Cheshire & Merseyside Cancer Alliance

HEALTH EQUALITIES GROUP

Cheshire & Merseyside Cancer Alliance: Strategic Obesity Project

Report on Findings from Public Survey on Healthier Weight & Obesity

(October-November 2022)

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1) Background to Study

This study is one strand of an insight research package carried out during the first year (2022-2023) of the Strategic Obesity Project funded by the Cheshire and Merseyside Cancer Alliance. In addition to the findings gained from this public-facing survey, the project has also conducted six public-facing focus groups with residents in Cheshire and Merseyside, and a two-stage process of Stakeholder Insight interviews.

2) Objectives of Survey Study

The primary objective of the survey was to collect the opinions and ideas of adults (18+) based in Cheshire and Merseyside about their understand of living with overweight and obesity, and the extent to which they thought this is an issue for the region. A target of collecting a minimum of 250 responses was set for this study.

Secondary objectives of the survey were to collect ideas on policy change and direct interventions addressing rates of overweight and obesity, and measurement of public awareness concerning the association between overweight, obesity and cancer prevalence.

Geo-demographic data for participants was collected through the survey, including data on gender, age, employment status and ethnicity.

3) Methods

The survey questions were developed by staff from Health Equalities Group's Food Active team with additional input from CMCA and the project's steering group. Specific consideration was given in design of the survey to ensure the questions were relevant, easy to understand, and non-biased.

The survey was pre-tested using the Survey Monkey platform with members of the project steering group in order to gain final feedback ahead of administering the survey with the public. The final version of the survey included 16 specific questions (with accompanying logic routing), in addition to the geo-demographic data capture.

It was anticipated that the survey would take an average of 12 minutes to complete. Any responses from outside of the Cheshire and Merseyside region were discarded, with a minimum age of 18 and no upper age limit set.

4) Administration of Survey

The survey was hosted through Food Active's Survey Monkey account and was open for an 8 week period between 23 September – 25 November 2022. In order to gain responses, the survey was promoted by a wide range of partner organisations across Cheshire and Merseyside, including CMCA, NHS Provider Trusts, Champs Collaborative, and VCFSE partners. Social media post and Meta platform advertising was also used to boost interest in the survey.

5) Responders & Characteristics

Responses: The survey received a total of 327 validated responses between 23 September – 25 November 2022. A set of geo-demographic data was captured through a series of mandatory questions at the beginning of the survey with findings presented below.

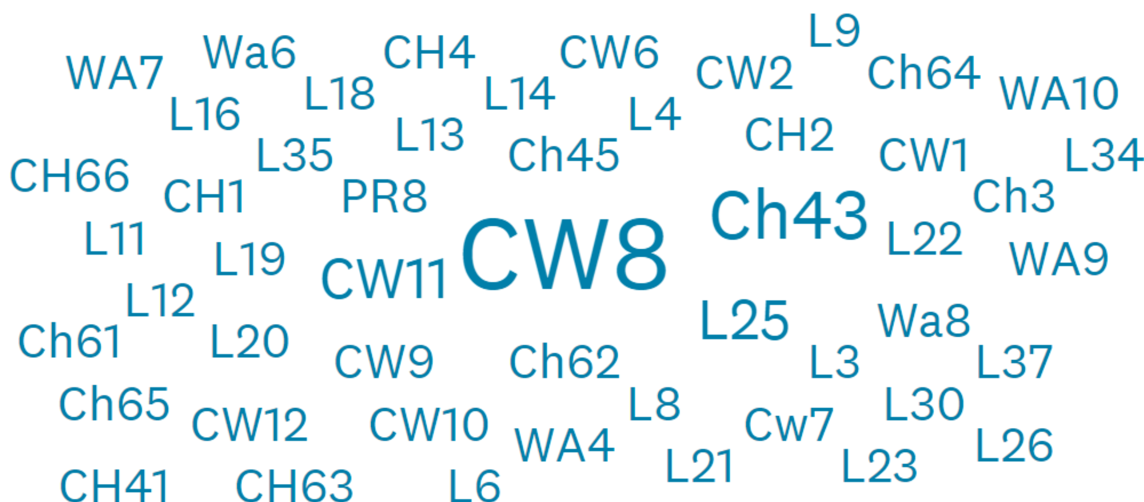
Gender: 91% (n=296) of responders identified as female, 8% (n=26) as male and 1% (n=5) preferring not to say

Age: The age group with the most responses (32%; n=104) was between 55-64 years old

18-24	25-34	35-44	45-54	55-64	65-74	75+	Prefer not to say
<1%	6%	9%	22%	**32%**	23%	7%	<2%

Above: Responder age ranges by groups

Geographical location: There was a relatively even spread of responders from geographical locations across Cheshire and Merseyside. The five postcodes with the highest number of responders were: CW8 (Northwich, CH); CH43 (Birkenhead, MER); CH44 (Wallasey, MER); CW11 (Crewe, CH); L25 (Liverpool, MER)



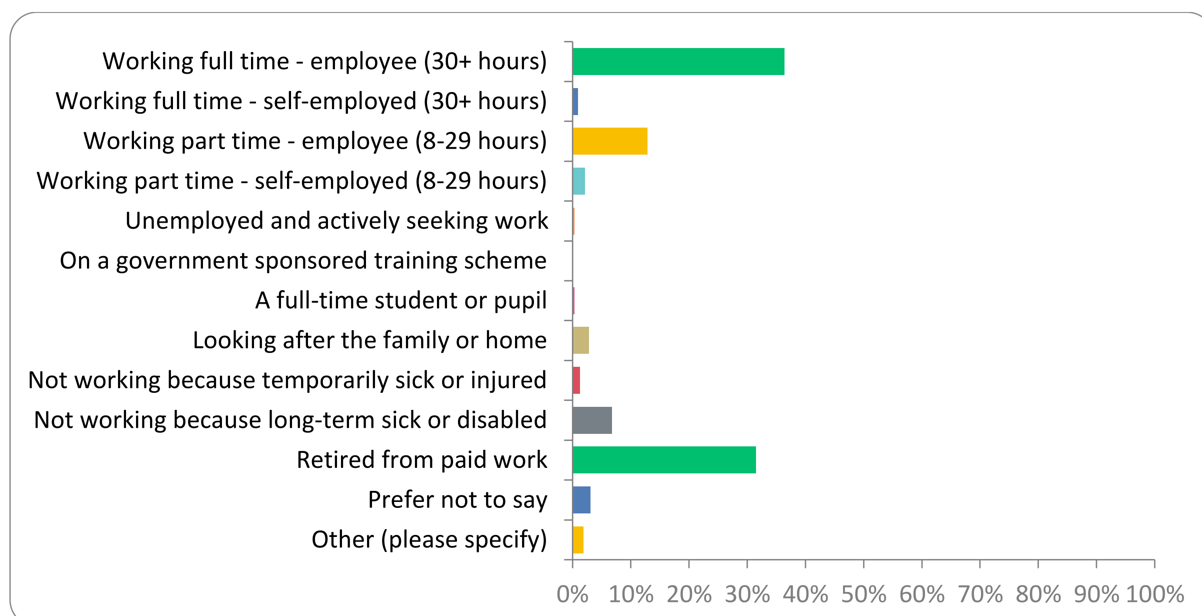
Above: Word cloud illustrating distribution of postcodes for responders.

Ethnicity: A majority of responders (93%; n=305) identified with being White British

White British	Asian/ Asian British	Black/African/Caribbean/ Black British	Mixed/ multiple ethnic groups	Prefer not to say	Other ethnic group
93%	<1%	<1%	<1%	3%	<1%

Above: Responder ethnicity by groups

Employment status: Responders were asked about their current employment status, with a majority (36.4%; n=119) working full-time, and 31.5% (n=103) retired from full-time work. Just one responder was unemployed and actively looking for work, whilst a total of 26 responders were not working because of sickness or disability.



Above: Summary of responder employment status

Parental status: The final data collected on characteristics concerned whether responders were the parent or guardian of one or more children *under* the age of 18. A large majority of responders (83%; n=270) were not currently a parent or guardian of one or more children *under* the age of 18, with 10% (n=34) currently a parent or guardian of one or more children aged between 11-17.

Yes (aged 0-4)	Yes (aged 5-10)	Yes (aged 11-17)	No
5%	8%	10%	**83%**

Above: Summary of parental status for one or more children under 18 years

6) Main Findings

Following the capture of geo-demographic data, responders were asked 16 questions concerning overweight, obesity and wider association with non-communicable diseases, including cancer. Some of the questions were accompanied by logic routing to allow for additional sub-questions, whilst some questions also asked for qualitative feedback through open text boxes. Not all questions in this section of the survey were mandatory to respond to.

6.1 Understanding of obesity

The first question in the survey simply asked: Do you know what obesity is? Unsurprisingly, a large majority of 99.08% (n=324) said they did know what obesity is, with 3 people responding that they didn't.

Responders who said yes were also asked to explain what obesity was using their own words. 305 people responded to this question, with a wide cross-section of definitions captured through the free-text box. Key themes and definitions are represented in the quotes from responders below:

"Being grossly overweight"

"Being overweight. Where your weight is higher than it should be to be in proportion to your height"

"A term used by the medical profession to shame fat people into thinking there is something wrong with them"

"Obesity is a multifactorial, complex and chronic disease"

"Carrying too much fat for your frame and height"

"Someone with obesity is at risk of a number of health issues"

"High BMI" & *"BMI over 30"*

"Carrying too much weight...which can lead to health issues like high cholesterol, heart issues etc"

"Unhealthy lifestyle choices – people need to take responsibly for themselves"

"I think it relates to a BMI calculation as opposed to a more qualitative formula"

6.2 Perceived prevalence of children living with overweight and obesity (National and Cheshire & Merseyside)

The second question assessed the *perceived prevalence* of childhood overweight and obesity at both national level (England) and sub-regional level (Cheshire and Merseyside). The question specifically wanted to investigate perceived levels of overweight and obesity in children owing to the more robust National Childhood Measurement Programme data set for children.

Participants were first asked what percentage of children under the age of 11 were living with overweight and obesity across all of England. A total of 33.22% of responders (n=101)

were of the opinion that approximately 30% of children under the age of 11 were living with overweight and obesity across all of England. Looking at the NCMP data for England as a whole published on 3rd November 2022, the estimated figure of 30% is lower than the figure of 37.8% of year 6 children living with overweight and obesity combined.

Approx 10%	Approx 20%	Approx 30%	Approx 40%	Approx 50%	Over 50%
3.62%	15.13%	**33.22%**	20.72%	15.79%	11.51%

Above: Estimated levels of children living with overweight and obesity across England

Participants were then asked what percentage of children under the age of 11 were living with overweight and obesity within Cheshire and Merseyside only. A total of 30.59% of responders (n=93) were of the opinion that approximately 30% of children under the age of 11 were living with overweight and obesity across all of England. Looking again at the NCMP data for Cheshire and Merseyside, the estimated figure of 30% is lower than the figure of 38.6% of year 6 children living with overweight and obesity combined.

Approx 10%	Approx 20%	Approx 30%	Approx 40%	Approx 50%	Over 50%
4.28%	15.79%	**30.59%**	22.70%	14.47%	12.17%

Above: Estimated levels of children living with overweight and obesity across Cheshire & Merseyside

It is worth noting that the above two questions resulted in responses that underestimated the actual levels of children living with overweight and obesity at both national (England) level, and at the sub-regional level across Cheshire and Merseyside.

6.3 Perception of one's own weight

Participants were asked whether, at the current time, did they consider themselves to be underweight, overweight, or about right? A total of 67% of responders (n=203) considered themselves to currently be overweight, with 25% (n=77) believing their weight was 'about right'.

Underweight	Overweight	About right	Prefer not to say	Other
>3%	**67%**	25%	>2%	>3%

Above: Perception of one's own current weight status

The next question then asked participants to consider whether they had either lived with obesity or experienced problems with their own weight. Again, a significant number of 61% of responders (n=184) believed that they had experienced living with obesity or problems with their own weight.

Yes	No	To some extent	Prefer not to say
61%	20%	19%	>1%

Above: Experience of living with obesity and/or problems with weight

Participants who answered yes to the above question were then asked whether living with obesity or having problems with their own weight had additional problems associated with physical and mental health and wellbeing, plus employment opportunities, ability to travel and self-esteem. Responders were allowed to select all additional associated problems that they felt applied to their own circumstances. A highly significant 83% of responders (n=198) believed that their self-esteem was affected, whilst 58% of responders (n=140) cited physical health problems, and 45% (n=109) experienced associated anxiety.

Self-esteem	Physical health problems	Anxiety	Depression	Social life	Personal aspirations & goals
83%	58%	45%	37%	33%	32%

Above: Experience of additional problems associated with living with obesity and/or problems with weight

6.4 Experience of others living with obesity and/or problems with weight

Participants were also asked whether they knew of family members or close friends that lived with obesity or had problems with their weight, either currently or the past. Once again, a significant proportion of responders (65%; n=197) answered yes, with only 21% (n=62) saying no.

Yes	No	To some extent	Prefer not to say
65%	21%	12%	2%

Above: Experience of others living with obesity and/or problems with weight

As with 6.3, participants who answered yes to the above question were then asked whether they thought that family members of close friends living with obesity or having problems with their own weight had associated problems. A highly significant 73.5% of responders (n=172) cited physical health problems, whilst 53% of responders (n=125) cited problems with self-esteem, and 35% (n=83) experienced associated depression.

Self-esteem	Physical health problems	Anxiety	Depression	Social life	Personal aspirations & goals
53%	**73.5%**	32%	35%	32%	23.5%

Above: Problems associated with obesity experienced by family members or close friends

6.5 Attempts to lose weight and reasons to lose weight

Participants were asked whether they had ever tried to lose weight since the age of 18. A very significant majority of 90% (n=270) replied yes, with 10% (n=31) saying no.

Responders who answered yes were then asked to select from a list of potential reasons as to why they wanted to lose weight and asked to pick any that applied to them. The reason that scored highest was because responders wanted to improve their overall health (73%; n=194), following by wanting to improve the way clothes fitted (72%; n=159), wanting to improve confidence (59%; n=159), and then wanting to be more physically active (57%; n=155).

I wanted to improve my overall health	I wanted to improve the way my clothes fit	I wanted to improve my confidence	I wanted to be more physically active	My weight prevented me from doing things I wanted to do
73%	72%	59%	57%	36%

Above: Reasons for wanting to lose weight

6.6 Media representation of overweight and obesity

The final question in this section of the survey asked participants whether they thought that people living with obesity are discriminated against by the media, for example, made fun of or joked about. The question revealed that participants thought the media does discriminate against people living with obesity at varying levels. The most common response from participants was 'sometimes' (47%; n=141), followed by 'most of the time' (27%; 81), and then 'always' (20%; 59).

Always	Most of the time	Sometimes	Rarely	Never	Other
20%	27%	**47%**	4%	>2%	>1%

Above: Does the media discriminate against people living with obesity

6.7 Effectiveness of policy change and direct interventions to address obesity

From this question onwards, the focus of the survey changed to capture opinions on how best to address the prevalence of overweight and obesity, and the association between obesity and non-communicable diseases.

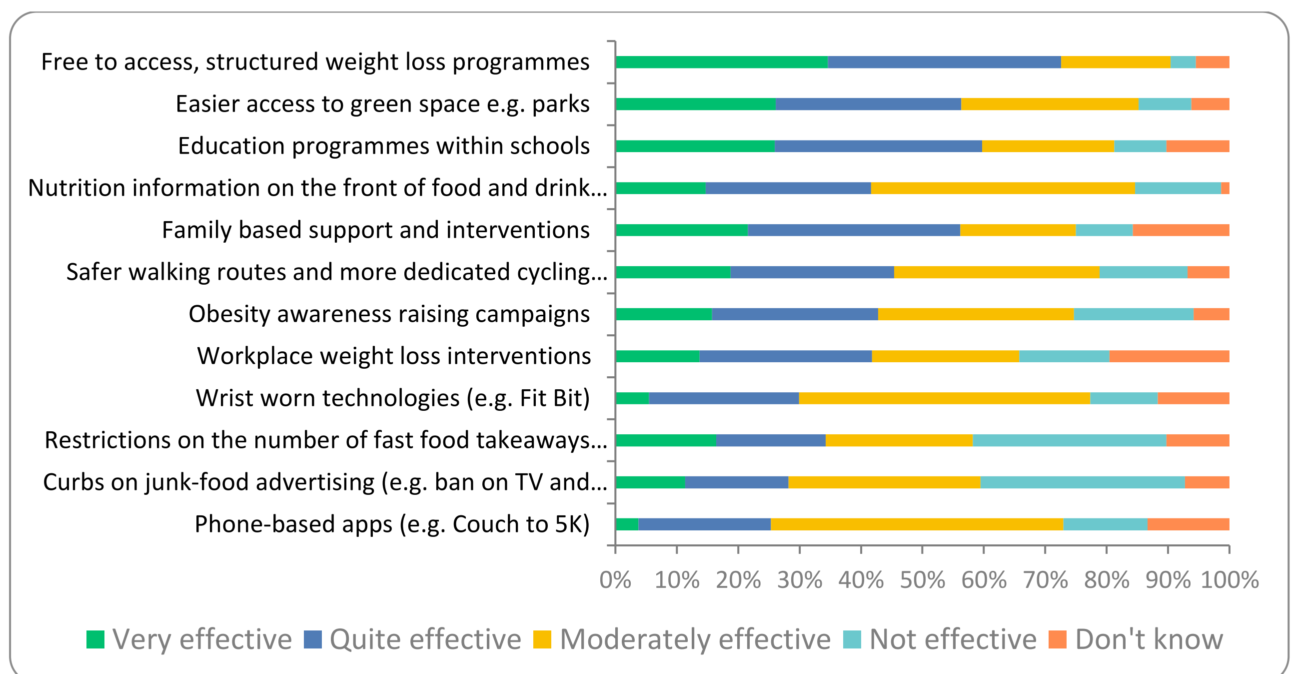
The first of these questions asked participants about the effectiveness of certain types of policies, direct interventions and public education programmes to address overweight and obesity across Cheshire and Merseyside. Participants were asked to rate the effectiveness of a list of 11 interventions across 5 categories: very effective, quite effective, moderately effective, not effective, don't know.

Considering the weighted average for each of the suggested interventions, the top two interventions cited as most effective of the 11 suggested interventions were:

- 1) Free to access, structured weight loss programmes (very effective 35%, n=101; quite effective 38%, n=111)
- 2) Easier access to green space (very effective 26%, n=76; quite effective 30%, n=88).

Considering the weighted average for each of the suggested interventions, the two interventions cited as least effective of the 11 suggested interventions were:

- 10) Curbs on junk-food advertising (not effective 33%, n=97; moderately effective 31%, n=91)
- 11) Phone-based apps (not effective 14%, n=40; moderately effective 48%, n=139)



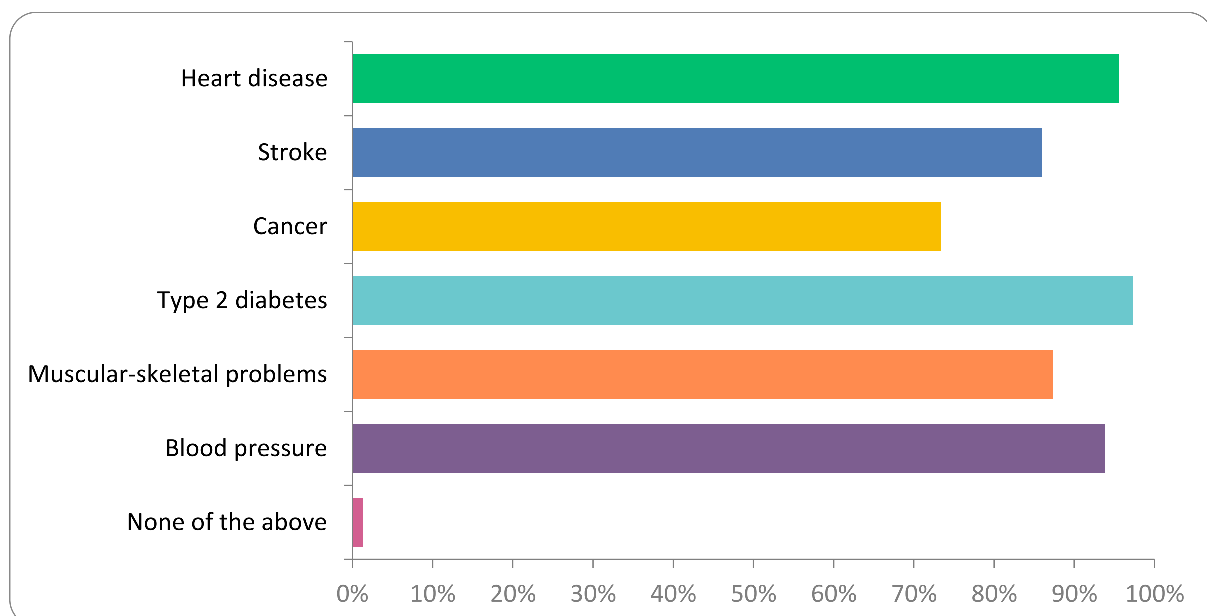
Above: Effectiveness of interventions to address overweight and obesity

In addition to the interventions suggested, participants were asked to include any additional ideas they had that could help to lower levels of overweight and obesity within Cheshire and Merseyside. Many of these ideas were covered by the type of interventions provided in the first part of the question, but there were a number of separate themes and interventions suggested by responders. A brief digest of these suggestions is compiled in Annex 1 of this report.

6.8 Association between obesity and other health conditions

Participants were then asked a series of questions about the links between living with obesity and other longer-term health conditions. The first of these questions asked participants which of the following long-term *physical* health conditions are associated with obesity: Type 2 diabetes, heart disease, blood pressure, stroke, muscular skeletal conditions, cancers, none of these. Participants were able to pick multiple options from the list.

Only 4 responders (1.37%) thought that obesity didn't have any association with the physical health conditions mentioned above. 97% of responders (n=285) correctly believed that obesity is associated with incidence of type 2 diabetes, whilst 96% of responders (n=280) also correctly believed that living with obesity an associated risk factor for heart disease. Only 73% of responders (n=215) correctly believed that living with obesity is a risk factor for certain cancers, whilst 1.37% of responders (n=4) believed there wasn't any association between obesity and additional physical health conditions.



Above: Perceived association between living with obesity and additional associated physical conditions.

Participants were then informed that living with obesity is linked to 14 types of cancer, including breast, bowel, uterus, oesophagus and kidney, and were asked to what extend they were aware of this association. Just under half of all responders (49%; n=143) answered 'Absolutely: I was aware of the association and links with certain cancers'. A smaller number of 37% of responders (n=106) answered 'Yes: I was aware there was an association, but no further details'. Finally, of particular significance for this project, 14% of responders (n=41) answered 'No: I wasn't aware of any link between obesity and cancer until now'.

Absolutely, I was aware of the association with certain cancers	Yes – I was aware there was an association, but no further details	No – I wasn't aware there was an association
49%	37%	14%

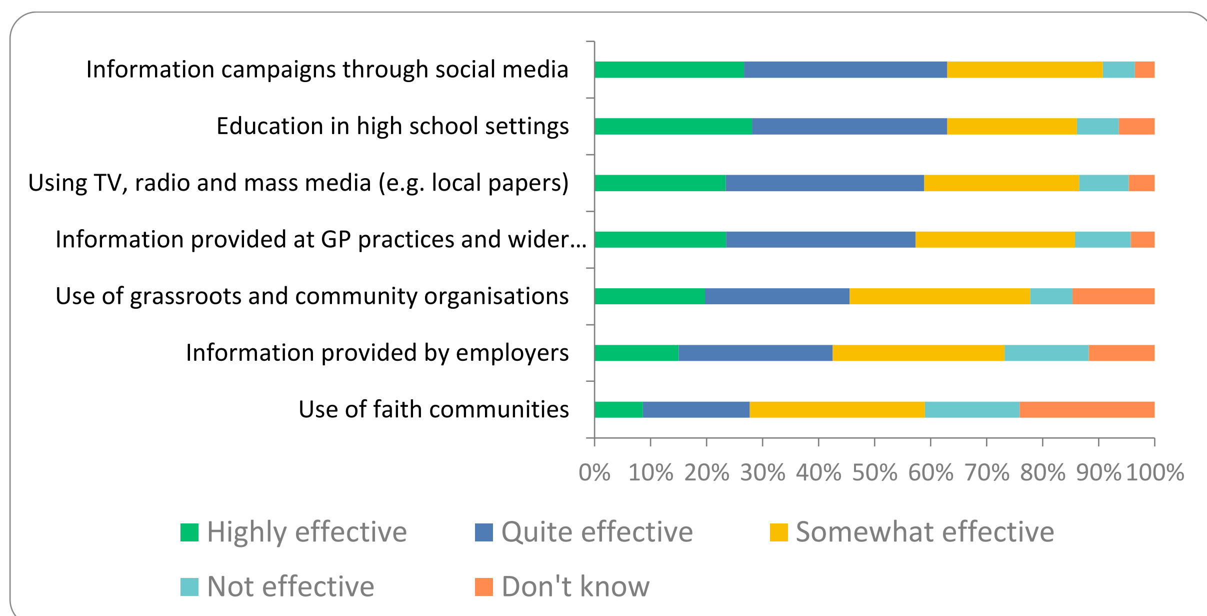
Above: Awareness of association between overweight and cancer prevalence

This section of the survey then asked participants whether they thought that there should be greater levels of education and information on the association between obesity and cancer? A total of 50% of responders (n=140) were of the opinion that there should be a lot more information sharing and education on the association between obesity and cancer, whilst 40% of responders (n=114) thought that further information would be helpful.

The final part of this section of the survey then asked participants about the best ways of informing communities in Cheshire and Merseyside about the association between obesity and cancer, and participants were asked to grade the effectiveness of seven suggested ways of communicating these messages, e.g. information campaigns through social media channels.

Considering the weighted average for each of the suggested communications techniques, responders cited information campaigns through social media as the most effective, with 27% of responders (n=75) responders grading this as highly effective, and 36% of responders (n=102) grading this as quite effective.

Conversely, responders graded use of faith communities as the least effective way to communicate messages on obesity's association with cancer, with just 9% of responders (n=24) responders grading this as highly effective, and 19% of responders (n=53) grading this as quite effective.



Above: Effectiveness of communications techniques to inform communities about the association between obesity and cancer

6.9 Final thoughts on overweight, obesity and association with cancer

The final question in the survey was qualitative in nature and asked participants whether there was anything else on the topic of lowering the prevalence of overweight and obesity, or the association between obesity and cancer, that they wanted to add that hadn't been covered in the survey.

This question garnered 85 responses from participants and covered a wide range of opinions and subject matters, including: prevention and early intervention, role of the NHS, influence of wider wellbeing and mental health, interventions to lower prevalence of

overweight and obesity, and a significant amount of feedback on weight stigma. The themes and quotes are group below:

Prevention & early intervention

“Any initiative has to be funded to support people long-term. Not "here's some strategies now get on with it" Ongoing reinforcement and encouragement is important too.”

“I'd like to see it as a safeguarding issue for families. And have a multi-disciplinary approach. I'd like to see active follow up by GP's with specialist nurses. With children I'd like to see training on how to recognise if a child is showing some signs of addition to food and health staff engaged in schools to actively work with children as a whole while monitoring the health and wellbeing of the children and families. I recall my own daughter school picking up that she was underweight (she had a health condition), so why aren’t we picking up on children who are showing signs of potential/actual obesity.”

“Don’t limit assistance to the high BMI ranges or diabetes. Provide help early on to prevent obesity.”

“Weight loss groups such as slimming world, weight watchers, Herbalife do not work for people with a long term weight issue because as soon as they lose weight and stop dieting they put weight and more weight back on that the weight they started at.”

“Earlier intervention on progress of weight gain would prevent more illness and save NHS money in long term. Waiting until the age of 60 to do regular health checks is too late. It is harder to change your lifestyle if the problems of joint pain and diabetes, heart disease etc have already set in. That in turn can lead to depression worrying about it all. I think there should be as much focus on this as there is on smoking. People choose to smoke and get free support to stop. When people gain weight, sometimes through medications, the support is not enough. Telling someone they need to exercise more is like telling a smoker to quit with no support.”

Initiatives to lower prevalence of overweight & obesity

“Education by Health visitors for new born children, and exercise programmes for new mums with dietary support on weight loss.”

“Nutrition & cooking should be a compulsory subject all the way through high school to teach kids how to cook nutritious meals.”
“Improvement to walking routes is urgently required, including many more pedestrian crossings, and more continuous cycle paths to prevent cyclists riding on footpaths, posing a risk to pedestrians. Cycling on footpaths should be illegal whether or not a cycle path is present. These measures would encourage walking as it would be safer. Also improvements to public transport so that longer journeys, part walking, part public transport are feasible.”

“Large posters in places where younger people go, hairdressers, nail bars, dress shops, keep telling them, show people like them keeping healthy. Doesn’t have to be a health centre or GP surgery.”

“Help children at least have one healthy meal a day whilst at school. People know a lot about what we should be eating. But it's hard financially now. Maybe cookery classes using slow cookers etc.”

“People need help with cheaper alternatives with food. Portion control. Free exercise programmes. Teaching home economics in schools with teachers that can actually cook decent healthy food. Home carers that can actually cook even if it’s only a poached egg, some can’t even do that. Making food look and taste appetising.”
“Teach folk cooking and nutrition. They don't know about the rubbish in processed food.”

Influence of wider wellbeing & mental health

“Focus on reasons why a person is overweight. Depression and anxiety are often overlooked and it is hard to control eating when a person has these issues. I find it harder to lose weight than I found giving up smoking because you can choose not to smoke but you always have to eat and plan meals but it means you think about food a lot.”

“I have been overweight for many years more so during the menopause. More info should be available for weight loss in menopause for women.”

“As more and more people are hard pressed for money healthy eating is going to get harder as is paid for exercise. Depression and other mental illnesses are also on the rise and with that comes the genuine inability to self-care which also includes eating well and exercising.”

The role of health professionals & NHS

“Being able to access a GP practice easily”

“Health care professionals need to be role models in the fight against obesity. A significant percentage of them are obese. This is highly problematic.”

“Ensure GPs/nurses/etc aren't snotty about it, they are there for education and to help, not to make you feel judged.”

Weight stigma and compassionate approaches

“Stigmatising fatness and fat people DOES NOT HELP ANYONE. I am of a normal BMI (22) but had a period where I rapidly gained 4 stone due a medication side-effect. During that time, every health complaint I had was designated a weight related issue. Having lost over 4 stone, those issues are now receiving appropriate attention. I deserved that attention when I was fat.”

“Unfortunately any comments linking obesity to any illness can be taken as "fatphobia" so any attempt at education needs to be done very carefully.”

“Sensitivity. Obesity is not always the fault of the person. Sometimes its genetic. Sometimes its medical. Sometimes it’s a mobility issue due to a mobility illness. Sometimes its all of them. So please, be sensitive in your approach.”

“I recall a Cancer Research UK billboard campaign about 'guess what is the biggest preventable cause of cancer after smoking' with the word obesity with a few letters missing from the word obesity. I hated this campaign. It was offensive to people like myself who have struggled with weight management for most of my life. It effectively shamed and blamed and it felt as though it was giving those without the condition to look at those who are obese as weak-willed people who don't care about their health. Obesity needs to be addressed for what it truly is - a condition that often develops alongside socio-economic deprivation. And

once you have the condition it becomes harder to get out of the cycle of weight loss and regaining weight. I hope any further campaigns that develop from your study will treat people with obesity with dignity, compassion and support."

Obesity and association with cancer

"I didn't know obesity can be associated with cancer."

"I'd like to see more research regarding cancer being a symptom of obesity and not obesity causing cancer. The narrative around the 2 conditions needs to be addressed. The stigma and bias that obesity is a choice but cancer isn't."

7) Conclusions and next steps

Data collected through this survey has provided significant insight into public knowledge and opinions on a wide range of topics relating to overweight, obesity and cancer. This data will be used in combination with the qualitative and quantitative data from Year 1 of the CMCA funded Strategic Overweight and Obesity Project to shape areas of concern and key actions for subsequent years of the programme.

Key learning and conclusions from the survey data are presented below:

- Almost all responders stated that they understood the concept of living with obesity, but there were a multitude of different definitions and subjective meanings that were associated with the term.
- Public understanding about the prevalence of overweight and obesity in young people under 18 (at national level and Cheshire & Merseyside) underestimates the actual prevalence of overweight and obesity by approximately 10%.
- Around two thirds of all responders believed they were currently overweight or had been overweight at some point in their life, and this caused associated problems with their self-esteem.
- 90% of responders stated that they had tried to lose weight at least once during their adult life, and the main reason given for this was to improve their health.
- Over 90% of all responders believed that people living with obesity are discriminated against by the media, with 20% of responders believing this was always the case.
- Responders believed that, from the suggested provided, the two most effective interventions for reducing levels of obesity were free to access, structured weight loss programmes, and easier access to green space.
- Just under half of all responders were substantially aware of the association and link between living with obesity and with certain cancers, whilst 90% of responders believed there should be further education and information on this link.
- Responders who wanted to see further education and information on the association between living with obesity and cancer believed that the most effective ways of

communicating this would be through social media messaging, and education in high school settings.

- Finally, the key subjects that were of concern to responders covered the following themes: prevention and early intervention, role of the NHS, influence of wider wellbeing and mental health, interventions to lower prevalence of overweight and obesity, and a significant amount of feedback on weight stigma.

Annex 1: Ideas for local interventions to address overweight and obesity suggested by responders in follow up to questions covered in Section 6.7

- Park exercise equipment
- Supermarkets stopping selling cheap sweets & cakes & selling cheap fruit & healthy snacks instead
- Parental role models are crucial. Parents teaching their children to cook meals, instead of relying on take aways.
- Prescription drugs, especially new drugs proven to work like Semaglutide
- Psychological support for emotional eating
- Easier access to counselling/therapies aimed at the psychology of eating as I think most people with weight problems eat when they aren't hungry e.g. comfort eating
- School education re obesity should start in primary school. School dinners should be more healthy.
- Feed all children a healthy school lunch for free.
- The wait times to get help are too long. Refer people to dieticians, psychologists and weight loss programmes more quickly.
- Access to budget cooking skills free exercise classes and health food at social supermarket or food bank
- Free or heavily discounted access to weight loss clubs such as slimming world or gym memberships for obese people. Not just for 12 weeks. When you have a lot to lose but can’t afford to attend such clubs it's so difficult to stay motivated.
- Healthy cooking programmes in primary schools. Lessons on detrimental junk food, sweets and choice.
- Weight loss mentors. Using recovery principles. 1 to 1 exercise support. Specific groups for people over 60 whom are very overweight

- More courses along the lines of NHS sponsored pre-diabetes programmes. Better food. Less processed rubbish. More benefits for the poorest to enable them to eat better.
- I think must not shame people at school or work, most people who are obese are very well aware of it. Rather than focusing on exercise and food packaging need to look at mental health support, low self esteem and things like anxiety and depression are the reason many are fat.
- Encourage businesses to work with community pantries and foodbanks to provide healthy options to poor with their zero waste fruit and veg. Provide free cookery lessons in the community and in schools to educate people how to cook from fresh.
- A better understanding from health professionals that “just lose weight” without any structured support isn’t easy with health conditions such as PCOS.
- A real attempt to offer CBT or other therapy to people with weight-loss issues, free access to gym's and pools.
- Reduce poverty, ensure people lived in decent accommodation and could afford to eat healthily and teach children from an early age to cook food from scratch.