Stigma and obesity: the crux of the matter

Published Online
October 10, 2019
https://doi.org/10.1016/
S2468-2667(19)30186-0

The extent and gravity of the obesity crisis is, unfortunately, matched only by the neglect and stigma faced by people with obesity. Overweight and obesity affect more than 2 billion adults, and prevalence has nearly tripled over 40 years.[1] Obesity is a chronic, complex disease, and a driver of non-communicable diseases (NCDs). Without adequately addressing obesity as a health issue, current efforts to achieve universal health coverage (spearheaded in September 2019, at the UN General Assembly) will fail. Yet, obesity is not effectively prevented or managed across health systems and societies.

Research on weight-management services[2] in 50 countries shows that health systems are ill equipped to address obesity. Gaps include absence of quality guidelines for preliminary assessment and treatment pathways, inadequate health-care professional training, and substantial financial barriers to services, leading to marked inequalities. The low priority attributed to obesity is reflected in the failure to develop and finance comprehensive approaches to population-wide obesity prevention, within and beyond the health sector, as well as evidence-based treatments. Of nine NCD targets set by WHO and agreed by all member states in 2013, only one—to halt the increase of diabetes and obesity at 2010 levels by 2025—is likely to be missed in every country in the world. Obesity is considered neither as one of the WHO's five major NCDs nor as one of the five NCD risk factors, and so it might not be systematically included in national NCD strategies based on WHO's framework. Failure to tackle commercial determinants of health or to include obesity in comprehensive packages of health care also contribute to the growing toll of childhood obesity.[3] Resistance to the adoption of obesity as an NCD contributes to stigmatising media campaigns, siloed policies that oversimplify potential solutions, and pervasive internalised shame among people with obesity.

Much of the inertia in addressing obesity can be attributed to the prevailing and persistent framing of obesity as matter of personal responsibility. In reality obesity is rooted in a complex web of genetic, physiological, psychosocial, and environmental factors, requiring systems-level action.[4] In addition, obesity is defined as excessive adiposity, whereas body-mass index (BMI) is only a surrogate marker of adiposity, used for screening and population measurement; a focus solely on BMI exacerbates the misunderstanding and stigma that is rife within the current narrative. This prejudice manifests both as overt fat-shaming and as conscious or unconscious bias, including from health professionals and policy makers who should be providing and supporting care.

The complex drivers of fat-mass regulation are not widely understood by health-care professionals, nor included in most medical curricula or public-health training. Addressing obesity as a chronic disease requires understanding the biological regulation of food intake and the physiological mechanisms that control regulation of fat mass.[5] Even modest weight loss improves glycaemia, blood pressure, lipids, mobility, and quality of life,[6] benefits that do not require a return to so-called normal BMI.

This failure to recognise and treat obesity as a chronic disease is at the heart of stigma, and the preconceived notions faced by people with obesity when seeking medical advice are barriers to effective management.[7]

Continuing to neglect and stigmatise children, young people, and adults with obesity is unethical and violates patients' human rights. Biases and gaps in knowledge must be addressed across a range of sectors, involving providers and public health professionals. Programmes should incorporate medical and population health training, and include professional development in evidence-based clinical obesity management and policy. Within health-care settings, person-centred care and people-first language should be the norm;[8] health-care professionals should treat people with obesity with the same dignity, professionalism, and non-discrimination afforded to patients with other NCDs.

As we celebrate a new unified World Obesity Day (from 2020, March 4), we share a collective responsibility to identify obesity and stigma as the crux of the matter, a central driver of the world's NCD burden, and to take a central role in reshaping the narrative, placing people with obesity at the centre of our policies and practices.

*Monika Arora, Simón Barquera, Nathalie J Farpour Lambert, Trevor Hassell, Steven B Heymsfield, Brian Oldfield, *Donna Ryan, Ximena Ramos Salas, Wendy Scinta, Michelle Vicari*
Public Health Foundation of India, Gurgaon, Haryana, India (MA); Instituto Nacional de Salud Pública, Cuernavaca, Mexico (SB); European Association for the Study of Obesity, Teddington, UK (NJFL); University Hospitals of Geneva, Geneva, Switzerland (NJFL); Healthy Caribbean Coalition, St Michael, Barbados (TH); The Obesity Society, Baton Rouge, LA, USA (SBH); Monash University, Melbourne, Australia (B0); Pennington Biomedical, Baton Rouge, LA 70808, USA (DR); Obesity Canada, University of Alberta, Edmonton, AB, Canada (XRS); Obesity Medicine Association, Denver, CO, USA (WS); Obesity Action Coalition, Tampa, FL, USA (MV)
donna.ryan@pbrc.edu

SBH reports personal fees from Medifast, Janssen Pharmaceuticals, and Tanita, outside the submitted work. BO reports honoraria for attending meetings and is part of the scientific advisory board for Novo Nordisk, outside the submitted work. DR reports personal fees from Alyvant, KVK Tech, Phenomix, Quintiles, and ReDesign Health; personal fees and non-financial support from Amgen, Boeringer Ingelheim, Epitomee, Gila Therapeutics, Ifa Celtics, Janssen, Novo Nordisk, Real Appeal (United Health Care), Sanofi, and Scientific Intake; and non-financial support from Xeno Bioscience, all outside the submitted work. WS reports honoraria and speaker fees, and is part of the advisory board for Novo Nordisk, outside the submitted work. All other authors declare no competing interests.

Copyright © 2019 The Author(s). Published by Elsevier Ltd. This is an Open Access article under the CC BY-NC-ND 4.0 license.

1 WHO. Obesity and overweight. 2018. https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight (accessed July 15, 2019).
2 Barata Cavalcanti O. Obesity and health systems in Latin America. 2019. http://s3-eu-west-1.amazonaws.com/wof-files/LATAM_presentation_Regional_Dialogue__Barata_cavalcanti_FINAL.pdf (accessed July 15, 2019).
3 WHO. Commission on ending childhood obesity. 2017. https://www.who.int/end-childhood-obesity/en/ (accessed July 15, 2019).
4 Ralston J, Brinsden H, Buse K, et al. Time for a new obesity narrative. *Lancet* 2018; **392:** 1384–86.
5 Berthoud HR, Munzberg H, Morrisonn CD. Blaming the brain for obesity: integration of hedonic and homeostatic mechanisms. *Gastroenterology* 2017; **152:** 1728–38.
6 Ryan DH, Yockey SR. Weight loss and improvement in comorbidity: differences at 5%, 10%, 15%, and over. *Curr Obes Rep* 2017 Jun; **6:** 187–94.
7 Phelan SM, Burgess DJ, Yeazel MW, et al. Impact of weight bias and stigma on quality of care and outcomes for patients with obesity. *Obes Rev* 2015; **16:** 319–26.
8 Obesity Action Coalition. People-first language for obesity. http://www.obesityaction.org/wp-content/uploads/People-First.pdf (accessed July 15, 2019).