EveryBODY Matters
3rd Canadian Weight Bias Summit
May 26-27, 2016
Edmonton, Alberta

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Report prepared for: Canadian Obesity Network

Date: June 9, 2016

Contents

Introduction

The purpose of the 3rd Canadian Weight Bias Summit was to engage in a research and practice workshop to develop consensus on key weight bias reduction messages and strategies.

The two-day summit, held at the Matrix Hotel in Edmonton, Alberta brought together 42 individuals from across the country as well as representatives from the United States. Participants included individuals living with obesity, researchers studying weight bias, health professionals, industry partners, policy makers, civil servants, knowledge translation experts, and Canadian Obesity Network staff and volunteers. Along with the two formal days of presentations and work, opportunities for participants to network and engage outside of the Summit schedule were available.

The objective of the Summit was to share best practices and move towards consensus on key weight bias reduction messages and strategies in order to better evaluate the impact of those efforts locally, provincially and nationally through research, education and action.

A reflexive dialogue method was used to explore the following questions:

- **How? (Explanation):** How is weight bias experienced, addressed and contested by individuals living with obesity, health professionals and other obesity stakeholders?
- **What? (Description):** What are some weight bias reduction interventions and resources available in Canada?
- **So What? (Synthesis):** What are some common messages, strategies, principles and language used from existing weight bias interventions that we can all agree will advance changes in practice and policy?
- **Now What? (Action):** How can we incorporate these messages, strategies, principles and language into future weight bias reduction interventions?

Overview of Day One

Opening remarks were brought by Dr. Arya Sharma, Scientific Director, Canadian Obesity Network, setting the stage for the Summit. Research updates and practical knowledge exchange were presented by 13 presenters in a Pecha Kucha style format (short 8-10 minute presentations). Following each section of speakers the group participated in a facilitated discussion to reflect on key messages and recommendations from the presentations.

The presentations included:

- Sharing of narrative accounts from people living with obesity about their experiences with weight bias in the health care and education systems.
- Sharing results of a systematic review of weight bias reduction interventions among health professionals.
- Discussing how accommodations, inclusive language and policies can reduce weight bias; and share results from a weight bias survey in Alberta Health Services.
- Discussing critical weight studies' history, theory, language and major findings.
- Discussing lessons learned from the field of social justice education; and, sharing results from the emerging field of critical obesity pedagogy.
- Highlighting existing weight bias reduction interventions, approaches and resources.

- Sharing strategies and best practices from conducting stigma reduction initiatives in other marginalized groups (e.g. sexual and gender minority individuals, people living with mental illness, diabetes, AIDS).

For a complete list of presentations, see Appendix A.

The large group discussion following each of the presentations helped to summarize the key points of the presentations and bring consensus to the direction of the Summit. Summary notes from these discussions are found in Appendix B.

The key points from these discussions focused on the following:

- Weight bias impacts the physical, mental and social health and wellbeing of people with obesity
- Importance of highlighting the costs associated with weight bias i.e. fiscal, human
- People with obesity (as defined as a chronic disease) deserve to be treated with respect and dignity in health care and education systems
- Challenge is to change the narrative of obesity that simplifies obesity to a lifestyle/behaviour choice
- Need to reframe obesity as a chronic disease while avoiding further weight bias and stigma
- Distinction between individuals who have obesity (i.e. defined as a chronic disease) versus individuals who identify themselves as fat and have good health
- Obesity – defined as a chronic disease that impairs health- is not a choice; people with obesity do not choose to have obesity and deserve to be treated with respect while also having access to evidence-based care for their disease
- Can still discuss obesity in health, education and policy settings if we develop standard definition/description
- There is a role for activism (i.e. nothing about us without us) in weight bias reduction efforts
- People with obesity often do not want to share their experiences because of fear of stigma and discrimination
- Power of narratives/storytelling
- Involvement of people with obesity as researchers and colleagues
- Importance of evidence-informed strategies – there is no single approach to prevent or reduce weight bias, but we have examples of best practices
- Requirement of multi-faceted approaches to address weight bias
- Weight-bias reduction messages should be developed with the target audiences and consider contextual factors
- Education is important but it is not enough. There is a need for more experiential learning, peer modeling, and patient narratives. Should consider education theories and resources on how to change behaviour and practice
- Need for champions to role model behaviour amongst health and education professionals
- Opportunities for collaboration i.e. industry, other groups that could put the weight bias issue on their agenda
- There are many similarities between weight bias and stigma in other communities and populations. We can learn from others who have led stigma reduction efforts in HIV/AIDS, mental illness, diabetes, and the LGBTQ community
- Be clear about our objectives before considering policy and legal approaches. There is no easy solution but there are opportunities within current federal laws to prevent weight-based discrimination. Changing laws and policies, however, will require patients to step up and be

prepared for a long process that is both painful and time consuming. There is a personal cost from speaking up as an individual living with obesity

- Important to recognize that it will take time to spark public interest and build confidence among people with obesity to speak up. In the US, the Obesity Action Coalition has spent the last ten years building a community of people with obesity that can act as self-advocates. After ten years, there has been progress in the US with obesity being recognized as a disease
- CON is uniquely positioned to address weight bias in Canada because it is able to bring together groups from different disciplines and perspectives
- CON can share best practices and the work that is happening around the country to reduce weight bias in health care, education and policy

Overview of Day Two

The objective of the second day of the Summit was to move toward consensus on common messages, strategies, language and/or principles from existing weight bias interventions. Prioritization exercises and consideration of strategies focused on three main sectors:

- Health
- Education
- Public Policy

Participants were pre-selected into small working groups by the organizing committee, to ensure appropriate representation of members in one of each of the three areas listed above. Two groups were assigned to work on each of health, education and public policy sectors. The schedule from Day 2 varied somewhat from that outlined in the program, with an hour and a half of small group work in the morning, followed by presentations from each group back to all participants. Similarly, after lunch, small group work resumed with about an hour of small group work and half an hour of reports back to the group as a whole.

Note takers were assigned to each table to capture the discussion around audiences, key messages, rationale, strategies and tactics, feasibility and outcome measures. In addition, each small group assigned a spokesperson to deliver the reports back to the large group.

See Appendix C for a sample template of the small working group documents that helped guide the discussion.

Findings and Discussion

This section provides a high level overview of the key messages, audiences, strategies, tactics and outcomes selected from the small working groups on the second day of the Summit. Small groups were requested to prioritize their top three audiences and key messages for their sector, followed by their top three strategies and tactics, and respective outcome measures. In some cases there were more than three components selected as priority areas and these have been captured here. The order presented below does not reflect any prioritization within the list. If specific strategies and tactics or outcome measures were identified for select audiences, these are reflected in the tables; otherwise lists of these items are presented by sector.

For the complete set of brainstorming notes from the small working groups, see Appendices D and E.

Health

Audience	Strategies and Tactics (specific to an audience)
Patients	• Social media • Public gatherings • Education (lunch and learns) • Media campaign • CON Facebook/Twitter
Policy Makers	• Standardized care protocol • One on one with political staff (Members of the Legislative Assembly, Members of Parliament) and government staff (Assistant Deputy Ministers and Deputy Ministers)
Health Care Professionals and Frontline Staff	• Change the curriculum for future health professionals • Educate current health professionals (lunch and learns, Continuing Medical Education programs) • Find champions in primary care to increase buy-in/deploy to the right groups • Engage patients to share their stories
Professional Organizations	• Submit articles to their monthly newsletters • Re-emphasize code of ethics • Patients to speak at national conferences

Key Messages:

- Obesity is a chronic disease
    - Not just eat less, move more
    - The right to be treated like everybody else/not discriminated
- It is okay to talk to your health care provider about your weight
- Patient first/people first strategy
- Weight bias will not be accepted or tolerated
- Be compassionate – don't blame the patient
- EveryBODY matters
- Meet the unique needs of patients with obesity
- Focus on behaviour and health outcomes, not body weight
- Understand the definition of obesity as a chronic disease (beyond Body Mass Index)

Strategies and Tactics:

- Sensitivity training to include patient stories
- 'Certification' checklist for bariatric access and quality care (Accreditation levels)
- Develop position statements – engage with professional associations via codes of conduct/ethics
- Peer mentoring
- Health care professionals who work in bariatric medicine experience discrimination because they work in this discipline- Address this discrimination among fellow HCPs
- Impact of health outcomes and tie it to health and safety strategies

Outcomes:

- Attendance at education events/learning sessions
- How many have signed up to CON Facebook page and Twitter
- How many hits/stories have happened
- Measure engagement – follow-up surveys/questionnaires
- Clinicians and patients present their stories as a team i.e. presentation at CON Summit in 2017
- Criteria to be included by Accreditation Canada and Required Organizational Practices (ROP)
- Join CON and become champions
- CON as the platform for successes and ideas

Education

Audience
Professional Associations
School Districts
Schools
Parents
Unions
Universities – pre-service teachers
Administrators
Provincial/National organizations (like ParticipACTION)

Key Messages:

- One size fits no-one: A multi-level approach to reducing weight bias
- Discrimination hurts everyone
- Obesity should not be the 'hook' for health news or education
- Appreciation of diverse body sizes benefits everyone
- Don't be the ass in bias (framed as an approach to social environments – mental vs physical)
- Decouple health and weight
- Promote body inclusivity
- Include body size diversity in bias and discrimination policies (not practical to isolate weight bias)
- Foster resilience in children and youth

Strategies and Tactics:

- Create resources, lesson plans, repository of resources, slide banks, links
- Invite collaborators and partners where we can consult and co-create appropriate resources
- Infiltrate (piggy back onto) existing programs and packages for the inclusion of weight bias reduction information such as nutrition, physical activity and anti-bullying
- Develop a coalition by sector to address weight bias
- Develop CON information briefs by section (use/augment existing resources i.e. videos)
- Initiate the CON Awards i.e. Champion recognition for body diversity
- Identify successes i.e. keep a database of resources, tools, and examples of success
- Peer to peer knowledge, resources, tools
- Citizenship
- Role models
- Develop a vulnerable populations strategy

Outcomes:

- Number of people accessing resources
- Number and type of consults regarding weight bias in education sector
- Number and type of education policy settings where weight bias is represented

Public Policy

Audience	Strategies and Tactics	Outcome Measures
Canadian Obesity Network	• Work with CON stakeholders to develop a clear definition of obesity as a chronic disease • Work with researchers to synthesize weight bias data in Canada	• CON policies in place to guide other policy makers • Clear picture of the problem
Federal civil service	• Add Weight Bias into the Gender-Based Analysis Plus (GBA+) education platform http://www.swc-cfc.gc.ca/gba-acs/index-en.html	• Utilize existing GBA+ evaluation [1]
Provincial civil service		
Professional associations		
Regulatory bodies that oversee professional associations		
Government – legislators and bureaucrats		
Canadian legal professionals		

Of note, it was mentioned that there may be potential for research funding to study the effect of adding weight bias to the GBA+ tool (via CIHR).

Key Messages:

- Treat obesity as a chronic disease (using CON's new definition)
- Understand obesity as a chronic disease
- Weight bias and obesity stigma needs to be prevented and addressed because it impacts the physical, mental and social health and well-being of Canadians
- Weight-based discrimination is not acceptable
- Addressing weight-based discrimination is as important as addressing other forms of discrimination

Strategies and Tactics:

- Consolidation of baseline data on weight bias in Canada
- Develop a better definition of obesity as a chronic disease (CON Position Statement based on consultations with key stakeholders; engage/consult others in this i.e. professional associations)
- Engage policy makers in identifying strategies for addressing weight bias as it relates to the CON position/definition
- Add weight bias into the Gender-Based Analysis Plus (GBA+) course that is available to all government employees
    - Synthesize research in weight bias prevalence and consequences in Canada that can be included in this course
    - Determine process to have content added to the GBA+ course

Outcomes:

- Accurately identifying the problem
    - Clean obesity definition

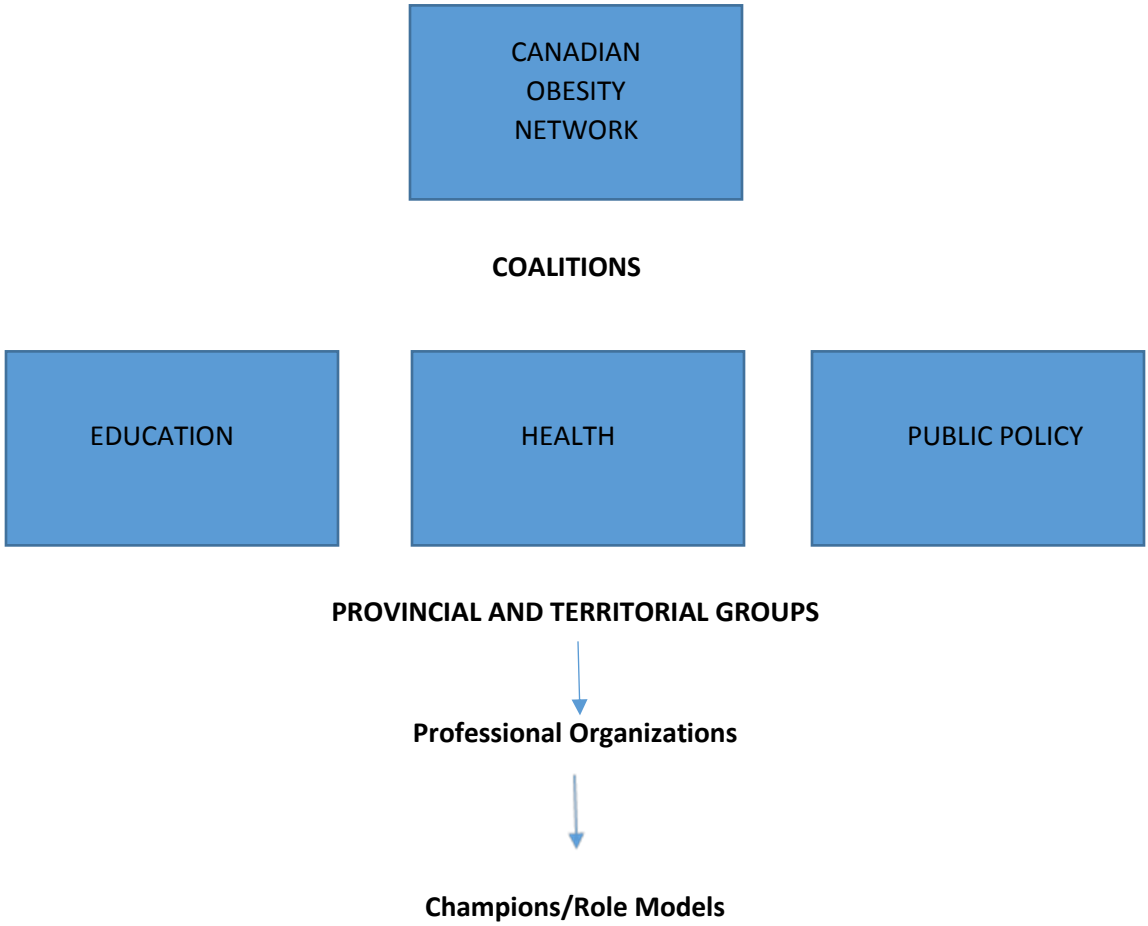
    - Accurate picture of the prevalence and consequences of weight bias in Canada (synthesize current weight bias data in Canada).
- Number of weight bias training initiatives
- Number of associations engaged (Quality of engagement)
- Utilize existing GBA+ evaluation metrics to measure the impact of weight bias training
- Potential for research funding to study the impact of adding weight bias into the GBA+ platform

From the small group priority setting, there are some key elements that are consistent across the three sectors, health, education and public policy. Some of these include:

- Defining obesity as a chronic disease
- Developing key messages with the audiences for which they are intended
- Recognizing that weight bias is a discrimination as serious as discrimination associated with gender, race and sexuality
- Storytelling and narratives as powerful tools to engage audiences and communicate messages
- Reframing the topic to not focus on weight, while still discussing and providing clarification on obesity
- Finding and developing champions to tell their stories and carry the message to appropriate audiences

A last discussion piece at the meeting focused on the development of coalitions within each sector, and with provincial and territorial representation in each. The concept is that these coalitions across jurisdictions would help to develop champions within the sectors and then begin to target key stakeholders in each area, with key messages and appropriate strategies and tactics as required. Figure 1 outlines the draft concept of the coalition model.

FIGURE 1: DRAFT CONCEPT OF COALITION MODEL



Recommendations for next steps

In terms of next steps, it is advisable that all of the material captured from the Summit be synthesized into a strategic plan of action. Many concepts and ideas were discussed at the Summit, and while priority areas were highlighted by the group, it is advisable that further work is done for clarification and selection of strategic goals to be achieved.

For instance, Summit participants discussed that the Canadian Obesity Network (CON) needs to position itself as the key resource and platform for obesity and weight bias information, research and advocacy in Canada; as well as increase its awareness and public base. If these are the goals – then the action plan could focus on ensuring that the identified audiences receive the messages associated with this.

Some of the next steps may include:

- Synthesize the findings and discussion notes from the Summit into a strategic plan.
- Use the more fulsome discussion notes and small group work notes to guide and develop further strategies, rationale and background information (see Appendices C through E) and to ensure no material or concepts were missed.
- Use the information from the presentations to help form the foundation of the action plan, including evidence-based background information and communications materials.
- Follow-up on potential funding opportunities with Canadian Institute for Health Research (CIHR) re: evaluation project and/or other possible funding options.
- Further develop the CON coalition model.
- Consider a stakeholder and Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis for alignment of strategies with partners and other relevant organizations.
- Identify opportunities for collaboration i.e. industry, other groups that could put the weight bias issue on their agenda.

Acknowledgments

We would like to thank the organizing committee, which consisted of the EveryBODY Matters Collaborative Core Members and the Canadian Obesity Network (CON) Staff, for all of their hard work and commitment to making the 3rd Canadian Weight Bias Summit a success.

With gratitude, the Summit would not have been successful without the time and effort of dedicated volunteers who assisted with registrations, note taking and more. To the members of the public and representatives of the CON Public Engagement Committee, your voices were imperative to the findings and discussion that took place at the Summit! We would also like to thank Jennifer Gallivan for producing this comprehensive report, helping with the planning of the two-day Summit and being a wonderful facilitator.

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Facilitation

Facilitation of the Summit was provided by Jennifer Gallivan, MPH, Consultant

Appendices

Appendix A: Summit Program[1]

[1] Double click on the program image above to see the full program.

Appendix B: Discussion points from Day 1

Research update discussion:

- Information is not enough
- Need broad reaching and sustainable education and information sharing
- Experiential learning
- Null curriculum – consider what isn't being said in health and education
- Increase the patient voice – encourage them to question and to ask
- Research supports that weight bias is pervasive in health and education systems
- Organizational level policy needs to change – need to 'prove' what you have been doing with numbers, not always able even though you might make an impact
- Where is the role of professional associations? Need to agree that weight bias is an issue
- Curriculum – patients report that health care providers never speak to them about weight; health care providers are worried about offending patients, and don't know how to discuss weight; CON has 5A's – need skill building to help health professionals address obesity as a chronic disease
- The Canadian Association of Occupational Therapists – for the first time ever had a standing room only session at their annual conference – with CON public engagement member speaking – most traction with stories; ongoing dialogue
- Encourage the use of patient speakers/public engagement committee
- Change one person's perspective is still change
- Up against 'impact' i.e. how much will addressing weight bias cost? How much will it save?
- Health administration – obesity and weight bias cost discussions have a discriminatory lens – not the same with other diseases i.e. cancer
- Weight bias costs – research supports negative health and social consequences of weight bias
- How much of cost is due to weight bias in the health system?
- We must change attitudes, beliefs, skills
- Treating patients with obesity in a safe and dignified manner is also about promoting safe patient handling practices. Safe patient handling – reduce time off work; reduce dollars/costs associated with time of work; reduce back injury in nurses, which is leading cause of time off work – need safe patient handling for all patients, need appropriate equipment to accommodate patients with obesity.

Practical knowledge exchange #1 discussion:

- What are the impacts of weight bias reduction resources/programs on students and health professionals?
- Example provided: Positive/negative response from family medicine course at the University of Alberta. Important to avoid blame and shame of health professionals and focus on role modeling appropriate practices and behaviour.
- Teachers are expected to provide advice on health but receive little to no training in their education programs. Teachers experience the same stereotypes of health that we all experience in society. Namely that health= thinness.
- Patient attitudes towards health care providers and health care providers' struggles with their own weight – little known literature on this area
- Change the narrative from weight to health – change the discussion with patients
- Need more voices speaking up against weight-based discrimination

- Corporate culture/environment also changing i.e. Blue Cross – new program called 'Balance' – opportunity for collaboration
- How do we inspire executive teams/wellness consultants to change the narrative
- Inclusion and accommodation of people with obesity in employment settings
- Focus on health/inclusion to help inspire/educate executive teams. E.g.: walking to meetings – focus on accessible environments
- Walk/talk meetings can increase stigma when someone can't keep up. Standing desks another example that can make weight stigma worse
- Helps to ask patients/people with obesity when pushing initiatives to make sure they are actually helpful

Practical knowledge exchange #2 discussion:

- Morality/immorality discussion: assumptions we make about people with obesity being lazy, unmotivated and non-compliant
- Power of the narrative to change
- Transformative education to create change (going beyond providing information)
- Use of language/terminology is important
- There are social/financial aspects associated with weight bias and obesity stigma
- The lung cancer stigma literature – an interesting group to research/look at as there is much 'stigma' associated in this area
- Patient / People with obesity perspective: The assumption that obesity is a choice needs to be questioned. If obesity was a choice, who would choose it? Why would you choose to be part of a group/community that is highly stigmatized in our society?
- Stigma assigned also to the practitioners/policy makers/funders helping and working with patients with obesity – 'courtesy stigma'
- A key target audience are clinicians but also policy makers and funders.
- People with obesity experience stigma when they seek weight management and when they don't
- Stigma for patients if they seek weight management in the health system, people think "why can't you do it on your own?"
- Reframe the policy objectives i.e. increase physical activity and healthy eating is for everyone not just for people with obesity. If we focus on obesity in healthy living we miss part of the population. There are unintended consequences of population health strategies that don't always help all.
- Public health policies and strategies should stop talking about obesity. Move from obesity to general health (healthy eating, physical activity, etc.) Especially if you want to reduce weight bias and obesity stigma.
- Are weight bias solutions for everyone? Evidence shows that there is no single intervention that is most effective. Rather we need a layered approach using multiple strategies.
- Activism i.e. nothing about us without us; grass roots approaches; Patient Perspectives: "choose to listen to us".
- Involve CON Public Engagement Committee as researchers/colleagues
- Activism, representation in stakeholders. Can't just consult population, they need to have an active voice.
- Link with Strategic Clinical Networks (SCNs) – involve patients in other networks

- Similarities across stigmatized diseases and communities (diabetes, HIV/AIDS, mental illness, LGBTQ community; can learn from others.

Summary Discussion of Day 1:

- Need to make this a personal connection i.e. everyone knows someone who has obesity and could be experiencing weight bias and stigma
- There are costs associated with recommendations for system changes, policy changes etc. – but there are costs to people and the healthcare system if we do nothing
- Need value data – beyond monetary data
- Use of the term obesity – needs to talk about the issue without further promoting misunderstanding
- Deal with internalized weight bias; recognize that self-loathing and fear is part of the issue – requires conversations/time;
- Internalized fat phobia, idea that fatness can't be talked about. Prevents self-advocacy.
- U.S.A. –Obesity Action Coalition (OAC) started 10 years ago and has been effective. Increased recognition in public of obesity as chronic disease. People with obesity don't want to be in the spotlight because of fear, discrimination. It took years for OAC to build a community of self-advocates. OAC has sparked public interest and built skills and confidence in the community.
- Mobilize advocacy community – politicians, policy makers, citizens, champions
- Enhancing healthy bodies, minds and individuals
- Has there been an increase in the number of individuals who believe that obesity is a chronic disease? Could investigate the impact of the Canadian Medical Association declaration of obesity as a disease on public attitudes and beliefs.
- Learn more about critical weight studies
- Find common ground with other organizations
- Find champions - build trust and confidence
- Identify special groups – i.e. children, First Nations, English as a Second Language, etc.
- Shape and tell a new story – broaden and expand the story
- Use of language and terms to include health for all
- Consider existing human rights and discrimination laws; challenge the Charter of Human Rights
- Need policy change – reframe and start taking about it in another way i.e. patient rights, professional codes of conduct.
- Personal connection. Policy members, MPs can also have this connection. Use this to move forward.
- Personal narratives are extremely important. Good to get politicians to listen to this
- Work with other groups where weight is part of their agenda where relevant i.e. diabetes, eating disorders
- Argument for policy makers- cost of not doing anything about weight bias
- Important to avoid making the conversation about physical activity and healthy eating all about obesity. This can promote weight bias.
- Everybody matters, not just obesity. Important to address all biases. Special/minority groups, they have unique issues.
- Shape a new story. Change from "fitness center" to "wellness center"
- "Network" – get many voices

- Be clear about our objectives before considering policy and legal approaches. There is no easy solution but there are opportunities within current federal laws to prevent weight-based discrimination. Changing laws and policies, however, will require patients to step up and be prepared for a long process that is both painful and time consuming. There is a personal cost from speaking up as an individual living with obesity.
- Patients with obesity are easy targets. Can't separate obesity from discussion
- Can we share success stories through CON? Can we bring different groups together to work against policy makers?

Appendix C: Small Group Discussion Guiding Documents

Small Group Discussion – Day 2 – Moving Toward Consensus

1. **WHO (20minutes)**

   Who are the relevant stakeholders or audiences that need to be targeted?

   Brainstorm all possible groups.

2. **WHAT (20minutes)**

   What is the message you want this audience to understand? Provide 2 or 3 key details for each group identified.

3. **WHY (20minutes)**

   Why is the messaging for this audience? What is the rationale for telling this group this message? What difference will it make?

IDENTIFY the top 3 audiences you want to focus on and report back to the group (3 minute reports and 2 minutes group discussion)

TEMPLATE

SECTOR OF FOCUS: **Health** **Education** **Public Policy (Select One)**

GROUP:

Audience	Key Messages	Rationale

Small Group Discussion – Day 2 – Moving Toward Consensus

Based on the top 3 selected audiences for your sector (Health, Education, Public Policy) – complete the following:

1. **HOW (35minutes)**

How will we tell the audience the message? What are the specific tactics and strategies needed to get the message to the audience? What are the practical ways we will tell them what they need to know?

2. FEASIBILITY (10 minutes)

Which of the strategies and tactics are most feasible for each audience? Which are not feasible and why not? Consider timelines, budget, access to the audience, politics, technical details etc.

RANK your strategies and tactics for each audience in order of priority (10 minutes)

3. OUTCOMES/MEASURES (25 minutes)

How will we know if the tactic or strategy made an impact? How will we measure the intended change or impact of what was done?

PRESENTATIONS to the group about the ranked tactics/strategies and outcomes (3 minute reports and 2 minutes group discussion)

TEMPLATE

SECTOR OF FOCUS: Health Education Public Policy (Select One)
GROUP:

AUDIENCE:

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures

Appendix D: Small Group Discussion Summary Notes from Day 2 - Morning

SECTOR OF FOCUS/GROUP: Health 1A

Audience	Key Messages	Rationale
Everyone, front line providers (e.g.: nurses, unit clerks, etc.) Decision makers within health – e.g.: executive of hospital, unit managers	What kind of contact do we have with patients with obesity through the health care journey? NOTE: Some hospitals that treat bariatric patients, are old and have toilets that are all wall mounted. Can try to get private room or in the bathroom if commode is needed Note: "Weight Wise Clinic" translates into being smart about your weight. Assumption is that you are not smart or that you are stupid. How do you tell your patient it's not about weight when weight is in the name? – Use weight management instead. Same thing with "obesity centre". Decide to medicalize it, use bariatric instead. Now its "bariatric care" then becomes bariatric standards. NOTE: Discrimination against bariatric workers: surgeons, nurses etc. You are seen as not needed. – this is why interventions should target everybody.	Want to know at all points of contact in healthcare system, where can things derail? - E.g. Blood pressure can't be measured, bathroom stalls are too small, surgery recovery units, appropriate equipment such as wheelchairs, wall mounted toilets, etc. Need to speak with decision makers in government
Provincial government	Get the word obesity out of all government documents to make more functional approach not blaming approach. NOTE: Changes in Ministerial positions occur so often that it makes it difficult to affect change. NOTE: In Newfoundland the government has approved the change to focus on health not weight,	- sets the tone
Health professionals/front	Weight management interventions tied to health outcomes and patient/provider safety – health and safety issue and quality	Promoting a better understanding of obesity as a chronic disease acts against weight bias.

Audience	Key Messages	Rationale
line workers, people who make decisions	standards. NOTE: Hospitals and any health centre that is supporting patients with obesity should be certified "bariatric friendly" – a form of accreditation. Set these standards and link them with key outcomes– e.g.: patient safety. CON could be a certifying agency. Can have gold, silver, bronze standards. Can be tied in with bariatric care report card in Canada. Can follow models from other disciplines. Include children's hospitals, long term care, etc. make sure visitor space is also bariatric friendly. Defining Obesity: Like in any chronic disease, weight management is about looking at the trajectory of the disease. If a patient is gaining weight suddenly, it is important to assess the reasons for the weight gain and identify strategies to prevent further disease development. But if the patient has been weight stable, there is no need to intervene. This should be key message – distinguish between weight now and weight trajectory. Not everyone who has a larger body size needs to be referred to weight management services. NOTE: Language is important. Let patients choose the terminology they prefer. But health care professionals should use obesity as the medical term for a chronic disease.	Health care professionals won't make assumptions when they see a patient for the first time. It is a powerful concept that can prevent weight bias and improve treatment of patients with obesity. Weight trajectory is clearer indicator of health. Same as Blood Pressure trajectories. One time measurement is not significant for clinical practice. It's the trajectory that matters. Advantage of integrating this message with frontline health care professionals is that you can create a culture and this can create diffusion beyond health care settings. This concept takes the negative connotation away from obesity.
Frontline workers/health care workers/ everybody they come into contact with	Behaviour and conduct: Message – do you want your friends/family to be treated this way? Important to be professional and respectful – don't say what you think. What kind of contact do you want to have with your patients? The certification/report card can help change behaviour and practice changes.	Patients will be able to feel the difference. If you cannot change someone's attitudes and beliefs then we can at least make them act professional based on a professional code of conduct. This can also start to change cultures
Everybody	Involve patients in education programs. Personal stories make a difference. Doesn't have to be bariatric surgery patients. Visuals	

Audience	Key Messages	Rationale
	help too.	
Professional associations	Include weight bias in each code of ethics – to be trained/respectful to bariatric patients. CON position statements on weight bias and obesity stigma.	Link position statements to existing provincial/federal strategies. CON could also help professional associations to update code of ethics for each discipline. NOTE: We need a champion of each discipline per province.
Administrators	Discrimination against health professionals who work in bariatric medicine. Define what we mean by "obesity" (as a chronic disease) Impact weight bias and tie it to health and safety strategies • weight bias impacts health outcomes, quality care, safety • weigh trajectory message as a way to improve understanding of obesity as a chronic disease. • Language – negativity around obesity as social construct.	

SECTOR OF FOCUS/GROUP: Health 1B

Audience	Key Messages	Rationale
Patients *Patients need to tell the stories to see what the gaps are to then take to Ministries of Health.*	1. *Obesity is a chronic disease (should be the same message given to everyone – adapted for the audience). Implies a self-management component but also means that you are not responsible for obesity (account for stigma/discrimination, unique medical requirements like anyone else with a chronic disease; needs to include a multi-disciplinary approach) 2. There is no cure for chronic diseases. It is not eat less, move	Very important audience as few patients stand up for their rights. Patients need support in hospital (i.e. after bariatric surgery) – from all HCP i.e. PT/OT – and make sure it is consistent care. Patient is driver for change (patient advocacy) – need to target all areas of health

Audience	Key Messages	Rationale
	more. But, you can manage a chronic disease. 3. You have the right to be treated like anyone else who has a chronic disease, and the right not to be discriminated against for asking for help or because you have a disease. 3. It is okay to talk to your health care provider about your weight.	care/policy. For example: a patient went to the Ministry of Health to get the adolescent bariatric program started in Toronto). Patients target all areas (top/middle) at same time so that it becomes focused effort – power of the patient (patient is driver even if they don't feel that). HOW: Need education to improve the understanding of obesity as a chronic disease. Obesity – the chronic disease – has implications for health. If your weight/size does not impair your health, then you do not have a chronic disease.
Policy makers (Ministry of Health, AHS Leadership, Politicians)	1. *Obesity is a chronic disease 2. There is no cure for obesity. It is not eat less move more. You can manage a chronic disease. 3. Weight bias is not acceptable and will not be tolerated. 4. Need a patient-first and people-first strategy.	To get change in policy need to implement from the top (with pressure from the bottom – identify gaps/what's needed). Need a multi-tiered approach. Mobilize the public and get support from policy makers. Need external regulators to support (i.e. Canadian Medical Association) to be effective. Have the ability to influence food security/access to food, physical activity. There are important cost implications (obesity – the chronic disease - puts at higher risk for other health conditions); treat the disease – cost-savings/value-for-money. Need to sort through competing priorities in

Audience	Key Messages	Rationale
		health care (acute diseases usually trump chronic diseases). Obesity needs to be a priority (focus on prevention to save down the road). Need education on: how obesity (the chronic disease) affects the body so that people understand the treatment options.
Health Care Professionals (physicians, nurses, pharmacists, Dietitians, administration…)	1. *Obesity is a chronic disease 2. There is no cure for chronic diseases. 3. Be compassionate, don't blame the patient; understand that it is a chronic disease. 4. Treat patient with obesity the same as you would treat those with other chronic diseases. 5. Everybody matters and meeting their unique needs is important.	HCP may be discriminated by patients for having obesity. Need to sort through competing priorities in health care (acute diseases usually trump chronic diseases). Obesity needs to be a priority (focus on prevention to save down the road). Patients with obesity need mental health support and need proper screening in primary care. HOW: Standard protocol after surgery (pre/post op for bariatric surgery – same as other surgeries). Built-in care pathway for patient care. Education on: how to approach the topic of obesity with patients.
Insurance companies	1. *Obesity is a chronic disease	Need creativity to enhance people's wellness i.e. proper accommodation, access to healthy

Audience	Key Messages	Rationale
	2. Need to focus on treatment and prevention.	foods, physical activity and medical management.

Other Notes:

- Standard of care pathway (one done for pre-natal care).
- Okay to recognize that people with obesity may have different needs
- Obesity is a disease…needs to be considered as a disease so that it is treated the same as other diseases…
- Message needs to come from patient (lived message) and go to all areas.
- Policy makers tired of only hearing from medical professionals.
- Clinicians need to give voice to complement lived experience (of patient).

SECTOR OF FOCUS/GROUP: Education 2A

Audience	Key Messages	Rationale
Public Schools (Children/Parents/Teachers) - - nutrition programs, PA groups, Comprehensive School frameworks, curriculums (ministries), policy re: anti-discrimination	- Use positive messaging rather than negative – we are doing "this" for everybody. - Elements of messaging – focus on the fact that weight bias effects everyone, need for improved care for those living with obesity, idea of hope and advances i. Discrimination hurts everyone ii. Obesity should NOT be the hook for health news or education iii. Appreciation of diverse body sizes benefits everyone	1. No conflicting messages for children (generational shift) 2. Focus on what to do (weight is not a 3. Piggy back approach to what already exists
Kids; need for a generational shift, kids who are champions, kids having their own voice.		
Media – where do people get their messages/information from?		
- safe and caring schools (under the Minister of Education-		

Audience	Key Messages	Rationale
Comprehensive School, positive social environment) -making the culture		
- Equlibre – body diversity – healthy minds/healthy bodies - Boards of Education (ministers) – accepting diversity (all types – cultural, gender, sexual orientation – size or weight, how can we utilize issues that are popular, how can we influence curriculum?		
Ministers /Members of Parliament.		
Networks of spokesperson (example of Dietitians of Canada – with media training)		
large group of voices (e.g. OAC with their large membership) -the general public -generational turn-over		
Universities pre-service teachers		
Provincial/National Organizations i.e. ParticipACTION		

Other notes:

- Is there a balance? Stop talking about “obesity” in schools, divorce physical education and nutrition from obesity
- You need a multi-level intervention/bullying; piggy-back approach to build on existing cultural shifts
- Example of Active 2020, ParticipACTION – the hook was obesity, BUT obesity should NOT be the HOOK.

SECTOR OF FOCUS/GROUP: Education 2B

Audience	**Key Messages**	**Rationale**
General comments -	Dismantle the association between health and weight – overarching theme for all audiences Promoting positive inclusivity and diversity Adding body size bias as a form of discrimination (to policy) – all body sizes, not just larger bodies Promote/foster resiliency in kids Don’t be the ass in bias – opens dialogue/can act as a hook	
Pre-service teachers	Might respond better to research than teachers	
Teachers – Different in primary, secondary, post-secondary levels	Benefits of reducing discrimination in students (they will be, more attentive, better performance, creating responsible citizens) Don’t want to learn that they have more to teach (already overwhelmed) How would teachers respond to the fact that some teachers discriminate against students because of their weight? What are other teachers doing? Trust this more than research	
Students/children	*want to involve students in developing the messages -can act as advocates /peer mentorship – students can relate to them -Rudd center videos: feels like an adult created it for students	Give time – students will eventually become parents themselves Might affect parents by what they bring home We can’t reach them directly, but indirectly

Audience	Key Messages	Rationale
	so they can't relate – need something better	through teachers
Post-secondary	Faculty of Education – training teachers	Post-secondary – feasible, large reach
Post-secondary students (on campus)	List of resources for promoting body diversity (inclusive language) for all campuses to use Self-awareness Weight bias messages: may be hard to move past the "obesity" message, the conversation needs to distinguish between obesity causes and consequences, and actually discriminating about weight (we need to be careful not to vilify the people doing obesity prevention) Mental well-being (a good "in" since all campuses are developing policies on this) – positive social environments, good for any type on inclusion -kids that have anxiety to be teased about their weight, might prevent their learning experience Not about obesity – might not be the sector for this Health is foundational to learning – rational for health promotion in schools Accepting who we are Curriculum (for phys ed) – lifelong participating in physical activity VS pedegogy (how it's taught) Physical school environment (desks, uniforms, privacy for changing)	

Audience	Key Messages	Rationale
Early childhood education		
Counsellors at the universities (health practitioners)		
Public health nurses that give kits to parents at check-up (pre-school) (info sheets with each object, which can be toys, music, games, physical literacy, book about body diversity)		
Parents	No fat talk (kids learn by observing/experience/modelling of the behaviour)	A sources of weight bias They can be role models Might not be discussed in other sectors (health and public policy) Limitation: don't want to give parents even more things to do
Minister of Education (policy maker)		
Professional associations (teacher associations) Teachers Unions		
Cadets/cubs/girl guides (after school sector)		

Audience	Key Messages	Rationale
Private enterprise in school	BMI report cards and biggest loser competitions should not be allowed in schools	
Indigenous governance (direct health and education in their communities) Vulnerable populations	Include a specific point on this for any group	High prevalence of obesity in these communities What is the prevalence of weight bias in indigenous communities? Education is Federally (under)funded on reserves
School boards/trustees/districts		School districts create and enforce policies
Departments		
Administrators/school support staff/Deans	• Don't let what you can't do interfere with what you can do (ex: might not want to focus on parents because administrators can't control what they do) • Messages translate across elementary/secondary/postsecondary • They want to know about academic impact/school reputations – grades and attendance might be affected (there is some research to support this) • Equating health and weight (weight-centered health approach) causes harm • No more weighing in schools, especially in public (different	Might administer the PD to teachers, which can reach students – they are the gatekeepers – they must be on board Large reach We want students to want to go to school the next day

Audience	Key Messages	Rationale
	with males and females) • No biggest loser staff challenges – can we replace it with something • Similar messages to bullying: include weight to the "safe and caring" messages • *Need an administrator at the table to craft the messages and have them on board (what would be successful) • Weight bias as a piece of the discrimination piece – so we need to ADD weight bias • -not practical to have weight bias in isolation, but need to add it to existing discrimination policies • Teachers have lower expectations from larger students, can have downstream effects – might not continue in education (research?) • Will it save schools money? • CEO of the schools: they care about how teachers treat their students	

SECTOR OF FOCUS/GROUP: Policy 3A

Audience	Key Messages	Rationale
CON-RCO	• Obesity *as a* chronic disease – with a clear definition and understanding of such • obesity on a spectrum • when it presents as a CD • when adiposity effects your health (there is individual variability) • BMI is not good for clinical use, screening tool only, • people who join CON need to see an organization that reflects their needs • public engagement group – needs to be specific and clear	
Professional Associations	1) cannot discriminate against someone b/c of their weight 2a) Regulatory bodies that oversee professional associations	
Government - Legislators - Bureaucrats	1. Obesity is a chronic disease 2. Weight-based discrimination is as important as other forms of discrimination 4. Include weight-based discrimination as part of the Charter (challenging to do). 5. Charter of Human rights already includes aspects that can protect people with obesity (the chronic disease as a disability)	
Legal Professionals	Train and help legal professionals understand health and the meaning of obesity as a chronic disease -it's already in the charter, physical disability -understand the message of obesity as a chronic disease and that it meets the criteria to protect against weight-based discrimination	
Judges	Obesity as a chronic disease can fall under the Charter (disability) Educate judges about what obesity as a chronic disease means so that they can apply the law and protect against weight-based	

Audience	Key Messages	Rationale
	discrimination.	

SECTOR OF FOCUS/GROUP: Policy 3B

Audience	Key Messages	Rationale
Politicians (provincial, federal, territorial and local)	• Tactic: Prevention or treatment / management (depending on your aim, you need to target your audience and your message in order to have your audience receptive)	
PHAC (Public Health Association of Canada)	Obesity is a chronic disease that requires prevention and management approaches. Weight bias impacts population health and increases health inequalities.	
Minister of Health, Minister of Education	Obesity is a chronic disease. Weight bias needs to be prevented and addressed.	
Provincial Government? • Since health care delivery is provincially mandated- it may be difficult to enforce a federal policy.	• Key Message: Care in the health care system as an individual living with obesity is dehumanizing. • Tactic: Need an evaluation component. • Tactic: Addressing weight bias in health care delivery- across the board (primary, secondary, tertiary care). • Tactic: Mandatory education for health care professionals. • Tactic: Can work with CON to educate health professionals. • Tactic: Need to go beyond education, and involve people in the learning process. Model where there is internal assessment of an organization. Perhaps practice modules where bariatric patients are involved on an on-going basis.	• Rationale: Can impact on quality of health care services, cost-effectiveness argument. • Rationale: Can relate to a broader notion of inclusivity across the health care system for other marginalized groups. For feasibility sake should likely focus on weight bias.
	• professional training within health care	

Audience	Key Messages	Rationale
	organizations. • Tactic: Ongoing education requirement for health care professionals- add credits on weight bias.	
Federal Government	• Key Messages: Weight bias is just as important as other components of GBA plus. • Tactic: GBA add on (weight bias). Federal government requirement. Currently covers age, religion, language, geography, culture, income, sexual orientation, education, ethnicity, ability. Adding a plus on weight bias is well needed. • Tactic: Synthesize research on weight bias, involve patient advocates. • Tactic: Include the Canadian Obesity Network	

Appendix E: Small Group Discussion Summary Notes from Day 2 - Afternoon

SECTOR OF FOCUS/GROUP: Health 1A

AUDIENCE: Health Care Providers (HCPs)

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
Join CON Patient stories Mentoring by a champion e.g.: Sue York List of tips for helping patients CON to host best practice	Train champions through courses like CON-HSERC Obesity Management Certificate Program for Post-Graduates/BalancedView Can leverage existing education resources	• Disseminate information about obesity and weight bias • Health professionals participate in education programs • New partnerships with professional associations • Measured by how many attend, download info, hospital certifications, etc. "process measures" • Measure through patient complaints/comments are acted upon • Number of staff injuries in health system • Decreased length of stay for patients

AUDIENCE: Professional Associations (e.g.: CARNA, CNA, CAOT)

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
CON to host meeting with champions		• Come up with ideas to be same across associations and their ethics/codes of conduct • Have joint workshops

AUDIENCE: Administrators

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
Certification of sites (try to get in ROP with Accreditation Canada)		• Push info through to everyone • Requires certification • Changes in certification status/report card (e.g.: clinic goes from "bronze" to "gold" standards)

SECTOR OF FOCUS/GROUP: Health 1B

The following tactics and strategies focus on these audiences: Patients, policy makers/administrators, health care provides/front-line staff, and professional organizations.

AUDIENCE: Patients

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
	All attainable goals in a relatively short period of time	
Mobilize patients using social media/newsletters (CON Facebook page/CON public members, Twitter). Create patient advocates.	Yes – through CON page; shared by other CON members	How many members/shares/likes…
Public gatherings – explain, understand, raise awareness		How many people attend sessions
Media campaign (Health Matters - Global News)		
Provide education to patients at hospitals (chronic disease, stages of change, not a "quick-fix", realistic expectations)		

AUDIENCE: HCPs/Frontline providers

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
	All attainable goals in a relatively short period of time	
Change curriculums for future HCPs at university; provide bariatric training.		
Education to hospital staff: let patient advocates tell stories to HCPs at meetings/learning events Education for staff on bariatric hospital units; implemented a weight bias presentation in orientation class for everyone working at bariatric hospitals		Questionnaire to staff – assess attitude change, key learnings
Education through: webinars, websites, lunch n' learns.		
Utilize Primary care networks as ambassadors to spread message	Difficult because privately owned; need champions	
Get buy-in from primary care; generate awareness, create buy-in. For example, lunch n' learn.		
Embed mental health into messaging so that people are aware of mental health issues that affect people with obesity.		
Have patients share their story – build compassion among HCPs		
Find champions in obesity to deploy to specific group.		

AUDIENCE: Policy Makers/Administration

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
	All attainable goals in a relatively short period of time	
Create standardized care protocol/pathway for patients with obesity.		
Have patients tell their stories – generate an emotional response.		
1:1 with key politicians to create buy-in.		

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
Embed mental health into messaging so that people are aware of mental health issues that affect people with obesity.		
Embed health and wellness into policies.		
Professional Organizations:		
Re-emphasize/Enforce code of ethics – obligation as HCP to treat patients with dignity, respect…		
Article/commentary in regulatory publications		
Have patients/HCP speak at regulatory/associations conferences		
Bridging gap between public and private organizations		

Other Notes:

- Need to craft a compelling message/story that the various audiences will buy into – and generate an emotional response ("lived story").
- Consistency among voices is important.
- Identify a champion in each area → deploy specific champion to the specific audience to increase buy-in.
- Create a culture → EveryBODY matters
- For example at the summit could have the patient-provider experience of providing care to a patient with obesity.

SECTOR OF FOCUS/GROUP: Education 2A

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
Audiences = schools, universities, and national/provincial organizations, unions, school districts, parents, pre-service teachers, administrators		

Starting with pre-service teachers: get into the BEd. Program (although professors have some leeway as to what they can present in a course)
 	
• Influencing independent faculty
• Resource that would help the professors (premade slide sets, videos) → design it for them
• Doesn't have to be a whole course, could be a few lectures (slide share website, perhaps posted on the CON website)
• Database of resources – could encourage people from other faculties to use this (e.g. kinesiology, health sciences, nutrition)
• If it's general messaging, it could also be used in high schools for teachers
• Similar strategy for pre-service teachers and for current teachers (repository of resources that could be used in different ways for education or bringing up discussion) (similar to the CON media bank)
• Resources already exist, it would just be about gathering them together and compelling people that it's important enough that they need to use it
• Getting it out to people that these resources exist (word of mouth, using images in media segments, etc.)
• Opportunities for presentations by CON at teachers' conferences (go to a conference and tell them about
		• Literature publications
		• Number of people who access the resources (but we don't know if they were accessed/used correctly)
		• Measure number of consults
		• Integrated dissemination plan (including survey – did you use this, how did you use it)
		• Formative evaluation – review before and after with teachers to get to a place where the resources will actually be used
		• Pilot acceptance study
		• May see influence on the curriculum eventually, may also see changes in policy in schools
		• Need a group of teachers interested in this area to come and help figure out what they would use and what they would measure
		  ○ Approach the ATA (teachers' organizations)
		  ○ Wouldn't want to create all this stuff if they're not going to use it
		  ○ CBPR in education research (participatory action research)

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
the resources → they will be more likely to attend if they can get resources as well, e.g. USB stick) • Body image kits to get traction had to go through vetting process through Alberta Education (takes at least a year to get approval). Then teachers are more likely to approve it. • Send the resources to a vetting organization first • Measure it with the number of hits to track how many times people have looked at it • Does this change the culture? • Peer collaboration • Make it trending, salient in the media • Until the course becomes mandatory, you will self-select the people who are most interested in the topic • Health Champions conference has been available for 250 students, the most that have attended 100 students • Chances to integrate it into courses that are already mandatory? • "anything is better than nothing" • The voluntary stuff to start with is a good idea, might help counteract some of that rebound effect (net negative effect) • Snowball effect (start with one small thing) – if there is pushback from Alberta Education, there's a chance to educate reviewers who have their own weight bias • Package with other things, opportunity to get people to think more progressively, things tend to cluster together (e.g. transgender, acceptance of people in general) → social justice type of issue (rather than		

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
just framing it as being about bodies, focus on diversity in general) • It's not mutually exclusive from race and gender bias (one way to sell it is that these marginalized groups are not completely distinct from each other) • Consider an indigenous perspective? Different ways of knowing? • Invite programs and services and offer some kind of consultation with someone that could look at what's being written about and how to make the language more inclusive (rather than just a prepackaged resource, we could help them to modify it, co-creation with people who have an understanding of weight bias) • Opportunity for activities to be peer-led (many of these groups have peer champions) e.g. Firefly (already have an "in" in the schools) • Does the general public (schools) even know weight bias exists? • Why should they care? • Lack of understanding, still reducing it to the individual level (crux of the problem) • There's a lot more that we still have to know about weight bias to understand it • It's feasible to come up with a sharehouse of resources, but how do you get people impassioned enough to think they need to be used? ○ How do you get the uptake? • Popular messaging • Finding your cohort and getting them engaged in a different way • Making it an aspect that's salient to their identity		

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
(frame it so it appeals to those different groups e.g. they want to be the gym teacher that is a social justice advocate) ○ How do we make weight bias palatable to different groups? • Everybody has weight bias, what are some other groups we could influence? • Anti-bullying is currently a big topic in schools ○ We have anti-bullying days in schools, but are we progressive enough as a society to have a "weight bias" day? ○ Teachers tend to be open to new perspectives (it's just so foreign to their thinking) • #1 idea = resources and linking to resources (lesson plans, slide banks, etc.) • #2 = consultation and co-creation (inviting people to come to us (CON) and consulting with us to adapt/review their resources) • #3 = infiltration (piggy-backing with existing programs e.g. nutrition, physical activity → we can add weight bias messages) ○ Who are the champions? ○ Connections with Firefly, HIV • Creation, invitation and infiltration •		

SECTOR OF FOCUS/GROUP: Education 2B

AUDIENCE: Administrators

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
Administrators' meetings (would have to go to each school jurisdictions)	Need to understand provincial differences, e.g., 62 school districts in Alberta, 2 in Newfoundland (one French, one English)	
1. Establish coalitions within CON, with people specifically involved with schools/education (action-based)		
Talk to provincial teachers association/find the channel that is specific for each province		
Healthy Schools Alberta – write article, this goes out to all the schools in the province		
Accountability pillar's survey (already exists): add a question about discrimination based on weight. Go through/need a contact Alberta Education to get the question(s) added (provincial civil servants who are doing the briefing)		
2. Resource creation: CON can create a briefing note/policy brief (why it's important, why you should care)		
3. Safe and caring policy/school acts: make sure body size is there for every province. Leverage the success of provinces so they each create one.		
Relationship building		

AUDIENCE: Teachers and Pre-service teachers

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
Get in to teachers conventions	But: there are so many sessions to choose from, might not get a large	

	audience	
Pairing with existing provincial organizations, example: pre-conference on weight bias -Professional organization conferences (e.g. health and physical education in Canada - PHE) -Health and physical education council, HPEC (each province has one). -CSSE (yearly, annual conference)	Find opportunities	
Might need to go jurisdiction by jurisdiction (professional learning)		
Create teacher ambassadors/champions: how it looks like in practice, what can they do on Monday.	Possible to find these teacher role models.	
Recognition award to identify/showcase the role models, "pro" list of teachers that are doing good work with this		
CON to create a better video than the Rudd center ones		
Sharing health courses for BEd faculties across Canada (from U Calgary for ex)		
Where are members of CON having success in the education sector? Who's been talking to who? Mapping	Might not be practical to collect this data with little staff. Possible to create a database?	

SECTOR OF FOCUS/GROUP: Policy 3A

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
Consolidate Baseline data on weight bias in Canada		→Accurately identifying the problem (definition, improvement in weight bias data, training, # of associations engaged, quality of engagement)
CON Identifying Obesity as a definition as a chronic disease → CON's Position →Consult/engage others	Yes	Helps health/policy makers/patients better understand the message of Obesity *as a* chronic disease
CON Position Statement	Yes	
Professional Association Approach with compelling reasons why they need to better understand and adopt as the approach as well as definition		Obesity as evidence by treatment Respect & dignity to treat equally across all practice, improving the interactions, its delivery
Approach the Professional associations and integrate them within these → Engage them on identifying strategies for addressing weight bias as it relates to CON's positions		

SECTOR OF FOCUS/GROUP: Policy 3B

AUDIENCE: Federal Government

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
	Need funding (therefore may have to have an evaluation component)	?
CON and stakeholders to Champaign locally within Alberta, start locally and spread federally.	?	?

Tactics and Strategies	Feasibility (yes/no) and why/why not	Outcomes/Measures
Make sure CON mission and key messaging is coherently and aligned with the rationales and tactics for this approach to public policy.	?	?
• Tactic: GBA add on (weight bias). Federal government requirement. Currently covers age, religion, language, geography, culture, income, sexual orientation, education, ethnicity, ability. Adding a plus on weight bias is well needed. • Tactic: Synthesize research on weight bias, involve patient advocates. • Tactic: Drafting a briefing document, framing it around the notion that weight bias is potentially as harmful and a risk as other forms of bias including, gender, education, age, etc. Note: Need to be cognisant of language (needs to be respectful language but also needs to be recognized)	We have access to various networks connected to CON that we could bring in. Bring in patients advocates.	Number of people that complete it. Number of jurisdictions that take it up.
• Training GBA+ educators on weight bias		