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COMMENTARY

A Call for Weight Stigma Reduction in Physical Activity, Exercise, and Sport Settings

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Key Points

- Individuals with higher weight experience weight stigma, discrimination, and inequities in physical activity, sport, and exercise settings.
- We recommend incorporating lived experiences of individuals with higher weight in the design of programs and guidelines so that every *body* feels welcome, safe, included, and not intimidated in exercise settings.
- We recommend adopting person-centered goals linking exercise with overall health and wellbeing (instead of weight loss) and using upstream approaches to reduce weight stigma in exercise settings.

Experiencing stigma is a determinant of health and a fundamental cause of social and health inequities.[1] Weight stigma, known as negative attitudes and stereotypes towards individuals with higher body weight (eg, disliking people, believing people are lazy), and discrimination (eg, mistreating people) are major public health concerns. A multinational study reported that 50% to 60% of people with obesity have experienced weight discrimination in their lifetime.[2] Experiencing weight stigma is associated with several adverse mental and physical health outcomes,[3] and a higher risk of premature mortality (beyond body mass index).[4] Exemplified in the media during the Paris 2024 Olympics, some athletes competing with higher body weights were publicly ridiculed for their body size[5] despite their status as Olympians, as the best athletes in the world in their sport. Individuals with higher body weight are often treated unfairly and unequally compared with those with smaller bodies, whereby individuals with higher weight get inequitable access and opportunities to physical activity (PA), resulting in adverse physical, mental, and social health outcomes. Whether individuals with higher weight are Olympic athletes or are engaging in PA for enjoyment and/or for chronic disease management, weight stigma is a social justice issue[6] that must be addressed in all exercise-related contexts. In this commentary, we provide 3 suggestions to advance research, practice, and policy to address weight stigma and reduce the inequities experienced by individuals with higher weight in PA, exercise, and sport settings (referred to as "exercise settings" hereafter for brevity).

Increase Inclusivity of People With Lived Experiences

Individuals with higher weight are rarely showcased participating in healthy behaviors like PA in various types of media (eg, movies, magazines, news, websites, social media, images used in professional associations, etc).[7] Instead, individuals with higher weight are often portrayed negatively, engaging in unhealthy and sedentary behaviors, amplifying stereotypical beliefs that people with higher weight are lazy, inactive, and unintelligent. In health care, although including patient values and preferences are highly recommended in gold-standard methods for developing clinical practice guidelines,[8] the perspectives of people living with higher weight are not consistently represented in PA guidelines and position statements. For example, the American College of Sports Medicine recently published a consensus statement on the role of PA within the context of body weight regulation among adults.[9] Although the authors explicitly acknowledge that weight stigma could negatively influence how people with obesity feel about exercise and can be a barrier to participation, it was not mentioned if individuals with lived experiences of higher weight were included in the development of this guideline. Fitness environments have long been described as intimidating and unwelcoming spaces for people with obesity.[10] We suggest applying the principle "nothing about us, without us," a saying originally coined by disability activists,[11] inferring that no decision or policy should be made without including the perspectives of the very people affected by these consensus statements to help ensure that the terminology, imagery, and practical recommendations made are safe, sensitive to their needs, feasible, and implementable for individuals with higher weight.

Adopt Person-Centered Goals for PA

Efficacy trials of exercise interventions marginally reduce body weight, with many not showing a clinically meaningful reduction in body weight and sustained weight loss over time.[12] Despite this evidence, weight loss is often prioritized as a health outcome criterion for "success," which may impose unrealistic, unhelpful, and potentially harmful expectations from individuals with higher weight. Canadian evidence-based recommendations suggest PA as part of obesity management with or without weight loss,[13] acknowledging the limitations of promoting exercise to manage weight. Given the dramatic rise in more intensive obesity

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treatment options (ie, glucagon-like peptide-1 receptor agonists and bariatric surgery), more research is needed to examine exercise in combination with these treatments.[9] While consistent evidence shows that PA is a vital behavioral target that helps manage chronic diseases and improves health and well-being, continuously and purposefully promoting exercise for weight loss as a primary health outcome is not well-supported by evidence and can perpetuate harmful weight stigmatizing narratives. Promoting exercise for weight loss can reinforce the belief that weight is solely under our own individual control, and this belief is a strong predictor of having negative attitudes toward people with higher weight (ie, weight stigma). We suggest avoiding linking exercise prescription with generic weight loss goals (eg, 5%–10% weight loss). Simply prescribing exercise to achieve weight loss as the primary goal has been associated with mental health issues and reduced adherence to exercise recommendations.[14] Instead, goals should be person-centered, focused on promoting self-determined enjoyment of movement, and highlights benefits of PA even in the absence of weight loss (eg, improved mobility, fitness, energy, quality of life, and mental health).

Table 1 Examples of Interventions That Could Be Implemented to Reduce Weight Stigma in Exercise Settings, Organized Using the Nuffield Council on Bioethics' Intervention Ladder as a Framework[19,20]

	Intervention ladder actions	Examples of actions that can be taken in exercise settings to reduce weight stigma
	Restrict choice	• Mandatory university curricula and practical skills training on weight stigma for students training to become exercise specialists. • Mandatory educational and practical skills training on weight stigma provided by professional sports medicine organizations as a requirement for professional certifications. • Mandatory training on creating body-inclusive spaces for owners of exercise and fitness facilities. • Implementation of anti-weight-discrimination laws in exercise and/or fitness settings. • Implementation of evidence-based clinical practice guidelines to reduce weight stigma. • Mandatory person-first terminology (ie, "person living with obesity" rather than an "obese person") and positive imagery that avoids negative stereotypes of people with large bodies (ie, include images of people with large bodies walking on a treadmill rather than sitting on a couch eating fast food) in conference proceedings, websites, scientific journals, media, and promotional materials.
	Guide choice through disincentives	• Implement penalties for evidence of weight stigma in students' course/lab work (eg, professors could deduct grades) or among exercise professionals (eg, higher administration gives notification letters when they have observed weight stigmatizing attitudes or behaviors among their staff).
	Guide choice through incentives	• Offer awards (monetary, recognition certificates, or other) to recognize a student, a professional, or an organization's actions taken to reduce weight stigma and/or promote body inclusivity in their course/lab work or in their professional exercise or fitness work setting.
	Guide choice through changing the default policy	• Create evidence-based guidelines to prohibit weight stigma and discrimination in exercise and fitness settings. • Depict positive images of people living with higher weights engaging in physical activity in the media, in promotional material, in educational content and curricula, etc. • Physical activity, exercise and sport governing bodies and organizations can partner with and coproduce educational resources aimed to reduce weight stigma in exercise settings with people with lived experiences of higher weight, weight stigma research experts, national/international scientific and patient advocacy organizations that are leaders in body inclusivity and weight stigma reduction initiatives.
	Enable choice	• Modify the built environment and the exercise equipment available in exercise and fitness settings to safely and comfortably accomodate individuals of all body weights (eg, purchase equipment with higher weight capacity and greater widths of exercise benches, include chairs without arm rests, include larger sized blood pressure cuffs). • Offer more variety of options and sizes of exercise clothing to better fit people with large bodies.
	Provide information	• Embed education on the complexity of weight management and weight stigma in postsecondary exercise science curriculum. • Include specialized continuing education on weight stigma for fitness professionals (courses, workshops, webinars, podcasts, etc). • Include more representation of body shape and size diversity of individuals engaged in different types of exercise in different settings in public educational campaigns and in the media. • Offer professional development training sessions through webinars, conference sessions, and continuing education credits on weight stigma in exercise and fitness settings.
	Do nothing or simply monitor the situation	• Collect data through surveys on the prevalence of weight stigmatizing attitudes among exercise science students and professionals. • Collect data on the experiences of weight stigma in exercise and fitness settings among people with higher weight. • Do nothing.

**Note:* Actions closer to the top of the ladder/arrow imply more upstream broader public health approaches to address weight stigma in exercise settings. This framework implies that although more upstream top-of-the-ladder actions are considered more restrictive and infringe upon individual agency (eg, mandatory policies to reduce weight stigma), they tend to be more effective in changing behaviors (in this context to reduce weight stigmatizing attitudes and behaviors) than more downstream actions (closer to the bottom of the ladder; eg, educate about weight stigma) that tend to be less effective in changing attitudes and behaviors.

Apply Upstream Strategies to Reduce Weight Stigma in Exercise Settings

Weight stigmatizing attitudes are common among exercise science students and professionals.[15] Previous studies have shown associations between experiences of weight stigma[16] and reduced self-efficacy[17] with avoidance of PA and the negative impacts of weight-based teasing trauma in childhood/adolescence on PA over the long-term.[18] There are also concerns regarding accessibility, safety, and comfort for people with large bodies in exercise settings. For example, do gyms and fitness facilities have equipment that safely and comfortably support individuals with higher body weight (eg, higher weight capacity of treadmills, wider bike seats, benches and floor mats)? Using the intervention ladder as a framework[19] and guided by some of our previous work,[20] we propose several upstream actions that can be applied to reduce weight stigma in exercise settings (Table 1).

Summary

In conclusion, this commentary highlights the need to (1) incorporate the perspectives of people with higher weight in exercise interventions and guidelines; (2) adopt person-centered goals with aims of improving physical, mental, and social health (rather than weight loss); and (3) target more upstream approaches to reduce weight stigma in exercise settings to shape the future of more inclusive spaces that promote PA engagement for every *body*.

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