South American Publishing

SAP Health and Policy. 2026;5:344
doi: 10.62486/shp2026344

ORIGINAL

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

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

Leticia Hernández Hernández[1]
Naomi Pamela Sánchez García[1]
María de los Milagros Morales Vázquez[1]

[1] Universidad Autónoma del Carmen, México.

Submitted: 03-05-2026 | Revised: 18-06-2026 | Accepted: 26-07-2026 | Published: 02-08-2026

ABSTRACT

Context: 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 diseases related to obesity. Method: Qualitative approach, part of a broader study with adult patients in a public health institution. Sample: Two women interviewed using a semi-structured approach. Results: Low income, informal jobs, lack of transportation, and excessive workload prevent healthy habits. In addition, emotions such as frustration and shame hinder treatment continuity. Discussion: Adherence is determined by structural and symbolic factors, beyond individual will. Treatment strategies must take into account patients' actual living conditions. Conclusion: Adherence should be understood as a process conditioned by social inequalities, and self-care as a right that requires decent material conditions, continuous emotional support, and context-sensitive policies.

Keywords: Obesity; Socioeconomic barriers; Treatment adherence.

RESUMEN

Antecedentes: 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), due to its growing prevalence and association with multiple chronic diseases such as type 2 diabetes, high blood pressure, cardiovascular diseases, and osteoarticular conditions. Clinical protocols and comprehensive programs to address this issue, 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 (2020; Funk et al., 2022).

Structural factors (poverty, informal employment, food insecurity, distance from services, and work overload) interact with psycho-emotional factors (frustration, guilt, stigma) and symbolic factors (low self-efficacy, body image), together shaping the 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 even more complex when considering that many people, especially women, face double- and triple-shift workdays, as well as family care responsibilities 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, as well as circuits of exclusion. From this perspective, it becomes necessary to ask: 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:

- Identify the material conditions (income, employment, transportation, access to healthy food) that limit the acquisition and maintenance of healthy habits.
- 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, in order 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 double or triple shifts, paid work, domestic work, and caregiving. This reality underscores the need to examine how social structures shape access to and the continuity of treatment, as ignoring them perpetuates clinical interventions that place responsibility solely 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), andSmith et al. (2021) point out 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 spaces for containment. This work focuses on socioeconomic barriers due to their structuring capacity and their role in reproducing health inequalities. By focusing on these barriers, we aim to contribute elements that enable the design of more context-specific and sustainable interventions.

Theoretical Framework

Obesity and its repercussions

Obesity is a chronic disease characterized by an abnormal or excessive accumulation of body fat that poses a health risk. From a biomedical perspective, its diagnosis is based on body mass

index (BMI): a BMI of 25 or higher is considered overweight, and a BMI of 30 or higher is considered obese(WHO, 2021).

It is a multifactorial condition involving genetic, metabolic, behavioral, psychological, social, and environmental factors. These include energy imbalances, a diet high in ultra-processed foods, a sedentary lifestyle, chronic stress, and insufficient sleep. Socioeconomic inequalities, limited access to health services, and unhealthy environments also contribute (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 the psychosocial sphere, 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 & 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 marked previous decades.

Strategies for the prevention and treatment of obesity

In Mexico, the Ministry of Health implemented the National Strategy for the Prevention and Control of Overweight, Obesity, andDiabetes (2013), focused on ensuring access to healthy foods, regulating the consumption of ultra-processed products, and promoting physical activity(Ministry of Health, 2013). Its actions include 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-SSA32017)includes changes in diet, increased physical activity, behavioral modification, 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 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 dietary and physical activity changes, ongoing medical monitoring, and, in some cases, pharmacological or surgical follow-up(Tettero et al., 2022). However, sustaining the changes required for long-term weight control is particularly complex due to social and economic factors that shape the ability to adopt healthy habits(Smith et al., 2021), as well as the psychological and subjective factors 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 distrust of the healthcare system(González and Pérez, 2022).

In addition to the above, low self-efficacy and fear of judgment in clinical settings trigger 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 & Bambra, 2015).

Socioeconomic barriers

Social determinants of health (SDH) 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 arising 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, lack of basic services or social protection, and hinder treatment adherence(Marmot et al., 2020; PAHO, 2022). These barriers not only manifest as practical limitations but also create a context that limits people’s 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 for vulnerable groups, such as women caregivers and 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) have identified that socioeconomic barriers, including informal employment, food insecurity, and a lack of reliable transportation, limit sustained access to treatment. They also note that social stigma and multiple work and family responsibilities affect continuity, underscoring the need for comprehensive, context-sensitive approaches.

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

Within the context of socioeconomic barriers, specific factors that interact with one another are identified. Poverty, understood as the deprivation of income, education, health, security, and fundamental human rights, limits access to healthy foods, thereby favoring 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, while 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 affect 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, as well as emotional management and actively seeking medical care(WHO, 2021).

Although many people are aware of weight-loss recommendations, 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.

Link to psycho-emotional and symbolic factors

Material conditions interact with symbolic and psycho-emotional factors that reinforce the difficulties of adherence. 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, and emotional exhaustion, lack of motivation, and low self-efficacy, while 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)emphasize the need for sustained emotional support to promote lasting change in people facing multiple vulnerabilities.

Treatment Adherence

In recent years, factors that hinder treatment adherence for weight control 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 lack of reliable transportation, whileSmith et al. (2021)pointed out 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, andSmith (2022)showed that social stigma, fear of discrimination in medical settings, and multiple family and work responsibilities affect treatment continuity, and they recommended 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, andRibeiro (2024)highlight that subjective and emotional difficulties affect adherence, including deficiencies in the therapeutic relationship and the lack of recognition of psychological factors, which contribute to the persistence of discomfort in patients.

Ramírez et al. (2022)emphasize 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.

METHODS

Design

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

Sample and sampling

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

Method for obtaining information

The information was obtained through semi-structured interviews, which allow for in-depth data collection without sacrificing 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 non-maleficence.

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 axes such as self-care, health, and body, using comparative matrices and worksheets that facilitated the integration of the 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), thereby guaranteeing the confidentiality, autonomy, and protection of participants' rights. Informed consent was obtained prior to participation, and it was ensured that the data would be used exclusively for academic, research, and training purposes, and that academic integrity would be maintained through the correct and transparent use of all sources consulted.

RESULTS

The results come 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 households, which represents a significant domestic and caregiving workload. Qualitative analysis of the interviews, supplemented by a review of documentation, identified socioeconomic barriers to treatment adherence. The findings are presented below, organized by emerging categories.

Informal employment and low income

Informal employment generates low income, economic instability, and a lack of social bene-

fits, 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 foods

The interviews reveal difficulties in adhering to medical dietary recommendations, highlighting a contradiction between the nutritional ideal proposed by the health system and the realities 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 they prioritize feeding their children, neglecting their own health. Low income and limited food support result in irregular access to adequate food, in terms of both 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, expensive journeys that make it difficult for them to attend the health center where they receive regular treatment.

"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 within their homes, which, added to their work activities, leaves them little room for self-care, maintaining healthy habits, or attending appointments.

"When I am not working, I am with my children or cleaning. Sometimes I do not even have the strength 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 accommodations for their economic reality. This ultimately weakens the therapeutic relationship and disrupts treatment continuity.

"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 treatment adherence is influenced by structural, symbolic, and emotional factors, not just individual willpower.

"I feel like I am failing... like I am not good at this. I do not want to go anymore because they scold me."

DISCUSSION

The results obtained 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 bySchmitz et al. (2020),Funk et al. (2022), andGonzález 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 meets 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).

Likewise, 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. AsRamírez et al. (2022)and Morales, Álvarez, andRibeiro (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 the patient in their social context, as well as recognizing structural and relational barriers in order 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 will 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.

Added to this are emotional and symbolic factors such as weight stigma, guilt, and low self-efficacy, acting 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 non-blaming 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.

REFERENCES

1. Barquera S, Sánchez-Pimienta TG, García-Chávez CG, Rodríguez-Oliveros G. Etiquetado frontal de advertencia en México: una herramienta para el control de la obesidad. Salud Pública Méx. 2020;62(6):1–5. Disponible en: https://www.insp.mx/images/stories/Centros/cinys/Docs/120821_revisionEtiquetadoFrontal.pdf
2. Cáceres A, González J, Pérez M. Perspectivas críticas del modelo biomédico en la atención de la obesidad. Rev Cienc Salud. 2020;18(2):95–107. https://doi.org/10.12804/revsalud18.02.2020.01
3. Colegio Mexicano de Profesionistas de la Psicología. Código ético del psicólogo. México: Colegio Mexicano de Profesionistas de la Psicología A.C.; 2010.
4. Crane MM, Li M, Suzuki S, Bleil ME, Sliwinski MJ, Appelhans BM. Rationale and design of the Response to Behavioral Obesity Treatment (REBOOT) study. Contemporary Clinical Trials 2025;159. https://doi.org/10.1016/j.cct.2025.108138.
5. Crochiere RJ, Freund AG, Huang Z, Maher JP, Forman EM. Within-person, prospective relations between sleep duration and efficiency and next-day physical activity among behavioral weight loss participants. Journal of Behavioral Medicine 2025;48:884–90. https://doi.org/10.1007/s10865-025-00581-y.
6. Funk LM, Foreman M, Smith AB. Socioeconomic disparities and bariatric surgery outcomes: a qualitative investigation of barriers to care and treatment engagement. Obes Surg. 2022;32(1):29–37.
7. González J, Pérez M. Estigma corporal y autopercepción en pacientes con obesidad: un estudio cualitativo. Psicol Salud. 2022;32(1):45–60.
8. Hama Faraj RI, Al-Tawil NG. Medication Adherence of Diabetic Patients in Erbil City: A Cross-Sectional Study. Al-Rafidain Journal of Medical Sciences 2025;9:110–7. https://doi.org/10.54133/ajms.v9i1.2285.
9. Haughton J, Khandker SR. Handbook on poverty and inequality. Washington D.C.: World Bank; 2009. https://doi.org/10.1596/978-0-8213-7613-3
10. Kaufer-Horwitz M, Pérez-Hernández JF. La obesidad: aspectos fisiopatológicos y clínicos. INTERdisciplina. 2022;10(26):147–165.
11. Marmot M, Allen J, Boyce T, Goldblatt P, Morrison J. Build back fairer: The COVID-19 Marmot review. London: Institute of Health Equity; 2020.
12. Menéndez EL. El modelo médico hegemónico: consecuencias para la atención de la salud y la formación de profesionales. Cad Saúde Pública. 2003;19(4):923–931. https://doi.org/10.1590/S0102-311X2003000400003
13. Miranda BCJ, Tustumi F, Nakamura ET, Shimanoe VH, Kikawa D, Waisberg J. Obesity and Colorectal Cancer: A Narrative Review. Medicina (Lithuania) 2024;60. https://doi.org/10.3390/medicina60081218.
14. Morales MM, Álvarez GC, Ribeiro R. Sobre las dificultades de pacientes en tratamiento para el control de peso en Campeche, México. Rev Psicol PUCP. 2024. Disponible en: https://revistas.pucp.edu.pe/index.php/psicologia/article/view/29094/26536
15. Organización Mundial de la Salud. Adherencia a los tratamientos a largo plazo: pruebas para la acción. Ginebra: OMS; 2003. Disponible en: https://www.who.int/publications/i/item/adherence-to-long-term-therapies-evidence-for-action
16. Organización Mundial de la Salud. Determinantes sociales de la salud. OMS; 2021. Disponible en: https://www.who.int/es/health-topics/social-determinants-of-health
17. Organización Panamericana de la Salud. Etiquetado frontal. OPS; s.f. Disponible en: https://www.paho.org/es/temas/etiquetado-frontal
18. Organización Panamericana de la Salud. Informe sobre equidad en salud en América Latina y el Caribe. OPS; 2022. Disponible en: https://www.paho.org/es/documentos/informe-sobre-equidad-salud-america-latina-caribe
19. Paixão C, Dias CM, Jorge R, Carraça EV, Yannakoulia M, De Zwaan M, et al. Successful weight loss maintenance: a systematic review of weight control registries. Obes Rev. 2020;21(5):e13003.
20. Park J, Kim OY. Macronutrients modified dietary intervention in the management of overweight/obese children and adolescents: a systematic review. Clinical and Experimental Pediatrics 2024;67:191–200. https://doi.org/10.3345/cep.2023.00262.
21. Puhl RM, Heuer CA. Obesity stigma: important considerations for public health. Am J Public Health. 2010;100(6):1019–28.
22. Ramírez A, Gutiérrez M, Torres D. Emociones, salud y obesidad: experiencias de mujeres en contextos de pobreza. Rev Latinoam Psicol Soc. 2022;20(2):120–136.
23. Rivera-Dommarco J, Colchero MA, Fuentes ML, González de Cosío T. Políticas públicas y la prevención de la obesidad en México. Salud Pública Méx. 2020;62(6):660–667.
24. Sánchez-Carracedo D. El estigma de la obesidad y su impacto en la salud: una revisión narrativa. Endocrinol Diabetes Nutr. 2022;69(10):868–877.
25. Schmitz BD, Ferreira TL, de Souza AC, Rodrigues RCM. Views and experiences of adults living with obesity regarding health promotion in primary care: a qualitative study in Southeast Brazil. Prim Health Care Res Dev. 2020;21:e43.
26. Schrecker T, Bambra C. How politics makes us sick: neoliberal epidemics. London: Palgrave Macmillan; 2015.
27. Secretaría de Salud. Estrategia Nacional para la Prevención y el Control del Sobrepeso, la Obesidad y la Diabetes. Gobierno de México; 2013. Disponible en: https://www.gob.mx/salud/documentos/estrategia-nacional-para-la-prevencion-y-el-control-del-sobrepeso-la-obesidad-y-la-diabetes
28. Secretaría de Salud. NORMA Oficial Mexicana NOM-008-SSA3-2017, Para el tratamiento integral del sobrepeso y la obesidad. Ciudad de México: Secretaría de Salud; 2017. Disponible en: https://www.gob.mx/cms/uploads/attachment/file/512100/NOM-008-SSA3-2017.pdf

29. Smith A, Foreman M, Funk L. Psychological barriers to obesity treatment: a qualitative analysis of stigma and self-efficacy. J Health Psychol. 2021;26(3):404–416.
30. Swinburn BA, Kraak VI, Rutter H, Vandevijvere S, Lobstein T, Sacks G, et al. Strengthening of accountability systems to create healthy food environments and reduce global obesity. Lancet. 2011;385(9986):2534–2545.
31. Teixeira PJ, Carraça EV, Markland D, Silva MN, Ryan RM. Exercise, physical activity, and self-determination theory: a systematic review. Int J Behav Nutr Phys Act. 2012;9:78.
32. Tettero OM, van Stralen MM, Visscher TLS. Barriers to and facilitators of lifestyle behavior change in adults with obesity after bariatric surgery: a qualitative study. Obes Sci Pract. 2022;8(4):442–451.
33. Yoneda M, Kobayashi T, Iwaki M, Nogami A, Saito S, Nakajima A. Nonalcoholic Fatty Liver Disease as a Systemic Disease and the Need for Multidisciplinary Care. Gut and Liver 2023;17:843–52. https://doi.org/10.5009/gnl220545.

FUNDING

None.

CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

AUTHORSHIP CONTRIBUTIONS

Conceptualization: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Data curation: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Formal analysis: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Research: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Methodology: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Project management: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Software: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Supervision: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Validation: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Visualization: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázque
Writing – original draft: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez
Writing – review and editing: Leticia Hernández Hernández; Naomi Pamela Sánchez García; María de los Milagros Morales Vázquez