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Breaking WEIGHT BIAS

Promoting Health without harming through digital training tools

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Desk Research Report

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2. Summary for each Country

a) Greece

There are not enough healthcare settings to treat obesity efficiently.

Healthcare professionals are not appropriately trained to diagnose and treat obesity.

There is no reference to weight stigma in national health policies and academic education of health professionals.

The majority of the campaigns about obesity were stigmatizing and promoted harmful messages that reinforce weight stigma.

Weight stigma is not recognized as a type of stigmas like the stigma of mental health and addiction.

The primary method that is promoted as the way to treat obesity is dieting. However, research has proved that dieting is a form of disordered eating that can lead to further weight gain, metabolic disturbances and reinforce yo-yo dieting, also known as weight cycling.

b) Poland

There are multiple strategies to prevent obesity and counteract discrimination based on obesity (including developing healthy habits, promoting physical activity, the law on equal treatment).

Access to a dietitian is free within the National Health Fund services.

The monitoring carried out by the Patient Ombudsman, inspired by the activities of the OD-WAGA Foundation (having as its primary purpose prevention, diagnosis, treatment and the fight against discrimination), showed that the health service is not adequately prepared to care for people with obesity.

Poland will implement a pilot program in the future to improve the quality and effectiveness of treatment for people suffering from morbid obesity.

In Poland, the profession of a dietitian is not well-spread.

In Poland, there is a lack of training and education on weight stigma for health professionals who work with obesity daily within the health care system.

c) Romania

Discrimination against obese people is present in Romania, along with other forms of discrimination. Although there are legal means to combat discrimination, it is not specific to obesity. Discrimination against obese people is present at any stage of their lives, with psychological solid impacts and compliance with treatments and lifestyle improvements.

The field of dietetics and nutrition is barely taking shape in Romania. The dietitian profession is missing from the team that should consult a patient suffering from obesity with a doctor, psychologist, physiotherapist or personal trainer.

Hospitals or other medical centres do not have the means to provide adequate accommodation.

Medical practitioners have prejudices and are not always willing to take other training courses to understand and manage a multidisciplinary obese patient.

There are no modules specifically designed to properly manage patients facing obesity in the academic environment, although the prevalence in Romania is relatively high.But there are non-formal education programs that can encourage medical practitioners to manage an obese person properly.

d) The Netherlands

In the Netherlands, the Situation of Weight Bias is somewhat unclear. The obesity rate increased in the last 20 years, though the government has settled a work plan to reduce obesity and overweight. Specific health insurance programmes were created to support the people who are willing to take up such activities for their health and to balance their weight and physical activity. These activities are covered by the public insurance model the country is following.

Rules for general discrimination and stigmatisation in all the fields of a person's everyday activity have been settled, though these rules are not evident in the case of weight stigmatisation.

In recent years, organisations and groups of people interested in this topic have been organised to raise awareness on weight bias. The results of these actions are not precise, and there are no available statistics on the overall impact of these activities on the whole country.

More training is required for health professionals and targeted research on reducing weight bias and the accessibility and equal opportunities to people who are overweight or with obesity.

e) United Kingdom

Weight bias is a prevalent form of discrimination in the UK. People with obesity and overweight face discriminatory behaviours in all aspects of their lives, and weight stigma is associated with adverse physiological and psychological outcomes.

Public weight management and weight loss policies and campaigns tend to reinforce weight stigma through an oversimplified portrayal of obesity that blames the individual and promotes thinness as an indicator of health.

People with obesity and overweight are not provided with the best care possible due to weight stigma, and they tend to avoid seeking medical care because of feelings of shame. Hospitals are not adequately equipped to accommodate all body sizes.

There is a deficient number of dieticians in the UK compared to other medical professionals such as nurses. Nursing courses do not always provide weight management and weight bias awareness training, which further increases the need for dieticians and nutritionists.

Some formal education providers offer courses in weight management and clinical nutrition, but the number of these courses is deficient. This suggests there is little training for the awareness of weight bias and support for healthcare professionals who work with people living with obesity.

Medicine, nursing and physiotherapy courses do not offer compulsory modules on obesity care, which suggests that healthcare professionals graduating from these courses may lack the training to support people struggling with weight bias.

Several non-formal training providers and short online courses empower healthcare professionals to provide the best care for individuals with obesity. These courses are optional, however, so they will not be undertaken by every healthcare professional. These courses also attempt to tackle the lack of mental health support for people that care for individuals living with obesity.

3. Country Profile Statistics

a) Greece

Country Profile Statistics				
Population (Worldometers, 2021)	10,374,487	Population under 18 (Statista, 2019)	0-14 yrs: 13.9%	
GDP per capita(current $)(World Bank & OECD, 2019)	19,581.0	HDI Index & Ranking (countryeconomy.com, 2019)	HDI: 0.888 Ranking: 32	
GNI per capita (current $) (World Bank & OECD, 2019)	19,750.0	Poverty headcount ratio at the national poverty line (% of the population) ((World Bank, Global Poverty Working Group, 2018)	17.9%	
Gini Index (World Bank, 2018)	32.9	Completion rate of lower secondary education (UNESCO Institute for Statistics, 2018)	94.3	
Nurses (per 1,000 people) (World HealthOrganization's Global Health Workforce Statistics, OECD, 2017)	3.6	Mental Health Professionals (per 1,000 people)	*No data available*	
Physicians (per 1,000 people) (World HealthOrganization's Global Health Workforce Statistics, OECD, 2017)	5.5	Dietitians and Nutritionists (per 1,000 people)	*No data available*	
Physicaltherapists (per 1,000 people) (Panhellenic Physiotherapists' Association, 2020)	8.41	Life expectancy at birth (World Bank, 2019 & Statista, 2018)	82yrs	
			79.3 yrs male	84.4 yrs female

b) Poland

Country Profile Statistics			
Population (The Word Bank,2019)	37,965.47	Population under 18 (stat.gov.pl, 2016)	7677
GDP per capita (current $) (The Word Bank, 2019)	15,694.7	HDI Index & Ranking (UNDP, 2019)	HDI: 0.88 Ranking: 35
GNI per capita (current	32,790	Poverty headcount ratio at	0.2

$) (The Word Bank, 2019)		the national poverty line (% of the population) (The Word Bank, 2018)		
Gini Index (The Word Bank, 2018)	30,2[4]	Completion rate of lower secondary education (The Word Bank, 2018)	94.334	
Nurses (per 1,000 people)(OECD, 2020)	5,2 [12]	Mental Health Professionals (per 1,000 people)(WHO, 2016)	0.02/1000	
Physicians (per 1,000 people)(CIA.gov)	2.38	Dietitians and Nutritionists (per 1,000 people)	*No data*	
Physical therapists (per 1,000 people)(x-rehab, 2020)	2	Life expectancy at birth (The Word Bank, 2019)	77,856	
			74.1 years male	81.8 years female
Prevalence of Type 2 diabetes (The Word Bank, 2019)	6.1	Literacy rate in adults (CIA.gov, 2015)	99.9% male	99.7% female
Prevalence of cardiovascular diseases (WHO,2018)	46%	Prevalence of overweight among adults (20 years and over) (WHO,2018)	25% male	26% female
Saturated fat intakefrom total calorie intake (WHO,2012)	9.8%	Prevalence of overweight among adolescents (5-19 years) (WHO,2018) [14]	10% boys	4% girls
Addedsugarsintakefrom total calorie intake	No data	Prevalence of overweight among children (0-5 years) (The World Bank, 2011)	5% overall children	
Fruit and vegetable supply in grams per capita per day (WHO,2009)	499 grams	Number of undernourished people (The Word Bank, 2018)	2.5 %	
Salt intake in grams per capita per day(WHO,2000)	7.0 grams	Prevalence of physicalinactivity in adults(WHO,2018)	33% boys	36%girls

c) Romania

Country Profile Statistics			
Population (The World Bank, 2020)	19,366,221	Population under 18 (ISSE, 2021)	3,614,653
GDP per capita (current $) (The World Bank, 2019)	12,913.1$	HDI Index & Ranking (Human development Report, 2020)	HDI: 0.828 Ranking: 49

GNI per capita (current $) (The World Bank, 2019)	29,497$	Poverty headcount ratio at the national poverty line (% of the population) (The World Bank, 2019)	23.8	
Gini Index (The World Bank, 2019)	35.8	Completion rate of lower secondary education (The World Bank, 2019)	88.0	
Nurses (per 1,000 people) (WHO, 2019)	7.4	Mental Health Professionals (per 1,000 people) (WHO, 2019)	0,26/1000	
Physicians (per 1,000 people) (The World Bank, 2013)	3.0	Dietitians and Nutritionists (per 1,000 people)	*No data available*	
Physical therapists (per 1,000 people)	*No data available*	Life expectancy at birth (Human development Report, 2020)	76.1 72.6 y male	79.5 y female
Prevalence of Type 2 diabetes (International Diabetes Federation, 2021)	Diabetes overall, in adults: 8.8%	Literacy rate in adults (The World Bank, 2020)	99% Male	99% Female
Prevalence of cardiovascular diseases (IPCCS, 2018)	hypertension prevalence about 45%	Prevalence of overweight among adults (20 years and over) (Medical Week, 2015)	64.6% male	45 % female
Saturated fat intake from total calorie intake (WHO, 2013)	9%	Prevalence of overweight among adolescents (5-19 years) (WHO, 2013)	27% Boys	10% Girls
Added sugars intake from total calorie intake	*No data available*	Prevalence of overweight among children (0-5 years) (WHO, 2013)	Overall children 25%	
Fruit and vegetable supply in grams per capita per day (WHO, 2013)	620 grams/day	Number of undernourished people (WHO, 2013)	3%	
Salt intake in grams per capita per day (WHO, 2013)	10-12 grams/day	Prevalence of physical inactivity in adults (20 years and over) (WHO 2013)	40% boys	45% girls

d) The Netherlands

Country Profile Statistics				
Population (The World Bank,2019)	17,344,874	Population under 14 Population female 15-19 Population male 15-19 (The World Bank,2019)	15.883% 5.789% 6.151%	
GDP per capita (current $) (The World Bank,2019)	52,295.039	HDI Index & Ranking	Index: 0.944 Ranking: 8	
GNI per capita (current $) (The World Bank, 2019)	61,480	Poverty headcount ratio at the national poverty line (% of the population) (The World Bank,2019)	13.6%	
Gini Index (The World Bank, 2018)	28.1	Completion rate of lower secondary education	-	
Nurses& Midwives (per 1,000 people) (The World bank, 2018)	11.2	Mental Health Professionals (per 1,000 people)	-	
Physicians (per 1,000 people)(The World bank, 2017)	4	Dietitians and Nutritionists (per 1,000 people)	-	
Physical therapists (per 1,000 people)	-	Life expectancy at birth (World Bank, 2019)	82	
			80 male	84 female
Prevalence of Type 2 diabetes	%	Literacy rate in adults (World Data Atlas, 2014)	99%	
Prevalence of cardiovascular diseases	-%	Prevalence of overweight among adults(20 years and over) (WHO, 2013)	56,4% male	48,7% female
Saturated fat intakefrom total calorie intake(WHO, 2009)	13%	Prevalence of overweight among adolescents (10-19 years) (WHO, 2013)	15% boys	12% girls
Addedsugarsintakefrom total calorie intake	12%	Prevalence of overweight among	-%	-%

(Nutrients-MDPI, 2016)		children (0-9 years)	boys	girls
Fruit and vegetable supply in grams per capita per day (RIVM Report, 2016)	250gr fruit and nuts 250gr Vegetables	Prevalence of underweight (World Bank, 2018)	2.5	
Salt intake in grams per capita per day(WHO, 2013)	8.8 gr	Prevalence of physical inactivity in adults (15 years and over)(WHO, 2013)	23,7% boys	16,4% girls

e) United Kingdom

Country Profile Statistics			
Population (ONS, 2020)	66,796,807 (as of 2019)	Population under 16 (ONS, 2019a)	19% of total population
GDP per capita (current $) (The World Bank, 2019)	$42,328.90	HDI Index & Ranking (HDR, 2020)	13 out of 189 countries. 0.932
GNI per capita (current $) (The World Bank, 2019)	$47,620	Poverty headcount ratio at the national poverty line (% of population) (The World Bank, 2017).	18.6%
Gini Index for 2019-20 (Statista, 2020)	36.3	Completion rate of lower secondary education (The World Bank, 2020)	101.394% of the total % of the relevant age group. Value is likely to be over 100% due to the time of population count compared to data collection time.
Nurses (per 1,000 people) (The World Bank, 2018a)	8.172	Mental Health Professionals (per 1,000 people) (World Health Organisation, 2020)	UK data not available
Physicians (per 1,000 people) (The World Bank, 2018b)	2.812	Dietitians and Nutritionists (per 1,000 people) (Health &Care professions council, 2017)	0.142 Dietitians No UK data for nutritionists
Physical therapists	1.108	Life expectancy at birth (ONS,	

(per 1,000 people) (Statista, 2020)		2019)	79.4 years male	83.1 Years female
Prevalence of Type 2 diabetes (diabetes.org, 2019)	Raw Count: 3,919,505 5.87%	Literacy rate in adults (UNESCO, 2016)	*No UK data published* Global: 90% male	*No UK data published* Global: 82% female
Prevalence of cardiovascular diseases (British Heart Foundation, 2019)	Raw Count: 7.6 Million 11.38%	Prevalence of overweight among adults (16 years and over) (NHS, 2018)	40% male	31% female
Saturated fat intake from total calorie intake (NHS, 2020) (Our World in data, 2017)	Recommended10% Actual 30%	Prevalence of overweight among adolescents (5-15 years) (Health Survey for England, 2017)	12% boys	13% girls
Added sugars intake from total calorie intake (NHS, 2020) (Our World in data, 2017)	Recommended10% Actual 20%	Prevalence of overweight among children (2-4 years) (Source, Year)	9% boys	10% girls
Fruit and vegetable supply in grams per capita per day (NHS, 2020) (Our World in data, 2013)	Recommended 400g Actual 230g	Percentage of undernourished people (The World Bank, 2018)	2.5%	
Salt intake in grams per capita per day (NHS, 2020) (NHS, 2010)	Recommended 6g Actual 8g	Prevalence of physical inactivity in adults (20 years and over) (Public Health England, 2019)	22% male	24% female

4. Obesity Management and prevention policies, strategis and services

a) Greece

Main national recommendations, strategies and policies on weight bias, stigma, and discrimination

There are no national recommendations, strategies, or policies on weight bias, stigma, and discrimination in Greece. Interestingly, although the National Strategic Plan for Public Health 2019-2022 addresses the stigma of addiction to drugs and alcohol and the mental health stigma, there is no reference to weight stigma. Moreover, the only recommendations regarding obesity focus solely on the importance of healthy eating, without mentioning the social determinants that affect the risk of developing obesity and the barriers to its treatment. Also, even though the importance of continuous training among healthcare professionals is highlighted in the National Strategic Plan, there is no attention to the significance of education about obesity (Ministry of Health, 2020). In addition, according to the available data from the World Obesity Federation about Greece, there is a lack of specialized training of health professionals in the prevention, diagnosis and treatment of obesity. At the same time, obesity is not recognized as a disease (World Obesity Federation,2020).

It is worth mentioning that there are no studies regarding weight stigma and discrimination in Greece, apart from postgraduate students' research. Notably, the authors' conclusions about the results of the first national survey that aimed to record the health status and dietary choices of the adult population in Greece referred to the personal responsibility of people for their health issues. This approach doesn't consider any of the well-established risk factors for obesity, including genetic, environmental, psychological and socioeconomic factors. It has been documented that overemphasizing only the responsibility of individuals lies within the root causes that drive weight stigma and discrimination. It is of utmost importance that the language used in research does not reinforce weight stigma to protect people from the harmful effects of stigmatizing health policies that promote blame instead of health (Brownell et al.,2010).

Greek financial crisis is related to poor nutrition (KaranikolosM et al., 2013), since people who have lost their jobs or their income has been dramatically reduced cannot afford nutritious food, including fresh fruit and vegetables and fish, and they turn to cheaper, highly processed food choices that are high in calories with little nutritional value (StucklerD. et al., 2009). Moreover, unemployment and economic hardship are strongly associated with increased levels of chronic stress, a well-known underlying factor for most of the prevalent mental illnesses and non-communicable diseases, such as depression and heart disease (Dettenborn L et al., 2010). It is worth mentioning that the COVID-19 pandemic has negatively influenced the economy of Greece, leading to even more insecurity and uncertainty. The COVID-19 lockdown was also a determinant factor that dramatically reduced physical activity levels in Greece (BourdasD. et al.,2020).

Partnerships and professional networks that work in nutrition, physical activity, and obesity

Unfortunately, there are no available partnerships and networks in Greece that address weight stigma. On the contrary, The Hellenic Medical Association for Obesity (HMAO) refers to the personal responsibility of people with obesity for not losing weight. The only initiative in Greece about weight

stigma occurs by a pharmaceutical company, which uses updated and validated data to treat obesity, without stigmatizing and harming patients. The latest press release of The Hellenic Dietetic Association on World Obesity Day (4th March 2021) referred to the weight stigma that exists even among health care professionals and made it clear that it should be liminated to help patients with obesity efficiently. However, the video created for World Obesity Day 2021 focused only on the alarming rates of obesity, its association with serious health issues, and the complexity of its causes. There was no reference to weight stigma and to the different ways through which it can negatively affect people's health. Also, the video used phrases like "obesity epidemic", which has been shown to have contributed to the increase of weight stigma. In 2018, the Hellenic Dietetic Association had published another video on World Obesity Day to raise awareness about weight stigma. Still, there have been no training programs or organized campaigns to address this issue thoroughly (Kousta E, 2021).

Coordination mechanisms among healthcare professionals in treating people with overweight and obesity

In Greece, there are no specific coordination mechanisms or guidelines that promote cooperation between different healthcare professionals to treat overweight or obesity. It is up to the discretion of each healthcare professional to choose if they want to refer one patient to another healthcare provider. However, there is a referral system in general hospitals between outpatient clinics (mainly for diabetes and hypertension) and the clinical dietitian of the hospital (if there is one). Moreover, "18 ano", a national drug-treatment unit, has created a team with different types of healthcare providers, including dietitians, psychiatrists and psychologists, who collaborate to offer an integrated treatment to people with obesity.

Social and cultural norms, awareness campaigns and media coverage related to stereotypical portrayals of people living with obesity

Unfortunately, the majority of the awareness campaigns promote messages, which reinforce the stereotypes related to obesity and, thus, weight stigma. The press releases of the Hellenic Dietetic Association on World Obesity Days emphasize on the alarming rise of obesity and its detrimental effects on health. They repeatedly use phrases like "the epidemic of obesity". "MychoiceMylife" is a campaign which is conducted by a pharmaceutical company that aims to contribute to the treatment of obesity. However, its official webpage uses phrases like "obesity pandemic" and implies that obesity is related to the "loss of control" around food and the strong desire to eat treats. It is well-established that obesity is one of the most complex health issues since there are many underlying causes that often interact with each other. Apart from this, guessing that an individual with obesity "has no control" and "craves sweets" represents a stereotype of weight stigma. Moreover, a big project named "Lose Weight-Gain Life" takes place in the General Children's Hospital "Pan. & Aglaia Kyriakou" and aims to reduce childhood obesity. However, the program's official website refers to the "obesity epidemic" and overemphasizes its "terrifying" effects on mortality and morbidity. Moreover, from our personal experience as volunteers of this project during our undergraduate studies, we witnessed very harmful behaviours and attitudes against children, with no empathy and total lack of respect and kindness. Last but not least, there was a campaign about childhood obesity took place by the mayor of Athens in 2008, which was mainly based on spreading threat and fear. The name of this campaign was "Drop the weight of the child", and one of its basic mottos was "It may be called childhood, but it can easily turn into a life imprisonment." The material of this

campaign kept emphasizing the problems of obesity and phrases like “you are what you eat”, “be careful not to overeat, because this may lead you to obesity”, “your everyday nutrition may destroy your health silently, without realising it” and promotes nutritional tips, such as “Instead of chocolate, eat fruit.” A growing body of evidence has proved that this type of approach is not only incapable of encouraging people to adopt a healthier lifestyle, but it can also trigger overeating, emotional eating and stress. This campaign also promoted self-weighing, a well-established factor that can increase eating disorders, disordered eating, body dissatisfaction and depression among adolescents (Pacanowski CR et al., 2015).

b) Poland

Main national recommendations, strategies and policies on weight bias, stigma, and discrimination

Overweight and obesity is a severe health and economic problem worldwide, and what is more, this problem increasingly affects children and young people. In Poland, there are many strategies aimed at preventing overweight and obesity and counteracting discrimination on the grounds of obesity, including:

- The National Health Programme- The operational objectives of the National Health Programme 2021-2025 include the prevention of overweight and obesity. The programme aims, among others, to shape health attitudes, promote proper nutrition and physical activity, promote breastfeeding, update nutrition standards for the population, define nutrition standards in hospitals, raise public awareness of health determinants, etc. This regulation entered in to force with effect from 1 January 2021(Council of Ministers of Poland).

- Law on Equal Treatment – This law defines areas and ways of counteracting discrimination based on sex, race, ethnic origin, nationality, religion, belief, worldview, disability, age or sexual orientation, as well as other bodies competent in this field (Internetowy System Aktów Prawnych, 2010).

- Charter on nutrition and physical activity of children and adolescents at school – The idea behind this programme is to ensure nutrition and opportunities for safe physical activity in Poland. The main objective is to ensure adequate knowledge and formation of skills and motivation related to rational nutrition and physical activity, provide children with appropriate nutrition at school, and ensure proper sanitary and organisational conditions for their consumption.

Environmental, social and economic factors:

Environmental factors: poor eating habits of parents, easy access to fast food, consumption of large amounts of sweets and sweetened drinks, skipping breakfast, reduced physical activity.

Social factors: inactivity imposed by urbanisation and consequently low physical activity, culture, customs, traditions, level of education, material and intellectual conditions of choice of the type of food consumed.

Economic factors: easy availability of sweets and sugary drinks, low prices of fast-food, financial situation of families.

Partnerships and professional networks that work in nutrition, physical activity, and obesity

Many clinics in Poland have been established to meet the needs of patients. Their methods are based on contemporary trends in holistic medicine and are equipped with modern medical equipment. The clinics employ specialists who know how to provide patients with comprehensive medical care and support.

Regarding organisations that fight against weight discrimination, we should mention the OD-WAGA Foundation of People Suffering from Obesity. The main aim of the foundation is to lead to the creation of a national system in Poland: prevention, diagnosis, treatment and rehabilitation of obesity, as well as the fight against discrimination of people suffering from obesity in all areas of social life. The foundation also disseminates reliable information on the disease of obesity and safe methods supporting its treatment (Fundacja OD-WAGA, 2020).

Coordination mechanisms among healthcare professionals in treating people with overweight and obesity

In Poland, if the patient would like to use the free dietetic clinic within the National Health Fund services, a referral from the general practitioner (to the clinic of the metabolic disease) is needed. The patient may also decide to visit a private clinic, which is not reimbursed; in this case, the patient must pay for the visit according to the price list of the dietitian.

The guidelines for the principles of management of overweight and obesity in family physician practice are described in detail in a document edited by the College of Family Physicians in Poland, the Polish Society of Family Medicine and the Polish Society for the Study of Obesity (2018) (College of Family Doctors in Poland, Polish Society of Family Medicine, Polish Society for the Study of Obesity).

We have not come across any information to suggest that health professionals are paid extra in managing people with obesity.

Social and cultural norms, awareness campaigns and media coverage related to stereotypical portrayals of people living with obesity

The campaign "PorozmawiajmySzczerze o Otyłości" was launched in 2019; the Polish Cardiodiabetological Society organises the movement. The campaign's main aim is to raise public awareness that obesity is a chronic disease and needs to be treated because it threatens health. On the campaign website, you can find information and educational materials about the disease, learn about the causes of obesity, and find out how to fight obesity. The campaign also provides information and practical advice on how to persevere and support people struggling with the disease. The website also includes doctors who deal with obesity treatment (Porozmawiajmy szczerze o otyłości).

On the other hand, the' Eat Carefully' campaign is an example of a campaign supposed to encourage people to change their eating habits, but in the meantime, stigmatised and gave complexes to people with eating disorders. This project aimed to draw attention to healthy lifestyle issues and encourage

people with obesity to change their culinary habits. Participants in the campaign were tasked with designing a poster on healthy eating, but it aroused much controversy. Many of the works referred to unhealthy eating habits and their consequences for human life. Some of the results, unfortunately, reinforced the image of obesity sufferers, so that their appearance in the public space caused a lot of controversy and very many negative comments (Wydawnictwo Medyczne Termedia, 2019).

Another good practice in counteracting discrimination against people suffering from obesity is the establishment of the Team for Counteracting Discrimination against People with Obesity, which was set up in the Office of the Patient Ombudsman. This team aims to develop promising practices for the staff of health care providers in promoting awareness of the rights of patients suffering from obesity, mainly to prevent discrimination on the grounds of appearance or lifestyle (Rzecznik Praw Pacjenta, 2019).

c) Romania

Obesity management and prevention policies, strategies and services related to a health-promoting lifestyle from Romania

On March 27, 2008, the Nutrition Committee was set up, which operates under the Ministry of Public Health. The purpose of the committee is to develop policies and strategies in the field of nutrition and to improve the health of the population. Also, in 2008, the new order appeared with a revision of the one from 2006 regarding the list of foods not recommended for pre-scholars and schoolchildren and the principles underlying a healthy diet for children and adolescents. These recommendations will undergo positive changes as soon as the Romanian College of Nutritionists and Dietitians is born, scheduled for the fall of 2021('Grigore T. Popa' University of Medicine and Pharmacy in Iasi).

So far there is only the Association of Dietitians in Romania, which includes part of the dietetic community. Obesity among dietitians does not have a general framework, with recommendations on attitudes towards obese people, which exist predominantly, is secondary and tertiary intervention, less prevention. In Romania, the Ministry of Health organizes and finances national health programs aimed at preventing and combating obesity in adults and children. Thus, within the "Action Plan" for the period 2014-2020 for the implementation of the "National Health Strategy", the following strategic directions are highlighted: increasing the effectiveness of the role of health promotion and disease reduction, promoting a healthy lifestyle, information and destigmatization campaigns as well as improving the health and nutrition of the mother and child and reducing the risk of maternal and infant death.

In 2008, the law approving the sale of fast-food products in schools was approved.

In 2017, the "Milk and corn" program was implemented at a national level and the program to encourage the consumption of fruits and vegetables in schools, thus ensuring Romania's participation in the EU School Program (National Institute of Public Health).

Specific determinants and their dynamics

Romania presents the epidemiological profile of all developed countries, with a low prevalence of communicable diseases and at the same time an increase in cardiovascular disease, cancer, and

external causes, including violence and accidents, as well as preventable lifestyle factors, mainly smoking, alcohol consumption and poor eating habits. (National Institute of Public Health)

Life expectancy has increased in Romania by six years since the Revolution; the sincerest indicator of the increase in living standards is in terms of food. Although rationalized, the primary foods were not found. The food shortage of the past and the lack of diversity formed for the Romanians strange eating habits, totally unhealthy, which were passed on to today's generations. After the Revolution, with the disappearance of restrictions and the emergence of diversity, other eating habits were created, just as unhealthy! However, Romania is in 7th place in the rapid increase of life expectancy, until 2030 (Last Hour – Independent Journal,2017).

Although the modern lifestyle, based on a chaotic, unbalanced diet, late meals, lack of sports activity, regular hours of sleep, stress due to raising a family, bank rate or unemployment causes high levels of cortisol and change food preferences (over 80% of the population declares pressure) (Simona Nicolaescu – Iordache).

The psychological problems associated with obesity are pretty common and sometimes very serious. Often obese people are stigmatized. Cultural and ethnic factors indeed modulate the social impact of obesity. Another natural consequence after the revolution is the social inequality directly proportional to obesity. Many experts claim that obesity is genetically determined, and no doubt genes play a role in obesity susceptibility. However, the rapidly increasing prevalence of obesity in less than two generations cannot be exacerbated by genetic factors but lifestyle changes. Romanian society is unprepared to accept and properly integrate people with obesity, so discrimination occurs, reduced work capacity, high absenteeism, low income, and inversely proportional to high health expenditures (Medical Manager,2021).

The direct costs of obesity are the resources used in the health care system, including excessive outpatient use, hospitalization, pharmacotherapy, laboratory or radiological tests, long-term care due to conditions favoured by excessive weight (cardiovascular disease, cancer, osteoarthritis). In addition to direct costs, there are high indirect costs, such as declining disability-free years and increasing pre-retirement mortality, early retirement, absenteeism or dropping productivity and disability pensions because of chronic obesity-related diseases (National Institute of Public Health).

Main national recommendations, strategies and policies on weight bias, stigma, and discrimination

The project entitled “Developing university study programs and expanding learning opportunities for the student and the labour market, a project funded by the European Social Fund 2007-2013 - ‘Investing in people ’addressed issues such as discrimination and anti-discrimination strategies.

In the Romanian legislation, there are government ordinances - Ordinance no. 137/2000 which defines discrimination as the difference in treatment of two or more persons in identical or comparable situations or, on the contrary, the equal treatment of persons in different cases if such treatment has no objective justification. Romanian legislation, mainly the Romanian Constitution, but also special laws, provide the following criteria: race, nationality, ethnicity, language, religion, social category, beliefs, sex, sexual orientation, age, disability, chronic non-communicable disease, HIV infection, membership in a disadvantaged class, another criterion whose purpose or effect is to

restrict, remove the recognition, use or exercise, on equal terms, of the rights recognized by law, in the political, economic, social and cultural field or any other area of public life.

The Government of Romania presents and defines the forms of discrimination: direct, indirect, harassment, victimization, and harm to the person's dignity. It also offers the legal framework to be followed for a person considered a victim of discrimination. It has several means at its disposal to counteract acts of discrimination: prosecuting the perpetrator, claiming damages in court, annulling the administrative act containing discriminatory provisions, or initiating an international procedure before the European Court of Human Rights if the proceedings did not lead to the desired results. However, in the same government ordinance no. 137/2000, the burden of proof of discrimination is reversed. The victim must prove the difference in treatment, and the person on whom the accusation is based must prove that such a difference in treatment is based on objective criteria (National Council for Combating Discrimination, 2021).

According to civil procedures, proving discrimination in this context becomes extremely difficult. The person in question does not have a system to follow but only establishes an attitude, opinion, or way of thinking. For the prosecution of the infringement, the person in question can make a complaint, based on the same ordinance, and addresses either the court or the National Council for Combating Discrimination (public authority in the field of discrimination, autonomous, with legal personality, under parliamentary control and guarantor of the observance of the application of the principle of non-discrimination - CNCD). CNCD provides a model petition that must be submitted within one year from the date of the act, with the mention that CNCD cannot grant moral or material damages. Although the Parliament and the Romanian Government have the legal framework for discrimination, defined categories and measures to be followed in case of unfavourable/favourable treatment apart from mentions on discrimination of non-contagious chronic diseases, there is no legal mention regarding the stigmatization of obese people (National Council for Combating Discrimination, 2021).

Partnerships and professional networks that work in nutrition, physical activity, and obesity

Private clinics provide a medical team that best serves patient-facing obesity, with programs designed especially for children. Evaluation and treatment planning are collaborative processes between doctors of different specialities because obesity is a disease with multiple diseases.

Whether the patient suffers from cardiovascular, pneumatological or locomotor problems, a multidisciplinary centre for the treatment of obesity will support several specialists through a complex and customized management for each patient (Medlife).

The multidisciplinary team generally consists of a cardiologist, a pulmonologist, a specialist in diabetes and metabolic diseases, internal medicine and endocrinology, a dietitian, a psychologist, a physiotherapist and a specialist in a bariatric and metabolic surgeon (Arcadia Hospitals and medical centre).

Coordination mechanisms among healthcare professionals in treating people with overweight and obesity

In 2006, Romania published its dietary guidelines for a healthy diet - led by the Ministry of Health, universities and nutrition institutes. Romania uses a food pyramid divided into seven food groups (Food and Agriculture Organization of the United Nations).

The food pyramid is a graphic expression of the nutritional standards, quantities and types of food that must be consumed daily to maintain health and reduce the risk of developing various food-related diseases. The old pyramids had limitations in practical applicability, food groups being expressed as a percentage of daily caloric needs. Today the indications are described in portions of food, whose daily consumption will provide essential nutrients. The current pyramid aims to get most of the energy from carbohydrates while limiting fat intake (Food and Agriculture Organization of the United Nations).

In general, the food pyramid comprises the following groups (1 - top of the pyramid & 5 - bottom):

- Meat, fish, eggs (2-3 servings a day).
- Milk and derivatives (2-3 servings per day);
- Fruits (2-4 servings per day);
- Vegetables and vegetables (3-5 servings per day);

Bread, cereals, rice and pasta (6-11 servings per day) (Food and Agriculture Organization of the United Nations);

Since 2006 Romania has had the same “dietary guidelines for a healthy diet”, and recent scientific studies regarding food intake, proportions, calories, portions etc., were not taken into consideration in the process of developing new guidelines for the general population.

Furthermore, Romania doesn’t have a coordination system in which overweight patients or those suffering from obesity are sent to dietitians or nutritionists with a medical referral ticket to refund the payments. The journey of an overweight person or a patient suffering from obesity is not adequately regulated because Romania lacks a College of Dietitians and Nutritionists.

Payment settlement (refunding) of medical services for overweight or obese people

In the list of medical conditions (diagnoses), medically resolved case in day hospitalization and the maximum rates per medically appropriate case: Obesity due to excess calories - 305.19 lei (The National Health Fund Services Romania, 2021).

Social and cultural norms, awareness campaigns and media coverage related to stereotypical portrayals of people living with obesity

In the period 2009-2011, the project financed from funds granted by the Norwegian Government in Romania took place, within which the Life Campaign took place. Four healthy behaviours were promoted: 1. Drink water, not juice; 2. Eat breakfast daily; 3. Consume three vegetables and two fruits daily; 4. Exercise vigorously for at least 60 minutes daily. The campaign had national coverage. Partnership agreements and county action plans have been signed. The target group was all children and adolescents between 3-19 years old. LIFE campaign - for a healthy community.(Zupernews Journal).

To reduce fat and sugar consumption among the population, the Ministry of Health and the Romanian Employers' Federation of the Food Industry (ROMALIMENTA) concluded a collaboration protocol in 2012. It was agreed to promote the reduction of fat and sugar consumption at the national level to improve health population. In 2015, an Intervention Guide for healthy eating and

physical activity in kindergartens and schools was published, with the promoter of the National Institute of Public Health. “. The guide provides models and tools for carrying out actions in support of healthy eating and physical activity in kindergartens and schools (National Institute of Public Health Romania).

In 2017, the National television started the "Children with Weight '' campaign, which consisted of a series of reports broadcast in the news on 2 national channels, as well as debates. It involved organizing events designed to form healthy habits and counteract obesity. Also, the local television initiated a petition in 2017 to introduce nutrition classes in schools. In 2021, this petition has not yet been approved, at least not in the free education system (Last Hour – Independent Journal, 2017). In the online community in Romania, there are support groups to support the positive image of the body, even anti-diet clubs.

A simple google search, the phrase "obesity pandemic", gave 31 results. Articles published on blog pages claim that "Most public health experts believe that a sedentary lifestyle is the main culprit for today's obesity pandemic."

In a YouTube search, countless videos appear, entitled "why not be obese", "I'm fat, I eat a little - why don't I lose weight?" "Are you fat and beautiful"?

Dove, together with Nivea or other personal care companies, promotes body positivity in Romania with messages "your skin, your story". Fashion bloggers or content creators with followers over 23K were involved in similar campaigns; the messages were sent both visually and in the form of slogans - "everybody is a beach body".

On the other side of the barrier, in the online environment, there are opinion leaders who promote an image of a fit person, starting from an obese person, without describing and presenting the difficult path and the difficulties encountered. Local music promotes and offers weak / fit people as role models, and obese or overweight people are ridiculed visually and especially through discriminatory descriptive messages.

d) The Netherlands

Up to 2014, the Dutch population self-reported as overweight was lower in comparison with other EU countries. Though, obesity is continuously rising as in the whole world. Obesity rose from under 10% in 2000 to nearly 13% in 2014 (compared to 15.9% in the EU), which has important implications for health, contributing to diabetes, CVD and selected cancers. (OECD and World Health Organization, 2017)

In 2018, 16 per cent of all children and young people in the Netherlands aged 2 to 24 years were overweight. This applied to nearly one-quarter of young adults (18 to 24 years). Overweight is most prevalent among children and young people with a non-western migration background (25.1 per cent) and 18 to 24-year-olds (24 per cent).(CBS Netherlands, 2019)

A survey conducted from 2016 to 2018 demonstrated that even though 67% of young adults - aged 18 to 24 years were satisfied with their body weight, three in ten overweight young adults are not comfortable with their bodies. At 29 per cent, the share of overweight young adults with a negative body image is higher than among those with healthy body weight (5 per cent). Dissatisfaction is more significant among young women than among young men.(CBS Netherlands, 2019)

Main national recommendations, strategies and policies on weight bias, stigma, and discrimination

In the Netherlands, there are no specific strategies and policies for weight discrimination. However, there is generally a legal prohibition for discrimination. According to the Dutch constitution, since 2018, every person is in the Netherlands should be treated equally. Discrimination on the grounds of religion, belief, political opinion, race, sex, or any other basis is not allowed. The General Equal Treatment Act (Algemene wet gelijkebehandeling - AWGB) enclosed in the constitution provides that everyone should have equal opportunities for a job and good working conditions, education and training course or a particular service or product. The Awgb focuses on employers, schools, hospitals, shopkeepers, catering, gyms, insurers, and other goods or services providers.(De Rijksoverheid. Voor Nederland)

Partnerships and professional networks that work in nutrition, physical activity, and obesity

Through the desk research, no professional work was found around weight bias but only on the proper and healthier nutrition of the Dutch citizens and the reduction of obesity. Such programmes are as follows:

The Dutch National Institute for public health and the environment (RIVM):

One of the institute's activities is around the healthier nutrition of the Dutch citizens for better public health and to decrease the risk of premature death, cardiovascular disease, and diabetes. The institute runs guidelines on the healthier nutrition of the citizens with meals rich in vegetables, fruit, legumes, nuts, fish, wholemeal products, sufficient low-fat dairy products, and low consumption of red meat and processed meat products, alcoholic beverages and sugary drinks, salt, and saturated fats (Health Council of the Netherlands: Dutch Dietary Guidelines 2015). RIVM Centre for Healthy Living supports professionals working at companies, schools, and childcare centres in developing an integrated approach to healthy food.(National Institute for Public Health and the Environment Natherlands, 2020)

The institute participates in international research projects such as the Horizon2020 PROMISS project and SEAFOODTOMORROW. PROMISS aims to better understand and prevent malnutrition in older people, thus promoting active and healthy ageing. SEAFOODTOMORROW works on creating nutritious, safe, and sustainable seafood for the consumers of tomorrow. More international projects on food and nutrition, in which RIVM is involved, can be found in our global project database (International projects | RIVM). (National Institute for Public Health and the Environment Natherlands, 2020)

Since 2008, RIVM's Department of Nutrition and Health has designated WHO Collaborating Centre (CC) for Nutrition. The department supports the work of the World Health Organization (WHO) on health and sustainable diets and the prevention of chronic diseases. RIVM's activities in healthy nutrition contribute to SDG2 Zero hunger and SDG3 Good health and well-being. (National Institute for Public Health and the Environment Natherlands, 2020)

The Dutch Foundation on weight (NederlandseStichting Over Gewicht)

The Dutch Foundation on Weight works either with people who want to lose weight or with people who accept their body structure. They support a world in which people can feel free and comfortable with their bodies. Everyone, regardless of their body size, can organise their lives in

equal positions and opportunities. They attempt for a better quality of care, treatment, and guidance.(Nederlandse Stichting Over Gewicht, n.d.)

Amsterdam Healthy Weight Programme (AHWP)(Amsterdamse Aanpak Gezond Gewicht- AAGG)/ Health Equity Pilot Project (HEPP)

In the Amsterdam, Healthy Weight Programme is participating the Amsterdam Municipality and the Public Health Service of Amsterdam. The programme was initiated in 2013 by the Amsterdam Municipality to give every child 'a healthy childhood and future. The overall objective is to achieve a healthy weight for all children in Amsterdam by 2033. The project aims to create preventive measures by educating the community, children, and parents on healthy nutrition habits. The communities primarily addressed by the programme are vulnerable groups with low socio-economic and educational status.(Brookes & Korjonen, 2018)

Coordination mechanisms among healthcare professionals in treating people with overweight and obesity

There is no explicit reference on this topic. In the healthcare system of the Netherlands, every person is treated equally.

Social and cultural norms, awareness campaigns and media coverage related to stereotypical portrayals of people living with obesity

During the desk research, some awareness campaigns that were found are as follows:

Action group Political Fatties (Actiegroep Political Fatties)

This group of women have undergone fat shaming. These women created this group to raise awareness about Weight Bias and Fat shaming. An interview in NOS magazine was settled together with a promotional video. The article is available at this link.

Fat-Shaming Puts Extra Lives At Risk In Corona Time (Fat-Shaming Brengt In Coronatijd Extra Levens In Gevaar)

An article was created in One-world online magazine by the author MarjonMelissen, a member of the organisation Women Inc. This article incorporates the weight bias and the stigmatisation the author received and analyses the phenomenon. The report is available at the following link.

e) United Kingdom

Main national recommendations, strategies and policies on weight bias, stigma, and discrimination

There have been several obesity prevention and weight management policies, strategies, and initiatives in the UK, organised by both public and private organisations. Unfortunately, most of them have contributed to weight stigma and harmful stereotypes regarding people with obesity and overweight. A report by Beat, a UK eating disorder charity, published in 2020, suggests that public health campaigns in the UK increase the risk of eating disorders and make their symptoms worse (Treasure and Ambwani, 2021). According to the report, putting calories on menu or food labels can cause distress and encourage thoughts and behaviours related to eating disorders. Practices that focus on weight loss falsely promote thinness as an indicator of health and encourage dieting, an

ineffective weight-loss tool associated with several mental and physical health risks (Treasure and Ambwani, 2021).

In July 2020, the UK government published a policy paper on obesity ('Tacking Obesity') to target overweight and obesity during the COVID-19 pandemic. Organisations and individuals have criticized the report that it is reinforcing weight stigma and fatphobia. More specifically, the Obesity Policy Engagement Network (OPEN) UK published a response to the 'Tackling Obesity' saying that part of the strategy promotes harmful and stigmatising stereotypes without committing any funding or investment to support people with obesity. Additionally, according to the OPEN UK, the government strategy uses an oversimplistic approach towards obesity, ignoring its complexity beyond the advice 'eat less, move more'. An individual's weight is affected by a wide range of medical, socioeconomic, and psychological factors, therefore blaming the person for their weight it only increases stigmatisation (Flint, 2019).

Additionally, the language used in the public discourse is essential. In the Tacking Obesitystrategy, people with obesity are presented as a burden to the National Health System (NHS). The paper mentions that: 'we owe it to the NHS to move towards a healthier weight. Obesity puts pressure on our health service' and that 'tackling obesity would reduce pressure on doctors and nurses in the NHS, and free up their time to treat other sick and vulnerable patients.'That is a discourse that shames people, blames them for their health conditions, which are not always related to weight, and the problems that the healthcare system is facing. However, studies have shown that people with obesity due to weight bias in healthcare are more reluctant to seek medical care. They are more likely to cancel doctor appointments and delay preventative health services. (Amy et al., 2005). Additionally, the stigma and internalised shame that fat people experience when blamed and fatalised during the pandemic has negatively impacted their psychological wellbeing (Brookes, 2021). Therefore, such policies do not contribute to the well-being of people with obesity but even worsen their situation.

Part of the government's new obesity strategy is The Better Health campaign. The National Health System (NHS) and Public Health England (PHE) campaign encourages people to lose weight to reduce COVID-19 risk through a range of free tools and apps. This includes a free app that offers a 12-week weight loss plan.

According to the researcher's Talbot and Branley-Bell (2020), the Better Health campaign is problematic. The researchers point out that it does not consider the 'mental health and societal factors that contribute to the obesity' and that its focus on weight and its fat-shaming could deteriorate the mental health wellbeing of people with eating disorders (Talbot and Branley-Bell, 2020). Additionally, the fact that the campaign tools rely a lot on counting calories ignores the nutritional value of a variety of foods. At the same time, it can trigger eating disorder behaviours (British Association for Nutrition and Lifestyle Medicine, 2020).

Lastly, the campaign blames obesity for COVID-19 mortality rates. However, metabolic disturbances and their diseases (hypertension, type 2 diabetes, atherosclerotic cardiovascular disease and hypertriglyceridaemia) are associated with worse COVID-19 outcomes and not weight itself (Public Health England). Also, there has been evidence that being overweight poses a lesser risk to one's health in terms of mortality from infectious diseases than being underweight (Hamer et al, 2018).

To our best knowledge, there are no official strategies on weight stigma and discrimination.

Partnerships and professional networks that work in nutrition, physical activity, and obesity

As mentioned above, plenty of initiatives focus on obesity, nutrition, and physical activity. Unfortunately, few of them address the issue of fatphobia.

However, there have been important initiatives from charities and individuals to talk about the impact of weight stigma on people's wellbeing.

Some examples are:

Obesity UK has been speaking up about the impact of weight bias on the wellbeing of individuals. They state that their mission is to 'improve access to healthcare for individuals with obesity, increase awareness that obesity is a chronic serious medical condition, advocate for nationwide obesity prevention and treatment strategies, and fight to eliminate weight-bias and discrimination.'

The eating disorder charity Beat supports people with eating disorders and has pointed out the harmful impact of weight management and weight loss campaigns.

In 2020 on World Obesity Day, a team of experts led by Professor Francesco Rubino from King's College London published a pledge to end the social stigma of obesity. The pledge was endorsed by more than 100 medical and scientific organisations, including the British Dietetic Association.

At the same time some individuals are talking about weight sigma such as the fatdoctor UK, and NHS doctor that is advocating for a weight inclusive medicine.

Coordination mechanisms among healthcare professionals in treating people with overweight and obesity

The National Health System (NHS) system offers free weight management support. More specifically, NHS implements a 3-step policy regarding weight loss. In the 1st step, the General Practitioner (GP) offers 'lifestyle advice' to the patient. In the next step, if the patient is identified as 'morbidly obese,' they are assigned an advisor that offers non-surgical solutions (counselling, exercise programmes, medication, and support from a dietician). This step lasts for at least 2 years before the patient is referred to the Weight Management Programme (WMP); this includes personalised support. Bariatric surgery can be considered.

The NHS also has a weight loss app that offers a 12-week weight loss plan and is free to download.

Social and cultural norms, awareness campaigns and media coverage related to stereotypical portrayals of people living with obesity

People in larger bodies have been often portrayed in stigmatising and wrong ways in media that contribute to weight bias (Flint et al., 2018). People with obesity are usually presented as lazy, incompetent, and responsible for their weight and a burden to the healthcare system and society in general (Flint et al., 2018).

Unfortunately, healthcare settings are not exempt; problematic representations of obesity and people with obesity are prevalent in health campaigns. An example is the 2018 and 2019 Cancer Research UK obesity campaigns. The charity launched an advertising campaign intending to inform the public that obesity is a preventable cause of cancer. The message aimed at provoking fear and

shock to the public in order to create behaviour change saying that obesity is the second biggest preventable cause of cancer. However, according to the American Cancer Society (2019) research, 'The links between body weight and cancer are complex and not yet fully understood. For example, while studies have found that excess weight is linked with an increased risk of breast cancer in women after menopause, it does not seem to increase the risk of breast cancer before menopause.'

Furthermore, presenting obesity as the result of personal decisions is an oversimplified approach that ignores the complexity of obesity and contributes to stigmatizing people living with obesity (Varshney, 2020).

5. Affected persons

a) Greece

Access to services and goods

Many of the biggest hospitals in Greece have separate departments staffed by clinical nutritionists to treat obesity, which is open to the public. Moreover, "Laiko General Hospital" has created an outpatient clinic to treat obesity that is open on specific days and times per week. In addition, there are departments for childhood obesity in children's hospitals, such as the General Children's Hospital "Pan. & Aglaia Kyriakou". Nonetheless, the offered services for obesity are not evenly distributed among the country, and there are many areas where they do not even exist. As a result, there is often a vast waiting list that discourages patients from reaching out for help.

Subsequently, no referral system between healthcare professionals could efficiently enable a more holistic approach to treat patients with obesity. It is worth mentioning that most health professionals are not even aware that specialized public services do exist. Moreover, the specialized services themselves do not effectively disseminate their offered services to facilitate cooperation between health professionals.

Another critical barrier to utilising healthcare services is not enough time for health professionals to interact with patients appropriately. This can negatively affect the quality of service and lead to misdiagnoses and or poor treatment of obesity. Patients are not allowed to ask questions and discuss their worries. Time is also a key element for building trust between doctor and patient. Trust takes time and requires respect and empathy.

Research shows that many doctors use fear and shame as a "tool" to motivate people with obesity for lifestyle changes. They have the misconception that threatening their patients about the possible complications of obesity and even premature death can be helpful. However, no matter how well-intended this approach may be, it is harmful and can lead to the exact opposite effects and even deter people from seeking help or continuing to visit the doctor (SackettandDajani,2019).

According to a study (Silvistopoulou E., 2021), most doctors in Thessaloniki (the co-capital of Greece) stated that the main reasons that explain their patients' obesity are related to their personality traits, including lack of motivation and will, denial of their problem and inconsistency.

However, when they were asked about the general causes of obesity, they seemed to recognise that many more factors affect obesity, such as socio-economic and psychological. This perception is

confirmed by a national program designed to prevent and treat childhood obesity that runs in the outpatient department of General Children's Hospital "Pan. & Aglaia Kyriakou", which the name of this program "Lose Weight-Gain Life" can be stigmatizing and cause harm.

Excluded groups

Unfortunately, most of the services are offered mainly in urban areas, particularly in Athens and Thessaloniki (the capital and co-capital of Greece, respectively). There is an unequal distribution of resources across the country. Also, it has been suggested that people in lower socioeconomic status (SES) are more vulnerable to obesity, which their limited access to healthcare settings can partly explain. Cost is the main barrier to accessing healthcare in Greece, in combination with the limits on reimbursed consultations (State of Health in the EU, Greece. Country Health Profile 2019, European Commission).

b) Poland

Access to services and goods

The monitoring carried out by the Patient Ombudsman, which was inspired by the activities of the OD-WAGA Foundation, showed that the health service is not adequately prepared to care for people with obesity. Therefore obese patients (especially those with morbid obesity) have difficult access to health services. According to the data collected, there is insufficient dissemination of knowledge about the disease, an inadequate number of specialists, and shortages of equipment in facilities.

For this reason, the Program of comprehensive medical care for patients with surgically treated giant obesity was created. This programme will be implemented in 2021 as a pilot in several coordinating centres. The main objective of the pilot is to improve the quality and effectiveness of treatment of patients diagnosed with giant obesity. Under the programme, the patient will be provided with comprehensive care at all stages of treatment.

c) Romania

Access to services and goods & Excluded groups

Within the private sector, at Regina Maria Center is available the "Group Therapy for overweight or obese patients" (Perla Polyclinic Obesity Center) - the first and only obesity management centre in Romania accredited by the European Association for the Study of Obesity (EASO). According to the American Psychological Association (APA), people who attend group meetings to support those struggling with weight (group psychotherapy) are more successful. The support group is a reliable source of support, which helps patients cope with challenges without feeling lonely, allows them to experience interpersonal learning and receive honest and constructive feedback.
Techniques:

- Cognitive-behavioural strategies for cognitive restructuring
- Relaxation techniques and hypnosis
- Directed imaging techniques (Regina Maria - Private Health Network, 2021).

d) The Netherlands

Access to services and goods

In the Netherlands since 2006, the Health Insurance Act merged the public and private insurances in the healthcare sector. According to this Act, all residents (and non-residents who pay Dutch income tax) must purchase statutory health insurance from private insurers. Adults choose a policy individually (no family coverage), and children under 18 are then automatically covered. The range is mandatory, and every citizen has the right to change and make a contract with another private insurer. The insurers are also obligated to approve any citizen willing to acquire health insurance without any discrimination. (Wammes, Stadhouders, & Westert, 2020)

Through this act, the Dutch government wanted to tackle the phenomenon that citizens were left uninsured or paid considerable amounts in private insurers while others could not afford this opportunity. The national government is responsible for setting health care priorities, introducing legislative changes when necessary and monitoring access, quality, and costs in the country's market-based system. The uninsured citizens are fined. Active members of the armed forces (who are covered by the Ministry of Defence) are exempted.(Wammes, Stadhouders, & Westert, 2020)

Income taxes and government grants are collected in a central health insurance fund and redistributed among insurers following a risk-adjusted capitation formula that considers age, gender, labour force status, region, and health risk (based mostly on past drug and hospital utilisation).(Wammes, Stadhouders, & Westert, 2020)

In addition to statutory coverage, most of the population (84%) purchases supplementary insurance covering a range of services not covered by statutory insurance, such as dental care, alternative medicine, physiotherapy, eyeglasses and lenses, and contraceptives reducing co-payments for non-formulary medicines. The government and insurers do not regulate the premiums of this type of insurance can screen applicants for risk factors. This type of extra insurance does not provide higher priority and access to care of any kind, nor do they have increased choice among specialists or hospitals. (Wammes, Stadhouders, & Westert, 2020)

Services covered: The government determines the statutory benefits package, and health insurers are legally required to provide the standard benefits. The mandatory benefit package includes:

- care provided by general practitioners (GPs)
- speciality care
- hospital care
- maternal care
- dental care up to age 18
- prescription drugs
- physiotherapy up to age 18
- home nursing care

- a limited number of health promotion programs, including those for smoking cessation and some weight management advice
- primary ambulatory mental health care for mild-to-moderate mental disorders
- specialized outpatient and inpatient mental care for complicated and severe mental disorders.

Long-term care is financed separately from statutory health insurance.(Wammes, Stadhouders, & Westert, 2020)

Prevention and social supports are not covered by statutory health insurance but are financed through general taxation. The Public Health Act describes municipal responsibilities for national prevention programs, vaccinations, and infectious disease management. Municipalities can install additional prevention programs, such as healthy living and obesity reduction programs, but the provision of such services can vary widely from one municipality to another.(Wammes, Stadhouders, & Westert, 2020)

In 2013, the government decided to cover weight loss advice and smoking cessation programs in the statutory benefits package. Regarding overweight people or those with obesity, a combined lifestyle intervention (GecombineerdeLeefstijlinterventie - GLI) is created for their care. The GLI is aimed at a behavioural change to achieve and maintain a healthy lifestyle. Within a GLI, advice and guidance are given aimed at:

- healthy food,
- healthy eating habits,
- healthy exercise.

This intervention lasts two years and consists of group meetings and individual contacts. The number of group meetings can vary per program but is on average 12 times. In addition, there are 1 or 2 individual contacts with the care provider who provides the GLI.(Zorginstituut Nederland, n.d.)

Not everyone who is overweight is eligible for a GLI. The following insured persons can receive a GLI:

- Insured persons with a BMI over 25 and an increased risk of cardiovascular disease or an increased risk of type 2 diabetes.
- Insured persons with a BMI over 30. (Zorginstituut Nederland, n.d.)

The diagnoses whether a person is eligible for GLIcomes from a General Physicians. A GLI can be given by lifestyle coaches, dieticians, physiotherapists, and/or remedial therapists. They can deliver the GLI alone, but they can also collaborate and deliver the GLI. The GLI motivates the insured to exercise regularly outside the GLI. For the actual exercise, the insured person must take the initiative and match the possibilities in their environment as much as possible. The care provider of the GLI can help the insured find the way to these options. A fitness subscription, the sports club or sports clothing are not part of the reimbursement for the GLI from the basic package.(Zorginstituut Nederland, n.d.)

If someone receives care under the Long-Term Care Act (Wet langdurigezorg- Wlz)because of their obesity or overweight, the GLI can be part of this treatment. (Zorginstituut Nederland, n.d.)

Excluded groups

Every four years, variations in health accessibility are measured and published in the Dutch Health Care Performance Reports by the National Institute for Public Health and the Environment, focusing on socioeconomic differences such as ethnicity and education. Geographic or regional variation is not measured consistently.

Undocumented immigrants do not have permission to health insurance. They must pay by themselves for most treatments, excluding acute care, obstetric services, and long-term care. However, some mechanisms are in place to reimburse costs that undocumented immigrants are unable to pay. Political asylum–seekers fall under a separate, limited insurance plan. Permanent residents living in the Netherlands for more than three months are obliged to purchase private insurance. Short-term visitors are required to purchase insurance for the duration of their visit if they are not covered through their home country.(Wammes, Stadhouders, & Westert, 2020)

Some treatments, such as general physiotherapy, are only partially covered for people with specific chronic conditions. Some elective procedures are excluded, such as cosmetic plastic surgery without a medical indication, dental care after age 18, and vision care without medical representation. Many medical devices are covered, including hearing aids and orthopaedic shoes, but wheelchairs and other walking aids are excluded.(Wammes, Stadhouders, & Westert, 2020)

e) United Kingdom

Access to services and goods& Excluded groups

According to research conducted by the British Liver Trust in 2018, weight stigma is the most common form of discrimination in the UK. Data suggest that approximately 80% of Britons think that obesity is viewed negatively. Additionally, 62% believe that people are likely to discriminate against someone because of their weight. In contrast, the number is lower for other forms of discrimination (e.g., 56% for sexual orientation and 40% for gender).

Weight stigma can be manifested in all the aspects of an individual's life, such as interpersonal relations, work settings, or education. A recent report by the Institute for Employment Studies suggests that 54% of the women with obesity have to experience weight-related discrimination from their colleagues and 43% from their employers or supervisors. Furthermore, most British employers believe that obesity is a personal choice and can be treated by blaming the individual; they also view employees in larger bodies as lazy and less competent. This leads employees to feel isolated, ashamed, and powerless to address stigma at work as they lack support (IES, 2020).

Disappointingly, the healthcare system is not exempt from prejudice against people with excess weight and obesity, with patients reporting receiving poorer care and having worse outcomes. A 2012 study showed that physicians are a source of stigma for people with overweight or obesity, with 69% of study participants having experienced stigmatising behaviours from doctors and 46% from nurses (Puhl et al., 2012).

Weight-related discrimination in healthcare is harmful to individuals with obesity as they tend to be more reluctant to seek medical care. They are more likely to cancel doctor appointments and delay preventative health services such as routine gynaecological cancer screening (Amy et al., 2005).

Another issue in healthcare that is caused by weight stigmas the lack of appropriate equipment. According to a Guardian article (2016), hospitals fail to accommodate fat patients. Ten patients are refered to other facilities that can even be miles away as many hospitals lack the appropriate equipment. Additionally, a survey conducted by the Royal College Of Surgeons Of England showed that hospitals in the UK are not adequately prepared and equipped to support the best care possible for people with obesity. This is associated with worse clinical outcomes for people in larger bodies.

These hostile and uncomfortable conditions are perceived and received by individuals with excess weight. They may contribute to creating multiple and significant barriers to the utilisation of health services, excluding a large number of the population from getting proper and sufficient medical support.

Weight stigma is also associated with adverse psychological outcomes. People who are the target of weight-related discrimination are more likely to experience anxiety, stress, substance use, antisocial behaviour, poor body image, disordered eating practices, binge-eating, avoidance of physical activity, and even depression (Papadopoulos and Brennan, 2015 &Puhl and Heuer, 2010)

Overall, weight bias is a common form of discrimination in all aspects of a fat person's life, even in healthcare. It can significantly impact an individual's physical and psychological wellbeing, preventing them from receiving the care and support that they deserve.

6. Educational and training for health professionals working with individuals with obesity

a) Greece

Formal training and education in undergraduate and postgraduate programs

Medical Programs

In Greece, there are 8 Medical Schools. Their curriculum includes subjects that approach obesity as a metabolic disease. There is also a subject in the undergraduate curriculum of the Medical School in Crete, which educates students about the etiology, prevalence and different treatments of obesity, including dietary changes, exercise and bariatric surgery. Moreover, some master's degrees are available for health professionals, such as "Diabetes and Obesity" and "Nutrition for Health and Disease". In addition, there are available webinars and training courses about the etiology and treatment of obesity that may be organized by organizations, such as the Hellenic Medical Association for Obesity (HMAO) and the Hellenic Atherosclerosis Society (HAS). However, none of those address weight stigma or the importance of communication to support patients properly.

Dietitian Nutritionist Programs

In Greece there are 5 Universities of Science of Nutrition and Dietetics. Their curriculum has several subjects that address obesity, including pathophysiology, epidemiology and public health, biochemistry, nutrigenetics, nutritional treatment of pathological issues, dieting and obesity. Most of them focus on the etiology, prevalence and consequences of obesity from a biochemical perspective and suggest lifestyle changes (such as diet and exercise) as its essential treatment. Harokopio University of Athens also has an optional subject named "Counselling and Communication" which helps students develop communication skills and familiarize them with Cognitive Behavioral Therapy

and Motivational Interviewing. However, there is no reference to weight stigma, and no attention is given to the proper use of language to avoid stigmatizing people with obesity. Students are mainly trained to formulate diet plans for weight loss, a method that has been proven to be insufficient to treat obesity in the long term (Lowe MR et al, 2013).

Nursing programs

There are 10 Nursing Programs in Greece. The only subject that addresses obesity is Pathophysiology that approaches it as a metabolic disease.

Physical therapy and kinesiology programs

There are 5 Physiotherapy Departments in Greece, but there is no subject related to obesity or weight.

Psychology programs

In Greece, there are 5 Schools of Psychology. Although there are subjects that address the stigma of mental health, disabilities, there is no reference to the stigma of obesity. They also have a topic about Values, Beliefs and Attitudes. Moreover, Social Psychology talks about discriminatory behaviours, whereas Psychology of Health refers to behaviours related to health, including obesity.

Pharmacy programs

In Greece, there are 4 Departments of Pharmacy. The subject of Pharmacology teaches students about different medicines for the treatment of obesity.

Occupational therapy programs

There are 2 departments of Occupational Therapy in Greece. Their curriculum does not involve any subjects related to obesity or weight

Other programs

The “Empathize With Me, Doctor!” project is a promising initiative, developed by Vassilios Kiosses and IoannisDimoliatis of the Medical Education Unit at the University of Ioannina Greece, which offers an experiential training program to improve healthcare professionals’ empathy. Thephilosophy of this project is based on the Person-Centered Approach (PCA) founded by Carl Rogers and includes theoretical training about verbal and non-verbal communication. It is worth mentioning that the “Empathize With Me, Doctor!” project won the International 2019 Global Person-Centered Innovation Award during the International Conference on Patient-CenteredCare.

Non-formal and Informal training and education

“Beyond the shadow of dieting” is an innovative, psychoeducational approach which is conducted by the Center for Applications of Psychology that educates dietitians to help people with overweight or obesity discover the underlying factors that lead to weight gain and support them to change their attitude towards food. Both The Hellenic Association for the Study of Obesity, Metabolism and Eating Disorders and the Hellenic Medical Association for Obesity organize postgraduate seminars and conferences about obesity. Still, there is no reference to weight stigma and its detrimental effects on health.

There are also available web-based training courses about obesity in children and adults for healthcare professionals, including doctors, dietitians, psychologists etc. More specifically, there is a seminar that focuses on the psycho-dietetic approach of child obesity that considers many different aspects that contribute to the development of obesity, including socio-economic and psychological

factors. The training of this program is based on Cognitive Behavioral Therapy. However, the description of the educational program does not include any reference to weight stigma.

b) Poland

Formal training and education in undergraduate and postgraduate programs

Medical Programs

In Poland, there are 9 medical universities and 5 Collegium Medicum. There are also university faculties with a medical specialisation (The World Bank) and non-public universities with a medical specialisation (The World Bank). According to the Act of 20 July 2018. Law on Higher Education and Science, universities in Poland are public universities and are supervised by the minister responsible for health (Internetowy System Aktów Prawnyc). Analysing the curricula at universities in Poland, we can observe that obesity is quite common. For example, at the Medical University of Bialystok, programmes on obesity are conducted. And at the Pomeranian Medical University in Szczecin, we can find a course entitled 'Obesity - an interdisciplinary issue'. Apart from training institutions, there are also many medical programmes in Poland which aim to prevent and treat overweight and obesity. An example of such a medical programme is the 'Programme for Prevention and Treatment of Overweight and Obesity', which aims at people trying to regain control of their figure and do not know where to start (Lecznice Citomed Toruń).

Dietitian Nutritionist Programs

In the years 2007, education in the profession of dietitian with the current requirements was conducted on faculties such as: food technology and human nutrition and public health. Currently, education in the career of a dietitian is provided at the level of higher vocational studies on the faculty of dietetics. During the studies, subjects such as food chemistry, human anatomy, biochemistry, clinical psychology, internal diseases, paediatrics, nutrition in diabetes, food toxicology etc. are implemented.

In Poland, the profession and specialisation of a dietitian are still not widespread. However, year by year, society's awareness about a healthy lifestyle is increasing, so more and more people take advantage of the advice and services of dieticians. There are many courses for dieticians, one of them is "Obesity, causes, effects and treatment methods", which addresses issues related to obesity. Still, we have not found any information that would mention specialisations or courses associated with counteracting weight discrimination.

Nursing programs

The training of nurses in Poland takes place exclusively at universities, which is regulated by law. Nurses are required to undergo continuing education. According to the ordinance of the Minister of Science and Higher Education in Poland, at the studies in nursing, we will encounter such classes as primary health care, health promotion, nursing in long-term care, etc. We have not reached any materials that suggest training on weight discrimination in the nursing curriculum.

Physical therapy and kinesiology programs

In Poland, each physiotherapist has to belong to physiotherapist self-government whose organisational unit is the National Chamber of Physiotherapists - KIF (Villa Medica). There are many educational materials, e.g. at skuteczna-fizjoterapia.pl, where materials define the specifics of rehabilitation with overweight and obesity. In higher education, it is widespread to find a course related to obesity. For example, the Higher School of Pedagogy and Administration in Poznan

introduced "Obesity Therapy". The main objective of this course is to provide knowledge and practical skills in the fight against obesity. The participants can be graduates of all higher education institutions. However, it is mainly addressed to graduates of physiotherapy, physical education, pedagogy and psychology.

Pharmacy programs

In Poland, studies on the pharmacy faculty include lectures, seminars and exercises in primary and directional contents and internships.

The curricula of pharmacy studies include such issues as nutritional recommendations concerning the composition of food and the diet of people in the prevention of civilisation diseases, such as obesity. However, after analysing the data, we do not notice any training programme that refers to the prevention of obesity.

Other programs

World Obesity Day, 2018 - On 11 October 2018, we celebrated World Obesity Day. This global action aimed to draw public attention to the development of the pandemic disease of obesity. In 2018, the theme was the stigmatisation of people suffering from obesity.

Non-formal and Informal training and education

In Poland, there is a lack of training and education on weight stigma for health professionals who work with obesity daily within the health care system. Several programmes, as cited in the previous section of this desk research, but we did not reach information where specific training on tackling stigma and discrimination against obese people would be provided. This is why it is so important to empower health professionals to effectively deal with weight bias situations and equip them with public health and human rights skills and methodological tools. These skills and materials will undoubtedly identify these biases and highlight the problems associated with discrimination.

c) Romania

Formal training and education in undergraduate and postgraduate programs

In Romania, there is the Romanian Agency for Quality Assurance in Higher Education (ARACIS) which has the task of external evaluation of the quality of education offered by higher education institutions.

Medical programs

Romania has a number of 10 Universities of Medicine and Pharmacy. At a brief analysis of the curriculum at all universities specializing in general medicine, some subjects treat obesity as a chronic non-communicable disease, endocrinological diseases and diabetes. Still, the only subjects that represent the area of interest is medical psychology and communication with the patient, but the courses do not include communication with the obese patient. The course of communication with the patient involves only the communication of bad news with children, the elderly, the disabled, or the terminal patient's family. Some platforms ensure a continuous, optional education of doctors or health specialists on obesity or nutrition, all of which can be accessed online and are free, offering the possibility of effective communication, including for patients suffering from obesity. Courses

include "The Impact of Nutrition on Mental Health", Type 2 Diabetes and the Integrated Patient Approach and Communication with the Chronic Illness Patient.

Nutrition and Dietetics Programs

Regarding Nutrition and Dietetics, the specialization has existed in Romania for over 10 years, but with an exponential growth and a broader applicability. Under the undergraduate program, there are 8 faculties throughout the country. The study programs within the leading Universities of Medicine and Pharmacy address obesity, causation, symptoms, complications, and treatment, but unfortunately, the stigma part, discrimination, is not addressed in any form.

There is the possibility of integrating an optional course, both in the 5 years of medicine and in the 3 + 2 master's degree programs of a subject that summarizes an education of the future health practitioner for communication and behaviour with the obese patient.

Nursing programs

Regarding the training of nurses in the 4 years of study in Romania (higher education) there are subjects in the study program aimed at the literacy of future practitioners in obesity, endocrine or metabolic diseases. Education in the topic of interest is not applicable, but some subjects could include an intervention in the desired direction - Behavioral Sciences / Medical Sociology / Medical Psychology. The post-secondary training regime for nurses in Romania (3 years of study) is similar to the higher education system. Continuing education platforms are dedicated to nurses, with courses that include 'How can you improve the nurse-patient relationship in just 5 steps?' Or Proper communication with the patient? '

Physical therapy and kinesiology programs

Specialty available in 5 centres in Romania studies subjects in the medical field, including a subject called hydro therapy, which presents methods of managing motor problems because of obesity but the only subject that requires communication with the patient is only medical psychology, a subject that does not obesity is treated as a subject of stigma.

Psychology programs

In Romania, there are 17 training faculties in psychotherapy; the labour market provides a large number of specialists for the education of medical staff to stop the stigmatization of obese people. There are subjects such as social psychology or social cognition in the curriculum where discrimination is addressed, but not based on obesity because it is not considered a mental illness.

Pharmacy programs

In the 10 higher education units in which there is the pharmacy speciality, in the 5th year of study the communication of the pharmacist with the patient is taught. The topics covered are generally similar to the academic unit, general information, without addressing the stigma of obesity.

Other programs

Bariatric surgery -In Cluj Napoca - in the state regime, there are 3 clinics that perform bariatric surgery for patients with morbid obesity. Surgery 1, 2, and 3 and 2 clinics that perform the intervention in private. There are 3 other centers in Bucharest, 6 in Brasov and 4 in Timisoara and 1 in Constanta. There are no continuing education programs for physicians in the emotional treatment of patients with bariatric interventions.

Nutrition technician courses are nutrition education courses to serve family physicians, resident physicians, and nurses who want to enrich their information about nutrition in general and therapeutic nutrition in particular.

Non-formal and Informal training and education

Romania lacks non-formal and informal training and education on weight stigma for health professionals working with individuals with obesity through the health system. However, the World Health Organization is working in four distinct areas to tackle the stigma experienced by people with obesity and encourage others to join them. The healthcare professionals from our country can do training in this field only within non-governmental organizations or associations trying to fill the gaps and mismatches in the Romanian Healthcare System.

Healthcare professionals education (WHO)

To tackle stigma in healthcare settings, WHO is calling for better obesity education for healthcare professionals and running their own e-learning platform SCOPE (*Scope*). Many healthcare professionals say they do not feel equipped to treat patients with obesity. Patients with obesity have self-reported their doctors as being a key source of stigmatizing remarks and WHO believes that by providing and advocating for healthcare professional education on obesity, they can reduce stigma amongst this group, leading to better treatment for people with obesity, as well as instilling compassion for people with obesity that will trickle into the rest of our society (Puhl, R. M., & Heuer, C. A. ,2010).

d) The Netherlands

Unfortunately, during the desk research limited information on such training opportunities was found.

An educational platform target to healthcare professionals and relevant to overweight is created by the Dutch Centre for Youth Health (NCJ). The educational modules for healthcare professionals are available in the following link.

e) United Kingdom

Formal training and education in undergraduate and postgraduate programmes

Programme	Organisation	(Number of HE providers in UK)	Undergraduate (UG) or Postgraduate (PG)
Obesity Care and Weight Management	College of Contemporary Health	10	PG
Nutrition and Dietetics	University of Surrey	36	UG

Clinical Nutrition	University of Roehampton	19	PG
Obesity and Clinical Nutrition	UCL	N/A	PG
Physical activity, exercise and health	Leeds Beckett	N/A	UG
Nursing	The Open University	88	UG
Medicine	Keele	44	PG
Physiotherapy	University of Birmingham	66	UG/PG
Nutrition, physical activity and public health	University of Bristol	N/A	PG
Occupational therapy	Northumbria University	63	UG
Pharmacy	Newcastle University	52	PG

The table above shows that a limited number of higher education providers deliver weight management and nutrition courses on an undergraduate and postgraduate level, compared to other classes. Although many providers offer nursing and physiotherapy programs, they do not have a specific focus on weight management or weight bias.

With the exceptions of weight management and clinical nutrition programmes, all other courses do not include any mandatory modules on weight awareness and weight bias. Therefore, health professionals completing these courses may not meet these with an in-depth, academic understanding of weight bias experienced by people with obesity.

Non-formal and Informal training and education

Research found several non-formal and informal educational providers in the UK that cover training offered for health professionals working with individuals with obesity through the health system. For example, the Royal College of General Practitioners provides multiple courses relating to the practicalities and management of obesity and challenging stigma and promoting discussions around healthy weight. This is designed to encourage long-term, sustainable behaviour change that focuses on health-promoting behaviours rather than solely on weight loss.

The table below outlines some non-formal education providers, the type of support they provide and whether the training is local, national, global or online.

Organisation	Type of Support/training	Scale
HOOP UK Support (Helping Overcome Obesity Problems)	Facebook support group for obesity problems	National
Obesity Health Alliance	Coalition of over 40 organisations who have joined together to reduce obesity	National
National Obesity Forum	"Group of health professionals and specialists who are sickened by the appalling obesity epidemics in the country - particularly the one which affects children - and are determined to do what [they] can to reverse the situation."	National
University of Leeds	Clinical Nutrition short course	Local
Royal College of General Practitioners	Practicalities of Obesity Management	Online
WHO	Training course for nutrition, physical activity and obesity in primary care settings	Online
Obesity - e-learning for healthcare	Obesity Programme - "for practitioners in the NHS and local authorities working in weight management"	Online
World Obesity	Scope - Empowering healthcare professionals around the globe to provide the best possible care for patients with obesity	Online
Easo	Obesity Management Masterclass	Online

Royal College of General Practitioners	Management of Obesity and Overweight -Obesity? The time to TALK is now REWIND: Addressing stigma and building confidence in discussions around healthy weight.	Online

Gaps in the training of healthcare professionals regarding obesity issues are evident and emphasised in several reports, as listed below:

- Management of obesity: improvement of health-care training and systems for prevention and care:*University of Nottingham*
- The training of health professionals for the prevention and treatment of overweight and obesity: *The training of Health Professionals for the prevention*
- A Practical Guide to Engaging Individuals with Obesity: McGowan, B. M. (2016). *A practical guide to engaging individuals with obesity*.

The demand for training of healthcare professionals regarding weight bias is high, and several programmes are attempting to tackle this issue. It is primarily due to the lack of weight bias awareness training in formal courses such as nursing and medicine programmes, which means healthcare professionals are left to find additional non-formal courses to supplement their understanding. Such understanding is crucial when working with individuals with obesity and, if not properly understood, could lead to such problems as unintentional or intentional weight bias.

7. Appendices

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