

REVIEW

Changing the global obesity narrative to recognize and reduce weight stigma: A position statement from the World Obesity Federation

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Summary

Weight stigma, defined as pervasive misconceptions and stereotypes associated with higher body weight, is both a social determinant of health and a human rights issue. It is imperative to consider how weight stigma may be impeding health promotion efforts on a global scale. The World Obesity Federation (WOF) convened a global working group of practitioners, researchers, policymakers, youth advocates, and individuals with lived experience of obesity to consider the ways that global obesity narratives may contribute to weight stigma. Specifically, the working group focused on how overall obesity narratives, food and physical activity narratives, and scientific and public-facing language may contribute to weight stigma. The impact of weight stigma across the life-span was also considered. Taking a global perspective, nine recommendations resulted from this work for global health research and health promotion efforts that can help to reduce harmful obesity narratives, both inside and outside health contexts.

KEYWORDS

global health, obesity, weight stigma

For affiliations refer to page. 6

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1 | INTRODUCTION

Weight stigma has been identified as a significant social determinant of health that directly impacts biopsychosocial health outcomes and is a barrier to health equity and the attainment of the health-related sustainable development goals.^{1,2} Weight stigma leads to discrimination and is therefore also a matter of human rights. It is essential to consider how weight stigma may be impeding health promotion globally. A group of experts and advocates convened by the World Obesity Federation (WOF) came together to review the evidence on weight stigma in the context of obesity prevention and management practices in different world regions. The goal was to issue a statement with recommendations focused on eliminating weight stigma globally as well as increasing the representativeness of research in different regions of the world.

2 | WEIGHT STIGMA

People with higher body weights and individuals living with obesity are vulnerable to societal stigma and discrimination based on their weight.¹ In Western countries, rates of experienced weight stigma are over 60% in some adult weight management samples.³ Weight stigma leads to systemic disadvantages and inequities as well as numerous adverse health consequences,⁴⁻⁷ especially among those who internalize weight-stigmatizing beliefs and attitudes.⁸ Recent systematic reviews highlight consistent evidence that people who experience and/or internalize weight stigma are at risk for biopsychological distress.⁵⁻⁸ Researchers documenting the physical and psychological health consequences of weight stigma have found that it is associated with increased physiological dysregulation (e.g., increased cortisol and inflammation),^{9,10} symptoms of depression and anxiety,^{11,12} disordered eating behaviors including restrictive eating,¹³ exercise avoidance,¹⁴ and suicidal ideation.¹⁵

Most weight stigma research has been conducted in high-income countries (HICs). However, a scoping review focused on non-Western countries identified 130 papers on weight stigma from 33 countries and territories, demonstrating that weight stigma is present globally.¹⁶ Further, a narrative review of attractiveness ideals across cultures found thinness to be an increasingly common beauty ideal in non-Western countries.¹⁷ While many cultures have traditionally emphasized higher body weights as indicators of status, wealth, and attractiveness, especially within low- and middle-income countries (LMICs),¹⁸ the global preference for thinness is increasing, particularly among people in higher socioeconomic status groups.¹⁷ Thus, within LMICs, cultural messages related to health, wealth, and attractiveness may vary widely, contributing to weight stigma at both ends of the body weight spectrum.¹⁶

Regardless of sociocultural context, adiposity-based chronic disease such as obesity requires comprehensive prevention and management strategies.¹⁹ Research highlighting the limitations of body mass index (BMI)^{20,92} provides an opportunity to examine obesity-focused public health messages in different regions of the world and to shift

the narrative of causes and solutions to one that is focused on health, not body size. In 2021, the WOF created a working group composed of scientific, policy, youth advocates, and public members from different regions of the world to determine if a global approach to understanding and reducing weight stigma in the context of obesity prevention and management was possible and to help identify shared solutions. This position statement represents the outcome of this working group. The remaining sections of this paper summarize the working group process, findings, and recommendations for reducing weight stigma globally.

3 | WORKING GROUP PROCESS

Working group members included 41 representatives from Australia, the Bahamas, Bangladesh, Brazil, Canada, the Caribbean, Chile, France, India, Ireland, Kenya, Kuwait, Malaysia, Mexico, New Zealand, Nigeria, Singapore, Sweden, the United Kingdom, and the United States. Members of the working group included healthcare practitioners, obesity researchers, weight stigma researchers, health policymakers, youth advocates working in obesity contexts, and individuals with lived experience of obesity. Some members of the working group held more than one of these roles (e.g., a healthcare practitioner as well as an individual with lived experience). The overall goal of the group was to discuss weight stigma on a global scale, identify knowledge gaps, examine the impact of obesity-related narratives on weight stigma, and propose recommendations applicable across different global regions. To achieve this goal, the working group identified three specific objectives: (1) to discuss the understanding of weight stigma on a global scale and identify gaps in knowledge; (2) to consider how scientific, policy, and public-facing language and efforts aimed at obesity prevention and management in different regions of the world may unintentionally be contributing to stigmatization; and (3) to make recommendations for changing obesity research, policy, and public-facing language that can reduce weight stigma and have applicability across countries and contexts.

At the first group meeting, it was recognized that both the language and framing of obesity in cultural discourses were critical to understand in order to make recommendations to reduce weight stigma across world regions. The working group decided to engage in reading and extended discussion related to these issues. To facilitate discussion, the working group was divided into four sub-groups that focused on the following areas: (1) implications of the overall obesity narrative on weight stigma; (2) implications of narratives related to nutrition and physical activity on weight stigma; (3) the impact of weight stigma across the lifespan; and (4) implications of scientific, policy, and public-facing language related to obesity on weight stigma. In using the word narrative, we broadly refer to dominant cultural messaging in language and imagery about obesity, weight, and health, including ideas about what constitutes a “healthy weight,” the role of lifestyle behaviors in health, weight, and weight loss, as well as cultural beliefs about the controllability and morality of weight.^{21,23,92}

The overall working group was co-chaired by two authors (CC and XRS). Each of the four sub-groups had a chair, who helped to facilitate the sub-group working and writing process. Between March and November of 2021, these four sub-groups met approximately every 4–6 weeks. Discussions were conducted online, recorded, and shared across sub-groups. These discussions as well as recommendations from each sub-group were summarized in four white papers to World Obesity. These summaries and recommendations from each sub-group were then synthesized and integrated to form this global position statement. Three new investigators (SN, LE, and TSN) and two World Obesity staff (JR and SS) worked together with the working group co-chairs to prepare the full working group statement for publication. All other working group members reviewed, provided input, and approved the final version of the manuscript (with editing support provided by KB). The literature pertaining to the discussion of each sub-group is summarized below, followed by the nine recommendations of the working group.

4 | OVERALL OBESITY NARRATIVE

The way higher body weights have been portrayed within research, healthcare, policy, the media, and society at large has contributed to weight stigma.¹⁸ People with higher body weights are often stereotyped as lazy, gluttonous, unintelligent, unattractive, and non-compliant,¹ including stereotypical portrayals in news,^{24,25} advertising,²⁶ social,^{27,28} and entertainment media.²⁹ These stereotypes are also fueled by dominant cultural narratives related to weight, weight loss, “healthy weight,” and personal responsibility for weight, also referred to as “healthy weight discourse”²³ or “diet culture.”²¹ Weight stigma has a significant negative impact on the quality and quantity of healthcare,³⁰ experiences in educational settings,³¹ and opportunities in the workplace^{32,33} and can adversely affect interpersonal relationships.^{34,35} Weight stigma contributes to negative attitudes and beliefs by reinforcing the incorrect notion that individuals with higher body weights or obesity have moral character flaws.³⁶ There is a common belief that consuming fewer calories and being more active is the “one-size-fits-all” treatment for obesity.³⁶ This ignores the significant evidence that body weight is determined by a complex, interconnected set of factors,³⁷ including biological (e.g., genetics, epigenetics, psychological factors, and hormones) and social determinants of health (e.g., income, education, employment status, and access to healthcare), food industry practices (e.g., food marketing and lobbying), access to opportunities for physical activity,³⁷ and lived experiences with other forms of stigmatization.³⁸

The use of anthropometric measures such as the BMI to define or diagnose obesity at the individual level may also contribute to weight stigma (e.g., via its incorrect use as a diagnostic tool). An obesity diagnosis requires a medical assessment to determine if and how excess or dysfunctional adiposity is impairing a person's health (e.g., through conversations with the patient and laboratory tests).^{19,39} Anthropometric measures such as BMI and waist

circumference have been used in population studies to estimate the prevalence of obesity and clinically as a screening tool,^{39–41} but are insufficient for a medical diagnosis.⁴² The use of anthropometric measures alone to determine access to, and quality of, healthcare—for example, via higher insurance premiums or the denial of medical procedures—can contribute to weight-based discrimination and lead to health and social inequities.^{20,43,92}

Weight stigma exists on a global scale, including within societies that have historically preferred larger bodies.¹⁸ One possible explanation for this is the migration of thin-ideal and “fat-is-bad” narratives of the West to other parts of the world.⁴⁴ Researchers have documented a globalization of anti-fat attitudes in 10 countries, with Mexico, American Samoa, and Paraguay showing the highest levels of weight stigmatization.⁴⁵ Furthermore, a study with participants in 41 LMICs demonstrated that adolescents with a higher BMI are more likely to be bullied than peers with a lower BMI.⁴⁶ Given the ever-evolving global cultural landscapes, it is important to understand that weight stigma may exist in a society even if it has not in the past or is not perceived as the dominant narrative.

5 | FOOD AND PHYSICAL ACTIVITY NARRATIVES

Simplistic obesity prevention messages focusing solely on individual food intake and physical activity promote weight stigma by disregarding the many interconnected biological, psychosocial, and environmental determinants of health.³⁷ Such messages also overlook the additional intersectional barriers to physical activity and healthy eating that women, children, and other vulnerable and marginalized populations may experience around the world.^{47–49} These include socioeconomic limitations, self-consciousness related to physical activity, and lack of safe spaces to be physically active.^{47–49} The current global food environment also runs contrary to health promotion efforts, as food deserts prevail in vulnerable neighborhoods and regions^{50,51} and ultra-processed foods become an increasingly prominent part of diets globally.^{52,53}

In addition, nutrition and exercise-focused interventions have demonstrated a lack of effectiveness for long-term sustainable obesity treatment.⁵⁴ Health-related benefits can be gained from health behavior changes with little change in body weight,^{55,56} yet health messages primarily focus on weight loss and Western thin ideals, as well as diet and fitness cultures that stigmatize people with higher body weights.^{57,58}

Similarly, many healthcare providers lack specific training on obesity and weight stigma^{59,60} and may contribute to promoting prevention and treatment approaches that focus on weight rather than health.⁶¹ This view may also contribute to weight stigma and discrimination in healthcare encounters,⁶² with potential significant consequences for health. Individuals who experience weight stigma can internalize it, applying weight-biased beliefs and attitudes towards themselves (e.g., self-stigma).⁸ The experience or internalization of

weight stigma can negatively impact eating behaviors for individuals across the weight spectrum, increasing the risk of developing disruptive eating behaviors.⁸ For youth, these effects often continue into adulthood.⁶³ Additionally, weight stigma has been associated with a decrease in physical activity and avoidance of activity to circumvent further stigmatization in sport.⁶⁴ Thus, shifting the obesity narrative beyond simplistic messaging (e.g., “eat less, move more”) can remove unwarranted blame from individuals and increase focus on wellness for individuals across the weight spectrum.

6 | WEIGHT STIGMA THROUGHOUT THE LIFESPAN

To examine the influence of weight stigma across the lifespan, the literature was summarized across four life stages: pregnancy/postpartum; infancy and childhood; adolescence; and adulthood.

6.1 | Pregnancy/postpartum

The frequency of weight-stigmatizing experiences in pregnancy is associated with perinatal complications, including gestational diabetes, preeclampsia, and postpartum depression; however, these data do not establish causation with weight stigma alone.^{65,66} In most HICs, people who have higher body weights in pregnancy will receive specialized obstetric care for increased monitoring and risk management.⁶⁷ Unfortunately, the prenatal healthcare environment in HICs has been identified as a prominent source of weight stigma, along with a lack of diverse representation of pregnant bodies in the media.^{67,68} An understudied area is prenatal weight stigma in LMICs; qualitative accounts suggest that this is an issue in low-income populations and often intersects with other social stigmas, such as socioeconomic status and food insecurity.⁶⁹ In the postpartum, where mothers feel social pressure to rapidly return to pre-pregnancy weight, weight stigma is associated with postpartum weight retention⁷⁰ and is a risk factor for postpartum depression.⁷¹

6.2 | Infancy/childhood

The global narrative on higher body weights among younger age groups is variable. For example, in some cultures, mothers prefer their children to have higher body weights because it is perceived as a sign of good health.⁷² As observed in studies from HICs, children with higher body weights are vulnerable to weight-based bullying, which has severe consequences for emotional and physical development, poor self-esteem, absenteeism in school, and poor academic achievement.⁷³ Weight-based stereotypes and preferences to play with lower weight peers can emerge as early as 5 years of age.⁷⁴ Sources of weight stigma during infancy/childhood include family, peers, teachers, healthcare professionals, and the media, which often portray children with higher body weights unfavorably.⁷³

6.3 | Adolescence

Similar to younger age groups, adolescents are globally vulnerable to weight stigma and its consequences, including teasing, bullying, social exclusion, poor physical health, and psychological distress.⁶³ One of the key sources of weight stigma in this life stage is social media, which is fervently used by most adolescents globally.⁶³ Social media provides an accessible platform to receive weight-related messaging, which often devalues individuals with higher body weights and can contribute to weight bias internalization.⁷⁵ Among adolescents, experiencing weight stigma is associated with increased depression, anxiety, suicidality, disordered eating, and substance use.⁷⁶

6.4 | Adulthood

In an industry-funded six-country study with adults participating in a commercial weight loss program, more than 50% experienced weight stigma at least once, and this was associated with maladaptive eating behaviors, higher stress, and avoidance of physical activity.⁷⁷ Adults may be subjected to weight discrimination including reduced job opportunities and associated financial implications, limited healthcare access and quality, and poor interpersonal relationships.⁴ A critical gap in our understanding of weight stigma is the geriatric population, with limited evidence suggesting that weight stigma continues to be pervasive and harmful in this demographic.^{78,79} More research focusing specifically on aging populations globally will elucidate the experience of, and harms associated with, weight stigma among older adults.

7 | SCIENTIFIC, POLICY, AND PUBLIC-FACING LANGUAGE

The language and imagery used to communicate about weight and obesity play an important role in shaping social norms and narratives in research, education, policy, healthcare, and media. Of note, a focus on English-only definitions and evidence may contribute to assumptions about how body weight and weight stigma are experienced by individuals in different regions of the world.

7.1 | Obesity definitions

There is a general lack of clarity regarding the definition of obesity in research, policy, practice, and among the public. The World Health Organization (WHO) defines obesity as “abnormal or excessive fat accumulation that presents a risk to health.”⁸⁰ Researchers have criticized BMI-based definitions of obesity as not taking into account the location, distribution, and function of adiposity and that adiposity-based chronic disease occurs when there is abnormal, dysfunctional adipose tissue.⁸¹ Further, recent recommendations include a call to move away from BMI as a sole criterion for obesity diagnosis.^{42,43,83} It is important to discard definitions of obesity that rely solely on BMI

or other anthropometric metrics and instead to conceptualize obesity as a chronic disease that occurs *when* excess or dysfunctional adiposity impairs health. To prevent weight stigma, it is important to distinguish between body size or weight and the disease of obesity. Individuals can be healthy and unhealthy across the weight spectrum.^{20,92} Not all individuals who have higher body weights have obesity, and individuals with a BMI in the “healthy weight” range may have adiposity-related complications.^{38,84} Thus, the clinical term “obesity” should not be used to refer to a person's body size and should only be used when an individual has been appropriately medically diagnosed with obesity.

7.2 | Scientific and clinical language

Many scientific articles on nutrition, weight, or obesity use sweeping generalizations about weight and health,⁸⁵ which detract from efforts to understand the complexity of weight and obesity in the context of health. As scientific research is often perceived as a source for reliable information and best practice, scientific writing must be held to the highest standards of accuracy. Additionally, it is important to note that language commonly used in medical settings (i.e., obesity, morbid obesity, abnormal fat, and excess fat) is often regarded as stigmatizing. A recent systematic literature review demonstrated no universal preference for weight terminology across 33 studies.⁸⁶

7.3 | Policy language

There is a recognition that the use of common language and terms related to non-communicable disease (NCD) policy may support obesity advocacy efforts. However, language that could inadvertently increase weight stigma—including “the burden of obesity,” “the war on obesity,” and “eliminate obesity”—should not be used in public-facing communications, to avoid shaming, blaming, and implying that people with higher body weights or those living with obesity are a problem to be eliminated. While such phrases may be commonly used in economic research and NCD advocacy, it must be considered how these phrases can be interpreted as reinforcing weight stigma.

7.4 | Public-facing language

As stigma is a driver of poor health, wellbeing, and social outcomes, stigmatizing language, imagery (including pictorial and video portrayals of people with higher body weights), and messages in public health campaigns and particularly the media are often extremely problematic.³⁶ Incorrect definitions of obesity (e.g., BMI-based) and oversimplified obesity prevention and treatment messages (e.g., “eat less and move more”) may inadvertently result in people with lower weights perceiving that health-promoting messages are not relevant for them⁸⁷ and simultaneously propagate weight-based stereotypes. Researchers documented increasing coverage on obesity in British

news between 2008 and 2017, focusing mostly on individual responsibility as part of dominant cultural obesity narratives as well as food and physical activity narratives.^{24,25} Similar findings have been reported in examinations of social media^{27,28} and popular media.²⁹

8 | RECOMMENDATIONS FOR A GLOBAL EFFORT TO REDUCE WEIGHT STIGMA

With the aim of reducing weight stigma across countries and cultural contexts, the working group has identified key recommendations that will target the overall obesity narrative, food and physical activity narratives, weight stigma throughout the lifespan, and scientific, policy, and public-facing language about obesity.

1. *Distinguish between body size and obesity.* To reduce the conflation of health with weight and size, health providers, advocates, and the media should use an accurate definition of obesity that moves beyond a solely BMI-based measurement and ensure that obesity is used to refer only to individuals with an obesity diagnosis. Although BMI may be used as a population measure and a clinical *screening* tool, it should not be used as a medical *diagnostic* tool.²⁰ We recognize that not all healthcare contexts will have the resources to engage in adequate medical diagnostics, such as a thorough examination of metabolic, mechanical, mental health, and social markers and encourage healthcare providers in these contexts to clearly distinguish between obesity risk and diagnosis. Person-centered conversations around health and the promotion of healthier behaviors when indicated, without an emphasis on patient weight, may allow for positive outcomes by healthcare providers without unintentional reinforcement of weight stigma.
2. *Use person-first language.* Person-first language is a type of linguistic prescription which puts a person before their diagnosis or stigmatized identity, describing what a person “has” rather than asserting what a person “is.”⁸⁸ Person-first language can help to reduce stigma and has become an established standard by many health organizations and research journals.⁸⁴ It should be understood that person-first language, as rooted in English, may differ in other languages and contexts, and its applicability in other languages ought to be explored and documented.
3. *Consider individual language preferences.* Language is dynamic, and there is no universally preferred terminology to refer to weight.⁸⁶ Individuals with higher body weights have their own beliefs regarding weight-based terms and may have personal preferences in the use of language (e.g., fat, bigger body, and higher weight). Requesting and respecting individual preferences is critical to delivering people- and patient-centered care.^{89,90}
4. *Use non-stigmatizing language and imagery.* In communication about body weight and obesity, language and imagery should not perpetuate stereotypes or blame and shame individuals for their weight. Communications should also avoid alarming, catastrophizing, or combative language. This recommendation needs to be particularly reinforced among the media and in public health communication.⁷⁵

5. *Engage in weight-neutral health promotion.* Given that current narratives equating weight and body size with health contribute to weight stigma, health promotion strategies should focus on health outcomes instead of weight.⁹¹ A shift is needed away from a focus on weight, weight loss, and a predetermined notion of “healthy weight” (based on BMI) towards a holistic focus on health and wellbeing for an individual, regardless of their weight or size.
6. *Engage in legislative and policy efforts to reduce weight stigma.* Governments and policymakers should consider weight stigma in all health promotion efforts and should engage with weight stigma researchers and people with lived experience in the development and evaluation of policy and legislative actions. Legislation and policy efforts to reduce weight stigma are needed to address weight-based discrimination⁸² in education, healthcare, employment, and media, including in advertising, promotions, and the entertainment industry.
7. *Promote human rights-based approaches to tackle weight stigma and discrimination.* While body weight or obesity may not be an explicitly protected characteristic in human rights codes, discrimination based on health status is prohibited in some countries. Further, discrimination based on weight in the workplace may also be a breach of employment law. Campaigning for weight-based human rights protections may contribute to efforts to reduce weight stigma, promoting the notion that all people are equal in dignity and basic human rights. Establishing efforts to hold health providers, educators, and the media accountable for using non-stigmatizing language may accelerate a shift to more positive and health-promoting narratives around health and weight.
8. *Raise awareness of weight stigma.* Weight stigma is evident throughout the lifespan. Therefore, knowledge of weight stigma in professional training programs as well as continuing education opportunities is especially important in education, healthcare, and workplace contexts to improve equity for children, adolescents, and adults.
9. *Increase the global evidence base.* The literature on weight stigma provides considerable evidence of its prevalence and harms in HICs. It is critical to expand this research globally, particularly in LMICs and through research in different languages, to identify the most effective strategies to reduce weight stigma. Future research should explore how weight stigma is enacted and experienced across countries and cultures. Importantly, scientific journals are encouraged to provide copy editing support to researchers whose primary language is not English. Gray literature and other forms of media may provide evidence of weight stigma in societies where peer-reviewed publications are lacking.

9 | CONCLUSION

Common social narratives, language, and images used to discuss body weight, obesity, nutrition, and physical activity perpetuate weight stigma and contribute to negative health and social outcomes for individuals throughout the lifespan and across the body weight spectrum.

There is growing evidence of stigma against people with higher body weights in all regions of the world. Given the far-reaching and detrimental impacts of weight stigma, it is critical for the global community to address this significant social determinant of health and wellbeing and to make efforts to change public discourse to reduce weight-stigmatizing narratives. With increased efforts targeting weight stigma, we may accurately and equitably represent people of all sizes, support healthy bodies and minds, and promote societies that embrace body diversity and inclusion of all people for their health and wellbeing.

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