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Towards a Weight-Inclusive Approach in Public Health

Presented by:

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Disclosures:

Amy and Jess are employed as a Public Health Dietitians at Ontario Public Health Units and members of Ontario Dietitians in Public Health.

Both have received partial coverage of expenses as speakers at Dietitians of Canada conferences.

Personal disclosure: both have OMERS pension plans and mutual funds.

Ontario Dietitians in Public Health (ODPH)

Our Vision

Ontario Dietitians in Public Health are recognized and valued as leaders in public health nutrition working to promote the health of Ontarians

Our Mission

► To advance public health nutrition through member and partner collaboration in order to improve population health and health equity locally and provincially



www.odph.ca

ODPH Body Diversity Workgroup Acknowledgements

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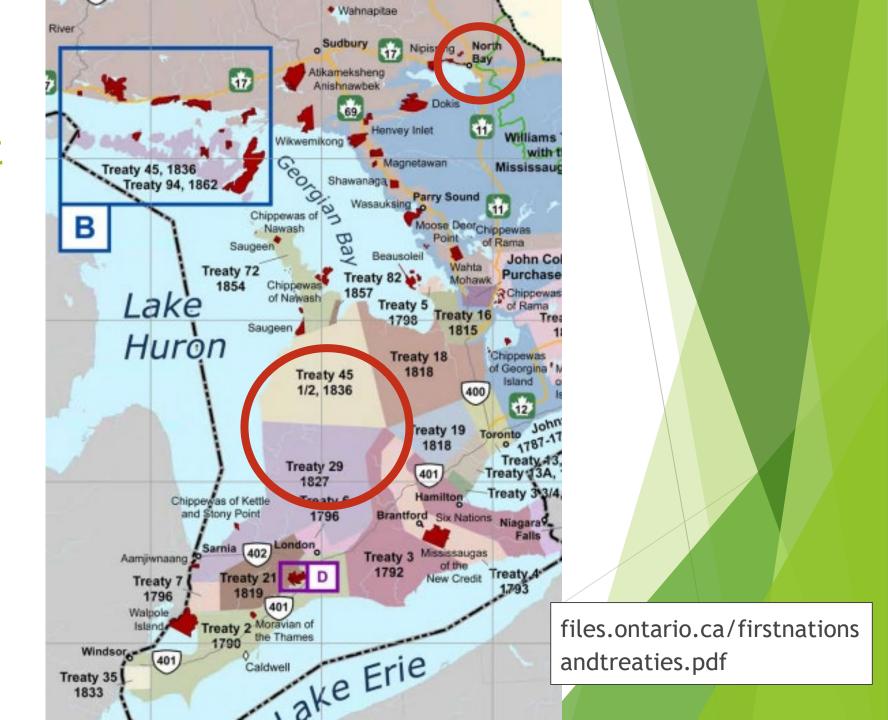
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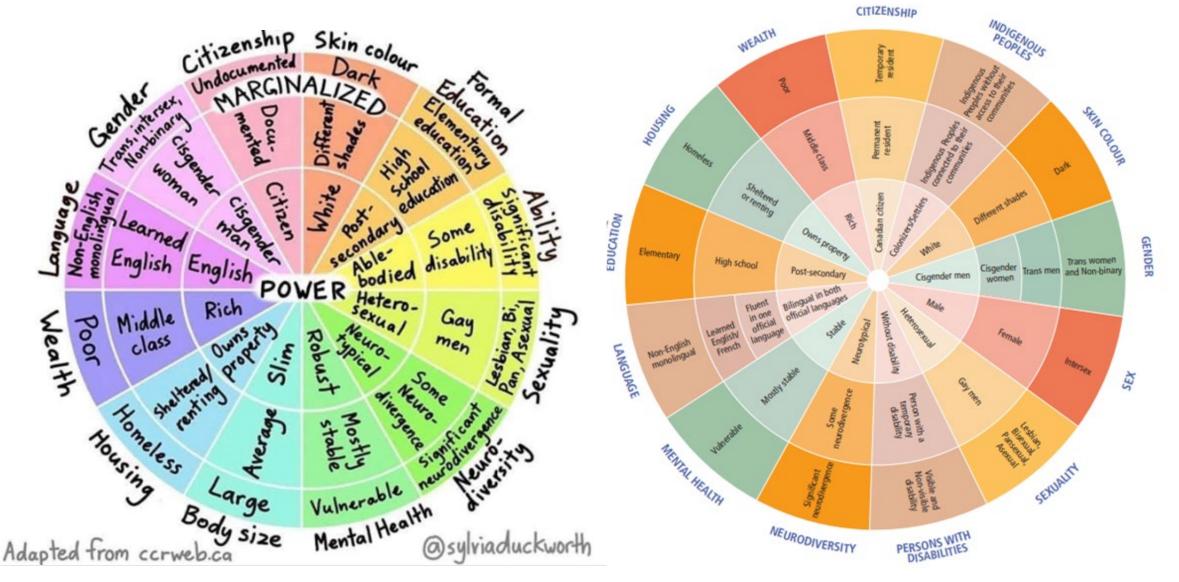
Learning Objectives:

- 1. Describe why an intersectional approach to addressing weight bias is an important health equity and social justice issue of public health importance
- 2. Identify opportunities for addressing weight bias within their public health unit or organization
- 3. Identify actions they can take to address weight bias within their workplace in ways that align with equity, diversity and inclusion priorities

Land Acknowledgement



Acknowledging Power and Privilege



https://sdpride.org/wp-content/uploads/2022/11/Wheel-of-Power-Privilege-Sylvia-Duckworth.pdf and https://www.canada.ca/content/dam/ircc/documents/pdf/english/corporate/anti-racism/wheel-privilege-power.pdf

Acknowledging Privilege

- Work at local public health units, funded by provincial and municipal governments
- Power as regulated health professionals and being paid professionals
- Dietetics shaped by colonialism and White supremacy
 - "White cis-gender middle and upper class women" as traditional RD
 - Unethical nutrition experiments on Indigenous children in the residential school system: informed the development of Canada's Food Guide

Terms

- ► Weight Bias: Negative attitudes, beliefs, assumptions and judgements towards individuals based on their weight, shape, appearance or BMI
- ► Weight stigma: When people are labelled and stereotyped based on their body size.
- ► Weight discrimination: Unjust treatment of people in larger bodies.

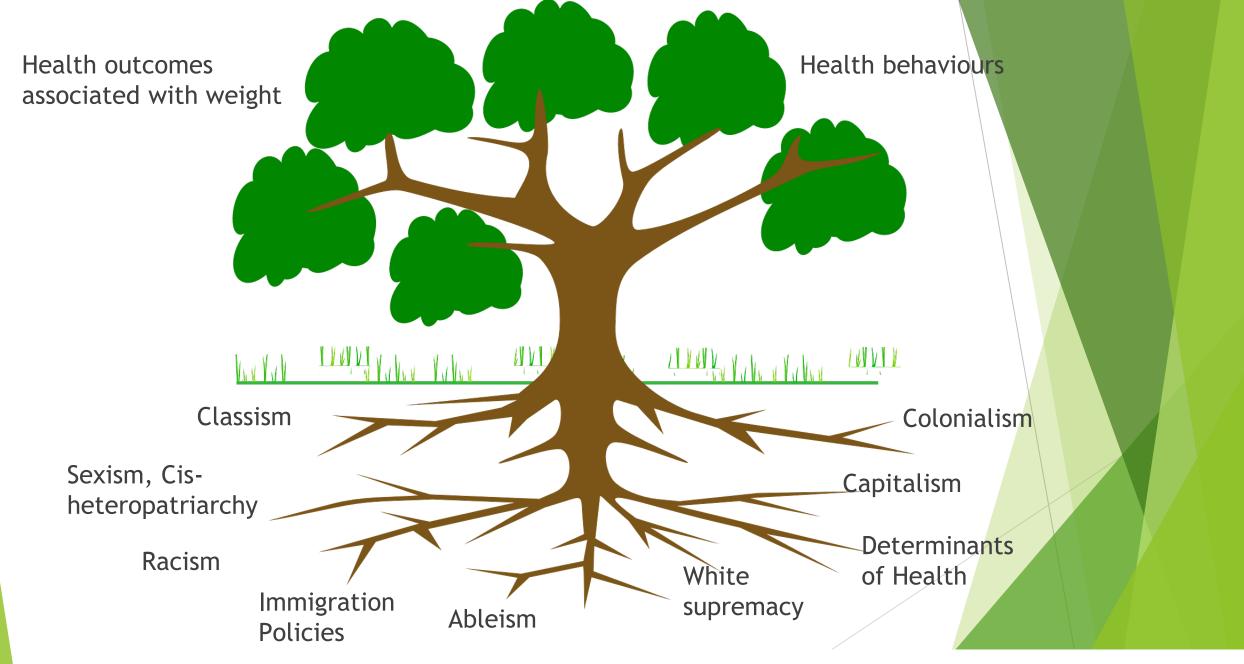


Image by Clker-Free-Vector-Images from Pixabay. Inspired by NCCDH, 2024.

ODPH Position Statement, 2024

Target audience:

- ► Public health dietitians/public health nutritionists and public health colleagues
- Other professionals and community partners

Purpose: To explain why public health should be taking a weight-inclusive approach to health promotion and health care and to provide recommendations for how to do so.

Objectives: To support those who use the position statement to make their organization and initiatives/projects more weight inclusive

Discussion on Language

What words do we use to describe body size?

What are the pros/cons of using any of these words?

Overweight Obese Higher weight Curvy Heavy Person with obesity Large Unhealthy weight Fat

Ragen Chastain Weight and Healthcare newsletter

"Inclusive Language for Higher-Weight People."

Nov 3, 2021.

ODPH Position on Language

- "Obese" and "overweight" medicalize & pathologize larger bodies; are rooted in racism and sexism
- We use:
 - o "obesity" & "overweight" when citing research
 - 'higher weight' or 'larger bodied' otherwise
- Others use 'fat':
 - Preferred term by fat activists
 - We support its use in the appropriate context

(Strings, 2019; Harrison DL, 2021; Chastain, 2021; Puhl, 2019; Calogero, 2019; Meadows & Danielsdóttir, 2016)

Health

"Research shows that the social determinants can be more important than health care or lifestyle choices in influencing health." - WHO (1948)

- Shift from "what's the matter with you?" to "what matters to you?"
- Risks of focusing solely on health behaviours:
 - Increase stigma and blames individual
 - Moralization of health (worth tied to health status)

(Crawford, 1980; WHO 2008; WHO, 1998; Mundel & Chapman, 2010; Huber, 2011; Lebesco, 2011; Amzat & Razum, 2014; Auger et al, 2016; Lee & Pausé, 2016; Crammond & Carey, 2016; Brown, 2018; Leonardi, 2018; Ambwani et al, 2020; Richardson & Crawford, 2020; Braveman et al, 2022; Olstad et al, 2019; Lau & Kurrein, 2020; Ng, 2023)

Roots of Weight Bias Anti-Black Racism and Colonialism

- Origins in transatlantic slave trade and spread of White Anglo-Saxon Protestantism in Europe and Americas
- Skin colour, and other physical features, used to rank people
 - ► Beauty and intelligence = thin White bodies
 - ► Idle, lazy, hypersexual, and morally corrupt = Black Africans and other races (non-White)

Roots of Weight Bias -Anti-Black Racism and Colonialism

- ➤ Settler colonizers created system of policies and legislation to dehumanize Indigenous peoples and to destroy, eradicate, and replace Indigenous cultures, structures, practices and ways of knowing
- ► Believed that slender bodies were racially and morally superior; thinness = American exceptionalism
- MMIWG2S: bodies were to be controlled and continue to be today

History of the Body Mass Index

- Invented nearly 200 years ago by Adolphe Quetelet
- Early 1900's: Height/weight tables by Insurance companies
- ▶ 1970's: Ancel Keys rebrands QI as BMI
- ► 1995: WHO "the method used to establish BMI cut-off points has been largely arbitrary"
- ▶ 1995: Industry-funded International Obesity Task Force formed
- ▶ 1998: US adopted and relabelled WHO BMI categories

(WHO, 1995; Keys *et al*, 1972, reprinted 2014; Blackburn & Jacobs, 2014; Nuttall, 2015; Komaroff, 2016; Strings, 2023)

History of the Body Mass Index

- ► BMI was not originally developed for use specifically as an index of fatness
- BMI has serious limitations when used as an indicator of percent of body fat mass
- Misleading in regard to effects of body fat mass on mortality rates

AMA Journal of Ethics®

Illuminating the Art of Medicine

JUL 2023

How We Over Rely on BMI

Volume 25, Number 7: E467-572

https://journalofethics.amaassn.org/issue/how-we-over-relybmi

(Keys et al, 1972, reprinted 2014; Blackburn & Jacobs, 2014; Nuttall, 2015; Komaroff, 2016; Flegal et al, 2007; Flegal et al, 2013; Flegal, 2021; Flegal, 2023; Strings, 2023)

Research on Weight

- "Obesity" prevention and control research is highly funded vs. research weight bias, stigma, and discrimination
- Majority of researchers and participants not diverse
- ▶ NO strong evidence of long-term weight loss.
 - Weight regained within 2-years, by 5 years majority at their pre-intervention body weight
 - More likely experience weight cycling
 - Weight loss attempts increase risk of disordered eating and eating disorders

Weight and Health

- ► Relationship is complex
 - Presumption that high weight causes poor health
 - Correlation does not mean causation
 - Weight stigma and weight cycling are confounding factors
 - Stress caused by experiencing weight stigma and discrimination and the influence of the social determinants of health increases health risk

Weight Bias is Pervasive

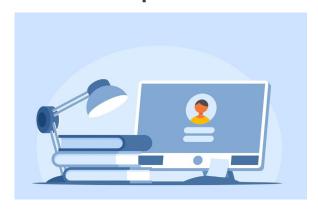
1. Healthcare



2. Media



3. Workplaces



4. Schools



5. Interpersonal Relationships



Public Health's Role in Perpetuating Weight Bias

- Framing "obesity" as a public health crisis or epidemic, and economic burden
 - Often use aggressive and disrespectful language
 - Campaigns that frame "obesity" as a public health crisis do not increase motivation to improve one's health and decrease feelings of self-efficacy over one's health status
- Focusing on weight as a modifiable chronic disease risk factor that can be controlled by an individual's behaviour change

Three Weight Paradigms

Weight-normative/ Weight-centred Health/
Complication
Centric

Weight Inclusive

Weight-Normative/Weight-Centred

- Weight loss to improve health
- ► Blame is placed on individuals, fear-based messaging is often used to motivate one to lose weight
- Promotes modified eating behaviours and physical activity as a means to lose weight

Health/Complication-centric Approach

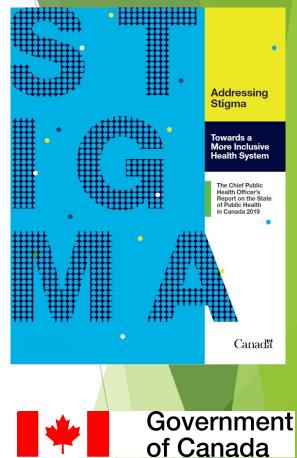
- ► Views "obesity" as a chronic disease
- Acknowledges the impacts of weight stigma and the various factors that affect weight change
- Acknowledges the inaccuracy of using BMI (may use alternative assessment tools)
- May advocate for weight loss surgery/pharmaceutical interventions

Weight-Inclusive Approach

- Social justice-oriented and anti-oppressive approach
- Focuses on dismantling systems of oppression for those with higher weights/larger bodies
- Addresses impact of weight-based discrimination and SDH on health
- Recognizes that weight and BMI are inaccurate indicators of health
- Against the idea of "obesity" being a disease or the use of the term "obesity"

Addressing Stigma: Toward a More Inclusive Health System

- Begins with the labelling of differences and negative stereotyping of people
- ▶ "Us" vs. "Them"
- Devalued, subjected to discrimination, unjust treatment, exclusion
- Inequitable social and health outcomes
- People and institutions with resources and power shape "norms"





Weight-Inclusive Recommendations for Public Health Practice

- 1. Collaboration and Partnership
- 2. Communications
- 3. Supportive Environments and Policy
- 4. Education and Training/Capacity Building



Recommendations: Collaboration and Partnership

- Foster partnership and collaboration
 - Consult with local partners and communities
 - Ensure individuals with lived experience (e.g., those living in larger bodies) are compensated appropriately and commit to amplifying their voices as experts
- ► Raise awareness of weight bias, stigma, and discrimination, through training and advocacy initiatives
- Empower & support partners to update policies, resources, and discontinuing harmful programs/messaging

Recommendations: Communications

- Update and advocate for updates of resources and messages
 - Avoid "healthy weights", "normal weight", and BMI categories
 - Avoid using the terms "obesity" or "overweight" in messaging
 - Avoid listing "obesity" as a chronic disease and framing it as a public health crisis (or using violent connotations)
- Use positive, non-stigmatizing images.

Recommendations: Supportive Environments and Policy

- Physical spaces furniture and equipment designed to accommodate people of diverse body sizes
- Ask clients how the space may be changed so that they feel safer and more comfortable
- Remove items that promote thin ideal or may stigmatize larger bodies
- Advocate for upstream programs and policies that address the SDH instead of focusing specifically on individual behaviour change

Recommendations: Education and Training/Capacity Building

- Public health professionals, educators, community partners, and related provincial organizations
- Promote and distribute position statement for consistency in messaging
- ► Encourage critical self-reflection of personal attitudes, biases, beliefs, cultural identity, and privilege
- ► Improve skills and knowledge
- Commit to unlearning colonial narratives of racial superiority and oppression, and how this intersects with weight-based discrimination

Case Studies in Position Statement: Practical Examples to Reduce Weight Bias

- 1. Community initiative to address weight and health
- 2. Workplace interested in a weight loss challenge
- 3. Individuals with weight and body concerns
- 4. Quitting smoking
- 5. School concern re: students with "unhealthy" lunches
- 6. School concerns about disordered eating
- 7. Concerns with infant growth
- 8. Taking a weight when medically indicated
- 9. Parent concerned with a coach's emphasis on weight
- 10. Diet culture in conversations
- 11. Weight bias in health care settings

Key Concepts

- All bodies are worthy of equitable care, regardless of size, weight, ability, health status, eating pattern, and physical activity choices
 - Importance of non-judgement
- ► Health is independent of weight. Weight and BMI are inaccurate indicators of health.
- Bodies have, and continue to, come in a range of shapes and sizes that are largely influenced by factors beyond individual control

Example: Weight bias in health care settings

A client comes into the Health Unit to access services. The clinical equipment (e.g. gown, exam table, blood pressure cuff, vaccine needle) or furniture is not appropriate and doesn't meet their needs.

What to Say/Do:

- Apologize and own our failure. Assure it is not their fault.
- Make adjustments in order to provide services in a non stigmatizing way
- Use the opportunity to think about how we can ensure our spaces will be accessible to all bodies and to prevent future incidents
- Bring the issue forward to accessibility committee
- Refer to ODPH Checklist (will be available in French) and implement changes

"The only thing that anyone can diagnose, with any certainty, by looking at a fat person, is their own level of stereotype and prejudice towards fat people."

- Marilyn Wann, The Fat Studies Reader



(https://nyupress.org/9780814776315/the -fat-studies-reader/)

Ontario Dietitians in Public Health: Position, 2024

- ► Weight bias and the resulting stigma and discrimination is a significant public health problem and social justice issue that leads to health inequities.
- ► Public health must **not** frame higher weights as a disease or epidemic as this contributes to weight discrimination.
- A weight inclusive approach reduces harm and promotes health for individuals in larger bodies. All public health professionals need to work together to support a weight-inclusive approach that improves health outcomes for all.



Thank You!

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