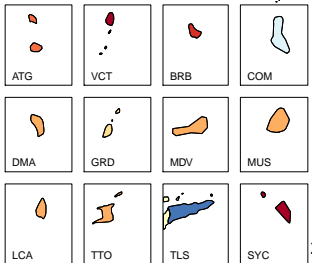
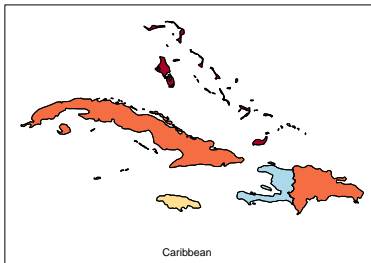
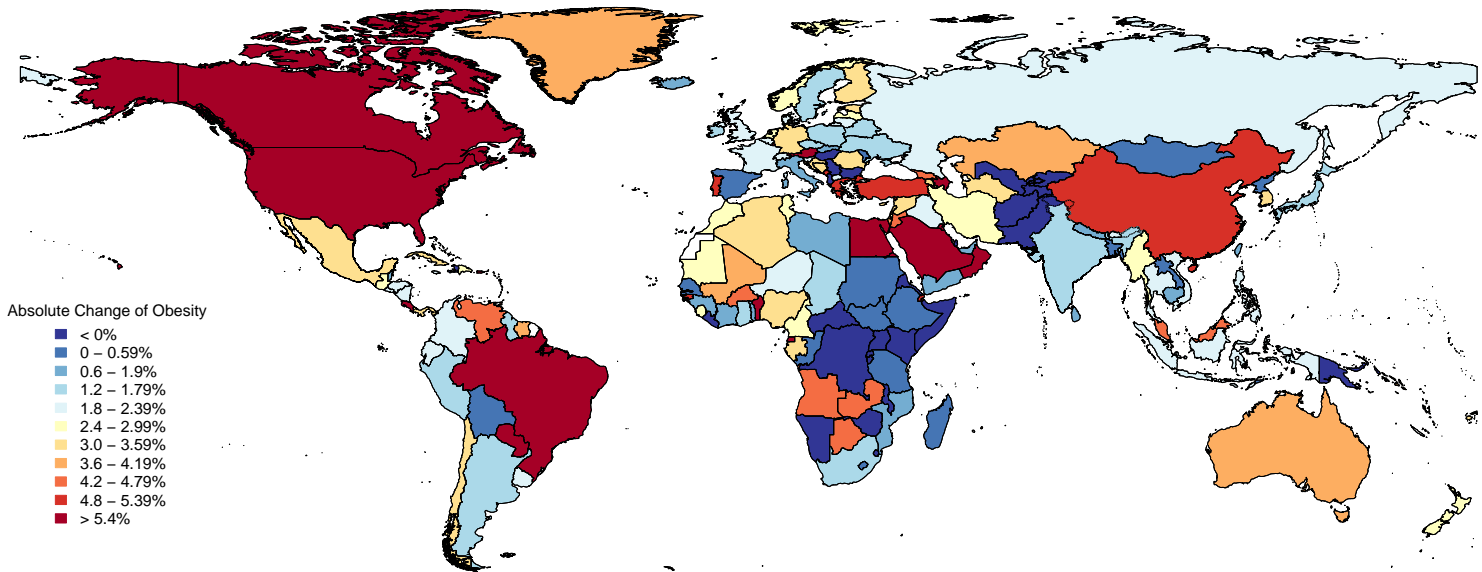


Figure S2c. Age-standardized Absolute Change of Prevalence of Obesity for Males (ages 2 – 19) in 2015



Absolute Change of Obesity

- < 0%
- 0 – 0.59%
- 0.6 – 1.9%
- 1.2 – 1.79%
- 1.8 – 2.39%
- 2.4 – 2.99%
- 3.0 – 3.59%
- 3.6 – 4.19%
- 4.2 – 4.79%
- 4.8 – 5.39%
- > 5.4%

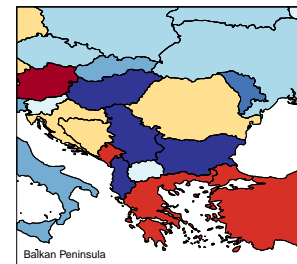
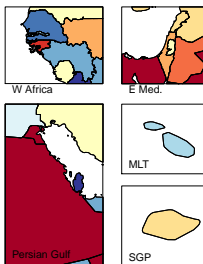
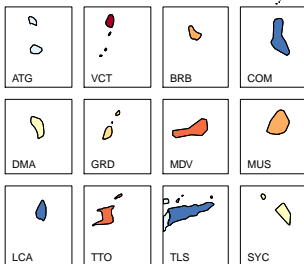
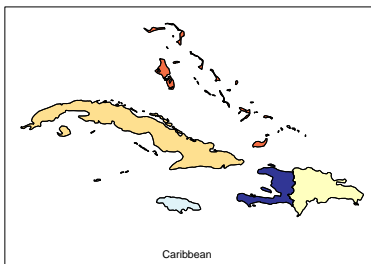
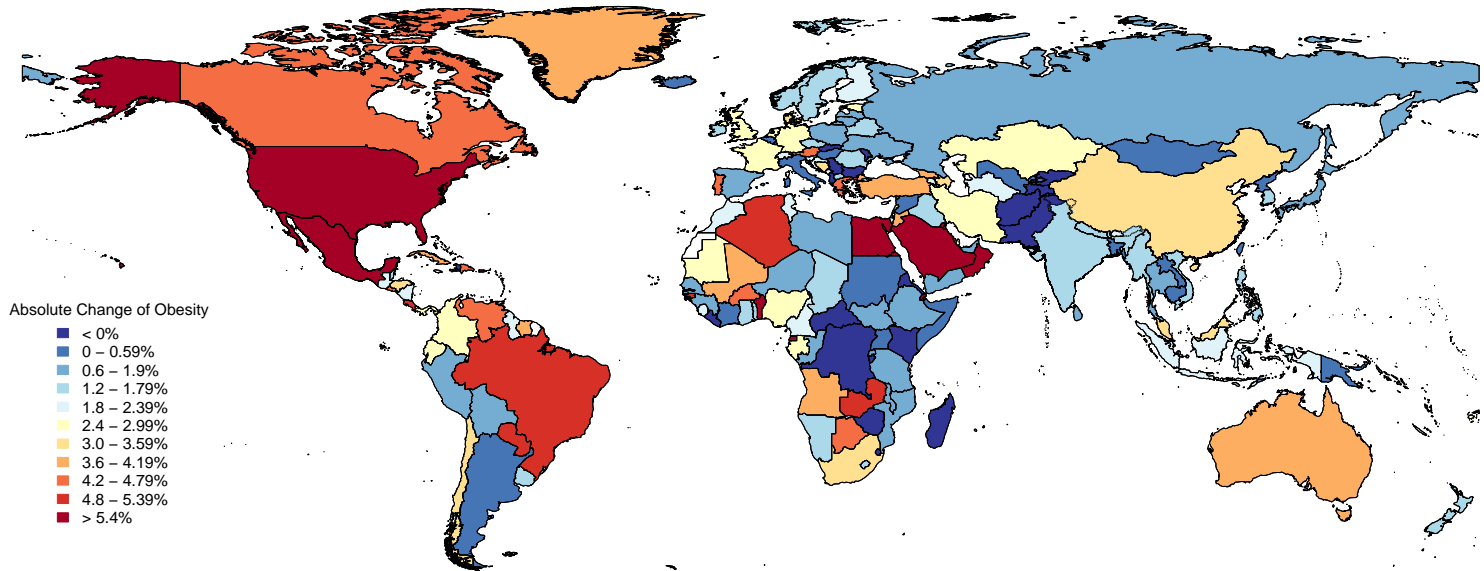


Figure S2d. Age-standardized Absolute Change of Prevalence of Obesity for Females (ages 2 – 19) in 2015



Absolute Change of Obesity

- < 0%
- 0 – 0.59%
- 0.6 – 1.9%
- 1.2 – 1.79%
- 1.8 – 2.39%
- 2.4 – 2.99%
- 3.0 – 3.59%
- 3.6 – 4.19%
- 4.2 – 4.79%
- 4.8 – 5.39%
- > 5.4%

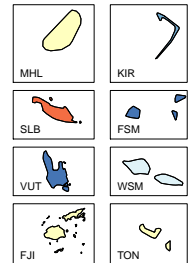
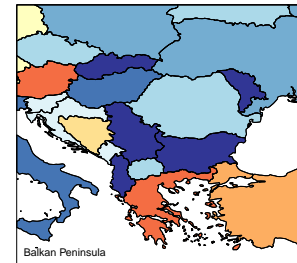
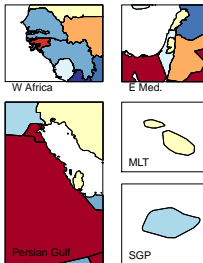
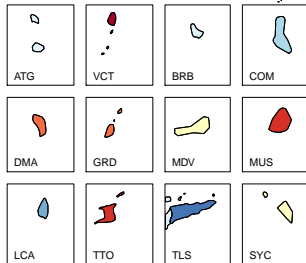
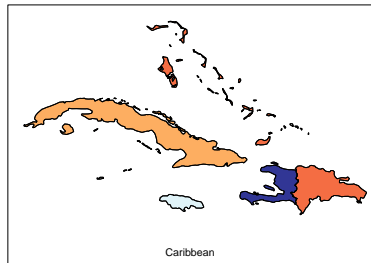


Figure S3a. Age-standardized Mortality Rate Attributable to High-BMI for Males (ages ≥ 25) in 2015

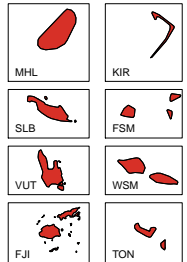
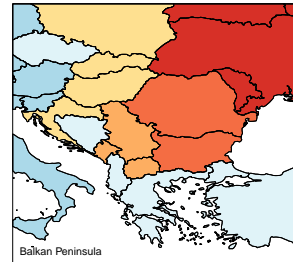
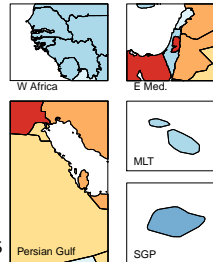
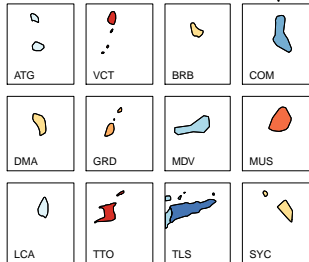
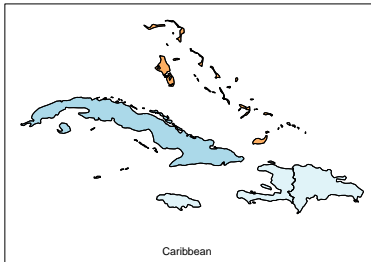
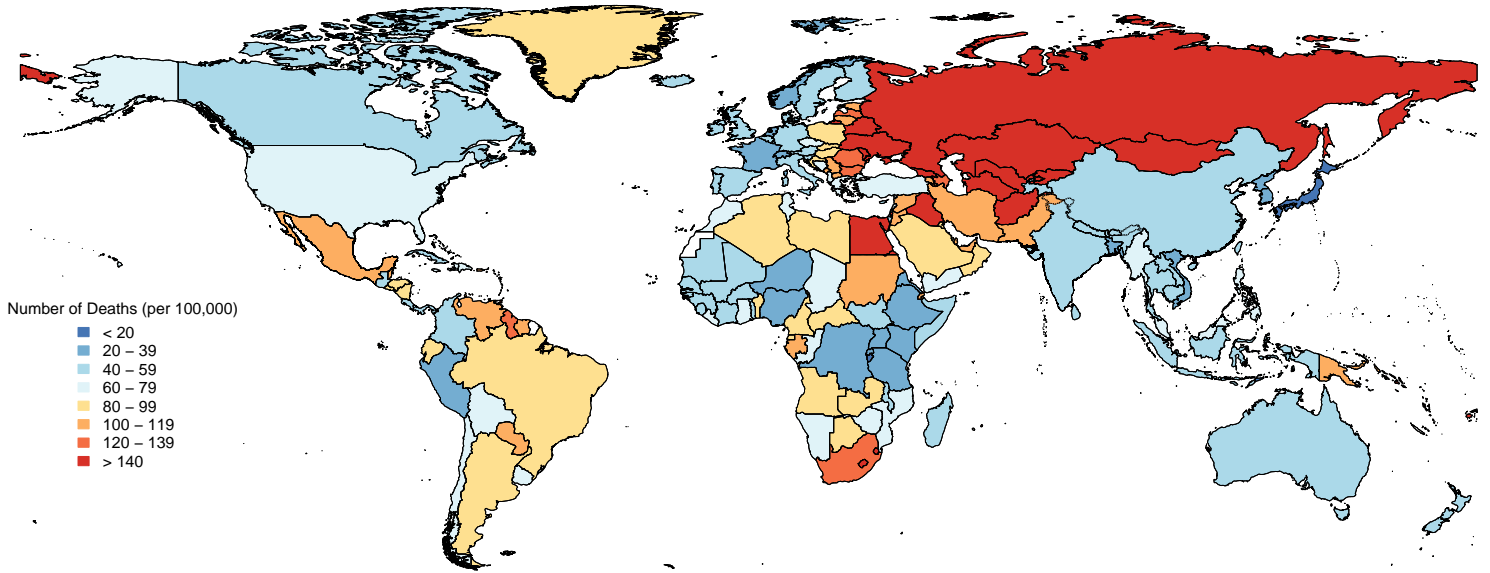


Figure S3b. Age-standardized Mortality Rate Attributable to High-BMI for Females (ages ≥ 25) in 2015

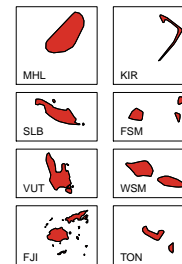
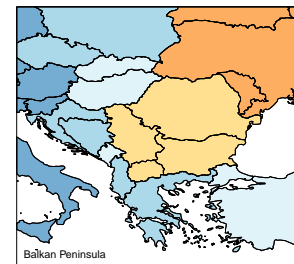
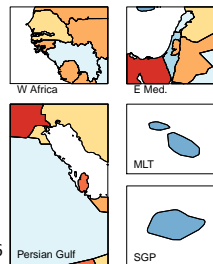
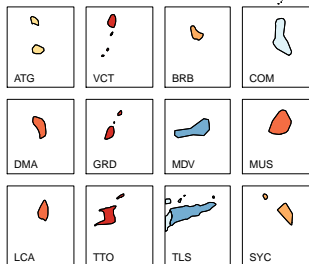
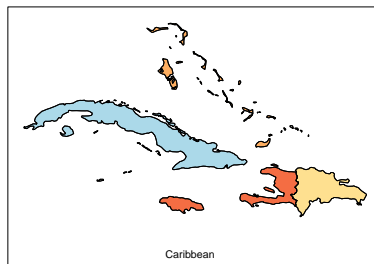
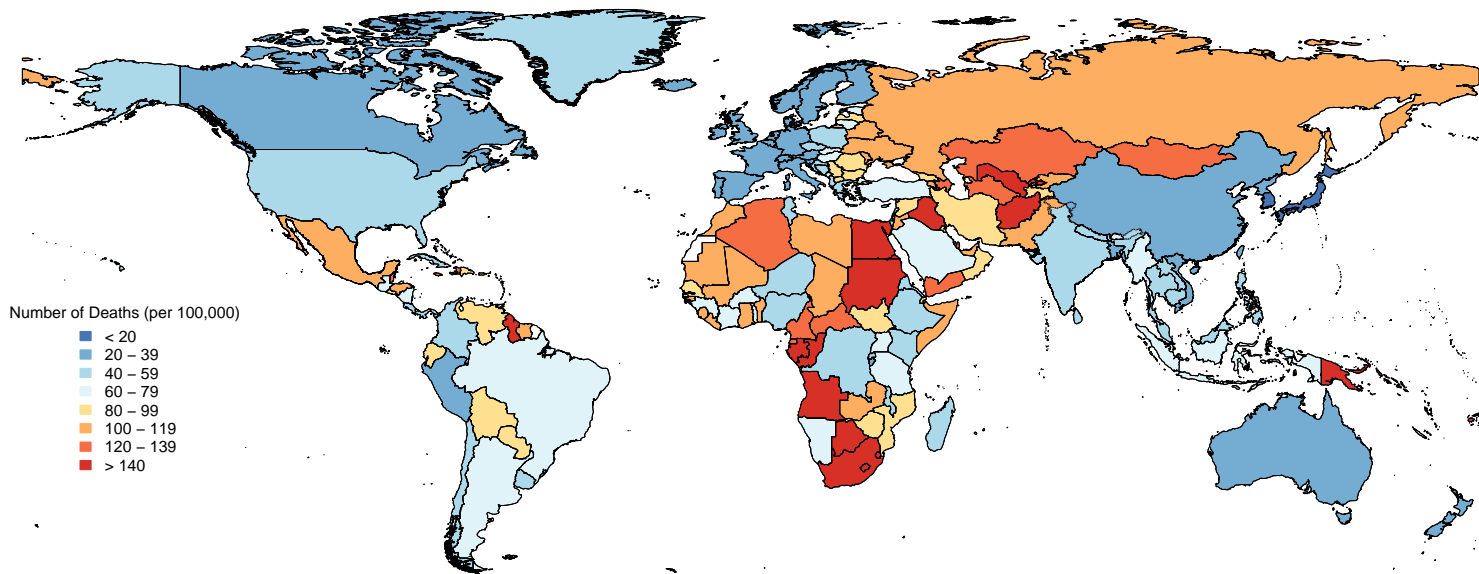
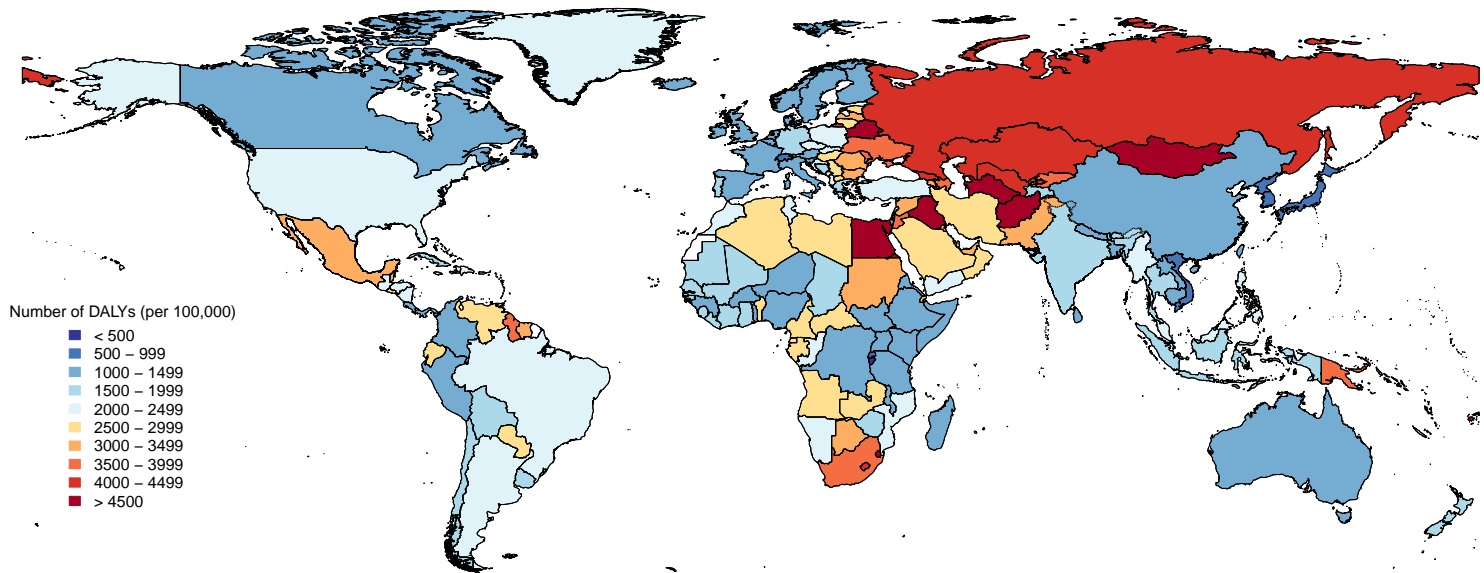


Figure S3c. Age-standardized DALY Rate Attributable to High-BMI for Males (ages ≥ 25) in 2015



Number of DALYs (per 100,000)

- < 500
- 500 – 999
- 1000 – 1499
- 1500 – 1999
- 2000 – 2499
- 2500 – 2999
- 3000 – 3499
- 3500 – 3999
- 4000 – 4499
- > 4500

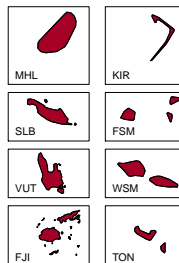
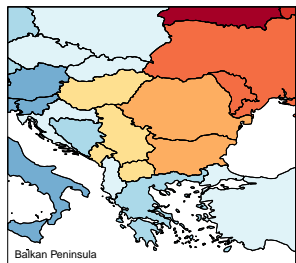
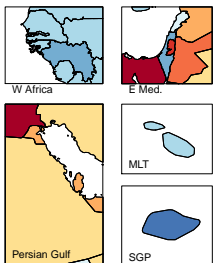
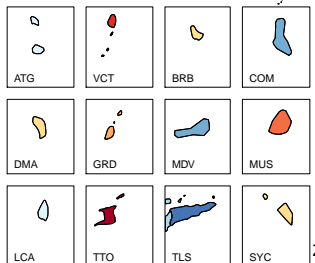
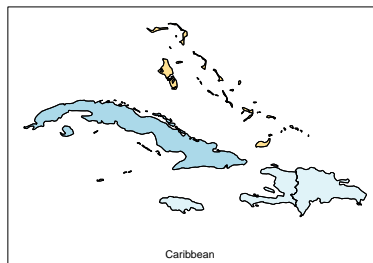
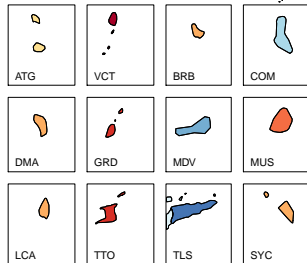
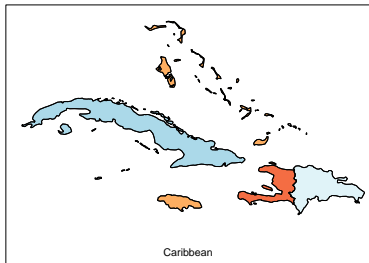
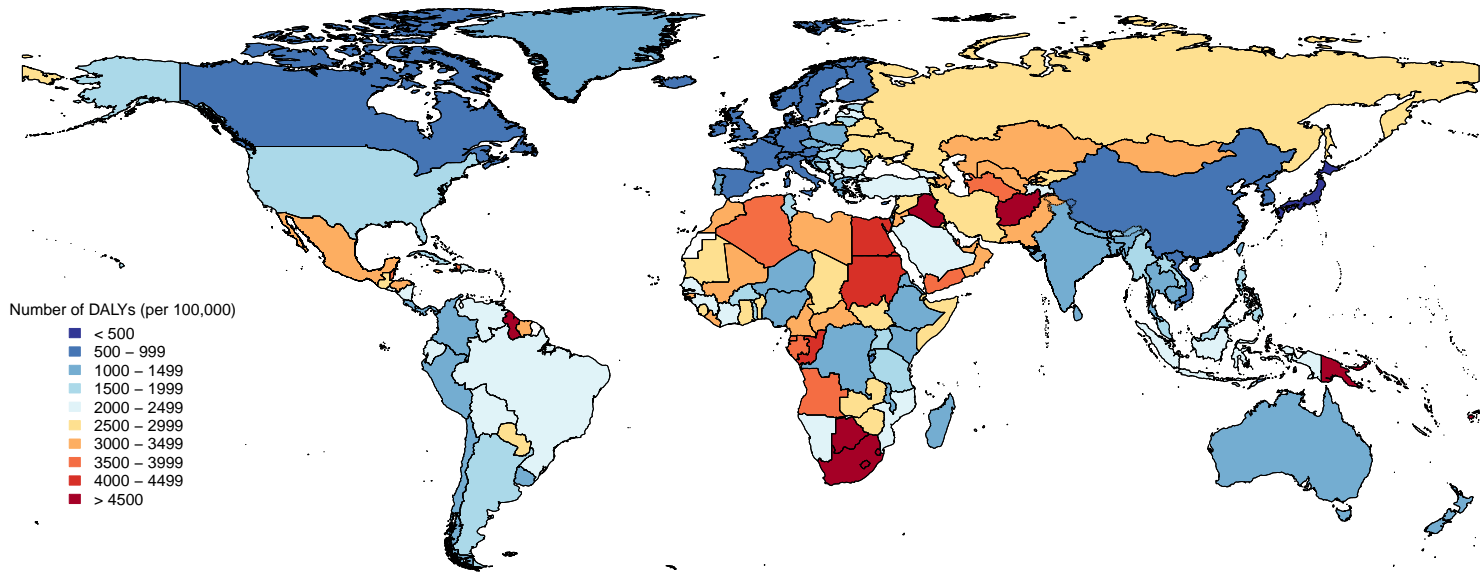


Figure S3d. Age-standardized DALY Rate Attributable to High-BMI for Females (ages ≥ 25) in 2015



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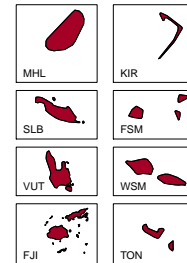
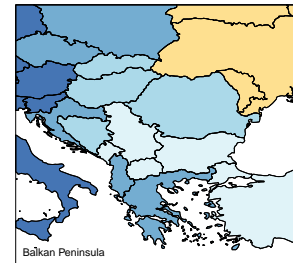
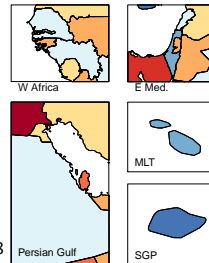


Figure S4. Selection process of scientific literature and survey data (PRISMA diagram)

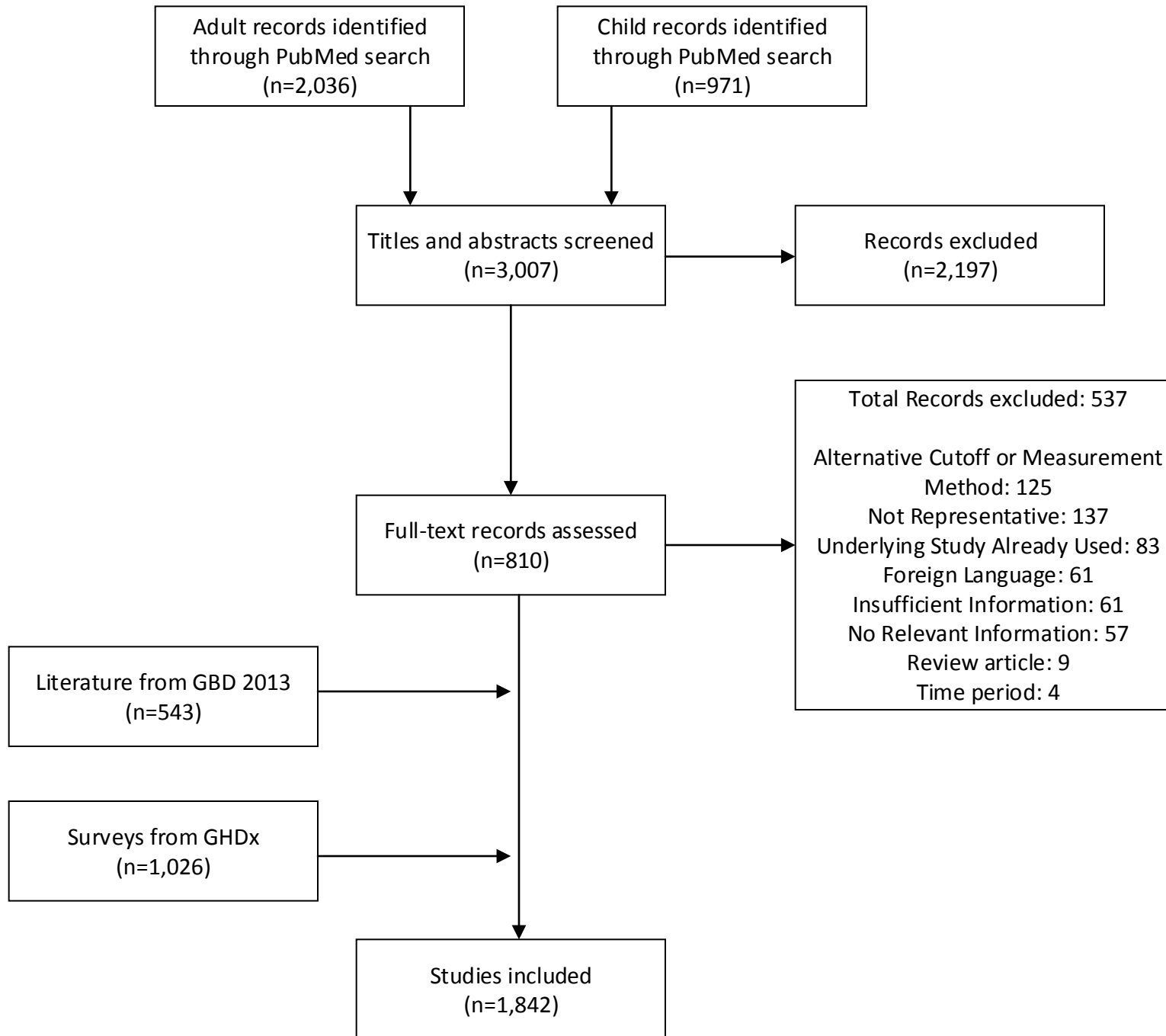


Figure S5. Process diagram for estimating the disease burden of high BMI

Body Mass Index

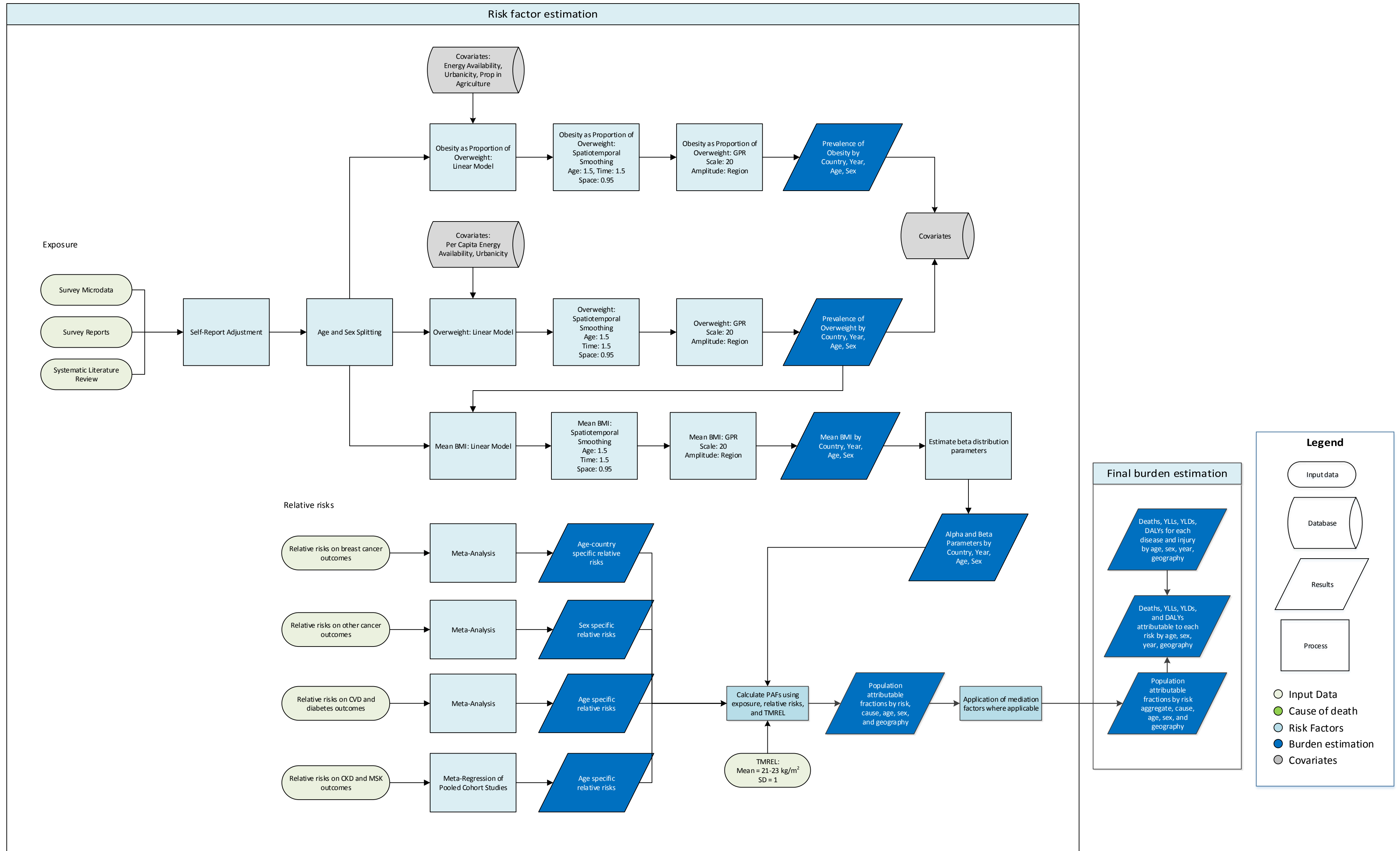


Table S1. Epidemiological evidence supporting causality between high body mass index (BMI) and disease endpoints.

To evaluate the magnitude of the effect sizes, we evaluated the RR comparing the 75th percentile with the 25th percentile of the exposure distribution at the global level. RR=relative risk.

Risk	Outcome	Prospective observational studies (n)*	Prospective observational studies with significant association in the opposite direction (%)	Lower limit of RR > 1.5	Dose-response relationship	Biologic plausibility†	Analogy‡
Metabolic risks							
High body-mass index	Oesophageal cancer	8	0	●	●	●	●
High body-mass index	Colon and rectum cancer	38	0	●	●	●	●
High body-mass index	Liver cancer	34	0	●	●	●	●
High body-mass index	Gallbladder and biliary tract cancer	10	0	●	●	●	●
High body-mass index	Pancreatic cancer	20	0	●	●	●	●
High body-mass index	Breast cancer (Post-menopause)	44	2	●	●	●	●
High body-mass index	Breast cancer (Pre-menopause)	25	8	●	●	●	●
High body-mass index	Uterine cancer	37	0	●	●	●	●
High body-mass index	Ovarian cancer	31	3	●	●	●	●
High body-mass index	Kidney cancer	28	0	●	●	●	●
High body-mass index	Thyroid cancer	16	0	●	●	●	●
High body-mass index	Leukaemia	17	0	●	●	●	●
High body-mass index	Ischaemic heart disease	129	..	●	●	●	●
High body-mass index	Ischemic stroke	102	..	●	●	●	●
High body-mass index	Hemorrhagic stroke	129	..	●	●	●	●
High body-mass index	Hypertensive heart disease	85	..	●	●	●	●
High body-mass index	Diabetes mellitus	85	..	●	●	●	●
High body-mass index	Chronic kidney disease	57	..	●	●	●	●
High body-mass index	Osteoarthritis	32	0	●	●	●	●
High body-mass index	Low back pain	5	0	●	●	●	●

● Yes
● No

Footnotes

*Prospective cohort studies or non-randomised interventions.

†Whether there is any biologic or mechanistic pathway that could potentially explain the relationship of the risk-outcome pair.

‡Whether the risk is associated with another outcome from the same category and there is evidence that it can cause the current outcome through the same pathway.

Table S4. Disability adjusted life years (DALYs), deaths, and years lived with disability (YLDs) attributable to high body mass index (BMI) caused by the below causes in males and females in 1990 and 2015. Rates presented as number per 100,000 at the Global level for all adults over the age of 25, age-standardized.

Cause	1990 DALYs		2015 DALYs		1990 Deaths		2015 Deaths		1990 YLDs		2015 YLDs	
	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females	Males	Females
Ischemic heart disease	674.06 (374.26 - 1012.62)	441.67 (279.54 - 624.03)	597.59 (350.59 - 870.58)	360.63 (240.5 - 491.5)	30.21 (16.27 - 46.88)	23.49 (14.3 - 34.15)	25.44 (14.49 - 38.17)	18.65 (11.85 - 26.53)	20.15 (9.34 - 35.54)	18.16 (9.95 - 29.08)	23.42 (11.47 - 39.59)	20.31 (11.53 - 31.72)
Ischemic stroke	133.92 (69.47 - 213.4)	140.95 (87.91 - 209.12)	116.91 (64.62 - 177.7)	99.76 (64.73 - 141.92)	6.19 (3.11 - 10.32)	6.98 (4.05 - 10.98)	5.13 (2.71 - 8.33)	4.8 (2.84 - 7.42)	9.03 (4.01 - 16.26)	10.09 (5.56 - 16.96)	10.51 (5.1 - 17.71)	10.87 (6.33 - 17.44)
Hemorrhagic stroke	291.15 (148.11 - 467.83)	309.29 (186.37 - 454.3)	302.92 (174.16 - 443.92)	243.39 (161.33 - 335.02)	10.21 (4.99 - 16.88)	11.03 (6.4 - 16.81)	10.23 (5.59 - 15.62)	8.61 (5.46 - 12.37)	8.27 (3.85 - 14.63)	10.56 (5.88 - 17.35)	10.75 (5.53 - 17.83)	11.5 (6.86 - 17.91)
Hypertensive heart disease	88.7 (42.88 - 148.14)	102.72 (58.83 - 154.28)	90.99 (52.06 - 137.94)	93.2 (59.61 - 128.6)	4.23 (1.84 - 7.6)	5.26 (2.68 - 8.47)	4.4 (2.22 - 7.34)	5.1 (2.79 - 7.71)	2.15 (0.88 - 4.08)	2.89 (1.48 - 4.88)	3.04 (1.39 - 5.39)	3.88 (2.08 - 6.28)
Diabetes mellitus	263.9 (150.09 - 400.29)	321.24 (212.24 - 451.08)	419 (260.66 - 598.06)	435.92 (309.22 - 588.74)	5.36 (3.02 - 8.02)	6.9 (4.59 - 9.46)	8.04 (4.93 - 11.47)	8.61 (6.02 - 11.47)	137.85 (68.76 - 225.53)	165.59 (98.85 - 254.06)	229.05 (125.88 - 352.47)	245.55 (153.55 - 361.77)
Chronic kidney disease	92.04 (45.88 - 149.24)	96.69 (56.26 - 146.39)	129.17 (70.53 - 197.9)	123.96 (77.1 - 176.01)	3.33 (1.56 - 5.62)	3.2 (1.67 - 4.98)	4.85 (2.45 - 7.7)	4.51 (2.5 - 6.83)	23.43 (11.5 - 39.59)	29.1 (16.37 - 45.16)	29.06 (15.5 - 46.42)	33.71 (19.94 - 50.8)
Esophageal cancer	36.89 (6.28 - 82.55)	16.67 (0.62 - 37.75)	36.34 (6.86 - 74.45)	12.25 (0.49 - 25.58)	1.61 (0.27 - 3.61)	0.75 (0.03 - 1.71)	1.65 (0.31 - 3.41)	0.58 (0.02 - 1.23)	0.39 (0.07 - 0.88)	0.18 (0.01 - 0.41)	0.49 (0.09 - 1.04)	0.18 (0.01 - 0.38)
Colon and rectum cancer	29.43 (14.81 - 46.42)	9.63 (4.24 - 17.23)	31.52 (17.01 - 48.05)	8.95 (4.06 - 15.68)	1.49 (0.74 - 2.38)	0.49 (0.21 - 0.87)	1.59 (0.85 - 2.44)	0.46 (0.2 - 0.8)	1.14 (0.52 - 1.94)	0.36 (0.15 - 0.67)	1.59 (0.79 - 2.6)	0.44 (0.19 - 0.81)
Liver cancer	39.98 (9.72 - 90.75)	13.7 (2.14 - 31.98)	54.14 (15.26 - 109.67)	14.26 (2.41 - 30.8)	1.59 (0.4 - 3.56)	0.57 (0.09 - 1.33)	2.17 (0.61 - 4.41)	0.65 (0.11 - 1.41)	0.32 (0.07 - 0.75)	0.12 (0.02 - 0.3)	0.51 (0.14 - 1.05)	0.17 (0.03 - 0.38)
Gallbladder and biliary tract cancer	3.46 (0.59 - 7.54)	12.88 (6.94 - 20.19)	2.91 (0.51 - 6.23)	8.71 (4.89 - 13.44)	0.18 (0.03 - 0.4)	0.66 (0.35 - 1.04)	0.16 (0.03 - 0.34)	0.46 (0.25 - 0.72)	0.05 (0.01 - 0.11)	0.17 (0.08 - 0.29)	0.05 (0.01 - 0.1)	0.13 (0.07 - 0.22)
Pancreatic cancer	5.68 (-0.09 - 14.14)	6.07 (2.24 - 11.3)	6.49 (-0.1 - 15.53)	7.1 (2.71 - 12.77)	0.27 (0 - 0.68)	0.32 (0.12 - 0.59)	0.32 (-0.01 - 0.77)	0.38 (0.14 - 0.68)	0.05 (0 - 0.14)	0.06 (0.02 - 0.13)	0.07 (0 - 0.17)	0.08 (0.03 - 0.16)
Breast cancer	-	15.96 (8.49 - 25.9)	-	21.77 (12.39 - 34.07)	-	0.79 (0.44 - 1.24)	-	0.98 (0.58 - 1.49)	-	1.84 (0.9 - 3.18)	-	3.09 (1.61 - 5.17)
Uterine cancer	-	22.12 (14.07 - 31.48)	-	21.68 (14.96 - 28.92)	-	0.92 (0.58 - 1.29)	-	0.88 (0.61 - 1.17)	-	1.72 (1.01 - 2.68)	-	2.68 (1.66 - 4.07)
Ovarian cancer	-	3.42 (-0.11 - 7.88)	-	3.41 (-0.12 - 7.58)	-	0.14 (0 - 0.32)	-	0.14 (0 - 0.31)	-	0.11 (0 - 0.27)	-	0.12 (0 - 0.29)
Kidney cancer	8.12 (4.2 - 13.06)	6.23 (3.78 - 9.16)	9.59 (5.32 - 15)	6.35 (4.1 - 8.95)	0.37 (0.19 - 0.6)	0.29 (0.17 - 0.42)	0.44 (0.24 - 0.7)	0.3 (0.19 - 0.42)	0.31 (0.14 - 0.55)	0.25 (0.14 - 0.42)	0.64 (0.31 - 1.08)	0.5 (0.3 - 0.79)
Thyroid cancer	0.98 (0.28 - 2.01)	1.17 (0.61 - 1.94)	1.39 (0.42 - 2.76)	1.24 (0.68 - 1.93)	0.04 (0.01 - 0.09)	0.05 (0.03 - 0.09)	0.05 (0.02 - 0.1)	0.05 (0.03 - 0.07)	0.08 (0.02 - 0.16)	0.11 (0.06 - 0.21)	0.36 (0.1 - 0.71)	0.32 (0.17 - 0.55)
Leukemia	5.86 (2.44 - 10.92)	7.18 (2.99 - 13.26)	6.84 (3.13 - 12.22)	7.69 (3.43 - 13.52)	0.25 (0.11 - 0.47)	0.29 (0.12 - 0.54)	0.3 (0.14 - 0.54)	0.32 (0.14 - 0.56)	0.22 (0.08 - 0.42)	0.24 (0.09 - 0.45)	0.32 (0.14 - 0.61)	0.34 (0.14 - 0.61)
Osteoarthritis	17.21 (7.73 - 30.65)	32.13 (17.42 - 52.46)	24.57 (11.76 - 42.2)	43.58 (24.85 - 69.51)	-	-	-	-	17.21 (7.73 - 30.65)	32.13 (17.42 - 52.46)	24.57 (11.76 - 42.2)	43.58 (24.85 - 69.51)
Low back pain	33.61 (14.47 - 62.1)	42.68 (21.97 - 74.73)	40.66 (19.07 - 72.26)	50.64 (27.81 - 84.65)	-	-	-	-	33.61 (14.47 - 62.1)	42.68 (21.97 - 74.73)	40.66 (19.07 - 72.26)	50.64 (27.81 - 84.65)

Table S5. Decomposition of percent changes in cause-specific deaths and disability-adjusted life years (DALYs) related to high body mass index from 1990 to 2015 due to population growth, population ageing, risk exposure and the underlying rates of deaths and DALYs by quintiles of Socio-demographic Index.

Deaths	Low SDI	Low-middle SDI	Middle SDI	High-middle SDI	High SDI
Cardiovascular Diseases					
% change due to population ageing	-1.26	34.71	59.19	43.7	21.65
% change due to population growth	125.05	74.34	41.71	21.29	7.59
% change due to risk exposure	60.28	78.94	76.29	35.93	23.22
% change due to risk-deleted mortality rate	-41.17	-40.31	-71.43	-63.86	-57.14
Total % change	142.9	147.68	105.77	37.05	-4.68
Diabetes Mellitus					
% change due to population ageing	-5	45.92	70.32	54.77	26.18
% change due to population growth	140.08	92.22	60.83	45.52	14.91
% change due to risk exposure	96.21	105.64	105.44	45.98	39.85
% change due to risk-deleted mortality rate	-18.44	31.3	-21.08	-46.51	-59.3
Total % change	212.84	275.09	215.51	99.75	21.64
Neoplasms					
% change due to population ageing	-6.43	32.8	75.98	56.57	28.75
% change due to population growth	126.68	76.4	26.57	27.67	11.88
% change due to risk exposure	80.73	77.86	86.7	49.82	25.97
% change due to risk-deleted mortality rate	-33.68	-31.4	-62.94	-46.97	-24.11
Total % change	167.3	155.65	126.31	87.09	42.49
DALYs	Low SDI	Low-middle SDI	Middle SDI	High-middle SDI	High SDI
Cardiovascular Diseases					
% change due to population ageing	-0.93	34.53	59.27	47.01	24.45
% change due to population growth	128.18	77.64	45.19	25.89	9.75
% change due to risk exposure	60.04	85.16	84.96	43.95	29.01
% change due to risk-deleted DALY rate	-43.37	-44.59	-78.19	-73.99	-64.7
Total % change	143.92	152.75	111.23	42.87	-1.49

Table S5. Decomposition of percent changes in cause-specific deaths and disability-adjusted life years (DALYs) related to high body mass index from 1990 to 2015 due to population growth, population ageing, risk exposure and the underlying rates of deaths and DALYs by quintiles of Socio-demographic Index.

Diabetes Mellitus					
% change due to population ageing	-3	45.51	70.77	60.92	31.73
% change due to population growth	147.1	95.43	64.98	51.83	21.92
% change due to risk exposure	89.39	116.9	119.9	65.25	61.79
% change due to risk-deleted DALY rate	-7.55	18.65	-25.83	-35.34	-47.3
Total % change	225.94	276.49	229.82	142.67	68.14
Neoplasms					
% change due to population ageing	-5.85	33.2	76.29	60.79	32.94
% change due to population growth	129.03	79.77	28.37	30.79	14.1
% change due to risk exposure	82.2	82.87	94.42	57.59	30.07
% change due to risk-deleted DALY rate	-36.3	-34.11	-64.53	-53.09	-25.64
Total % change	169.07	161.73	134.56	96.08	51.47
Musculoskeletal disorders					
% change due to population ageing	-3.5	35.81	70.46	54.23	23.74
% change due to population growth	137.06	82.99	52.06	35.28	15.27
% change due to risk exposure	72.32	81.12	83.59	42.83	32.42
% change due to risk-deleted DALY rate	2.19	-5.54	-2.59	-2.18	-4.12
Total % change	208.07	194.38	203.51	130.17	67.32

Tunisia	72.56 (37.89 - 111.69)	75.38 (49.39 - 105.75)	71.87 (37.24 - 118.82)	58.44 (34.71 - 87.31)	2065.44 (1134.89 - 3084.82)	2248.31 (1594.15 - 2947.42)	2165.43 (1242.28 - 3352.41)	1889.11 (1269.76 - 2570.83)
Turkey	125.95 (76.89 - 178.24)	112.91 (81.8 - 145.35)	74.13 (48.86 - 99.74)	61.36 (46.16 - 77.26)	3654.52 (2339.69 - 5014.29)	3200.24 (2456.58 - 4043.27)	2315.21 (1604.18 - 3030.03)	2002.61 (1534.25 - 2490.24)
Turkmenistan	154.57 (83.8 - 228.41)	144.53 (96.9 - 193.14)	184.06 (114.97 - 254.7)	138.55 (97.63 - 180.79)	4082.67 (2307.25 - 5828.74)	3639.93 (2540.07 - 4711.78)	4981.55 (3260.37 - 6600.6)	3610.82 (2705.92 - 4523.01)
Uganda	29.69 (9.23 - 63.03)	70.57 (30.84 - 123.92)	39.79 (11.43 - 98.43)	73.83 (25.34 - 155.26)	833.96 (264.44 - 1722.03)	1614.18 (729.09 - 2750.8)	1173.48 (366.49 - 2762.14)	1877.33 (722.4 - 3730.45)
Ukraine	146.84 (88.11 - 208.21)	118.28 (83.21 - 154.9)	154.54 (92.98 - 217.21)	111.15 (77.21 - 145.26)	3608.87 (2217.54 - 4976.42)	2736.72 (2032.41 - 3451.02)	3837.2 (2375.28 - 5252.31)	2601.6 (1931.09 - 3290.83)
United Arab Emirates	128.62 (76.26 - 188.48)	153.14 (100.08 - 214.72)	103.93 (60.16 - 156.17)	103.84 (68.82 - 148.44)	4028.43 (2596.37 - 5648.56)	4675.86 (3270.41 - 6389.66)	3425.1 (2209.42 - 4864.85)	3491.93 (2522.12 - 4661.11)
United Kingdom	97.16 (60.2 - 134.76)	56.51 (37.4 - 77.06)	51.32 (35.1 - 68.1)	30.13 (20.69 - 40.41)	2360.41 (1521.05 - 3195.28)	1356.02 (947.04 - 1795.73)	1390.91 (984.53 - 1801.34)	860.44 (623.82 - 1121.81)
United States	76.45 (43.94 - 111.21)	52.25 (35.29 - 70.93)	72.67 (52.01 - 93.87)	50.08 (38.07 - 62.65)	2217.56 (1356.7 - 3073.57)	1552.09 (1113.42 - 2032.37)	2329.97 (1728.55 - 2936.51)	1686.65 (1332 - 2064.87)
Uruguay	103.98 (61.94 - 148.71)	75.69 (51.32 - 102.11)	77.51 (49.59 - 106.38)	53.42 (37.65 - 69.72)	2579.09 (1610.07 - 3559.15)	1848.5 (1324.12 - 2412.8)	1968.1 (1321.96 - 2605.24)	1317.3 (983.35 - 1675.01)
Uzbekistan	177.7 (108.6 - 252.5)	138.52 (89.23 - 191.56)	163.25 (99.87 - 229.99)	142.89 (100.99 - 186.14)	4413.69 (2849.78 - 5990.48)	3219.68 (2173.71 - 4277.73)	4222.8 (2766.68 - 5646.49)	3494.54 (2659.82 - 4328.77)
Vanuatu	151.06 (73.69 - 258.79)	229.1 (133.79 - 368.2)	186.88 (97.99 - 307.89)	227.7 (126.8 - 378.11)	4749.71 (2409.1 - 7977.85)	6649.91 (4099.57 - 10432.15)	5906.64 (3296.18 - 9536.35)	6640.34 (3957.73 - 10690.74)
Venezuela	85.85 (45.96 - 129.27)	96.5 (64.25 - 130.22)	104.26 (63.41 - 147.23)	85.8 (58.46 - 117.79)	2370.9 (1370.69 - 3392.64)	2596.6 (1833.77 - 3339.64)	2881.75 (1911.17 - 3895.68)	2305.1 (1708.48 - 2973.35)
Vietnam	9.55 (1.88 - 23.94)	13.74 (4.03 - 29.93)	26.07 (8.52 - 53.67)	21.81 (7.69 - 43.1)	301.58 (61.54 - 734.94)	398.16 (121.95 - 832.71)	741.42 (237.94 - 1526.04)	592.88 (230.57 - 1141.89)
Virgin Islands, U.S.	109.55 (66.26 - 156.33)	109.62 (76.96 - 143.06)	133.67 (87.95 - 180.36)	108.24 (81.95 - 135.52)	2986.91 (1919.01 - 4081.66)	2836.12 (2121.6 - 3544.58)	3702.94 (2611.34 - 4819.18)	2822.63 (2296.04 - 3449.01)
Yemen	74.5 (27.15 - 149.71)	106.81 (42.95 - 205.83)	78.14 (31.08 - 158.74)	124.35 (59.22 - 225.41)	2246.97 (881.47 - 4390.23)	3017.44 (1304.31 - 5529.79)	2373.03 (1016.22 - 4579.63)	3639.91 (1893.85 - 6356.37)
Zambia	42.18 (18.29 - 74.55)	98.65 (51.59 - 153.77)	89.21 (36.94 - 159.17)	113.19 (49.16 - 215.87)	1264.35 (585.62 - 2193.06)	2285.79 (1210.99 - 3487.17)	2670.71 (1132.41 - 4687.58)	2871.02 (1353.13 - 5295.06)
Zimbabwe	33.14 (13.4 - 63.72)	73.42 (43.12 - 108.45)	62.6 (22.79 - 124.12)	89.81 (37.97 - 183)	1050.45 (484.92 - 1891.77)	2055.23 (1302.8 - 2859.84)	1921.89 (752.42 - 3634.3)	2633.36 (1348.49 - 4809.23)

Table S7. Comparison of the root-mean-square error (RMSE) from models using only measured data with the models using both self-reported and measured data

	Measured only	Measured and self-report
Overweight	0.063	0.07
Obesity	0.033	0.036

Table S8. Sources of epidemiological evidence used for assessment of causality between high body mass index and disease endpoints.

Risk	Outcome	Citation/Note
High body-mass index	Oesophageal cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Colon and rectum cancer	Karahalios A, English DR, Simpson JA. Weight change and risk of colorectal cancer: a systematic review and meta-analysis. <i>Am J Epidemiol</i> 2015; 181: 832–45.
High body-mass index	Colon and rectum cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Colon and rectum cancer	Schlesinger S, Lieb W, Koch M, et al. Body weight gain and risk of colorectal cancer: a systematic review and meta-analysis of observational studies. <i>Obes Rev</i> 2015; 16: 607–19.
High body-mass index	Liver cancer	Chen Y, Wang X, Wang J, Yan Z, Luo J. Excess body weight and the risk of primary liver cancer: an updated meta-analysis of prospective studies. <i>Eur J Cancer</i> 2012; 48: 2137–45.
High body-mass index	Liver cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Liver cancer	Rui R, Lou J, Zou L, et al. Excess body mass index and risk of liver cancer: a nonlinear dose-response meta-analysis of prospective studies. <i>PLoS ONE</i> 2012; 7: e44522.
High body-mass index	Liver cancer	Tanaka K, Tsuji I, Tamakoshi A, et al. Obesity and liver cancer risk: an evaluation based on a systematic review of epidemiologic evidence among the Japanese population. <i>Jpn J Clin Oncol</i> 2012; 42: 212–21.
High body-mass index	Liver cancer	Wang Y, Wang B, Shen F, Fan J, Cao H. Body mass index and risk of primary liver cancer: a meta-analysis of prospective studies. <i>Oncologist</i> 2012; 17: 1461–8.
High body-mass index	Gallbladder and biliary tract cancer	Park M, Song DY, Je Y, Lee JE. Body mass index and biliary tract disease: a systematic review and meta-analysis of prospective studies. <i>Prev Med</i> 2014; 65: 13–22.
High body-mass index	Gallbladder and biliary tract cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Pancreatic cancer	Alsamarrai A, Das SLM, Windsor JA, Petrov MS. Factors that affect risk for pancreatic disease in the general population: a systematic review and meta-analysis of prospective cohort studies. <i>Clin Gastroenterol Hepatol</i> 2014; 12: 1635–1644.e5; quiz e103.
High body-mass index	Pancreatic cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Breast cancer (Pre-menopause)	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Breast cancer (Pre-menopause)	Xia X, Chen W, Li J, et al. Body mass index and risk of breast cancer: a nonlinear dose-response meta-analysis of prospective studies. <i>Sci Rep</i> 2014; 4: 7480.
High body-mass index	Breast cancer (Post-menopause)	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Breast cancer (Post-menopause)	Xia X, Chen W, Li J, et al. Body mass index and risk of breast cancer: a nonlinear dose-response meta-analysis of prospective studies. <i>Sci Rep</i> 2014; 4: 7480.
High body-mass index	Uterine cancer	Aune D, Greenwood DC, Chan DSM, et al. Body mass index, abdominal fatness and pancreatic cancer risk: a systematic review and non-linear dose-response meta-analysis of prospective studies. <i>Ann Oncol</i> 2012; 23: 843–52.
High body-mass index	Uterine cancer	Jenabi E, Poorolajal J. The effect of body mass index on endometrial cancer: a meta-analysis. <i>Public Health</i> 2015; 129: 872–80.
High body-mass index	Uterine cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Ovarian cancer	Aune D, Navarro Rosenblatt DA, Chan DSM, et al. Anthropometric factors and ovarian cancer risk: a systematic review and nonlinear dose-response meta-analysis of prospective studies. <i>Int J Cancer</i> 2015; 136: 1888–98.
High body-mass index	Ovarian cancer	Collaborative Group on Epidemiological Studies of Ovarian Cancer. Ovarian cancer and body size: individual participant meta-analysis including 25,157 women with ovarian cancer from 47 epidemiological studies. <i>PLoS Med</i> 2012; 9: e1001200.
High body-mass index	Ovarian cancer	Liu Z, Zhang T-T, Zhao J-J, et al. The association between overweight, obesity and ovarian cancer: a meta-analysis. <i>Jpn J Clin Oncol</i> 2015; 45: 1107–15.
High body-mass index	Ovarian cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Kidney cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> 2008; 371: 569–78.
High body-mass index	Kidney cancer	Wang F, Xu Y. Body mass index and risk of renal cell cancer: a dose-response meta-analysis of published cohort studies. <i>Int J Cancer</i> 2014; 135: 1673–86.
High body-mass index	Thyroid cancer	Ma J, Huang M, Wang L, Ye W, Tong Y, Wang H. Obesity and risk of thyroid cancer: evidence from a meta-analysis of 21 observational studies. <i>Med Sci Monit</i> 2015; 21: 283–91.
High body-mass index	Thyroid cancer	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> . 2008; 371(9612): 569-78.
High body-mass index	Leukaemia	Castillo JJ, Reagan JL, Ingham RR, et al. Obesity but not overweight increases the incidence and mortality of leukemia in adults: a meta-analysis of prospective cohort studies. <i>Leuk Res</i> 2012; 36: 868–75.
High body-mass index	Leukaemia	Renehan AG, Tyson M, Egger M, Heller RF, Zwahlen M. Body-mass index and incidence of cancer: a systematic review and meta-analysis of prospective observational studies. <i>Lancet</i> . 2008; 371(9612): 569-78.
High body-mass index	Ischaemic heart disease	Singh GM, Danaei G, Farzadfar F, et al. The age-specific quantitative effects of metabolic risk factors on cardiovascular diseases and diabetes: a pooled analysis. <i>PLoS ONE</i> 2013; 8: e65174.
High body-mass index	Cerebrovascular disease	Singh GM, Danaei G, Farzadfar F, et al. The age-specific quantitative effects of metabolic risk factors on cardiovascular diseases and diabetes: a pooled analysis. <i>PLoS ONE</i> 2013; 8: e65174.
High body-mass index	Hypertensive heart disease	Singh GM, Danaei G, Farzadfar F, et al. The age-specific quantitative effects of metabolic risk factors on cardiovascular diseases and diabetes: a pooled analysis. <i>PLoS ONE</i> 2013; 8: e65174.
High body-mass index	Diabetes mellitus	Singh GM, Danaei G, Farzadfar F, et al. The age-specific quantitative effects of metabolic risk factors on cardiovascular diseases and diabetes: a pooled analysis. <i>PLoS ONE</i> 2013; 8: e65174.
High body-mass index	Chronic kidney disease	Emerging Risk Factors Collaboration, Wormser D, Kaptoge S, et al. Separate and combined associations of body-mass index and abdominal adiposity with cardiovascular disease: collaborative analysis of 58 prospective studies. <i>Lancet</i> 2011; 377: 1085–95.

Table S8. Sources of epidemiological evidence used for assessment of causality between high body mass index and disease endpoints.

Risk	Outcome	Citation/Note
High body-mass index	Chronic kidney disease	Ni Mhurchu C, Rodgers A, Pan WH, Gu DF, Woodward M, Asia Pacific Cohort Studies Collaboration. Body mass index and cardiovascular disease in the Asia-Pacific Region: an overview of 33 cohorts involving 310 000 participants. <i>Int J Epidemiol</i> 2004; 33: 751–8.
High body-mass index	Chronic kidney disease	Prospective Studies Collaboration, Whitlock G, Lewington S, et al. Body-mass index and cause-specific mortality in 900 000 adults: collaborative analyses of 57 prospective studies. <i>Lancet</i> 2009; 373: 1083–96.
High body-mass index	Osteoarthritis	Jiang L, Rong J, Wang Y, et al. The relationship between body mass index and hip osteoarthritis: a systematic review and meta-analysis. <i>Joint Bone Spine</i> 2011; 78: 150–5.
High body-mass index	Osteoarthritis	Jiang L, Tian W, Wang Y, et al. Body mass index and susceptibility to knee osteoarthritis: a systematic review and meta-analysis. <i>Joint Bone Spine</i> 2012; 79: 291–7.
High body-mass index	Osteoarthritis	Silverwood V, Blagojevic-Bucknall M, Jinks C, Jordan JL, Protheroe J, Jordan KP. Current evidence on risk factors for knee osteoarthritis in older adults: a systematic review and meta-analysis. <i>Osteoarthritis Cartilage</i> 2015; 23: 507–15.
High body-mass index	Low back pain	Shiri R, Karppinen J, Leino-Arjas P, Solovieva S, Viikari-Juntura E. The association between obesity and low back pain: a meta-analysis. <i>Am J Epidemiol</i> 2010; 171: 135–54.

Table S9. Citations for all sources used for estimating body mass index, overweight, and obesity.

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