TABLE 2. CONSENSUS STATEMENT ON THE STIGMA OF OBESITY

1.	***Prevalence of Weight Stigma and Weight-based Discrimination***	Grade
1. 1	A substantial body of evidence demonstrates that weight-based stigma is extremely pervasive among people of diverse ages and backgrounds.	A
1.2.	People with obesity are often subject to unfair treatment and discrimination in the workplace, education, and healthcare settings.	U
1.3.	Weight-based discrimination is one of the most common forms of discrimination in modern societies.	A
1.4.	Women are more likely to suffer weight-based discrimination compared to men; this has the potential to contribute to inequalities in employment and education.	A

2.	***Weight Stigma and the Media***	Grade
2.1	Media portrayal of obesity is influential; it plays an important role in shaping public attitudes and beliefs about people with obesity and related diseases.	U
2.2	In news media, obesity is frequently attributed to personal responsibility, and afflicted individuals are often represented – without evidence – as being lazy, gluttonous, and lacking will power and self-discipline.	U
2.3	Media portrayals of diet and exercise as the only appropriate therapies for obesity are scientifically inaccurate and may deter patients from pursuing additional evidence-based interventions	U
2.4	Media portrayals that encourage weight-based stigma and discrimination are harmful and should be discouraged.	U

3.	***Weight Stigma in Healthcare***	Grade
3.1	Many healthcare professionals hold negative attitudes about obesity, including stereotypes that affected patients are lazy, lack self-control and willpower, are personally to blame for their weight, and are noncompliant with treatment.	A
3.2	Weight-based stigma among healthcare professional is unacceptable, especially among those who are specialised in the care of people with obesity.	A
3.3	Many healthcare facilities are inadequately equipped to treat patients with obesity.	U

4.	***Weight-Based Discrimination***	Grade
4.1	Obesity stigmatization and discrimination occur in schools, such that children and adolescents living with obesity are at an increased risk for poor peer relations and experience high rates of bullying.	A
4.2	Weight-based stigma unfairly undermines opportunities for employment, career progression, and income for people with obesity.	A
4.3	For most people with obesity who experience discrimination in recruitment or in the workplace, there is no legal protection under current legislation.	A

5.	***Physical and Mental Health Consequences***	Grade
5.1	Weight-based stigma and internalised weight bias can be particularly harmful to mental health, increasing risks of depressive symptoms, anxiety, and promoting lower self-esteem, social isolation, stress, and substance use.	U
5.2	Adults and children who experience weight-based stigma are more likely to avoid exercise and physical activity, and to engage in unhealthy diets and sedentary behaviors that increase the risk of worsening obesity.	A

6.	***Quality of Care, Access to Care***	Grade
6.1.	Quality of health care is adversely affected by weight-based stigma	U
6.2	Fear of prejudice and internalized weight bias cause direct and indirect harm to patients with obesity, as they are less likely to seek and receive appropriate treatment for obesity or other conditions.	A
6.3.	Despite the well-recognized risks of obesity and related illnesses, it is common for health insurance companies to have significant limitations or complete lack of coverage for evidence-based treatments of obesity – especially bariatric/metabolic surgery. These policies can cause harm, are indefensible, and ethically objectionable.	A

7.	***Weight Stigma and Public Health***	Grade
7.1	Despite significant evidence that weight-based stigma causes damage to individuals and society, public health efforts to date have not widely addressed stigma as a barrier to combat the obesity epidemic.	A
7.2	Stigmatizing public health campaigns that emphasize the role of personal responsibility and "healthy lifestyle" choices focusing only on nutrition and physical activity overlook important societal and environmental factors that critically contribute to the epidemic of obesity.	A
7.3	Some public health campaigns appear to embrace stigmatization of individuals with obesity as a means to motivate behaviour change and achieve weight loss through self-directed diet and increased physical exercise. These approaches are not supported by scientific evidence, and they risk further increasing societal discrimination against people with obesity, yielding the opposite to the intended effect.	A

8.	***Weight Stigma and Research***	Grade
8.1	Misconceptions about the causes of obesity are likely to play an important part in public support for obesity research and relative allocation of public funding, compared to other diseases that are believed not to depend on factors completely controllable by individuals' actions (e.g., cancer, infectious diseases, etc.).	A
8.2.	Diseases such as obesity and type 2 diabetes receive far less research funding than do other chronic diseases, relative to their prevalence and the costs they impose upon society.	A

9.	***Causes and Contributors of Weight Stigma/Discrimination***	Grade
9.1	Causal attributions of personal responsibility for obesity are associated with stronger weight bias, whereas lower levels of weight-based stigma are associated with stronger beliefs in genetic/physiological or environmental causes of obesity	U
9.2	The absence of policies to prohibit weight discrimination communicates a message that weight stigma is acceptable and tolerable, thus reinforcing weight-based inequities.	A
9.3	The idea that the causes of obesity depend on individuals' faults, such as laziness and gluttony, provides the foundation for stigma against obesity.	A

10.	**The Science of Obesity *vs.* Misconceptions in the Public Narrative of Obesity**	
10.1	The assumption that body weight is entirely under volitional control and that voluntarily eating less and/or exercising more can entirely prevent or reverse obesity is at odds with a definitive body of biological and clinical evidence developed over the last several decades.	U
10.2	Popular expressions such as "energy in *vs*. energy out" or "calories in *vs*. calories out" are misleading because they inaccurately imply that body weight and/or fat mass are solely influenced by the number of food calories	A

	ingested and the amount of energy burned through exercise. This narrative is not supported by evidence and provides a foundation for popular, stigmatizing views that blame individuals' lack of willpower for their obesity.	
10.3	The idea that obesity is a "choice" is a misconception, inconsistent with both logic and scientific evidence showing that obesity results primarily from a combination of genetic, epigenetic, and environmental factors.	A
10.4	There is a widespread assumption, including among many medical professionals, that voluntary lifestyle changes (diet and exercise) can entirely reverse obesity over long periods of time, even when severe. This assumption runs contrary to indisputable scientific evidence demonstrating that voluntary efforts to reduce body weight activate potent compensatory biologic responses (e.g., increased appetite, decreased metabolic rate) that typically promote long-term weight regain.	A
10.5	Bariatric/metabolic surgery is not an "easy way out" but an evidence-based, physiologic approach to treating obesity and type 2 diabetes, given its ability to influence underlying mechanisms of energy and glucose homeostasis.	A

11	***Obesity: "Condition" or "Disease" ?***	Grade
11.1	There is objective evidence that in many patients, obesity presents the typical attributions of a disease status, which include specific signs and/or symptoms, distinct pathophysiology, reduced quality of life, and increased risk of complications/mortality.	U
11.2	Although prevailing evidence supports a rationale for obesity to be defined as a disease, as recognized by leading worldwide authority bodies and medical associations, current diagnostic criteria for obesity (only based on BMI levels) are inadequate to accurately diagnose obesity.	A

12. Recommendations

	Generalities	Grade
1.	Weight-based stigma and obesity discrimination should not be tolerated in education, healthcare, or public-policy sectors.	U
2.	Explaining the gap between scientific evidence and the conventional narrative of obesity built around unproven assumptions and misconceptions may help reduce weight bias and alleviate its numerous harmful effects.	A
3.	The conventional narrative of obesity built around unproven assumptions of personal responsibility and misconceptions about the causes and remedies of obesity causes harm to individuals and to society. Media, policy makers, educators, HCPs, academic Institutions, public health agencies, and government must ensure that the messages and narrative of obesity are free from stigma and coherent with modern scientific evidence.	A
4	Obesity should be recognized and treated as a chronic disease in health-care and policy sectors.	A

	Media	Grade
5.	We call on the media to produce fair, accurate, and non-stigmatizing portrayals of obesity. A commitment from the media is needed to shift the narrative around obesity.	U

	Healthcare and Education of HCPs	Grade
6.	Academic institutions, professional bodies, and regulatory agencies must ensure that formal teaching on the causes, mechanisms, and treatments	U

	of obesity are incorporated into standard curricula for medical trainees and other HCPs.	
7.	HCPs specialized in treating obesity should provide evidence of stigma-free practice skills. Professional bodies should encourage, facilitate, and develop methods to certify knowledge of stigma and its effects, along with stigma-free skills and practices.	A
8.	Given the prevalence of obesity and obesity-related diseases, appropriate infrastructure for the care and management of people with obesity, including severe obesity, must be standard requirement for accreditation of medical facilities and hospitals.	U

	Public Health	Grade
9.	Public health practices and messages should not use stigmatizing approaches to promote anti-obesity campaigns. These practices are objectively harmful and should be banned.	A
10.	Public health authorities should identify and reverse policies that promote weight-based stigma, while increasing scientific rigor in obesity-related public policy.	A

	Research	Grade
11.	Research in obesity and type 2 diabetes should receive appropriate public funding, commensurate to their prevalence and impact on human health and society.	A

	Policies and Legislation	Grade
12.	There should be strong and clear policies to prohibit weight-based discrimination	U
13.	Policies and legislation to prohibit weight discrimination are an important and timely priority to reduce/eliminate weight-based inequities.	U