Dead weight: an analysis of how obesity is dealt with in Brazilian legislation

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DOI: 10.21747/21833745/lanlaw/6_1a2

Abstract. *The objective of this study is to analyze Brazilian laws regarding overweight and obesity in order to understand how these two concepts, and the relation between weight and health, are construed through discourse. In order to do that, we rely on the 'Legitimation in Discourse' framework proposed by van Leeuwen (2007). The results indicate that Brazilian legislation defines obesity basically on the basis of the BMI and focuses on obesity as a result of inadequate individual choices, which is a reductive interpretation of a complex social problem.*

Keywords: *Legitimation, Legal Discourse, Brazilian Legislation, Obesity.*

Resumo. *O objetivo do presente trabalho é analisar leis brasileiras que tratam de sobrepeso e obesidade para compreender como esses dois conceitos e a relação entre peso e saúde são discursivamente construídos. Para tal, utilizamos categorias analíticas do modelo de 'Legitimação no Discurso', proposto por van Leeuwen (2007). Os resultados revelaram que a legislação brasileira define obesidade basicamente em termos do IMC. A legislação brasileira foca a obesidade como resultado de escolhas individuais inadequadas, o que expressa uma interpretação reducionista da complexidade desse fenômeno social.*

Palavras-chave: *Legitimação, Discurso Legal, Legislação Brasileira, Obesidade.*

Introduction

In 2010, Karsten Kaltoft, a Danish childminder, lost his job allegedly because of his weight. As this situation was not clearly covered by the Danish Law, in 2014 the European Court of Justice was asked to decide on whether or not obesity could fall under the definition of 'disability' and, therefore, if Mr. Kaltoft could sue his former employer for discrimination. The case[1] triggered great controversy in the media and in the legal community, and while some expressed positive opinions about the possibility of benefits and appropriate conditions for overweight people to function in society, others did not agree with the classification of obesity as disability, arguing it is self-inflicted and easily reversed through self-discipline and commitment.

Obesity has become a hot topic globally. The WHO published a fact sheet[2] on obesity and overweight, last updated in 2016, pointing out that worldwide obesity has nearly tripled since 1975; 39% of adults aged 18 years and over were overweight in 2016, and 13% were obese; most of the world's population live in countries where overweight and obesity kills more people than underweight.

On a national scale, a telephone survey on risk factors and protection for chronic diseases (Vigitel – Vigilância de Fatores de Risco e Proteção para Doenças Crônicas por Inquérito Telefônico)[3], carried out in 2017 by the Brazilian Ministry of Health, indicated that approximately 54% of the country's population was overweight, and 18,9% was considered obese.

Considering that obesity is seen as epidemic (James, 2008; Rigby *et al.*, 2006; Chopra *et al.*, 2002), and thinking about the legal implications of being declared 'obese' (such as in the Danish case mentioned above), in this article we investigate how Brazilian laws deal with the matter of obesity and obese people, focusing on the solutions and actions presented in legislative discourse, in order to understand how the relation between weight and health is construed and legitimated, and what representations it generates. Our position is not to dispute that overweight can become a health problem, but rather to question the necessary discursive conflation of overweight and lack of health, and the blaming of overweight people for their condition.

Theoretical background

Legitimation in discourse

In this study we are dealing with the discourse of legislation, a powerful and legitimate public discourse. As discourse analysts, we are interested in how legitimacy is constructed in the legislative representation of a specific social problem (in the present study, the fat epidemic). To carry out the analysis, we selected the framework for legitimation in discourse and communication proposed by van Leeuwen (2007), which sees language as the most important tool to establish and maintain legitimacy. There are four major categories of legitimation in the framework: *authorization*, *moral evaluation*, *rationalization*, and *mythopoesis*. These categories may be present in text separately or combined, and they can be both legitimizing and de-legitimize mechanisms.

Authorization concerns legitimation by reference to the authority of tradition, custom and law, and to people who have some kind of institutional authority. If we consider legitimation to be the answer to "Why should I do this?", the answer in authorization would be "because I say so", with no justification needed. This category may take the form of obligation modality, such as 'have to', of verbal or mental processes, such as 'believes' or 'claims', and the use of some adjectives and adverbs, such as 'mandatory' and 'compulsory'. In *authorization*, legitimacy may be provided by *personal*, *expert*, *role model* or *impersonal authority*, *the authority of tradition* and *of conformity* (van Leeuwen, 2007).

The key linguistic identifiers of *Moral Evaluation* are evaluative adjectives such as 'good/bad', 'desirable/undesirable', 'natural', 'healthy', and so on. However, most of the time, it is realized implicitly within discourses of moral value.

Rationalization is subdivided into two other categories: *instrumental rationalization* and *theoretical rationalization*. The first is related to legitimation by reference to the goals and uses of institutionalized social practices. In texts, it can be realized, for example, by

a purpose clause with 'to', 'in order to', 'so as to', etc.; in other words, "I do X in order to do Y". In the latter, legitimation is related to naturalization and, according to the author, to whether the practice 'is founded on some kind of truth, on *the way things are*' (van Leeuwen, 2007: 103).

Mythopoesis is legitimation conveyed through narratives with outcomes that reward legitimate actions and punish non-legitimate actions; in other words, it is legitimation achieved through storytelling. There are two subgroups in *mythopoesis*: *moral tales*, in which protagonists are rewarded for engaging in legitimate social practices, and *cautionary tales*, which explore what happens when one does not conform to social norms.

Critical studies on weight and body representation

Until the end of the 20th century, the matter of weight was mostly investigated within health-related disciplines, but in the 21st century a more interdisciplinary approach to weight appeared, ranging from psychological, sociological, political and economic perspectives, to literary, cultural, film and media studies (Rothblum, 2011). Fatness and obesity are words often used interchangeably, and express concepts of unhealthiness and lack of value in individuals, usually isolated from cultural and social contexts. McCullough and Hardin (2013) argue that a critical analysis of fat and obesity exposes "culturally located morality discourses woven into concepts and beliefs about fatness, including the belief that all fat equals ill health. It is hard to imagine something of value and beauty in fat." (p. 5)

Although recognizing that defining concepts and ideas is not a simple task – it is in fact a political choice – McCullough and Hardin (2013) understand obesity as a medical term, while fatness is read as a political label with distinct meanings, such as simply weight, a negative evaluation of individuals, and even a term activists use to promote body positivity. Both terms (fatness and obesity) are, therefore, culturally, politically and socially located.

The WHO defines overweight and obesity as "abnormal or excessive fat accumulation that may impair health."[4] In order to indicate whether a person is overweight, physicians around the world have been using the BMI (Body Mass Index). The BMI is a measure of weight relative to height, and encompasses different degrees of overweight. The average adult should have a BMI between 21 and 23 kg/m^2 to be considered healthy, but, according to the WHO, one should aim at a BMI between 18.5 to 24.9 kg/m^2. To be considered overweight, an adult has to have a BMI superior to 25 kg/m^2, whilst obesity starts when the line crosses 30 kg/m^2.

Even though the WHO itself claims that "it should be considered a rough guide because it may not correspond to the same degree of fatness in different individuals"[5], the BMI remains the go-to tool for overweight and obesity diagnosis. According to Eknoyan (2006), obesity experts agree that the BMI is not an effective measure used on its own since it does not account for other physical aspects such as body fat and waist circumference – which has been recurrently linked to heart diseases and diabetes. For instance, the British National Health Service (NHS) claims that the risk of certain health problems is affected by where people's body fat is stored, as well as by their weight. Carrying too much fat around the waist can increase the risk of developing conditions such as heart disease, type 2 diabetes and cancer. As the NSH asserts in their site, "You can have a

healthy BMI and still have excess tummy fat – meaning you're still at risk of developing these diseases"[6].

Although we can find countless statistics and figures on obesity and overweight around the world, there seems to be much less discussion on the social, political, economic and emotional origins and implications of being obese or overweight – both for those individuals who try to lose weight and those who do not. Unfortunately, these statistics are many times used to reinforce the idea that "fat is an unacceptable stigma to target, as well as portray fat and fat people as blameworthy and unhealthy [...] The medicalization of obesity, combined with ideas about the questionable moral status of fat and fatness, saturates social life" (McCullough and Hardin, 2013: 2).

People who are overweight and obese are frequently faced with restrictions when dealing with everyday life. They are monitored with regards to what and how much they eat, what they wear and how they behave, and are often disqualified and marginalized based on the amount of fat in their bodies.

The data

As stated before, this article aims at investigating how Brazilian laws concerning obesity and obese people relate weight and health, and in doing so how they construe legitimacy in their discourse.

To find and collect the Brazilian laws, we searched the law database Jusbrasil[7] in March 2016. For this study, only the results for laws and decrees containing the keyword 'obesidade' were analyzed.

Table 1 - Results from Jusbrasil

Keywords	Results by Level of Government			TOTAL
	Federal	State	City	
Laws addressing '*obesidade'*	**0**	**20**	**131**	**151**
Decrees addressing '*obesidade'*	**1**	**3**	**8**	**13**
Complementary Laws addressing '*obesidade'*	**0**	**0**	**5**	**5**

The laws and decrees returned from the search for the keyword 'obesidade' were categorized in eight different themes or types, as shown in Table 2.

Table 2 – Groups of Brazilian Laws and Decrees

Groups	Number of Laws and Decrees
Group 1: Calendar	49
Group 2: Programs and Policies	48
Group 3: School	15
Group 4: Treatment	7
Group 5: Accessibility and Inclusion	14
Group 6: Discrimination	1
Group 7: Physical Activities	3
Group 8: Others	27
TOTAL	164

Analysis and discussion

In this section, we describe and analyze the Brazilian legislation regarding obesity, discussing which legitimizing strategies were used. All the examples are numbered in-between brackets, according to the order they are mentioned (e.g. [1]), and the words and phrases that directly exemplify what is being discussed are underlined. The legislative power which produced each law is also indicated, and the original text in Portuguese can be found in the endnotes.

Some choices in discourse, such as levels of formality, pronouns and clausal mood, expose social and power relations among participants, reflecting their social roles, positions and relations. The selected Brazilian laws are, as expected, of a very formal tone and mainly imperative, written either in the simple future or simple present tenses. There is also some use of modality, primarily in passages describing what can be done in events related to the prevention and combat against obesity, and who can be invited to organize and define such events, as in example 1.

[1] Law 2319, of 17 November 2006 – Council Chamber of Timbó/SC

> [...] Art. 5º Doctors, nutritionists, psychologists, nurses, teachers and other health professionals, as well as people with knowledge in areas related to obesity, **might be invited** to participate in the definition of informative and educational procedures and in the organization of events related to the [Fight Obesity] Week.[8] [...]

In terms of semantic fields, variants and synonyms of the words 'control' and 'discipline' are frequently used, in keeping with the view that individuals should self-discipline themselves, and also that the Law and the State play a role in this disciplinary process, participating in the way the community members deal with their own bodies – the State, sometimes represented by other entities such as schools, should monitor and control obesity and obese individuals, as we can see in example 2.

[2] Law nº 6476, of May 02 2006 - Council Chamber of Presidente Prudente/SP

> ESTABLISHES THE CITY PROGRAM FOR THE PREVENTION AND CONTROL OF OBESITY IN CHILDREN AND ADOLESCENTS [...]
> Art. 3º - The actions targeted at the prevention and **control of obesity** in children and adolescents in public health services will include, among others: [...][9]

In the corpus, the laws categorized under *Group 1* established specific days, weeks or months of the year to be part of the official calendar for campaigns and activities targeting obesity, all of them focused on teaching the population about the dangers of obesity, so that family and individuals can exert group or self-control:

[3] Law nº 2319, of November 17 2006 - Council Chamber of Timbó/SC

> [...] Art. lº – [The present law] establishes the Week for the Fight and Prevention of Child Obesity, to take place annually in the week of the 11th of October, which is the Global Day Against Obesity.
> Art. 2º – The Week for the Fight and Prevention of Child Obesity aims at raising the awareness and orienting the population, through informative, educational and organizational procedures, about the evils of child obesity, its causes, consequences, and ways of preventing or treating it. [...] Art. 4º – The city government, through the Education, Culture and Health Secretaries, is authorized to set and organize schedules of activities to be developed during the said Week.[10]

Group 2 includes laws that establish different programs and policies related to obesity and the obese. Similarly to the Calendar group, these laws do not clearly design the structure of each program; rather, in most cases they transfer such responsibility to lower levels of management, such as schools and the community.

By making partnerships and delegating the control of campaigns to lower administrative levels, the law does not take on the role of disciplining and monitoring bodies exclusively on itself. This can be understood as legitimation in terms of *institutional authority* and *expert authorization*, since the responsibility is assigned by the legislators not to anyone, but to public authorities, such as state and municipal governments, and to health experts.

[4] Law nº 5196, from March 05th 2008 - Rio de Janeiro State Government

> [...] Art. 1º. The state government is authorized to establish a **Program to Fight Obesity among Public and Private Schools Students**. [...]
> Art. 3º. Once registered in the program, **the student will be evaluated** and, if obesity is diagnosed, **they will get free medical assistance and treatment**.
> Art. 4º. **The State Secretary of Health will be in charge of indicating specialists in the topic for the development and implementation of the program**.
> [...]
> Art. 7º. The health professionals that will assist the student in treatment will invite parents or legal guardians to, on previously set dates, attend **educational lectures**, so they can give and receive information essential to the success of the treatment.[11] [...]

Seventy two laws contained the expression 'fight *obesity*' ('*combate/r à obsesidade*'), as in example 5, and forty nine laws created special events and programs tackling obesity, as in example 6. The majority of them establish that state and city governments have to organize events to inform about, prevent and treat obesity.

[5] Law nº 12.283, from February 22nd 2006 – São Paulo State Government

> [...] Art. 1º – [The present law] establishes the Policy to **Fight Obesity and Overweigh** in the State of São Paulo, entitled "Lighter São Paulo", with the aim of implementing **effective actions to reduce weight and fight obesity**, both in adults and children, and **morbid obesity** in the population of São Paulo.[12]
> [...]

[6] Law nº 3433, from June 30th 2000 – Rio de Janeiro State Government

> [...] Art. 1º – The state government is authorized to implement, at state public hospitals, **programs for the prevention and treatment of obesity** and its resulting diseases, as well as **nutritional guidance**.[13] [...]

The Brazilian laws that define obesity do it based solely on the individual's BMI. These definitions do not specify what other aspects or conditions make a person obese, apart from the index. In fact, from the 164 texts, only ten include a definition of obesity (see examples 7 and 8), all of them based on the WHO's recommended measurement of obesity, the BMI (see example 7). Again, our point here is not to dismiss the BMI as a health factor, but to argue that it cannot be considered completely accurate diagnostically, as the WHO itself points out. However, that is not the understanding of the Brazilian legislation:

[7] Law nº 5038, from June 06 2007 – Rio de Janeiro State Government

> [...] Single paragraph – **According to the WHO** (World Health Organization), **morbid/grave obesity is understood as a BMI (Body Mass Index) the same or higher than 40 Kg/m^2**. Morbid/grave obesity is seen as a disease caused by several genetically related factors, producing a significant increase in clinical, psychological, social, physical and economic diseases.[14] [...]

[8] Law nº 3196, from February 22nd 2010 – Council Chamber of Sapucaia do Sul/RS

> [...] Art. 2º – For the purposes of the present law, **a person is considered obese if they reach a body index-BMI the same or higher than 35 Kg/m^2**.[15]

By relying on the WHO's definition, and basically on the BMI, the Brazilian legal system is referencing, again, the *authority of institution* and its role as a source of expert information, carrying a sense of legitimation both from tradition and science. However, the legislation makes use of only one voice of authority and expertise, and one single index, which makes the few definitions present in the Brazilian legislation reductive of the complexity of obesity as a health problem.

Group 3 included laws regarding nutrition and food in school environments. These laws range from listing what types of food and drink can be sold inside schools (see example 9), to determining that schools should provide specific foods to students who have special nutritional needs, such as diabetes and high blood pressure.

[9] Law nº 4508, of January 11 2005 – Rio de Janeiro State Government

> [...] Art. 1º – **It is forbidden to sell, buy, produce or distribute products which contribute to child obesity**, in cafeterias located in public and private schools in the state of Rio de Janeiro.
> Art. 2º – **The following products are included under article 1**: crisps, sweets, chocolate, jelly beans, chewing gum, lollypops, caramels, powder juices, soft drinks, [...] food products with more than 3 (three) grams of fat in 100 (a hundred) kcal of the product, with more than 160 (a hundred and sixty) mg of sodium in 100 (a hundred) kcal of product, food products that contain artificial dyes, additives or anti-oxidants (observing the nutritional information in the package), or food products without labels, nutritional composition and expiration date.[16] [...]

There are seven laws under the *Treatment* category. The general content of these laws is to establish that obese people have the right to free treatment for their disease (see example 10). Very few of the laws in this group specify what exactly the treatment should include, except dieting and surgery. This indicates that the discourse of the law focus on obesity as a matter of personal choice, of whether or not to eat healthy and exercise properly.

[10] Law nº 1799, of October 30th 2003 –Council Chamber of Tijucas/SC

> **ESTABLISHES THE OBLIGATION OF FULL CARE TO PREVENT AND TREAT OBESITY**, IN THE SCOPE OF THE MUNICIPAL HEALTH SYSTEM [...]
> Art. 1º – the municipal health system will offer **full care to prevent and treat obesity**, and will include an **educational program** to give patients information on obesity, **diet recommendations** and the necessary measures to avoid the complications of the disease.[17] [...]

Except for dieting, information on obesity prevention is given in vague, general terms. Forms of treatment of the disease are even less explored. All the laws highlight that there should be treatment and that it should be offered free of charge by the government; however, in most laws there is no further specification of what this treatment should include, apart from dieting, as in examples 11.

[11] Law nº 3433, of June 30 2000 – Rio de Janeiro State Government

> [...] Art. 1º – **The State Government is authorized to implement**, at the state hospital system, **a program about the prevention and treatment of obesity and its connected diseases**, as well as nutritional orientation. [18] [...]

Nutritional counseling is mentioned several times as part of the treatment, as well as part of prevention, in terms of 'appropriate' and 'safe' eating habits (see example 12).

[12] Law nº 12.283, of February 22 2006 – São Paulo State Government

> [...]
> I – promotion and development of inter-sectorial programs, projects and actions that implement, at the state level, the universal human right to adequate **food and nutrition**;
> [...]
> IV – the promotion of: a) awareness campaigns to offer basic **information on adequate eating**, through informational and institutional materials;
> [...]
> V – the capacity building of civil servants who work directly with the population, enabling them to become full disseminators of **food and nutritional safety**;
> VI – the integration of state and federal policies for **food and health safety**[19];
> [...]

Nonetheless, there are no specifications as to what are considered 'healthy' or 'adequate' eating habits. Although specialized medical treatment is mentioned, the course of treatment that is more clearly stated in these laws is surgery (bariatric and/or other surgical techniques) and follow-up medication. Nine laws attest that surgery is one of the rights of obese people, as in example 13.

[13] Law nº 8615, of July 11 2003 – Council Chamber of Belo Horizonte

> [...]
> Art. 2º – To the purposes of the present law, **the state government will guarantee to the carrier of morbid obesity**:
> I – diagnosis and clinical evaluation;
> II – specialized medical assistance;
> III – **access to bariatric surgery**;
> IV – **single waiting list to the surgical procedure**, managed by the city council;
> V – **post-surgery assistance**;
> VI – **free access to medication aimed at carriers of morbid obesity who have undergone bariatric surgery**;
> VII – **plastic surgery**, 18 (eighteen) months after the **bariatric surgery**;
> [...]
> § 2º – **Bariatric surgery** is a **surgical procedure suitable exclusively to**:
> I – **morbid obese people with Body Mass Index – BMI – above 40** (forty);
> II – those who present a high BMI and whose **need for the procedure** is attested;

> III – **those who have undergone other treatment with unsatisfactory results**[20]
> [...]

In terms of **accessibility and inclusion**, there are laws demanding a percentage of adapted seats in theatres, allowing obese people to avoid passing through the ticket gate of buses, and, in a more general manner, ordering all public establishments to promote accessibility.

As the numbers indicate (see table 2), the Brazilian laws on obesity focus on education and treatment. **Discrimination against overweight or obese people** is a marginal topic, with only one law about it and of limited range, as it was a municipal law. Although **physical activities and exercises** are mentioned as part of the habits that should be encouraged and enabled through the programs and events mentioned in most of the laws in groups 1 and 2 (Groups Calendar and Programs and Policies respectively), there are only two laws and one decree which account exclusively for physical activities.

The remaining 27 laws categorized under the group '*Others*' do not deal directly with the topic of obesity. About half of these laws are alterations of previous laws, and the remaining ones are budget plans for a certain period and other managerial and governing measures.

In the laws analyzed the recurrence of the same set of actions – inform, diagnose, and treat –, sometimes proposed in a compulsory manner in schools, or voluntarily in community spaces such as parks and public health care clinics –, shows that the focus is mostly on diagnosing and treating the obese. Medical practitioners, members of health departments and the general population are encouraged to provide or seek medical treatment.

It is worthy of notice that in many laws and decrees studied, as in example 14, people who are overweight or obese are referred to as "*portadoras de obesidade*" (*carriers of obesity*):

> **[14]** Law nº 3286, of October 18 2001 - Council Chamber of Rio de Janeiro/RJ
> [...]
> § 1 For the purposes of this law, **a morbid obese person is the carrier of an acquired disease** in which extreme obesity results in high risk diseases or the aggravation of existing pathologies.[21]
> [...]

In Portuguese, *portador/a* (carrier) means the person/thing that carries something or the person/thing which is infected by a disease. In the Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing, and Allied Health (2003), 'carrier' is defined as "an individual who harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection; the condition of such an individual is referred to as the carrier state."[22] The choice of the term '*portador/a*' is, therefore, critical, since not only does it imply that the obese individual is necessarily ill, but also that they are a potential threat, a source of contamination to society. It also conveys the idea that the individual carries obesity as if it were a burden, or as if the weight was not a constituent part of the person, but something extra they carry, and that they would no longer be 'ill' if they stopped carrying it. In sum, the use of '*portador/a*' conveys negative connotations of impurity and contagion, and places the responsibility exclusively upon the 'carrier'.

The analysis of the Brazilian corpus revealed that, in practical terms, the actions and measures towards obesity proposed by the laws (involving mainly orientation, diagnosis and treatment) are transferred successively from the federal level to the state and to the municipal levels – at the end of the day, it is the responsibility of local authorities to choose the professionals to treat obesity and organize events, according to their own judgment, since the laws tend to be generalist and do not specify what exactly should be done. In their turn, state and municipal governments transfer this duty once again to schools, teachers, community centers, and other health professionals. In this process of fragmentation of responsibility, the focus is on nutritional education and medicalization of the overweight or obese individual, giving little attention to the discrimination faced by overweight people, and leaving no room for considerations about the social, cultural and economic implications of weight and health.

Concluding remarks

In contemporary societies, a healthy lifestyle is linked to success and happiness, and being healthy means being thin. The discourse of the Brazilian law follows the same view. The legislation studied establishes a clear relation between overweigh and lack of health. By indicating that obesity is the result of inadequate eating habits, the legislators also reinforce the representation of obesity as a self-inflicted disease resulting from 'wrong' life choices, therefore contributing to the blaming of overweight people for their health condition.

The laws investigated do not offer a comprehensive definition of obesity (the BMI is the only parameter), and neither do they explain how overweight people can be protected from fatphobia and discrimination. By relying exclusively on an index (BMI) to define obesity and to establish connections between weight and health, the Brazilian legislative discourse renders the term restrictive and contentious.

Authorization is the main legitimation strategy used in the laws and regulations analyzed. The WHO and medical experts are referenced, providing legitimation by *scientific*, *expert* and *professional authority*. In addition, the Brazilian legislators automatically add legitimacy to whatever they produce, as they themselves represent *institutional authority*.

According to the WHO, the fundamental cause of obesity[23] is "an energy imbalance between calories consumed and calories expended", which means an increase of high-energy food consumption and a decrease in physical activity. This concept is widely accepted amongst governments and experts, which includes Brazilian legislators. However, the WHO also problematizes who or what, besides the individual, is to be held responsible for that imbalance and for the attempt to solve it, and points out that "changes in dietary and physical activity patterns are often the result of environmental and societal changes associated with development and lack of supportive policies in sectors such as health, agriculture, transport, urban planning, environment, food processing, distribution, marketing, and education."[24]

Although the Brazilian legislation uses the WHO's definition of obesity, it does not seem to follow the organization when it comes to who should take part of the solution. The WHO divides the task of reducing and preventing overweight and obesity into different sectors, such as individual, societal, food industry and so on: "Governments, international partners, civil society, non-governmental organizations and the private

sector all have vital roles to play in contributing to obesity prevention"[25]. The Brazilian laws agree that individuals must take control of their eating habits and physical activities, yet they ignore the other sectors which should be involved (e.g. the media, the food industry).

Once again, this study was not intended to disprove obesity as something potentially harmful to human health, but to suggest that other aspects, besides the BMI, must be taken into account to declare someone obese, and to establish a relation between overweight/obesity and health. The matter of malnutrition, for example, is ignored by the Brazilian legislation in its weight control discourse. Even though the laws studied encourage improvements in the population's eating habits, this is only justified in terms of overweight and obesity. By focusing exclusively on one aspect of the relation weight-health, that of overweight and lack of health, the Brazilian legislative discourse ignores that lack of physical activity and bad eating habits are not problems found exclusively in overweight people, but in society in general.

In addition, there are overweight people who are quite active and healthy, as well as thin people who are not. As there is not a single comprehensive measure of health, one cannot assess how good or bad a person's health is based only on their weight and BMI. Nonetheless, what this study indicates is that the Brazilian legislation links overweight necessarily to unhealthiness, and portrays it as the result of the inadequate individual choices in terms of diet and lifestyle, which is a reductive interpretation of a complex problem such as obesity that does not really help and protect overweight people.

Acknowledgements

Notes

[1]http://curia.europa.eu/juris/document/document.jsf?text=&docid=160935&pageIndex=0&doclang=en&mode=req&dir=&occ=first&part=1&cid=216919

[2]https://www.who.int/news-room/fact-sheets/detail/obesity-and-overweight

[3]http://bvsms.saude.gov.br/bvs/publicacoes/vigitel_brasil_2017_vigilancia_fatores_riscos.pdf

[4]http://www.who.int/topics/obesity/en/

[5]http://www.who.int/topics/obesity/en/

[6]https://www.nhs.uk/common-health-questions/lifestyle/why-is-my-waist-size-important/

[7]Jusbrasil is a community that collects and organizes Brazilian legal content online. The database includes laws, court cases, publications, articles, news reports and legal consulting. https://www.jusbrasil.com.br/

[8]"Médicos, nutricionistas, psicólogos, enfermeiros, professores e outros profissionais de saúde e afins, bem como pessoas com conhecimentos nas áreas relativas à questão da obesidade, poderão ser convidadas a participar da definição dos procedimentos informativos, educativos e da organização dos eventos relacionados à Semana [de Combate à Obesidade]."

[9]CRIA O PROGRAMA MUNICIPAL DE PREVENÇÃO E CONTROLE DA OBESIDADE EM CRIANÇAS E ADOLESCENTES.

Art. 3º – Das ações destinadas a prevenção e ao controle da obesidade em crianças e adolescentes realizadas nos serviços públicos de saúde constarão, entre outras: [...]

[10]Art. 1º – Fica instituída a Semana Municipal de Combate e Prevenção à Obesidade Infantil, a ser realizada, anualmente, na semana em que esteja compreendido o dia 11 de outubro, instituído como Dia Mundial de Combate à Obesidade.

Art. 2º – A Semana Municipal de Combate e Prevenção à Obesidade Infantil terá por objetivo conscientizar e orientar a população, através de procedimentos informativos, educativos e organizativos sobre os males provocados pela obesidade infantil, suas causas, consequências, e formas de evitá-la ou tratá-la.

Art. 4º – Fica o Executivo Municipal, através das Secretarias de Educação, de Cultura e de Saúde, autorizado a estabelecer e organizar calendários de atividades a serem desenvolvidas durante a Semana ora instituída.

[11]Art. 1º. Fica o Poder Executivo autorizado a implantar o **Programa de Combate à Obesidade do Estudante das Redes Pública e Privada de Ensino**.

Art. 3º. Uma vez cadastrado no programa, **o estudante será avaliado e**, diagnosticada a obesidade, **receberá tratamento e acompanhamento** médico gratuito.

Art. 4º. Ficará a critério da Secretaria de Estado de Saúde a indicação dos especialistas afetos ao assunto para o desenvolvimento e bom desempenho do referido programa.

Art. 7º. Os profissionais de saúde que acompanharão o tratamento do estudante convidarão seus pais ou responsável para, em dias previamente agendados, assistirem **palestras educativas**, para prestarem e receberem orientações indispensáveis ao sucesso do tratamento.

[12]Artigo 1º – Fica instituída a Política de **Combate à Obesidade** e ao Sobrepeso no Estado de São Paulo, denominada "São Paulo Mais Leve", com a finalidade de implementar **ações eficazes para a redução de peso, o combate à obesidade, adulta e infantil, e à obesidade mórbida** da população paulista.

[13]Art. 1º – Fica o Poder Executivo autorizado a implantar, na rede hospitalar pública estadual, **Programa de prevenção e tratamento** da obesidade e das doenças dela decorrentes, **assim como orientação nutricional**.

[14]Parágrafo único – **Segundo a OMS** (Organização Mundial de Saúde), **entende-se por obesidade mórbida/grave um IMC (Índice de Massa Corporal) igual ou acima de 40 Kg/m^2**. A obesidade mórbida/grave é considerada uma doença causada por vários fatores geneticamente relacionados, tendo como consequência o aumento significativo de doenças clínicas, psicológicas, sociais, físicas e econômicas.

[15]Art. 2º – Para efeitos desta Lei, **entende-se por obesa as pessoas que atingir o índice corpórea – IMC igual ou superior a 35 Kg/m^2**.

[16]Art. 1º – **Fica proibido comercializar, adquirir, confeccionar e distribuir produtos que colaborem para a obesidade infantil**, em bares, cantinas e similares instalados em escolas públicas e privadas situadas no Estado do Rio de Janeiro.

Art. 2º – **Incluem-se no disposto do "caput" do artigo 1º os seguintes produtos**: salgadinhos, balas, chocolates, doces a base de goma, goma de mascar, pirulito, caramelo, refresco de pó industrializado, refrigerantes, qualquer alimento manipulado na escola ou em ambiente não credenciado para confecção de preparação alimentícia, bebidas alcoólicas, alimentos com mais de 3 (três) gramas de gordura em 100 (cem) kcal do produto, com mais de 160 (cento e sessenta) mg de sódio em 100 (cem) kcal do produto e alimentos que contenham corantes, conservantes ou anti-oxidantes artificiais (observada a rotulagem nutricional disponível nas embalagens), alimentos sem rotulagem, composição nutricional e prazo de validade.

[17]DISPÕE SOBRE A OBRIGATORIEDADE DO ATENDIMENTO INTEGRAL PARA PREVENIR E TRATAR A OBESIDADE, NO ÂMBITO DA REDE PÚBLICA MUNICIPAL DE SAÚDE

Art. 1º. – O atendimento no âmbito da **rede pública municipal de saúde oferecerá assistência integral ao paciente para prevenir e tratar a obesidade** e incluirá **programa de educação** destinada a prestar ao paciente informações utilizadas sobre a obesidade, as **recomendações dietéticas** e os cuidados necessários para evitar as complicações da doença.

[18]Art. 1º – **Fica o Poder Executivo autorizado a implantar**, na rede hospitalar estadual, **Programa de prevenção e tratamento da obesidade** e das doenças dela decorrentes, assim como orientação nutricional.

[19][...]

Art. 2º - Para fim do disposto nesta Lei, o Executivo garantirá ao portador de obesidade mórbida:

I – diagnóstico e avaliação clínica;

II – atendimento médico especializado;

III – acesso à cirurgia bariátrica;

IV – fila única gerenciada pelo gestor municipal para a realização do procedimento cirúrgico;

V – acompanhamento pós-operatório;

VI – fornecimento gratuito de medicamentos destinados exclusivamente a portador de obesidade mórbida submetido à cirurgia bariátrica;

VII – cirurgia plástica reparadora, após 18 (dezoito) meses da realização de cirurgia bariátrica.

[...]

§ 2º – A cirurgia bariátrica é procedimento indicado exclusivamente:

I – a obeso mórbido com Índice de Massa Corpórea - IMC - superior a 40 (quarenta);

II – àquele que apresentar elevado IMC e cuja necessidade de procedimento cirúrgico seja atestada;

III – àquele que já se submeteu a outros tipos de tratamento e não obteve resultado satisfatório

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[20]I – **promoção e desenvolvimento de programas**, projetos e ações, de forma intersetorial, que efetivem no Estado o direito humano universal à **alimentação e nutrição** adequadas;

IV – a promoção de campanhas: a) de conscientização que ofereçam **informações básicas sobre alimentação adequada**, através de materiais informativos e institucionais;

V – a capacitação do servidor público estadual que trabalha diretamente com a população, tornando-o um agente multiplicador da **segurança alimentar e nutricional** em sua plenitude;

VI – a integração às políticas estadual e nacional de **segurança alimentar e de saúde**;

[21]§ 1 Para efeito desta Lei, **obeso mórbido é o portador de doença** adquirida na qual o grau de obesidade extrema traz para seu portador doenças de alto risco ou agravamento de patologias preexistentes.

[22]https://medical-dictionary.thefreedictionary.com/carrier

[23]http://www.who.int/topics/obesity/en/

[24]http://www.who.int/mediacentre/factsheets/fs311/en/

[25]http://www.who.int/features/factfiles/obesity/en

References

Chopra, M., Galbraith, S. and Darnton-Hill, I. (2002). A global response to a global problem: The epidemic of overnutrition. *Bulletin of the World Health Organization*, 80, 952–958.

Eknoyan, G. (2006). A history of obesity, or how what was good became ugly and then bad. *Advances in Chronic Kidney Disease*, 13(4), 421–427.

James, W. P. (2008). WHO recognition of the global obesity epidemic. *International Journal of Obesity*, 32, 120–126.

M. B. McCullough and J. A. Hardin, Eds. (2013). *Reconstructing Obesity: The Meaning of Measures and the Measure of Meanings*. New York: Berghahn Books.

Miller, B., Keane, C. and O'Toole, M. (2003). *Miller-Keane Encyclopedia & Dictionary of Medicine, Nursing & Allied Health*. Philadelphia: Saunders, 7 ed.

Rigby, N. J., Kumanyika, S. and P., J. W. (2006). Confronting the epidemic: the need for global solutions. *Journal of Public Health*, 25, 418–434.

Rothblum, E. D. (2011). Fat Studies. In J. Cawley, Ed., *The Oxford Handbook of the social science of obesity*. New York: Oxford University Press, 173–183.

van Leeuwen, T. (2007). Legitimation in discourse and communication. *Discourse & Communication*, 1, 91–112.