

Consultation on proposed national obesity strategy

Submission prepared by Women's Health Victoria, December 2019

Introduction

Women's Health Victoria (WHV) welcomes the opportunity to provide input into the proposed national obesity strategy. WHV is committed to improving women's health, including through advocacy and awareness raising, primary prevention, capacity building and direct service delivery. As a Victorian statewide women's health promotion service, we collaborate with health professionals, researchers, policy makers, service providers and community organisations to influence and inform health policy and service delivery for women.

WHV is committed to the social model of health which focuses on addressing the social and economic determinants of health, such as freedom from discrimination and harassment, and equitable access to economic power and resources. A social determinants approach to health aims to improve health in the population and reduce inequities by focusing on improving the conditions in which people are born, grow, live, work and age.ⁱ

WHV welcomes the strategy as a positive step towards improving the health and wellbeing of all Australians. We would be happy to provide further clarification on any of the matters raised in this submission should this be required.

Overview

WHV supports the proposed strategy's aim to support all Australians to have a healthy lifestyle. We recommend that this is framed using a weight-inclusive framework that emphasises health and healthy behaviours as opposed to weight. This aligns with the evidence and the consultation paper which states that 'the strategy will support all Australians to have a healthy lifestyle, regardless of weight.' Focusing on body size rather than healthy behaviours increases weight stigma, which leads to poor health outcomes. Additionally, WHV advocates for a gendered approach to the priority areas identified in the proposed strategy, acknowledging the disproportionate impact of body image concerns, eating disorders and weight stigma on women and girls.

WHV applauds the proposed strategy's aim to build a healthier and more resilient food system, and to facilitate the Australia population's participation in healthy behaviours regardless of weight. We also applaud the strategy's aim to develop tailored initiatives with Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities and people with disabilities.

Key principles

1. Focus on health, not weight

A person's weight is often used as a proxy for their health status. However, evidence shows that weight alone does not determine health status and this focus can increase harm by increasing stigma and shame. Focusing on weight, shape and size is a narrow and counterproductive way of understanding our health and wellbeing; one which prioritises concerns for physical health over mental health and social well-being. Public health campaigns that focus on ideal body weight and shape are associated with increased stigma and body dissatisfaction in individuals of all weights.ⁱⁱ On the other hand, a weight-inclusive approach focuses on supporting the health of people across the weight spectrum, has a holistic focus incorporating both physical and mental health, and challenges weight stigma, especially in health care settings, contributing to better health outcomes overall.ⁱⁱⁱ

By focusing on the weight, shape and size of bodies through obesity prevention campaigns, our understandings of why many individuals do not consume the recommended daily servings of fruit and vegetables, and do not regularly engage in physical activity, remain unexamined.

WHV recommends that a focus on weight is removed from the strategy to ensure it does not unintentionally contribute to body dissatisfaction, eating disorders and reinforce weight stigma.

Body dissatisfaction

Dissatisfaction with the appearance of the body can lead to an uncomfortable relationship with food and one's body, as the focus of behaviour is always on preventing weight gain.^{iv} Statistics show that body dissatisfaction and eating disorders are common in young people.^v

- Body dissatisfaction is an established risk factor for eating disorders.^{vi}
- Among Australian women, body dissatisfaction mainly manifests in concerns about weight, even in those who are underweight or a healthy weight.^{vii}
- Body dissatisfaction often emerges during childhood and peaks in adolescence when young women are 'acutely attuned' to their body weight and shape.^{viii}
- Regardless of BMI, adolescents who perceive themselves to be underweight or overweight have poorer physical activity and eating patterns, compared to adolescents who perceive their weight to be "about right".^{ix}
- The postnatal period is not a good time for weight-focused 'guidance and support' as proposed in 1.1.4. The perinatal period is a time associated with high risk for the development an eating disorder^x and poor body image for women.^{xi}

Eating disorders

Eating disorders are severe mental illnesses that have a high mortality rate^{xii} and are a leading contributor to the non-fatal burden of disease among Australian women aged between 15-44 years.^{xiiiixiv}

- Disordered eating behaviours, such as yo-yo dieting, and compensatory behaviours, such as self-starvation, bingeing, and purging, that develop in response to body dissatisfaction and weight stigma often begin in adolescence and predict poorer health in adulthood.
- Campaigns and programs targeting eating, physical activity and other health-promoting behaviours should be aligned with a do-no-harm approach.^{xv}

Weight stigma

Another harm of focusing on the weight, shape and size of bodies is the potential to reinforce stigmatising attitudes and bullying. Pathologising certain body shapes and sizes while idealising others contributes to weight stigma. More information on weight stigma in Australia is provided on page 4.

When evaluating the strategy and associated health promotion programs and interventions, more comprehensive measures of success such as quality of life and psychological and eating disorder outcomes should be reported on, rather than an over-reliance on BMI and weight loss. This approach is recommended by the National Eating Disorders Collaboration.^{xvi}

Recommendations:

1. Remove focus on weight and rename strategy to reduce the impact of a weight-focused narrative on the health and wellbeing of women and girls who are at high risk of experiencing body dissatisfaction and body image concerns.
2. Refocus Priority Area 1 to **Supporting children and families: starting early to support *healthy habits* throughout life**
3. Refocus Priority Area 2 to: **Mobilising people and communities: using knowledge, strengths and community connections to enable *healthy habits and wellbeing***
4. Priority Area 1.1.4: Ensure that 'healthy eating and physical activity guidance and support' offered to new parents is not weight-focused.
5. Amend Proposed Enabler 2: Data. We strongly encourage the strategy to measure initiatives using health-related, behaviour-based, quality of life and equity-impact indicators.

2. Take a gendered approach

When promoting healthy activities, it is important to take a gendered approach. The causes, impacts and barriers to good health differ for males and females and therefore strategies need to consider the specific needs of women and girls.

A key challenge in health promotion is that 'losing weight' and 'health' goals for women are linked to appearance norms and thinness pressures in our culture. Young women are more likely to report body image concerns than their male counterparts.^{xvii}

Physical activity

Barriers to regular physical activity for women and girls need to be addressed in the strategy including:

- Concern about the presence of males when exercising and **worry about being judged, humiliated and harassed**.^{xviii}
- A reduction in young women's interest and confidence in physical activity in adolescence due to combination of **puberty, body image concerns and gender norms**.^{xix}
- Parental and individual **perceptions of safety** influence participation in active play. Girls are less likely than boys to report that their parents let them walk or ride to places, or visit local parks on their own.^{xx} Feeling unsafe in your neighbourhood also limits women's participation in community life. The [Victorian Women's Health Atlas](#) shows a large discrepancy between male and female perceptions of safety in their local area.^{xxi}
- **Time pressure** is common among Australian women and negatively influences diet, eating habits and physical activity.^{xxii} Understanding the sources of time pressure, particularly on women who are mothers and carers, is important if policy-makers are to implement successful health policies, including recommendations for physical activity and preparation and consumption of healthy meals.

The strategy must address these barriers to the participation of women and girls in healthy behaviours. VicHealth's *This Girl Can* campaign is an example of an effective initiative addressing the barriers to women's participation in physical activity.^{xxiii}

Breastfeeding

The proposed strategy recommends supporting mothers to exclusively breastfeed for six months, but this will not always be realistic or possible. Currently, many mothers do not receive adequate social and structural support to facilitate exclusive breastfeeding for 6 months. Breastfeeding is a learned behaviour and not all mothers or their babies are able to breastfeed.

- The pressure to breastfeed can impact the mental health of new mothers, and make those who cannot breastfeed feel as though they have failed.^{xxiv}
- After giving birth, women report a lack of breastfeeding support and are increasingly sent home from hospital before their milk comes in.^{xxv}
- Women in larger bodies report breastfeeding for shorter periods of time than their smaller counterparts due in part to body image concerns.^{xxvi}

Any recommendation to promote exclusive breastfeeding for 6 months must be accompanied by investment in initiatives to significantly increase breastfeeding support, with a particular focus on women in bigger bodies. While we support policy efforts to limit the aggressive marketing of infant formula, we caution against limiting availability.

Income inequality

The adequacy of income support is a key issue in tackling inequities in dietary behaviours.

- Unemployment benefits in Australia have declined steadily compared to other benefits and cost of living.
- Australian research has shown that parents living below the poverty line prioritised 'filling up' their children on carbohydrate-rich foods rather than focusing on nutritional value due to significant income and time-related constraints.^{xxvii}
- Research also shows that single mothers receiving the unemployment benefit Newstart are forced to treat food as a discretionary item due to their limited income, and frequently worry about how this is impacting their children's health and wellbeing.^{xxviii}

Increasing the payment level for Newstart would significantly improve the equity of income distribution and health.^{xxix}

Recommendations:

5. Focus on healthy behaviours rather than weight, especially when encouraging women and girls to participate in physical activities and consume a healthy diet.
6. Plan and evaluate actions associated with the strategy using a gender analysis to ensure that women, men and gender diverse people are all being reached.
7. Address the barriers to the participation of women and girls in physical activity, including initiatives to support positive body image and improve (perceptions of) safety in public space.
8. Advocate to increase social security payments, including Newstart, to facilitate equitable access to healthy food.
9. Amend Proposed Priority Area 1.1.3 to ensure it will not decrease the availability of infant formula. To support women to breastfeed exclusively for six months, invest in initiatives to increase breastfeeding support, with a particular focus on women in bigger bodies. The conditions described in Priority Area 2.5 must be met before setting targets for breastfeeding.

3. Take an active role in reducing weight stigma

WHV is pleased that the strategy recognises that reducing weight stigma is essential. Weight stigma is common in Australia and experienced by 86% of people in the obese BMI category.^{xxx} Weight stigma is not caused by an individual's body weight, but rather biased attitudes to bodyweight and appearance.

Longitudinal research shows that being teased about weight by family members or peers during adolescence predicts adverse health outcomes including binge eating, unhealthy weight control practices, poor body image, higher BMI and obesity 15 years later, especially among women.^{xxxi}

The experience of weight stigma is associated with a range of negative physical, psychological and social health issues. A systematic review found that weight stigma is independently associated with adverse physiological and psychological outcomes, including diabetes risk, eating disturbances, depression, anxiety and low self-esteem.^{xxxii} Women report higher rates of weight stigma than men,^{xxxiii} and also report that they begin to experience weight-based discrimination at lower weights.^{xxxiv}

Experiences of weight stigma are not only detrimental to a person's emotional health and wellbeing,^{xxxv} but also to their motivation to participate in physical activity, especially for women.^{xxxvi} Experiencing weight stigma can trigger psychological changes (higher stress levels and cortisol) and behavioural changes (binge eating, avoidance of exercise and people) linked to poor metabolic health and increased weight gain.^{xxxvii}

Research on adolescent girls and boys has found that weight-based victimisation in adolescence can lead to increased risk of depression, low self-esteem, suicidal ideation and poor body image, higher levels of disordered eating, harmful weight control behaviours, weight gain and lower levels of physical activity.^{xxxviii}

Multiple international and Australian studies have found that experiences of weight stigma prevent people in bigger bodies from taking part in health promoting activities like exercising in public as they do not want to be ridiculed or 'on display'.^{xxxix} The National Eating Disorder Collaboration reports that obesity prevention campaigns can increase eating disorder risk factors such as preoccupation with body weight or shape, and restrictive eating.^{xl}

Recognise the lived experience and expertise of people in bigger bodies

People in bigger bodies are rarely, if ever, consulted regarding health interventions, even when they are the target audience. WHV recommends that the strategy and ensuing actions are co-designed by people in bigger bodies as they are best placed to identify the barriers and enablers for improving their health. For example, a Gold Coast Community Jury on Obesity reported that weight stigma was a major barrier to socialisation and service access and that safe and inclusive environments were needed for people of size to exercise.^{xli}

Reduce weight stigma among health professionals

Weight stigma impacts a person's access to healthcare and the quality of care received and should be considered under the strategy's section on building the workforce. Women in bigger bodies often delay going to the doctor for health issues, which can lead to presenting with more advanced health issues.^{xlii}

Australian and international research shows that health professionals underestimate their bigger patients' weight loss attempts, feeding into stereotypes that people with a high BMI are unmotivated.^{xliii} They may also over-attribute a patient's symptoms and health issues to weight, therefore failing to consider treatment beyond weight loss or to recommend further diagnostic testing.^{xliiv} Even health professionals who specialise in obesity-related issues report high levels of anti-fat bias, and increasing numbers have endorsed explicit anti-fat sentiments in recent years.^{xliiv} This highlights the need for weight stigma training for doctors and medical students.

Recommendations:

11. Amend Proposed Enabler 1: Governance should include a reference group comprised of people with lived experience of higher body weight from a range of socio-economic backgrounds. Their expertise should be used to frame health promotion activities, strategy implementation and evaluation.
12. Amend Proposed Enabler 3: *Build the Workforce* should include training to reduce weight stigma among health professionals.

Contact

Dianne Hill, **Chief Executive Officer**, (03) 9664 9300, ceo@whv.org.au

Endnotes

ⁱ WHO (2014) [Social determinants of mental health](#). World Health Organization. Geneva.

ⁱⁱ National Eating Disorders Collaboration (2017) *Eating Disorders and Obesity Treatments: A systematic review of the physical, psychological and eating disorders outcomes from obesity treatments*, Sydney.

ⁱⁱⁱ Tylka, T. L., Annunziato, R. A., Burgard, D., Danielsdottir, S., Shuman, E., Davis, C., & Calogero, R. M. (2014). The weight-inclusive versus weight-normative approach to health: Evaluating the evidence for prioritising well-being over weight loss. *Journal of Obesity*, xx, 18.

^{iv} Jovanovski, N. (2017). *Digesting femininities: The feminist politics of contemporary food culture*. New York: Palgrave Macmillan.

^v Hay, P., Girosi, F., & Mond, J. (2015). Prevalence and sociodemographic correlates of DSM-5 eating disorders in the Australian population. *Journal of Eating Disorders*, 3(1), 19.

^{vi} National Eating Disorders Collaboration (n.d.). [Risk and protective factors](#).

^{vii} Eating Disorders Australia (2013) [Australians' body image distorted](#).

^{viii} Webb, H. J., & Zimmer-Gembeck, M. J. (2014). The role of friends and peers in adolescent body dissatisfaction: A review and critique of 15 years of research. *Journal of Research on Adolescence*, 24(4), 564-590.

^{ix} Patte, K. A., Laxer, R., Wei, Q., & Leatherdale, S. T. (2016). Weight perception and weight-control intention among youth in the COMPASS study. *American Journal of Health Behavior*, 40(5), 614-623.

^x EDV (2016) [High risk groups \[Webpage\]](#). Eating Disorders Victoria, Abbotsford, Vic.

^{xi} Hodgkinson EL, Smith DM, Wittkowski A (2014) [Women's experiences of their pregnancy and postpartum body image: a systematic review and meta-synthesis](#). *BMC Pregnancy and Childbirth*. 14 (330):1-11.

^{xii} Arcelus J, Mitchell AJ, Wales J, Nielsen S. (2011). Mortality rates in patients with anorexia nervosa and other eating disorders: a meta-analysis of 36 studies. *Archives of General Psychiatry*, 68(7):724-731.

^{xiii} Australian Institute of Health and Welfare. *Australian Burden of Disease Study: Impact and causes of illness and death in Australia 2011*. Canberra: AIHW; 2016.

^{xiv} O'Hara L, Gregg J (2006). The war on obesity: a social determinant of health. *Health Promotion Journal of Australia*, 17 (3):260-3.

^{xv} National Eating Disorders Collaboration (2011). [Evaluating the risk of harm of weight-related public messages](#). Sydney.

^{xvi} National Eating Disorders Collaboration (2017) *Eating Disorders and Obesity Treatments: A systematic review of the physical, psychological and eating disorders outcomes from obesity treatments*, Sydney.

^{xvii} : Hall, S., Fildes, J., Perrrens, B., Plummer, J., Carlisle, E., Cockayne, N., and Werner-Seidler, A. (2019) [Can we Talk? Seven Year Youth Mental Health Report - 2012-2018](#). Mission Australia: Sydney, NSW

^{xviii} van Bueren D, Elliott S, Farnam C (2016) 2016 Physical Activity and Sport Participation Campaign : insights reportt, p. 7.

^{xix} Webster A, Anderson R, Barr M (2017) [Growing up unequal: how sex and gender impact young women's health and wellbeing](#). Women's Health Victoria. Melbourne. - (Women's Health Issues Paper; 12)

^{xx} VicHealth (2017) Youth 12-17 : physical activity insights, p. 5.

^{xxi} See Victorian Women's Health Atlas, Violence Against Women, Perceptions of Safety 2015.

^{xxii} Otterbach S et al (2016) The effect of motherhood and work on women's time pressure: A cohort analysis using the Australian Longitudinal Study on Women's Health, *Scandinavian Journal of Work, Environment and Health*, 42(6).

^{xxiii} [The Girl Can- Victoria: Year one campaign report \(2018\)](#), VicHealth 2019.

^{xxiv} Woolhouse H, James J, Gartland D, McDonald E, Brown S (2016) **Maternal depressive symptoms at three months postpartum and breastfeeding rates at six months postpartum: implications for primary care in a prospective cohort study of primiparous women in Australia**. *Women and Birth*. 29 (4):381-7

-
- ^{xxv} Victoria. Parliament. Family and Community Development Committee (2018) **Inquiry into perinatal services: final report**. Victoria. Parliament, Melbourne. Available from:
- ^{xxvi} Newby R, Davies P (2016) **Why do women stop breast-feeding? results from a contemporary prospective study in a cohort of Australian women**. *European Journal of Clinical Nutrition*. 70 (12):1428-32
- ^{xxvii} Burns, C., Cook, K., & Mavoia, H. (2013). Role of expendable income and price in food choice by low income families. *Appetite*, 71, 209-217.
- ^{xxviii} McKenzie, H., & McKay, F. (2017). Food as a discretionary item: The impact of welfare payment changes on low-income single mother's food choices and strategies. *Journal of Poverty and Social Justice*, 25(1), 35-48.
- ^{xxix} Sax Insitute (2019), Addressing the social and commercial determinants of healthy weight Queensland Department of Health.
- ^{xxx} Lewis, S., Thomas, S. L., Blood, R. W., Castle, D. J., Hyde, J., & Komesaroff, P. A. (2011). How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A qualitative study. *Social Science & Medicine*, 73(9), 1349-1356.
- ^{xxxi} Puhl, R. M., Wall, M. M., Chen, C., Austin, S. B., Eisenberg, M. E., & Neumark-Sztainer, D. (2017). Experiences of weight teasing in adolescence and weight-related outcomes in adulthood: A 15-year longitudinal study. *Preventive Medicine*, 100, 173-179.
- ^{xxxii} Wu and Berry (2017) Impact of weight stigma on physiological and psychological health outcomes for overweight and obese adults: A systematic review. *Journal of Advanced Nursing*
- ^{xxxiii} Gender differences in the relationship of weight-based stigmatisation with motivation to exercise and physical activity in overweight individuals *Health Psychology Open* 2018
- ^{xxxiv} Weight Bias: Does it Affect Men and Women Differently? *Obesity Action* 2018
- ^{xxxv} How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A Qualitative study, *Social Science and Medicine*, 2011
- ^{xxxvi} Experiences of weight stigma in everyday life: Implications for health motivation, *American Psychological Association*, 2016
- ^{xxxvii} How and why weight stigma drives the obesity 'epidemic' and harms health *BMC Medicine* 2018
- ^{xxxviii} Stigma Experienced by Children and Adolescents With Obesity *Pediatrics* 2017
- ^{xxxix} How do obese individuals perceive and respond to the different types of obesity stigma that they encounter in their daily lives? A Qualitative study, *Social Science and Medicine*, 2011
- ^{xl} Positive public health campaigns *in Obesity and Eating Disorders* [webpage], National Eating Disorder Collaboration, 2018
- ^{xli} Obesity on trial for community jury, *Health Waves +*, August/September 2017, p. 6.
- ^{xlii} Mensinger JL et al (2018) Mechanisms underlying weight status and healthcare avoidance in women: A study of weight stigma, body-related shame and guilt, and healthcare stress, *Body Image*, Vol 25, pp139-147.
- ^{xliii} Doctors underestimate obese patients' weight loss attempts: study SMH 2019 and Caterson, I., Alfadda, A., Auerbach, P., Coutinho, W., Cuevas, A., Hughes, C., Iwabu, M., Kang, J., Nawar, R., Reynosa, R., et al (2019). Gaps to bridge: misalignment between perception, reality and actions in obesity. *Diabetes, Obesity and Metabolism*, 21(8), 1914-1924
- ^{xliv} Phelan, S M et al (2015). "Impact of weight bias and stigma on quality of care and outcomes for patients with obesity." *Obesity reviews : an official journal of the International Association for the Study of Obesity* 16(4), pp 319-26. doi:10.1111/obr.12266
- ^{xlv} Tomiyama et al (2014), Weight bias in 2001 versus 2013: Contradictory attitudes among obesity researchers and health professionals in *Obesity* 23(1), pp 46-53.