Weight Bias Analysis Tool for Public Health Policies

obesity canada / obésité canada

Background

Obesity is now widely recognized as a chronic disease among health practitioners and researchers, and by NGOs such as Obesity Canada, the Canadian and American Medical Associations and the World Health Organization (1, 2).

The final frontiers for acceptance of obesity as a chronic disease remain within public health and health policy. While evidence tells us that obesity affects morbidity and mortality at the population level, and that weight bias and obesity stigma are fundamental drivers of health inequalities (3–4), much work remains to be done to provide the meaningful prevention and management strategies that need to be implemented if Canada and other jurisdictions are to truly adopt a chronic disease framework for obesity (5).

Too many current public health policies and strategies to address obesity are solely focused on prevention, are based on simplistic narratives of "eat less and move more" and fail to account for individual heterogeneity in body size and weight (6). Specifically, the current public health obesity narrative promotes and reinforces assumptions about personal irresponsibility and lack of willpower among people with obesity (7). These assumptions contribute to the beliefs that people with obesity and their children simply lack awareness and knowledge about healthy eating and physical activity and are therefore largely to blame for the obesity epidemic.

This is a challenge that is not insurmountable.

Public health can leverage existing health promotion frameworks, such as the "health for all policy framework" and the "global plan of action on social determinants of health" to address weight bias and obesity stigma (8–10). Within this context, however, public health decision makers need to ensure that strategies do not have unintended consequences for individuals and populations.

Public health can also directly address weight bias and obesity stigma by using a weight bias lens to identify strategies and policies that may be contributing to bias and obesity stigma. Supporting policy makers to operationalize obesity in a non-weight centric chronic disease framework may help mitigate tensions that exist between the public health obesity prevention discourse, clinical practice and the experiences of people living with obesity. Strategies such as critically reflecting on the unintended consequences of public health policies and discourses, questioning of simplistic assumptions about obesity's causes, shifting focus to health and well-being, addressing obesity as a chronic disease and prioritizing people-centered health promotion approaches have been recommended as potential solutions to prevent further weight bias and stigmatization in public health policies.

The following checklist is designed to support policy makers in critically assessing policies, strategies and programs and correcting for weight bias and stigma.

Weight Bias Question	Rationale
What is the overarching goal of the policy or program?	• Identifying specific policy goals can help determine whether the proposed strategies are specific to obesity prevention/ reduction or whether obesity is inappropriately being used as a hook for overall health promotion policies.
Is the policy goal to promote healthy behaviours or to prevent and/or reduce obesity?	• Behaviours like healthy eating and physical activity are important for population health. However, behaviour change alone may not sufficiently contribute to obesity prevention or reduction because obesity is a much more complex disease. • Obesity prevention and management strategies should go beyond the promotion of healthy eating and physical activity behaviour to include: i) more detailed and evidence-based information about the drivers of weight gain (including genetics, mental health, built environment, food environment, socio-economic status, cultural practices, physical challenges, education level, food addiction and more) and ii) information evidence-based treatments and supports for people living with obesity. • Positioning healthy eating and physical activity public health strategies as effective obesity prevention and management interventions may cause further weight bias and stigma. Such strategies may unintentionally position individuals with obesity as unhealthy or as targets for healthy behaviour strategies.
Does "obesity" even need to be mentioned in this specific health promotion policy or behaviour change strategy?	• If this is a policy to promote overall health, consider whether obesity needs to be mentioned at all. Positioning health promotion or wellness policies as obesity prevention strategies unfairly and inaccurately implies that only persons or populations with obesity need to engage in health promoting behaviours.
If this is an obesity prevention / reduction policy, what are the expected outcomes?	• The World Health Organization defines of obesity as a disease when excess or abnormal adiposity/weight impairs health. Health impairments may be different between individuals, communities and populations. There are many health consequences associated with obesity such metabolic, musculoskeletal, mental, and social issues. Evaluation measures need to consider the broad health impacts of obesity rather than just reduction in body weight.

Weight Bias Question	Rationale
Is body size being used as an obesity prevention/reduction strategy outcome?	• Many obesity policies have weight or BMI as outcomes. Although BMI is a surrogate measure for obesity (used mainly in population surveillance studies), it is not an adequate measure of a person's health. People come in different shapes and sizes, and individuals can experience health over a wide range of BMI levels. • BMI merely measures body size and in itself is not an adequate health measure. Therefore, the impact of obesity prevention/management strategies should not be measured by body size. • Like any other chronic disease strategy, obesity prevention and management strategies should be measured according to specific and measurable health/clinical outcomes.
Could this policy create unintended consequences such as labelling individuals according to their body size?	• Creating "healthy" versus "unhealthy" weight categories ends up labeling groups by their size and/or weight and contributes to weight bias. Population health outcomes need to focus on just that — health outcomes. This is important for prevention of further weight bias and stigma. • Be specific and distinguish between body size and obesity as a disease. Size is not a disease. Obesity is a disease.
Is the language in this policy appropriate?	• Be aware of the language used in policies. Always use "person-first-language" when referring to obesity. Avoid using the clinical term "obesity" when referring to a person's body size. Obesity is a clinical/medical term used when an individual has been diagnosed with obesity (i.e. direct health impairments due to excess or abnormal weight/adiposity). • Provide evidence-based messages about the link between weight/size and health. • Promote body size diversity and body positivity through images and language.
Have you engaged people with obesity in the development of this policy?	• In an era of people-centered health care, public health can and should engage people with obesity in the development of policies and strategies. • Having active participation of individuals with obesity can help change negative attitudes and beliefs and facilitate the development of compassionate and equitable population health strategies.

References

1. World Health Organization. Obesity: Preventing and Managing the Global Epidemic. Report of a WHO Consultation. Geneva, Switzerland: WHO, 2000; 0512–3054.

2. Kuk JL, Ardern CI, Church TS, Sharma AM, Padwal R, Sui X, *et al.* Edmonton Obesity Staging System: Association with weight history and mortality risk. Appl Physiol Nutr Metab 2011;36(4):570–76. PMID: 21838602. doi: 10.1139/ H11-058.

3. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. *Am J Public Health* 2013;103(5):813–21. PMID: 23488505. doi: 10.2105/AJPH.2012.301069.

4. Puhl RM, Heuer CA. Obesity Stigma: Important Considerations for Public Health. *American Journal of Public Health*. 2010;100(6):1019–1028.

5. Sharma AM, Ramos Salas, X. . Obesity Prevention and Management Strategies in Canada: Shifting Paradigms and Putting People First. *Current Obesity Reports*. 2018;7(2):89–96.

6. Kirk SFL, Price SL, Penney TL, Rehman L, Lyons RF, Piccinini-Vallis H, *et al.* Blame, shame, and lack of support: A multilevel study on obesity management. Qual Health Res 2014;24(6):790–800. PMID: 24728109. doi: 10.1177/1049732314529667.

7. Ramos Salas X, Fohan, M., Caulfield, T., Sharma, A.M., Raine, K. A critical analysis of obesity prevention policies and strategies. *Canadian Journal of Public Health*. 2017;108(5-6):e598–e608.

8. World Health Organization. Global Plan of Action on Social Determinants of Health, 2017. Available at: http://www.who.int/social_determinants/action_sdh/en/ (Accessed June 2, 2017).

9. World Health Organization. HEALTH21: The Health for all Policy Framework for the WHO European Region, 1999. Available at: http://www.euro.who.int/en/publications/abstracts/health21-the-health-for-all-policy-framework-for-the-who-european-region (Accessed June 2, 2017).

10. Weight bias and obesity stigma: considerations for the WHO European Region (2017) http://www.euro.who.int/en/health-topics/noncommunicable-diseases/obesity/publications/2017/weight-bias-and-obesity-stigma-considerations-for-the-who-european-region-2017