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Between precariousness and self-care: socioeconomic barriers to weight management treatment

Entre la precariedad y el autocuidado: barreras socioeconómicas para el tratamiento de control de peso

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ABSTRACT

Introduction: obesity is a public health problem in Mexico and Latin America, associated with chronic degenerative diseases. Although clinical protocols and intervention programs exist, adherence to treatment is low, especially in precarious populations, due to structural barriers that hinder self-care, such as poverty, informal employment, food insecurity, distance from health centers, and task overload. Added to this are symbolic and emotional factors (stigma, guilt, and low self-efficacy) that affect motivation.

Objective: to analyze the socioeconomic barriers to adherence to weight control treatment in people with chronic degenerative conditions related to obesity.

Method: this study is part of a broader qualitative research project conducted through semi-structured interviews with adult patients at a public health institution undergoing treatment for chronic degenerative conditions and weight control. Sample: Two female patients.

Results: low income, informal work, lack of transportation, and excessive workload hinder healthy habits. In addition, emotions such as frustration and shame make it difficult to continue treatment.

Discussion: adherence is significantly influenced by structural, symbolic, and subjective factors; emotions, beliefs, and personal experiences also condition self-care beyond individual will. It is essential to consider patients' actual living conditions in treatment strategies.

Conclusion: adherence must be understood as a process conditioned by social inequalities, while self-care must be positioned as a right that requires decent material conditions, continuous emotional support, and context-sensitive policies.

Keywords: Obesity; Socioeconomic Barriers; Treatment Adherence.

RESUMEN

Introducción: la obesidad es un problema de salud pública en México y América Latina, asociada con enfermedades crónico-degenerativas. Aunque existen protocolos clínicos y programas de intervención, la adherencia al tratamiento es baja, especialmente en poblaciones con precariedad, debido a barreras estructurales que dificultan el autocuidado como: pobreza, empleo informal, inseguridad alimentaria, lejanía de centros de salud y sobrecarga de tareas. A ello se suman factores simbólicos y emocionales (estigma, culpa y baja autoeficacia) que afectan la motivación.

Objetivo: analizar las barreras socioeconómicas en personas con padecimientos crónico-degenerativos relacionados con la obesidad, para adherirse al tratamiento de control de peso.

Método: este trabajo forma parte de una investigación más amplia, de orientación cualitativa, llevada a cabo mediante entrevistas semiestructuradas con pacientes adultos, de una institución pública de salud, en tratamiento por padecimientos crónico-degenerativos y control de peso. Muestra: Dos pacientes mujeres.

Resultados: bajos ingresos, trabajo informal, falta de transporte y sobrecarga de tareas obstaculizan tener hábitos saludables. Además, emociones como frustración y vergüenza dificultan la continuidad del tratamiento.

Discusión: la adherencia está influenciada considerablemente por factores estructurales, simbólicos y subjetivos, las emociones, creencias y experiencias personales también condicionan el autocuidado más allá de la voluntad individual. Es imprescindible considerar las condiciones reales de vida de los pacientes en las estrategias de tratamiento.

Conclusión: es necesario entender la adherencia como un proceso condicionado por desigualdades sociales, mientras que al autocuidado hay que posicionarlo como un derecho que exige condiciones materiales dignas, acompañamiento emocional continuo y políticas sensibles al contexto.

Palabras clave: Obesidad; Barreras Socioeconómicas; Adherencia al Tratamiento.

INTRODUCTION

Obesity is one of the main public health problems worldwide (World Health Organization [WHO], 2021) because of its increasing prevalence and association with multiple chronic diseases, such as type 2 diabetes, high blood pressure, cardiovascular disease, and osteoarticular conditions. Clinical protocols and comprehensive programs, such as the National Strategy for the Prevention and Control of Overweight, Obesity, and Diabetes in Mexico (Ministry of Health, 2013) and the WHO's "Global Action Plan for the Prevention and Control of Noncommunicable Diseases" (2013--2020), face significant challenges in terms of adherence, sustainability, and effectiveness in conditions of vulnerability (Funk et al., 2022).

Structural factors (poverty, informal employment, food insecurity, distance from services, and work overload) interact with psycho-emotional factors (frustration, guilt, and stigma) and symbolic factors (low self-efficacy and body image), shaping an individual's experience by blaming them and directly affecting their motivation and commitment to maintaining therapeutic adherence (Puhl & Heuer, 2010; Morales et al., 2024). This picture becomes more complex when many people, especially women, face double and triple work shifts, as well as family care tasks that limit the time and energy available for planning healthy habits (Tettero et al., 2022; González & Pérez, 2022).

Socioeconomic conditions, understood as the structural factor that conditions and amplifies other difficulties (Kaufer-Horwitz & Pérez-Hernández, 2022; PAHO, 2022), require a rethinking of clinical and community strategies from a perspective that does not pathologize obesity as an individual failure but rather understands it as a complex condition influenced by socioeconomic conditions; symbolic, biological, psychological, and cultural factors; and circuits of exclusion. From this perspective, it becomes necessary to ask the following questions: What are the socioeconomic barriers that people with obesity and chronic degenerative diseases face in adhering to their treatment?

Objectives

General objective

To analyze the socioeconomic barriers that some people with obesity and chronic degenerative

diseases face in adhering to weight control treatment.

Specific objectives

To identify the material conditions (income, employment, transportation, access to healthy foods) that limit the acquisition and maintenance of healthy habits.

To describe the relationship between structural inequality and treatment abandonment.

Justification

This research aims to investigate how structural inequalities and socioeconomic precariousness hinder sustained adherence to treatment for weight control and chronic degenerative conditions in people with obesity to understand how structural conditions influence health, the body, and self-care practices, prioritizing this dimension over psychological or cultural factors (Kaufer-Horwitz & Pérez-Hernández, 2022; Schmitz et al., 2020).

In Mexico, adult women postpone self-care because they face two or three shifts, paid work, domestic work, and caregiving. This reality reinforces the need to investigate how social structures condition access to and continuity of treatment, since ignoring them perpetuates clinical interventions that place sole responsibility on the patient without considering their actual living conditions (Tettero et al., 2022).

On the other hand, González and Pérez (2022), Ramírez et al. (2022), and Smith et al. (2021) noted that emotions such as body shame, stigma, and hopelessness interact to reinforce abandonment, self-exclusion, and internalization of guilt, creating a vicious cycle of anxiety, overeating, and relapse. These emotions cannot be resolved solely with medical prescriptions but require therapeutic support and space for containment. This work focuses on socioeconomic barriers because of their structural capacity and role in the reproduction of health inequalities. By focusing on these barriers, we seek to identify elements that will enable the design of more contextualized and sustainable interventions.

Theoretical Framework

Obesity and its repercussions

Obesity is a chronic disease characterized by abnormal or excessive accumulation of body fat that poses a health risk. From a biomedical perspective, obesity is diagnosed on the basis of body mass index (BMI), with a BMI of 25 or higher considered overweight and a BMI of 30 or higher considered obese (WHO, 2021).

It is a multifactorial condition involving genetic, metabolic, behavioral, psychological, social, and environmental factors. These include energy imbalances, a diet based on ultra-processed foods, a sedentary lifestyle, chronic stress, and a lack of sleep. Socioeconomic inequalities, limited access to health services, and unhealthy environments also play a role (Teixeira et al., 2015; Sánchez-Carracedo, 2022).

The repercussions of obesity are felt at different levels. In medical terms, it is associated with an increased risk of developing chronic noncommunicable diseases such as type 2 diabetes, high blood pressure, dyslipidemia, sleep apnea, and certain types of cancer. In psychosocial terms, it can lead to low self-esteem, anxiety, depression, and stigmatization. Economically, it increases healthcare costs and reduces labor productivity (WHO, 2021; Puhl & Heuer, 2010). However, in recent decades, obesity has gone from being conceived as a clinical-individual

phenomenon to a social phenomenon linked to structural transformations, such as the growth of the food industry, changes in urban planning, the digitization of work, and the weakening of care networks, becoming an indicator of social inequality (Kaufer-Horwitz and Pérez-Hernández, 2022). Thus, obesity as a public health problem reflects the transition to a scenario in which caloric overfeeding predominates, in contrast to the malnutrition that has occurred in previous decades.

Strategies for the prevention and treatment of weight control in obese individuals

In Mexico, the Ministry of Health implemented the National Strategy for the Prevention and Control of Overweight, Obesity, and Diabetes (2013), which focused on ensuring access to healthy foods, regulating the consumption of ultra-processed products, and promoting physical activity (Ministry of Health, 2013). Among its actions are front-of-package labeling (NOM-051, 2020) and campaigns such as “3xMiSalud” (3xMyHealth) and “Muévete y Métete en Cintura” (Get Moving and Get in Shape) (Barquera et al., 2020; Rivera-Dommarco et al., 2020). Likewise, its comprehensive treatment (NOM-008-SSA3-2017) includes changes in diet, increased physical activity, behavioral modifications, psychological support, medical follow-up, and, in some cases, pharmacological or surgical treatment. Treatment must be personalized and continuous, with multidisciplinary interventions that address the multiple dimensions that influence obesity (Ministry of Health, 2017).

The effectiveness of treatment depends on adherence, understood as “the degree to which a person’s behavior (taking medication, following a diet, and making lifestyle changes) corresponds to the recommendations agreed upon by a health professional” (WHO translation, 2003). In the case of obesity and other chronic degenerative conditions, adherence involves maintaining changes in diet, physical activity, medical monitoring, and, in some cases, pharmacological or surgical follow-up (Tettero et al., 2022). However, sustaining the changes involved in weight control over the long term is particularly complex due to social and economic factors that condition the actual ability to adopt healthy habits (Smith et al., 2021), as well as the psychological and subjective aspects involved. Adherence cannot be reduced to simple individual discipline; it is a process influenced by structural conditions and social stigma toward the obese body, which reinforces feelings of guilt, low self-esteem, and mistrust of the healthcare system (González and Pérez, 2022).

In addition, low self-efficacy and fear of judgment in clinical settings trigger the avoidance of medical follow-up, a cycle of relapse, and dietary dysregulation (Smith et al., 2021). In this sense, addressing obesity involves ensuring intersectoral public policies that articulate health, nutrition, decent work, and care networks, recognizing that this problem transcends BMI, diet, or exercise and constitutes the visible expression of profound inequalities that permeate the body, emotions, and daily life (Schrecker & Bamba, 2015).

Socioeconomic barriers

The social determinants of health (SDHs) are “the circumstances in which people are born, grow up, work, live, and age” and explain how structural factors influence well-being (WHO, 2021). Socioeconomic barriers, understood as obstacles derived from material and structural conditions that limit equitable access to services, opportunities, and conditions necessary for health care, include insufficient income, precarious employment, food insecurity, a lack of basic services or social protection, and hindered adherence to treatment (Marmot et al., 2020; PAHO, 2022). These barriers not only manifest themselves in practical limitations but also create a context that restricts people’s actual ability to sustain lifestyle changes and comply with

medical instructions.

In Latin America, socioeconomic barriers to health care are reflected in high rates of poverty (29 %), extreme poverty (11,2 %), higher maternal and infant mortality, and deaths attributable to unsafe water and inadequate sanitation (PAHO, 2022). The persistence of these structural inequalities shows that material conditions affect people's actual ability to access healthy food, plan care, sustain lifestyle changes, and cover medical expenses. These barriers are exacerbated in vulnerable groups such as women caregivers or informal workers, who have less access to support networks and less social security coverage (Schmitz et al., 2020; González & Pérez, 2022). Authors such as Funk, Foreman, and Smith (2022), Ramírez et al. (2022), and Smith et al. (2021) reported that socioeconomic barriers such as informal employment, food insecurity, and lack of reliable transportation limit sustained access to treatment. They also noted that social stigma and multiple work and family responsibilities affect continuity, highlighting the need for comprehensive and context-sensitive approaches.

Specific factors: poverty, employment, food, transportation, time, and care

Within socioeconomic barriers, specific factors that interact with each other are identified. Poverty, understood as deprivation of income, education, health, security, and fundamental human rights, limits the acquisition of healthy foods, which favors dependence on more accessible but less healthy ultra-processed products (Haughton & Khandker, 2009; Funk et al., 2022). Informal employment and long working hours reduce the time available for physical activity and medical care, whereas food insecurity forces people to prioritize quantity over quality (Schmitz et al., 2020). In addition, the lack of safe and affordable public transportation limits attendance at medical appointments and community programs. Similarly, the burden of care, which falls mainly on women, pushes self-care into the background (Kaufer-Horwitz & Pérez-Hernández, 2022).

Material barriers directly impact the ability to sustain self-care practices, understood as the set of intentional decisions and actions to care for physical, mental, and social health, including hygiene, nutrition, and exercise practices, as well as emotional management and actively seeking medical care (WHO, 2021).

Although many people are aware of the recommendations for losing weight, their living conditions make it difficult for them to implement them and encourage them to gradually abandon treatment (González and Pérez 2022; Tettero et al., 2022). Therefore, the responsibility for self-care cannot fall exclusively on the individual but must be understood as a result of the material conditions that sustain or limit it.

Links to psycho-emotional and symbolic factors

Material conditions interact with symbolic and psycho-emotional factors that reinforce adherence difficulties. Symbolic factors include aesthetic ideals, social mandates on self-care, being disciplined, and the stigma associated with the obese body (Menéndez, 2003). Economic insecurity and work overload generate anxiety, hopelessness, emotional exhaustion, a lack of motivation, and low self-efficacy, whereas stigma and body shame increase self-criticism and self-exclusion, reinforcing patterns of abandonment (Ramírez et al., 2022; Smith et al., 2021).

Any strategy to improve adherence to treatment for weight control and chronic degenerative conditions must consider not only socioeconomic barriers but also emotional support and stigma reduction to strengthen patient resilience and motivation. Tettero et al. (2022) emphasized

the need for sustained emotional support to promote lasting change in people facing multiple vulnerabilities.

Treatment adherence

In recent years, factors that hinder adherence to weight management treatment in people with obesity and their interaction with barriers and impediments have been explored. Schmitz et al. (2020) identified structural barriers such as informal employment, food insecurity, poor community support, and a lack of reliable transportation, whereas Smith et al. (2021) noted that the availability and advertising of ultra-processed foods and the absence of healthy markets in low-income urban environments constitute environmental barriers that hinder the adoption of healthy habits. In addition, Funk, Foreman, and Smith (2022) showed how social stigma, fear of discrimination in medical settings, and multiple family and work responsibilities affect treatment continuity, recommending an intersectional approach that considers gender, class, and life context. González and Pérez (2022) highlighted the need for a comprehensive view of obesity that recognizes structural factors and does not hold the patient solely responsible for treatment outcomes.

For their part, Morales, Álvarez, and Ribeiro (2024) highlight that there are subjective and emotional difficulties that affect adherence, such as deficiencies in the therapeutic relationship and a lack of recognition of psychological factors, which contribute to the persistence of discomfort in patients. Ramírez et al. (2022) emphasized the importance of emotional support, given that relapses and treatment abandonment are closely linked to negative emotional experiences during weight loss processes. Taken together, these studies show that sustaining lifestyle changes requires not only addressing socioeconomic and structural barriers but also considering the symbolic, emotional, and psychological factors that permeate the patient's experience.

METHOD

Design

This research is based on a qualitative approach, which allows for an understanding of social phenomena from the perspective of the subjects who experience them, with a focus on meanings, experiences, and contexts (Hernández-Sampieri et al., 2021). This work is part of a broader research project. This study is exploratory in nature and has a phenomenological design aimed at describing and understanding the lived experiences of two participants with obesity in relation to the barriers they face in adhering to treatment (Vargas, 2019).

Sample and sampling

The sample consisted of two interviews with adult female patients diagnosed with chronic degenerative diseases and obesity who were treated at a public health institution. Nonprobability convenience sampling was used, employing a typical case strategy and selecting participants who represented common characteristics of the phenomenon under study (Patton, 1990).

Method for obtaining information

The information was obtained through semistructured interviews, which allow in-depth information to be obtained without losing flexibility (González & Rodríguez, 2020). The interviews were conducted with the prior informed consent of each participant and recorded for later transcription, with the approval of the corresponding Ethics Committee and in accordance with all ethical principles of confidentiality, autonomy, and nonmaleficence.

Method of information analysis

A thematic content analysis was applied, identifying, coding, and categorizing units of meaning to construct interpretive patterns (Vargas, 2022, p. 155). Emerging categories (such as transportation, employment, food insecurity, and stigma) were recognized and organized around predefined themes such as self-care, health, and body, using comparative matrices and worksheets that facilitated the integration of data with the reviewed literature.

Ethical considerations

This research was conducted in compliance with the fundamental ethical principles established in the Code of Ethics for Psychologists of the Mexican College of Psychology (Colegio Mexicano de Profesionistas de la Psicología, 2010), guaranteeing the confidentiality, autonomy, and protection of the rights of the participants. Informed consent was obtained prior to participation, and it was ensured that the data would be used exclusively for academic, research, and training purposes, respecting academic integrity through the correct and transparent use of all sources consulted.

RESULTS

The results are from a pair of interviews conducted with adult women (aged 40 and 50) diagnosed with chronic degenerative diseases and obesity, mothers of at least two children and heads of household, which represents a significant domestic and caregiving workload. Qualitative analysis of the interviews, supplemented by a review of the literature, identified socioeconomic barriers that interfere with treatment adherence. The findings are presented below and organized into emerging categories.

Informal employment and low income

Informal employment generates low income, economic instability, and a lack of social benefits, conditions that limit healthy eating and time for rest.

“I work from early in the morning until late at night, and sometimes I only have time to eat whatever I can find on the street... whatever I can get.”

Limited access to healthy food

The interviews revealed difficulties in following medical dietary recommendations, revealing a contradiction between the nutritional ideal proposed by the health system and the reality of families living in precarious socioeconomic conditions.

“The doctor tells me to eat lettuce and vegetables, but that is expensive and there are several of us at home.”

Food insecurity

The participants noted that sometimes there is not enough food in their homes and that they prioritize feeding their children, neglecting their own health. Low incomes and a lack of food support lead to a lack of regular access to adequate food in terms of quantity and quality.

“Sometimes there is not enough for everyone, so I prefer to let my children eat first, and then I will see what I can eat.”

Accessibility to public transportation

The interviewees reported long and expensive journeys that make it difficult to attend the

health center where they receive treatment on a regular basis.

“To get there, I have to take two buses, and sometimes I do not have enough money or it takes me too long. If I go, I do not have time to do anything else.”

Domestic and caregiving workload

Both women perform caregiving duties in their homes, which, in addition to their work activities, leave them little time for self-care, maintaining healthy habits, or attending medical appointments.

“When I’m not working, I’m with my children or cleaning. Sometimes I do not even have the energy to think about myself.”

Lack of institutional support

The interviewees reported that although they receive medical advice, they do not receive follow-up, emotional support, or adjustments to their economic reality. This ultimately weakens the therapeutic relationship and affects the continuity of treatment.

“Sometimes I feel like I go and they tell me the same thing, but they do not help me with how to do it with what I have.”

Symbolic and emotional factors (emerging category)

The participants expressed feelings of guilt, body shame, demotivation, and frustration at the difficulty of losing weight, demonstrating that adherence to treatment is influenced by structural, symbolic, and emotional factors, not just individual willpower.

“I feel like I’m failing... like I’m not good at this. I do not want to go anymore because they scold me.”

DISCUSSION

The results show that, in patients with obesity, adherence to treatment for weight control and chronic degenerative diseases does not depend solely on individual willpower. As stated by Schmitz et al., 2020; Funk et al., 2022; and González and Pérez (2022), structural factors such as informal employment, low income, food insecurity, care overload, and distance from health centers limit the implementation and maintenance of healthy habits. This finding fulfills the first specific objective of the study by identifying the material conditions that limit the acquisition and maintenance of healthy habits, reinforcing the idea that the economic and social environment profoundly conditions dietary and health practices, especially in women living in contexts of structural vulnerability (Smith et al., 2021).

Similarly, this work shows that structural inequality manifests itself not only in material terms but also in symbolic terms. Although it was not the central focus of the analysis, it emerged as a relevant category that deepens inequalities, fulfilling the second specific objective by showing how weight stigma and pressure to meet unattainable medical expectations undermine motivation and reinforce distancing from the health system. As Ramírez et al. (2022) and Morales, Álvarez, and Ribeiro (2024) warn, these subjective experiences tend to be invisible in the traditional biomedical approach, despite their real impact on treatment continuity.

This highlights the need to adopt an interdisciplinary approach that considers patients in their

social context, as well as recognizing structural and relational barriers, to reframe self-care as a collective right that implies decent material conditions, support networks, and sustained emotional support, all of which are essential elements for designing effective intervention strategies.

CONCLUSIONS

The results of this research confirm that barriers to treatment adherence in people with obesity cannot be reduced to a lack of individual willpower or discipline. Factors such as informal employment, poverty, care overload, food insecurity, and limited access to health services create an environment that hinders self-care.

In addition, emotional and symbolic factors such as weight stigma, guilt, and low self-efficacy act as a silent but powerful barrier that affects motivation and reinforces unhealthy patterns. This shows that health care must be conceived as a collective right that requires decent material conditions, continuous emotional support, and strategies that are sensitive to the social context. From a psychological perspective, this research highlights the importance of intervening not only at the individual level but also in the social structures that condition well-being by promoting emotional support and nonblaming clinical and community practices.

Understanding obesity from a comprehensive and contextualized perspective allows us to reframe self-care as a collective possibility linked to social justice and the guarantee of fundamental rights such as health, nutrition, and well-being.

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