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Challenging the Let's Move Campaign: Advocating for a Weight-Inclusive Approach to Public Health Programming

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Introduction

The Let's Move initiative was established in 2010 under the Obama Administration to "solve the problem of childhood obesity within a generation" (Let's Move!, n.d., p.1). However well-intended the national initiative was to improve children's health in the U.S., the weight-stigmatizing language used in framing and the outcome measure of focusing on BMI measurements have had some unintended and harmful health outcomes for people in larger bodies. Throughout the course of this independent study, reviewing literature surrounding anti-fat bias in public health and healthcare and exploring fat studies literature, this paper aims to challenge embedded anti-fat bias in public health programming surrounding obesity prevention in programs like Let's Move and advocate for movement towards a weight-inclusive approach. Furthermore, through a content analysis of public resources and activities, 5-2-1-0 Missoula, Missoula's extension of the Let's Move initiative is explored as it relates to weight stigma to determine where program framing lies on a spectrum of weight normative to weight inclusivity. Potential evaluation techniques and outcomes for the future of Let's Move programs beyond BMI are also explored.

Language Usage

In this investigation, some common language pertaining to this topic will not be utilized because of the associated stigma and harm. In particular, the words obese and obesity will be used only when referenced in the literature. This is because these words are derived from the Latin word *obesus*, which means something that "has eaten itself fat" (Etymology Dictionary, n.d.). Many fat activists and fat studies literature discourage the use of the words because of their

stigmatizing origin. Therefore, words like people in larger bodies, larger-bodied, and fat will be used instead (McPhail & Orsini, 2021, p.1).

Literature Review

Anti-Fat Bias

It is imperative to this investigation to understand anti-fat bias or weight stigma to know the harm caused by it. Weight stigma is defined as the "social rejection and devaluation that accrues to those who do not comply with prevailing social norms of adequate body weight and shape" (Tomiyama et al., 2018, p.1). Therefore, the implicit or explicit bias of individuals and societies attributes higher or lower value to individuals based on body size. Anti-fat bias is one of the most commonly acceptable forms of discrimination today, even as larger body size as determined by the Body Mass Index is common in the U.S. population. Harvard University's Project Implicit is a study that tests explicit and implicit biases in multiple domains such as sexuality, race, gender, religion, age, disability status, weight, and more. Weight from the years 2007 to 2016 has been the only implicit attitude to have gotten worse, and explicit attitudes have been the slowest-changing of all domains (Gordon, 2020, p. 5). Thus, anti-fat bias is a highly acceptable form of social discrimination that is widely employed by many.

Anti-fat bias impacts larger-bodied individuals in numerous domains, including healthcare, education, social engagement, employment, transit, and interpersonal relationships. There are little legal protections for discrimination based on body size in the United States. As of last spring, in an article by Gonzales (2023), only one state, Michigan, and six cities explicitly prohibit workplace discrimination based on weight. A handful of other states where

anti-discrimination legislation can be applied to body size and more are considering adding legal protections (p.1). The legal efforts by these states and cities are tremendous starting points for protecting against body size discrimination. However, these are few; many only extend to workplace protection, and no federal-level policies exist.

Adverse Health Outcomes of Anti-Fat Bias

In the healthcare domain, the anti-fat bias in healthcare providers and public health professionals can immensely impact the care received and patients' health outcomes. In a study conducted by Phelan and colleagues (2015), health professionals' negative stereotypes, perceptions, and judgment toward larger-bodied patients impacted decision-making that influenced the quality of care and treatment, which in turn also affected patients' care-seeking (p. 2). Some patients have been dismissed, referred, or refused for care; providers refuse to touch patients based on their size and dismiss non-weight related health concerns or them to weight (Ryan, 2023, p. 9-11). Furthermore, some primary care providers believe that larger-bodied people are "less likely to be adherent to treatment or self-care recommendations, are lazy, undisciplined and weak-willed" (Phelan et al., 2015, p. 3). The impacts of these perceptions can cause providers to spend less time with patients and have less respect for them, which impacts health information, communication, and decision-making (p. 3). If patients feel disrespected and their health concerns ignored because of body size, then the likelihood of them seeking medical care dwindles, which could lead to further health complications.

Anti-fat bias negatively impacts physical and psychological health in people with larger bodies. Exposure to stigma is "linked to depression, anxiety, low self-esteem, eating disorders,

and exercise avoidance" (Vafiadis, 2024, p. 1). In addition, "exposure to weight bias triggers physiological and behavioral changes linked to poor metabolic health and increased weight gain," such as increased cortisol levels (Vafiadis, 2024, p.1). Additionally, Vafiadis (2024) describes how the internalization of anti-fatness might be more harmful to health than external stigma (p. 1). Tomiyama and colleagues (2018) found that medical students with internalized anti-fat bias reported "high levels of alcohol and substance use to cope" (p. 1). The social-ecological health model can be employed to understand how multiple levels of weight stigma can interact. This is a commonly utilized and easily understandable public health framework. Weight stigma can impact the domains of the individual, interpersonal, institutions, community, and policy levels, and the interactions between levels can compound and contribute to chronic social stress. The other levels inform individual ideas about weight stigma and the view of one's body. This can impact how an individual participates at more macro levels, such as interactions with loved ones. The embedded structural discrimination impacts the individual in ways such as employment, health outcomes, and travel participation.

The chronic social stress of weight stigma itself is so impactful that it can influence the mortality rate. In two different national studies, one containing 13,692 retirement participants and the other containing 5,079 midlife participants, "people who reported experiencing weight discrimination had a 60% increased risk of dying, independent of BMI" (Sutin et al., 2015, p. 2). In addition to more research on chronic social stress, Schmidt and colleagues (2010) found in animal models, there is evidence that biological factors make some individuals more or less resilient to chronic social stress exposure, which can impact the phenotypic expression of anxiety—and depression-like behaviors. Hence, the social stress placed on larger-bodied

individuals is causing more harm than beneficence (p. 1). As Tomiyama and colleagues (2018) discuss, "weight stigma is harmful to health, over and above objective body mass index. Weight stigma is prospectively related to heightened mortality and other chronic diseases and conditions" (p.1).

Anti-Fat Bias in Public Health and Interventions

The notion that bodies can be changed by an individual's behavior choices "can exert negative influences on public health policies, access to treatments, and research" (Rubino et al., 2020, p. 2). Body size is determined by various factors, not just by individual diet and physical movement behaviors but also by societal mechanisms and biology. Many public health campaigns that try to target larger-bodied individuals, such as nutrition, anti-fatness, and physical activity campaigns, use stigmatization "based on the assumption that shame will motivate behavior change and achieve weight loss through a self-directed diet and increased physical exercise" (Rubino et al., 2020, p. 9). As discussed above, this method is not effective; it only further increases "societal discrimination against people with obesity, yielding the opposite to the intended effect" (Rubino et al., 2020, p. 4). This is one reason why weight-normative approaches are ineffective and dangerous.

The inability to recognize that bodies can be healthy or unhealthy independently of body size limits intervention effectiveness and causes unintended harm to all. The weight normative approach is defined as the "principles and practices of health care and health improvement that prioritize weight as a main determinant of health" (Tylka et al., 2014, p. 2). One issue with the weight-normative approach is that it "is not effective for most people because of high rates of

weight regain and cycling from weight loss interventions, which are linked to adverse health and well-being" (Tylka et al., 2014, p. 1). Tylka and colleagues (2014) discuss that the issue is the idea that increased weight causes increased disease outcomes; however, there is evidence that this is not the case (p. 2). One such example is the mortality risk of each BMI class. "The risk for mortality is highest for people with BMIs < 18.5 (underweight) and BMIs > 35 (obese II), but lowest for people with BMIs 25 to <30 (overweight)" (Tylka et al., 2014, p. 3). Additionally, "the risk of those with BMIs 18.5 to <25 (average weight) and BMIs 30 to 35 (obese I) is comparable to and falls between the other groups" (Tylka et al., 2014, p. 3). Public health campaigns that exist to eradicate fatness to improve health "have been based on limited or poor quality evidence" (p. 2). Therefore, it is crucial to re-examine how we think about how body weight relates to disease etiology.

If these public health programs and healthcare in the U.S. continue pinning the blame of poor health outcomes on fatness and refuse to address the harms related to anti-fatness stigma, then it is a violation of the principle of non-maleficence, a vital tenet of biomedical and public health ethics (Tylka et al., 2014, p. 2). These fields need to recognize the harm of taking a weight-normative approach and understand other approaches may better serve our patients and communities.

Let's Move!

The Let's Move initiative was started in 2010 by the White House Task Force on Childhood Obesity during the presidency of Barack Obama. The goal was to create a national plan to mobilize public, private, and community partnerships to "solve the problem of childhood

obesity within a generation" (Let's Move, n.d., p.1). The ultimate health outcome of this program was to "reduce the childhood obesity rate to just five percent by 2030" (Let's Move, n.d., p.1). Throughout the program, more than "500 cities, towns, and counties, in all 50 states" (Let's Move, n.d., p.1) got involved in the program. To get cities started and keep the programs running, "Let's Move has connected municipalities with private grants and technical assistance from the U.S. Department of Health and Human Services" (Quinn, 2016, p.1). The national initiative formally ended in early 2017, although some cities still have programs today that do not have to be connected to the formal program .

The five main pillars of the Let's Move initiative are as follows: "creating a healthy start for children, empowering parents and caregivers, providing healthy food in schools, improving access to healthy, affordable foods, and increasing physical activity" (Let's Move, n.d.). These pillars show commitment to public health improvements, such as creating a healthy start for children and getting children more physically active. Others emphasize the need to address health disparities and identify how to reduce barriers related to social determinants of health, such as socioeconomic status. Providing access to healthy and affordable food, and working to empower parents and caregivers are evidence of this. These pillars are a great starting point for a public health program to recognize the structural forces at play. However, the issue relating to weight stigma lies in the outcome goal of reducing childhood obesity rates. Childhood obesity rates are a measure of body mass index (BMI) which is starting to be more recognized as a flawed outcome measure, but still prevalent in public health work. However, the other stigmatizing idea associated with this outcome is the correlation between body size and health, which from the emerging evidence in the above literature, this might not necessarily be the case.

BMI is a problematic outcome measure for several reasons. According to the American Medical Association, " the current BMI classification system is misleading about the effects of body fat mass on mortality rates" (Berg, 2023, p.1). Additionally, the AMA states that "the use of BMI is problematic when used to diagnose and treat individuals with eating disorders because it does not capture the full range of abnormal eating disorders" (Berg, 2023, p.1). A study by Goldschmidt and team (2008) researching eating disorders in children and adolescents found that children who are categorized as overweight "have been identified as a subset of the population at particularly high risk for endorsing such symptom" (p.1). Furthermore, the use of BMI for children is just an inaccurate measure; a study by Peterson and colleagues (2017) states that "during adolescent development, weight is not proportional to height squared, thus undercutting the validity of BMI in adolescents" (p.4). Therefore, the use of BMI as an outcome measure for such an expansive initiative should be called into question.

After doing a brief content analysis of the Let's Move website, there are sections discussing what the initiative is, the goals, the partners involved, achievements of the program, the White House report from the Task Force on Childhood Obesity, photos and videos of the former First Lady Michelle Obama getting involved, what obesity is, and the health problems that are related. Under this health problems tab, there is a paragraph discussing stigma and self-esteem outcomes for children with larger bodies. There are implications that social stigma can cause adverse health outcomes; "the psychological stress of social stigmatization can cause low self-esteem which, in turn, can hinder academic and social functioning" (Let's Move, n.d., p.1). This showcases what was discussed above, that these programs utalize stigma as a motivator, but instead have the opposite effect and can further cause harm. Further on in the

paragraph, the website states, "while research is still being conducted, there have been some studies showing that obese children are not learning as well as those who are not obese. Further, physical fitness has been shown to be associated with higher achievement" (Let's, Move!, n.d., p.1). Firstly, it might be problesome utilizing this information knowing this research is not published, peer-reviewed, or cited. There is an even greater risk that this article reinforces the notion that links body size with the ability to reach achievement, furthering the idea that an individual can not achieve without losing weight and not recognizing that perhaps the difference in achievement could come from the increased social stress of stigmatization. This method is an attempt at social categorization to create in-and-out groups (Stolier & Freeman, 2016, p.1). There is additional stigmatizing language throughout the website.

On the website's home page, a sentence states Let's Move is "dedicated to solving the problem of obesity within a generation, so that children born today will grow up healthier and able to pursue their dreams" (Let's Move, n.d.). The content framing of this statements utilizes stigmatizing ideas as it relates to larger-bodied children. These ideas were adapted and drew a basis from an article by Cook & Wilson (2019). First, there is the ethical concern that implies that fatness is a moral failure and that it limits an individual's achievement. Secondly, the statement also assumes that it should be the goal of all to pursue the eradication of fatness and maintain thinness. Thirdly, as covered in the literature review, fatness is equated with disease pathology and an overall lack of health. The language, framing, and content from the Let's Move website covey this program's weight-bias or weight-normative approach. Although many of this initiative's ideas, activities, and tenets emphasize productive public health programming that focuses on addressing health disparities, the use of BMI as an outcome measure for evaluation

and stigmatizing language usage has negative ethical implications and inhibits program effectiveness.

One of the Let's Move programs still operating today is 5-2-1-0 Let's Move! Missoula. Let's Move Missoula is a "community initiative mobilizing projects and partnerships that build healthy kids and residents of all ages" (Let's Move! Missoula, n.d., p.1) funded by the city. The central tenets of the program are "eat 5 fruits and vegetables, limit screen time to 2 hours per day, engage in physical activity for 1 hour per day, and consume 0 sweetened beverages" (Let's Move! Missoula, n.d., p.1). The program takes on the "focus on creating environments with access to physical activity and nutrition, and support for social cohesion" (Let's Move! Missoula, n.d., p. 1). Some of the more extensive programs include the mid-day move, where volunteers from the community can visit at lunchtime recess three days a week to build mentorship with elementary students at three schools. There is also the Free and Low-Cost Activity Calendar that goes beyond recommending nutrition and physical movement activities, but also involves community partners such as Missoula Public Library, holiday celebrations like Earth Day Cleanup, nature-related, and science activities. These activity offerings provide resources for community engagement and learning, and recognize barriers associated with socioeconomic status within that might make community participation more difficult.

BMI screening and surveillance of third graders is no longer done by the program, formally ending in 2019 (Let's Move! Missoula, n.d. 1). From the above information and the statement that "we hope to shape our efforts through the lens of health equity and ensure our efforts are cognizant of the impact weight bias and stigma have on youth" (Let's Move! Missoula, n.d., p. 1), it is evident that the program is moving toward a weight-neutral approach.

A weight-neutral approach focus on "increasing physical activity and other positive health behaviors without regard to change in body weight" (Gaessner & Angadi, 2021, p.2). Recognizing the impact of weight stigma, discarding the use of BMI as an outcome measure, and shifting the program framing to focus on health disparities and community engagement are essential to having a program that is beneficial and a positive health experience for participants.

Another approach to public health programming is a weight-inclusive framework. This framework believes that "everybody is capable of achieving health and well-being independent of weight" (Tylka et al., 2014, p. 2). One such approach that fits into this framework is Health at Every Size. Health at Every Size works to "respect body diversity, do not idealize or pathologize specific weights, enjoy movement at all sizes and abilities, and practice intuitively eating" (ASDAH, n.d., p.1). This goes further than a weight-neutral approach towards valuing body diversity.

As far as the Let's Move program goes, new potential evaluation measures for the still-existing programs could be created based on creating new goals annually or over a more extended period for each of the five pillars: creating a healthy start for children, empowering parents and caregivers, providing healthy food in schools, improving access to healthy, affordable foods, and increasing physical activity. Perhaps this looks like creating new community partnerships, activities, or educational materials. Maybe evaluation looks like surveys for parents about how much programming has helped them get their child involved in the community or increased access to healthful food. There is great potential for how to move forward towards programming that values body diversity.

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