MAPPS II
Management & Advocacy for Providers, Patients and Systems

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Exploring the obesity landscape in Spain

A deep dive study under the MAPPS II Programme.

WORLD OBESITY

01 Disease recognition
02 Perceptions and stigma
03 Policy and political will
04 Health systems and access
05 Lived experience voice
06 Culture and environment

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Foreword



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Overweight and obesity are among the principal public health challenges, particularly because of their marked social gradient. This gradient also creates a double inequality: the populations with the highest prevalence of obesity are also those with the least access to the resources needed to prevent and treat it. This report makes that clear: in Spain, where you live and your financial means determine the care you receive.

Obesity is often reduced to a matter of individual willpower. This view fuels the stigma experienced by the vast majority of people living with obesity and diverts attention from what really drives it: the conditions in which we live, work, eat and move. Understanding this would allow us to stop blaming individuals and start transforming their environments.

As the MAPPS II report highlights, greater attention from governments, private organisations and society as a whole is urgently needed. This attention must translate into structural and sustainable policies that are properly resourced, free from stigma and informed by the best scientific evidence, and that prioritise the populations who need the most institutional and social support. The response must combine equitable healthcare with prevention and improvements in living conditions: welfare policies that strengthen public services, and measures that protect the population from the practices of industries that promote unhealthy environments.

Obesity prevention policies, like those aimed at reducing inequalities, do not benefit only those at greatest risk, but the whole population, whether vulnerable or not, and whether living with obesity or not. Seeing it this way calls on all stakeholders to act and opens a shared path on which no one is left behind.



Jorge Medrano Rodríguez
Lived experience advocate

Obesity matters to me because its impact on health and everyday life demands a response that recognises the dignity of every person. I find this research especially valuable because it brings together the experiences of people living with obesity and the perspectives of those working in its prevention and care in Spain. At a time when we need to turn knowledge into concrete decisions, this report helps identify barriers and guide change, so that access to care no longer depends on where people live or what financial resources they have.

I would like more people to understand that obesity is a chronic, complex disease involving many factors. Reducing it to a matter of individual willpower fuels guilt and stigma, and makes it harder for people to seek and receive help. A deeper understanding would encourage respectful care, ongoing support, and policies that also address the social and environmental conditions that affect health.

I hope that those who read this report will recognise the need to listen to people living with obesity and to include their experience in the decisions that affect them. Their participation must have real consequences for the design of services and public policy.

My wish is that these pages drive lasting commitments: improving professional training, guaranteeing comprehensive and equitable care, and building environments that make healthy living easier. Every step forward should also be measured by its ability to improve people's wellbeing and quality of life.



Dra. María del Mar Malagón

President of the SEEDO Foundation

I would like to begin this foreword with a question: what can a person living with obesity expect from the healthcare system, from those around them, and from those who design health and social policy in our country? For now, the answer is not very encouraging. To give just one example, although obesity is formally recognised as a disease in some settings, the reality is that there is still no organised care pathway and no dedicated prevention plan with mechanisms to monitor progress and make adjustments to achieve specific goals.

In this context, the MAPPS II programme gives us an excellent opportunity to identify both the challenges and the factors that can support prevention and improve care for people living with obesity. It does so from a multifaceted, integrated perspective, bringing together the experiences of people living with obesity and those close to them with the views of healthcare professionals, policymakers, civil society, and the research community.

The Spanish Obesity Society (SEEDO) takes part in MAPPS II and shares its vision and objectives. We trust that this initiative, together with other SEEDO initiatives such as the GIRO Clinical Practice Guideline and the SEEDOCONTIGO programme, will help ensure that obesity is finally understood as a multifactorial, chronic, and complex disease. We also hope it will help address the challenges identified in the study, including access to qualified healthcare professionals and multidisciplinary teams, and the implementation of effective policies that guarantee equitable access to care, regardless of where people live.

To move forward, we must reduce the stigma associated with obesity and involve people living with this disease in designing and evaluating the care they receive. Let us not miss the opportunity MAPPS II offers us to turn these challenges into reality. The time has come to take action.

Acknowledgements

The World Obesity Federation would like to recognise the contributions of all collaborators and participants in this research. In particular, we owe a debt of gratitude to the MAPPS II Spain Working group, including representatives from the Asociación Nacional de Personas que Viven con Obesidad (ANPO) (Federico Luis Moya), GASOL Foundation (Santi F. Gomez and Paula Berruezo), Sociedad Española para el Estudio de la Obesidad (SEEDO) (Diego Bellido Guerrero and Gema Medina Gómez), Xandra Alemany Costa. They provided overall supervision of the design and execution of the research in Spain and supported with the review of this report. Without their dedication and contributions, this research would not have been possible.

We also thank all participants of the research, including those who attended the multisectoral round table, co-hosted with SEEDO, in Toledo on the 21st of November (a full list of attendees can be found in appendix 4).

Carla Montane led the qualitative data collection and analysis and the World Obesity Federation (Jessica Winters, Chandni Maria Jacob, Isabella Godley, Sarah Spreckley, Jaynaide Powis, Rachel Thompson and Maggie Wetzel) led the design, survey analysis, desk review and drafting of the report. Design by Matthew O'Flynn.

ABBREVIATIONS

AC	Autonomous Community
ANPO	National Association for People living with Obesity
BMI	Body mass index
EU	European Union
FGD	Focus group discussion
GIRO	SEEDO's Spanish guideline for the comprehensive and multidisciplinary management of obesity in adults
HCP	Healthcare Professional
NAOS	Strategy for Nutrition, Physical Activity and Obesity Prevention
NCD	Non-communicable disease
OOP	Out-of-pocket
PHC	Primary healthcare
PPCR	Public health, policy, civil society and research
PWLE	People with lived experience of obesity, including parents and carers
SEEDO	Spanish Society for the Study of Obesity
SNS	Sistema Nacional de Salud (Spanish National Health System)
UHC	Universal Health Coverage
WHO	World Health Organization
WOF	World Obesity Federation
VAT	Value Added Tax

Executive summary

Background and methodology: This research was conducted as part of the MAPPS II programme, which aims to strengthen how obesity is addressed within health systems and beyond. In Spain, data was collected through surveys, qualitative interviews and focus groups, and a multisectoral roundtable.

SIX KEY FINDINGS

01
The perceived **lack of recognition of obesity as a disease** is a cross-cutting barrier to obesity action in Spain. Although obesity is included in national plans, regional strategies and guidelines, dedicated funding remains limited, and progress is often lost between political cycles.

02
Negative perceptions of obesity and weight stigma affect action across the whole system. People living with obesity commonly experience stigma in all areas of life, most often in healthcare settings.

03
Lack of political prioritisation was reported by participants. Regional inequalities, partially attributed to decentralisation, were highlighted both in the environments in which people live, such as access to healthy foods and spaces for physical activity, and treatment access.

04
Health systems and care access was impacted by affordability and access to trained professionals and multidisciplinary teams.

05
Opportunities for people with lived experience to influence decision-making were limited. Yet, there was a recognition that involvement of people with lived experience was essential.

06
Socio-cultural and environmental factors shape obesity prevention and treatment. Local diets can be protective, while other social norms and the wider food environment were seen to make healthy choices difficult.

Seven priorities for action

This research identified seven key priorities for obesity prevention and care in Spain:

1. Recognition of obesity as a disease
2. Person-centred, multidisciplinary and life-course based management and care
3. Equity in access to care
4. Enhanced capacity for health professionals
5. Campaigns to address stigma and provide evidence-based dietary and physical activity advice
6. Improved multisectoral and regional collaboration
7. Environments that enable healthy behaviours



04
Introduction

4.1 MAPPS II in Spain

MAPPS II (Management and Advocacy for Providers, Patients and Systems) is a global initiative led by the World Obesity Federation that combines research and multi-stakeholder engagement to generate country-level insight and bring stakeholders together around how obesity is addressed across systems.

The overarching objective of MAPPS II is to strengthen how obesity is addressed within health systems and Universal Health Coverage by building shared understanding and engagement across stakeholders. Spain is one of six 'deep dive' countries studied in depth through multi-stakeholder roundtables and stakeholder consultations.

4.2 Obesity in Spain: the national picture

The prevalence of obesity in Spain

19%

of adults in Spain are estimated to live with obesity

11.6%

of children and adolescents aged 8-16 live with obesity

More than half of adults in Spain are estimated to live with overweight or obesity, including 19% with obesity (World Obesity Federation, 2026). Although childhood overweight and obesity levels appear to have plateaued in recent years, they remain among the highest in Europe (World Obesity Federation, 2026). The PASOS (2022-2023) study found that around one in three children and adolescents aged 8-16 live with overweight or obesity, including 11.6% with obesity (Gasol Foundation, 2023). Overweight and obesity are more common in males than females among both children and adults, with a markedly larger gap among adults (Gasol Foundation, 2023; World Obesity Federation, 2026).

Obesity in Spain also follows a clear socioeconomic gradient, with national surveys showing markedly higher prevalence among children from lower-income households (AESAN, 2025; Gasol Foundation, 2023) and among adults from less advantaged social classes, particularly women (Ministerio de Sanidad, 2025a).

Obesity treatment

21.5%

of total health expenditure is paid out of pocket, against an EU average of 15.1%

The Spanish National Health System (Sistema Nacional de Salud) has, on paper, a universal health coverage scheme which is funded primarily through taxation (Bernal-Delgado et al., 2024). It is decentralised across Spain's 17 Autonomous Communities (ACs), with each AC responsible for organising and delivering healthcare services within its territory. Most services are free at the point of use, excluding pharmaceuticals and medical devices which are partially reimbursed. Out-of-pocket (OOP) payments made up 21.5% of total health expenditure in 2024, well above the EU average of 15.1% (Eurostat, 2025).

In government policy documents, obesity is sometimes referred to as a chronic disease and is considered to be by some healthcare professionals (HCPs), however it is contested whether that is sufficient (Salvador et al., 2020). Rates of formal diagnosis and scheduled follow-ups are notably low compared to other chronic diseases and coverage of obesity management and treatment options under SNS is suboptimal (Salvador et al., 2020). Standard diets and physical activity programmes are the most often prescribed treatments given to people living with obesity (Alianza por la Obesidad, 2023). The SNS does not reimburse obesity medicines, so patients must pay the full cost. Partial reimbursement is limited to the treatment of diabetes. Bariatric surgery is covered only in severe cases (Breton et al., 2025).

Multidisciplinary obesity care is most commonly found in some private hospitals, where patients can access care from a team of endocrinologists, nutritionists, physiotherapists and surgeons, among other specialists (IMED Hospitales, n.d.; Quirónsalud, n.d.). This treatment is typically reimbursed through private insurance or mutual funds[1], creating potential differences in access between patients who can and cannot access private healthcare. There are, however, reported instances of multidisciplinary obesity care in the public sector (Rioja Salud, 2023).

There are no clinical guidelines for the treatment of obesity in adults that are officially adopted by the SNS. However, the Spanish Society for the Study of Obesity (SEEDO) has published the Spanish GIRO Guideline, updated in 2024, which aims to provide Spain-specific guidance for the multidisciplinary treatment of obesity as a chronic and multifactorial disease for adults. For children and adolescents, the Clinical Practice Guideline on the Prevention and Treatment of Childhood and Adolescent Obesity provides official national guidance, but it has not been updated or reviewed since 2009. In the absence of up-to-date official national guidance, several ACs, including Murcia (childhood only) (Servicio Murciano de Salud, 2021) and La Rioja (childhood and adult), (Rioja Salud, 2023) have developed their own guidelines for the management of obesity.

[1] Spanish civil servants are covered by their own public healthcare schemes, the *mutualidades*: MUFACE (central government civil servants), ISFAS (armed forces) and MUGEJU (justice administration). Each year, members can choose to receive care either through the regular public health system or through a private insurer under contract to their *mutualidad*. Members contribute to the cost of prescribed medicines through a *copago* (co-payment) of 30% of the retail price, with no monthly cap, regardless of whether they are working or retired. This differs from the general public health system, where the co-payment depends on income and is capped monthly. As of 2026, the *copago* for *mutualidades* was under review.



Government strategies and policies

Spain's main national health framework is the Public Health Strategy 2022 (Estrategia de Salud Pública, 2022), the first national strategy on public health, which is built on principles of equity and shared governance with a health-in-all-policies approach and includes a strategic line on improving health and wellbeing by promoting healthy lifestyles and health-generating, safe and sustainable environments (Ministerio de Sanidad, 2022). Care for people living with long-term conditions is guided by the Strategy for Chronic Disease Management in the SNS (Estrategia para el Abordaje de la Cronicidad), first published in 2012 and renewed with a 2025–2028 development document, which redefines the care model around a proactive, interdisciplinary and coordinated approach, with an eye on the sustainability of the system. Neither strategy identifies obesity as a distinct priority (Ministerio de Sanidad, 2025b).

Obesity-related strategies and policies

Spain has pursued a range of national and regional initiatives aimed at preventing obesity and addressing its underlying risk factors. The Strategy for Nutrition, Physical Activity and Obesity Prevention (NAOS), introduced in 2005 (AESAN, 2005) and later consolidated into law in 2011, established a national framework for promoting healthier diets and greater physical activity through a cross-sectoral approach, involving healthcare, education, the food industry and local governments.

More recently, the National Strategic Plan for the Reduction of Childhood Obesity (2022-2030), known as 'En Plan Bien', was introduced, aiming to reduce childhood overweight and obesity in the country by 25% by 2030 through intersectoral measures to increase physical activity, support healthy eating, and improve sleep and emotional wellbeing (Alto Comisionado contra la Pobreza Infantil, 2022). Alongside these efforts, the Value Added Tax (VAT) on sugary drinks was increased from 10% to 21% in 2021 (Agencia Tributaria, 2021).

In May 2024, Spain joined the frontrunner countries of the WHO Acceleration Plan to Stop Obesity, a cohort of 34 countries working with WHO and UNICEF to move from policy design to implementation, and Spain's work under the plan has centred on its National Strategic Plan for the Reduction of Childhood Obesity (WHO, 2026b).

Obesity is also addressed indirectly through strategies on other non-communicable diseases (NCDs) and their shared risk factors, such as physical inactivity and unhealthy diets.

The National Strategy for the Promotion of Sport against Sedentarism and Physical Inactivity (2025-2030), led by the Ministry of Education, Vocational Training and Sports, seeks to increase physical activity across the population to help prevent NCDs (Ministerio de Educación, 2024). The Prevention and Health Promotion Strategy of the Spanish SNS (2013-2026) sets out how the SNS should integrate and co-ordinate prevention work on healthy eating, physical activity and good emotional wellbeing (Ministerio de Sanidad, 2014). This includes comprehensive lifestyle counselling in primary healthcare and community education.

At a regional level, Galicia, Andalusia, the city of Madrid, and the Basque Country have strategies that aim to reduce overweight and obesity through the promotion of healthy eating and exercise. Some of these are part of wider health living plans (Xunta de Galicia, 2022; Junta de Andalucía, 2024; Madrid Salud, n.d.; Gobierno Vasco, 2019).



05
Methodology

This research used a mixed-methods approach, designed as a stakeholder consultation to capture the experiences and perceptions of people across the obesity prevention and care system in Spain.

It combined online surveys, interviews, focus groups, and a national multistakeholder roundtable. Three surveys, developed by the World Obesity Federation with its MAPPS II Global Working Group, were aimed at people with lived experience of obesity and their parents and caregivers (PWLE); healthcare professionals (HCPs); and public health, policy, civil society and research (PPCR). They were open from May 2025 to August 2026 and shared through Spanish partner networks and at the SEEDO annual congress. Survey responses were analysed descriptively, and the results are not intended to be representative or generalisable.

Qualitative data collection was carried out by a research consultant alongside the World Obesity Federation team, and analysed using thematic analysis. Discussions at a national multistakeholder roundtable hosted by the World Obesity Federation and SEEDO in Toledo were used to corroborate the findings and shape the priorities set out in this report.

A full methodology can be found in **Appendix 1** and detailed participant characteristics can be found in **Appendix 2**.

WHO TOOK PART

101
SURVEY
healthcare and medical professionals

76
SURVEY
people with lived experience of obesity, parents and carers

75
SURVEY
public health, policy, civil society and research participants

30
QUALITATIVE
interview and focus group participants

282 participants in total, plus a national multistakeholder roundtable hosted with SEEDO in Toledo. Survey responses are descriptive and not intended to be representative. **These colours mark each group's results and quotes throughout the report.**

06
Key findings



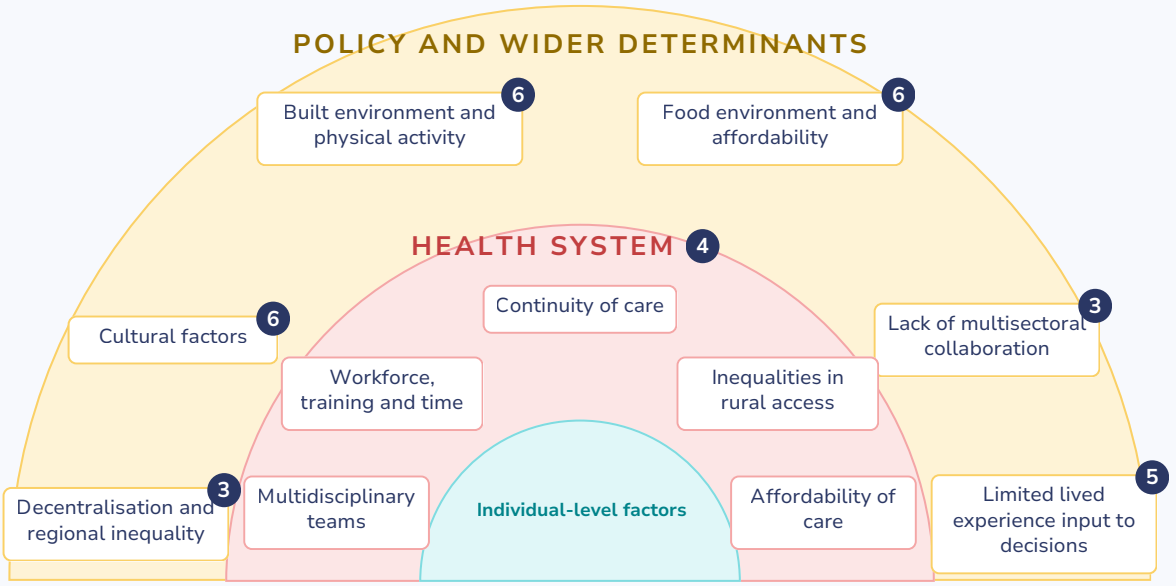
This research explored the perceptions and experiences of actors across the obesity care and prevention systems in Spain.

Findings demonstrated barriers and facilitators to obesity prevention and care in Spain across policy and wider determinants; the health system; and at the individual level (Figure 1).

The findings below are reported by the **six domains** identified from the surveys, interviews, focus groups and roundtable discussion:
i) recognition of obesity as a disease; ii) perceptions of obesity and stigma; iii) the policy environment and political will; iv) health systems and care access; v) opportunities for people with lived experience to influence decision-making; vi) and socio-cultural and environmental factors.

FIGURE 1

Barriers and facilitators to obesity prevention and care across the Spanish system



1 Obesity not recognised as a disease, raised at every layer

2 Weight stigma and individual blame, raised at every layer

FINDINGS DOMAINS

No element is sized or ordered by coding frequency.

1. Recognition of obesity as a disease
2. Perceptions of obesity and stigma
3. Policy environment and political will
4. Health systems and care access
5. Lived experience opportunities
6. Socio-cultural and environmental factors

Individual-level factors · Health system · Policy and wider determinants · Raised at every layer

The figure reflects findings from Spain only and should not be read as representative of other countries. Layered structure adapted from Dahlgren and Whitehead's model of the determinants of health (Dahlgren and Whitehead, 1991).

42%

of HCPs reported that their government did not recognise obesity as a disease

6.1 Recognition of obesity as a disease

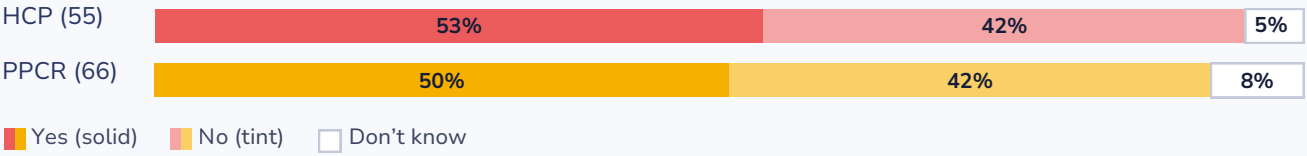
Perceived lack of recognition of obesity as a disease was a cross-cutting barrier to obesity action in Spain (Figure 1). For both participants of the HCP and PPCR survey, approximately half reported that their government recognises obesity as a disease, with the other half of participants reporting a lack of recognition or that they are unsure (Figure 2).

"Obesity isn't just an aesthetic and social issue, it's a disease…"

PPCR SURVEY · PUBLIC HEALTH PROFESSIONAL, CASTILE AND LEÓN

FIGURE 2

Does the national government officially recognise obesity as a disease?



HCP and PPCR professionals were asked: "Does your national government officially recognise obesity as a disease?" Percentages may not sum to 100 due to rounding.

Interviewees suggested that the lack of legislative recognition of obesity as a disease alongside insufficient dedicated funding and poor continuity between political cycles were fundamental barriers that prevented any other measures from being sustained.

"As long as we don't have obesity recognised as a disease at the legislative level, everything else is very difficult to implement because then it all falls apart."

EXPERT INTERVIEW · CLINICAL ENDOCRINOLOGIST AND RESEARCHER, GALICIA

"Guidelines and protocols exist, but implementation falls short."

HCP SURVEY · NUTRITIONIST, VALENCIAN COMMUNITY

The lack of legal recognition is partially compensated by other actions, such as the inclusion of obesity in the National Chronic Disease Plan, SEEDO's GIRO Guide (Spanish guide for the comprehensive and multidisciplinary management of obesity in adults) (Box 1), a multi-party proposal for a National Obesity Plan in the Senate, and regional plans such as Galicia's Zero Obesity Plan and the Canary Islands' Integrated Care Process for Overweight and Obesity (PAI S/O). Whilst these examples do not equate to national policy recognition, they effectively act as institutional recognition of obesity as a public health priority.

42%

of PPCR participants reported that their government does not recognise obesity as a disease

"As a regional government, we do not have the power to declare obesity a disease, but […] a comprehensive plan is already recognising that it is a top-priority public health problem."

EXPERT INTERVIEW · PUBLIC PLANNING AND MANAGEMENT PROFESSIONAL, GALICIA

Despite this broad consensus, the possible economic interests were raised as a concern.

"I have a personal concern that I believe there is a lot of lobbying or influence from companies that make money by getting it recognised as a disease and not just as a risk factor."

EXPERT INTERVIEW · RESEARCHER, MADRID

However, the movement to recognise obesity as a disease is not new, with the World Health Organization first describing obesity as a complex, multifactorial disease in 1997, and framing this recognition alongside the need for population-wide prevention (WHO, 2026a).

These findings point to a common view amongst all stakeholder groups that the lack of disease recognition is a fundamental barrier that prevents any other measures from being sustained.

BOX 1

SEEDO's GIRO Guide

SEEDO's GIRO Guide, endorsed by 37 scientific societies and 12 patient associations, sets out 144 recommendations for managing obesity in adults. It defines obesity as a chronic, relapsing disease rather than a matter of willpower. It moves diagnosis beyond body mass index (BMI) alone, recommending waist-to-height ratio, body-composition testing and staging systems such as Edmonton Obesity Staging System, and it extends the definition to people with overweight whose abdominal fat is already causing complications. It recommends that treatment focuses on health outcomes rather than weight loss alone and that it should combine personalised nutrition, exercise and psychological support, with medication from a BMI of 30 or 27 kg/m² with complications, and bariatric surgery from a BMI of 40 or 35 kg/m² with complications. The guideline states that lack of motivation should never be grounds for denying care. It calls for an end to weight stigma in healthcare, public funding of obesity medicines, shorter surgical waiting lists, and stronger multidisciplinary teams in primary care.

90%

of PWLE have experienced stigma or prejudice related to their obesity

6.2 Perceptions of obesity and stigma

Whilst there was a high level of personal recognition of obesity as a disease on the part of PWLE and their caregivers (Figure 3), PWLE and HCPs did not describe this being represented in the general public's perception of obesity, who often view obesity as *"laziness or idleness"*.

"People think you're overweight because you eat too much, but that isn't the case: every case is different."

PWLE SURVEY · GALICIA

90%

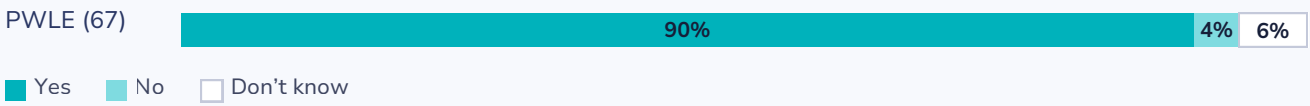
of PWLE consider obesity to be a disease

"Stigma perpetuates the idea that it is a disease linked to individual actions, without giving it the necessary structural focus"

PPCR SURVEY · PUBLIC HEALTH AND RESEARCH PROFESSIONAL, MADRID

FIGURE 3

Is obesity a disease?



"Do you consider obesity to be a disease?" Percentages may not sum to 100 due to rounding.

Stigma was widely experienced by participants, with 90% of PWLE survey participants reporting experiencing stigma or prejudice in relation to their obesity (Figure 4a). Although participants indicated that the stigma was experienced in various areas of their lives, the most common reported area was in healthcare settings (Figure 4b). Describing comments from professionals about excess skin after surgery, one participant said:

"I'm not someone who likes how I look aesthetically… [Facilitator: Who tells you that?] The surgeon says that."

PWLE FOCUS GROUP PARTICIPANT

FIGURE 4A

Experience of stigma or prejudice

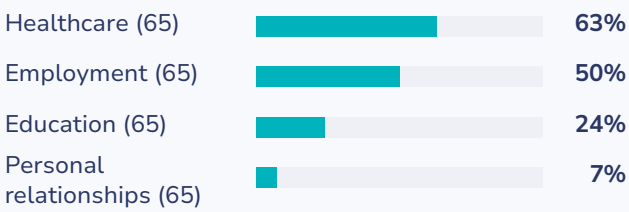


"Have you or the person you care for ever experienced stigma or prejudice related to their obesity?" Percentages may not sum to 100 due to rounding.

FIGURE 4B

Where stigma is experienced

Views of PWLE



"In what areas of your life have you experienced this stigma?" Percentage answering yes for each area.

These participants acknowledged the existence of stigma on the part of HCPs, with PWLE citing doctors using phrases like "*less food and more exercise*" and HCPs further describing how without training, HCPs themselves can develop a stigmatised view of PWLE.

> *"I myself had a very stigmatised view of obesity when I started treating these patients. It was through studying it, trying to understand the pathophysiology a little, seeing how complicated and complex it was, and also starting to listen to people's lives and circumstances, that [I was able to] destigmatise it somewhat."*

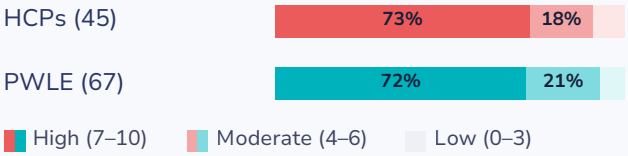
HCP FOCUS GROUP · PHARMACIST AND NUTRITIONIST, AC NOT PROVIDED

Experiences of stigma in healthcare were described as contributing to internalised stigma and delays in care seeking.

Both HCPs and PWLE reported that stigma and weight bias affect care seeking and the care received (Figure 5a). 73% of HCPs and 72% of PWLE rated stigma's impact on care as high. Despite this, HCPs reported a high level of confidence in treating patients in a non-stigmatising way (Figure 5b).

FIGURE 5A

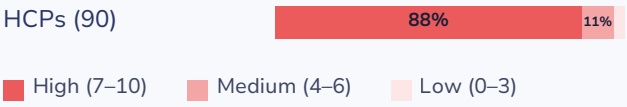
Stigma's impact on care



PWLE (including parents and carers) were asked: "To what extent do you think that stigma impacts the ability of people living with obesity to seek and access care?". HCPs were asked: "To what extent do you feel weight bias affects the care people living with obesity receive in your setting?" Rating 0–10.

FIGURE 5B

Confidence in providing non-stigmatising care



"How confident do you feel about treating and managing your patients living with obesity in a non-stigmatising way?" Rating 0–10.

94%

of PWLE say advertising portrays obesity negatively

Beyond stigma within the health system, the portrayal of obesity was overwhelmingly reported as negative. The vast majority of PWLE reported that obesity is portrayed negatively across popular media (89%), social media (92%), the news (88%) and advertising (94%).

Stigma is present across all areas of life in Spain and can have a great impact on PWLE, particularly in relation to seeking care.

6.3 Policy environment and political will

2.9/10

average rating of government financial support for obesity treatment, from HCPs

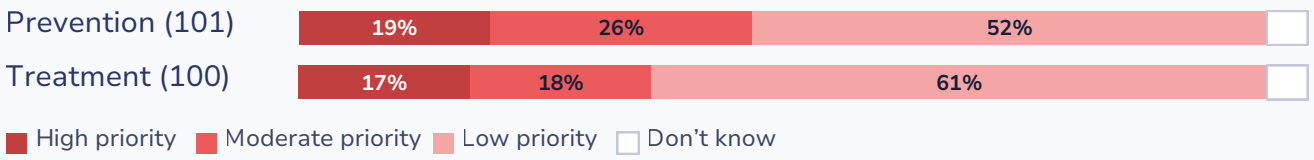
HCP participants viewed the prioritisation of both the treatment (61%) and prevention (52%) of obesity as low compared to other health and social problems (Figure 6). Government financial support was also rated poorly by HCPs, averaging just 3.3/10 for prevention and 2.9/10 for treatment (n=99).

The vast majority of PPCR survey participants (96%) thought that the Spanish government did not use fiscal policies (e.g. taxes) to encourage healthier diets. Participants felt this was a missed opportunity and highlighted the need to implement proven, effective fiscal and regulatory policies.

FIGURE 6

Government priority given to obesity

Views of HCPs



"Compared to other health and social problems, how much of a priority is obesity prevention, management and treatment for your national government?" Percentages may not sum to 100 due to rounding.

"Tobacco prevention and control policies […] have shown that what works best is increasing taxes […] and then reinvesting those taxes […] why don't we incorporate measures that we know work, such as taxes on sugary drinks […] and reinvest those taxes to subsidise the cost of fresh, healthy food?"

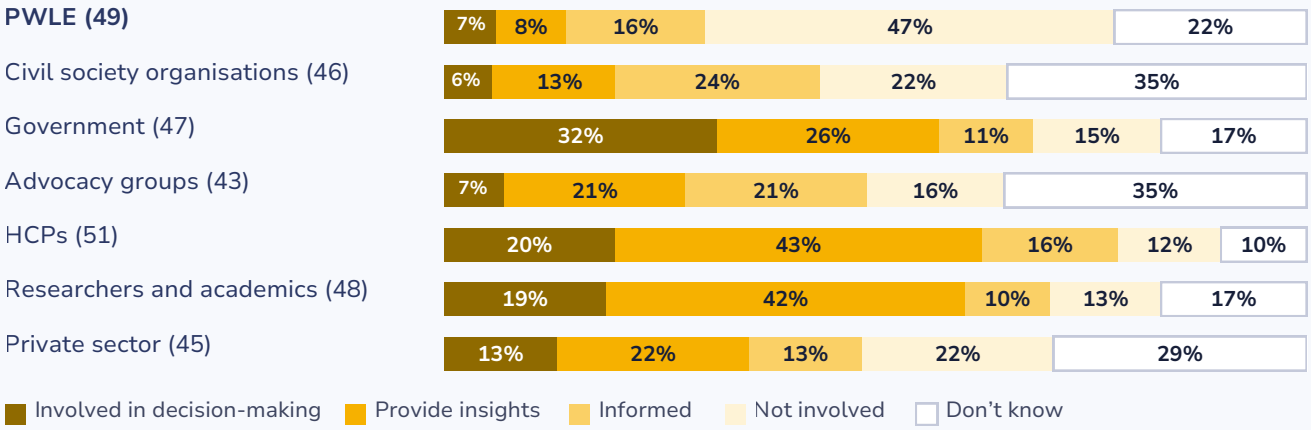
EXPERT INTERVIEW · RESEARCHER, MADRID

Alongside this, PPCR survey participants reported limited multisectoral involvement in decision-making, with government (32%), HCPs (20%) and researchers (19%) the most likely to participate. Notably, civil society (7%), advocacy groups (7%) and people with lived experience of obesity (6%) were least considered to be involved in decision making (Figure 7).

FIGURE 7

How actors engage in obesity policy, research and advocacy

Views of PPCR



"In your country, how do the following actors engage in obesity policy, research and advocacy?" Percentages may not sum to 100 due to rounding.

Obesity is perceived to receive low priority and limited funding, despite stakeholders' belief that evidence-based fiscal and regulatory measures could make a meaningful difference. There are also opportunities for improved, meaningful multisectoral engagement with stakeholders across the system to address this.

Decentralisation and inequality

There are further challenges to political action in Spain due to the existence of 17 autonomous health systems without a unified national obesity framework. Experts emphasised the challenge is establishing a common criterion; that there is a long bureaucratic process that requires any national regulation to be approved and budgeted in each autonomous community; and that the strong decentralisation of powers is a barrier to coordination. Collaboration between autonomous communities is also limited. Participants highlighted that promising initiatives, such as La Rioja's referral protocol, Galicia's Plan Obesidade Zero and SEEDO's GIRO guidelines currently develop in isolation, and there exists a need for a structured national mechanism to share and adapt good practice across regions.

"We don't have any forum… we've created a very decentralised system and that's irreversible… nobody is going to hand over the powers again… there is a stable lack of exchange of best practices between autonomous communities."

EXPERT INTERVIEW · PUBLIC PLANNING AND MANAGEMENT, GALICIA

This was reflected in the very different care experiences PWLE had in different regions. For example, Madrid's healthcare system was described as saturated but with a good public-private mix; Catalonia's, with fast primary care but waiting lists of up to eight months for tests; and Castilla-La Mancha's as "very bad," with extremely long waiting lists and a lack of scheduling flexibility. PWLE in different autonomous communities described the journey to surgery as varying from a few months to more than three years.

"It's very bad here. There's very little supply […] very long waiting lists the nurse is available on Wednesdays at eleven. I'm working at eleven"

PWLE FOCUS GROUP PARTICIPANT

"I had gastric bypass surgery […] I was on the waiting list for three and a half years […] I had to have the surgery through a private agreement after the public system collapsed."

PWLE FOCUS GROUP PARTICIPANT

BOX 2

"Post-code" obesity

"Post-code" obesity was a concept introduced by experts. The prevalence and consequences of obesity, especially in the child population, are distributed unevenly according to social class and autonomous region.

Participants also highlighted that the prevalence and consequences of obesity, especially in the child population, are distributed unevenly according to social class and territory, citing the Canary Islands and Andalusia, the autonomous communities with the greatest inequality associated with childhood obesity, linked to the underfunding of social services (Box 2).

"Socioeconomic inequalities condition access to healthy environments and quality food, disproportionately affecting the most vulnerable groups."

HCP SURVEY · SPECIALIST MEDICAL PRACTITIONER, MADRID

"…obesity has clearly become, (..) a disease with a very strong social patterning of disease. So you will barely see, overweight or obesity among, wealthy people. And you will see a lot of, obesity, both adult and childhood obesity among less fortunate or, or more vulnerable populations."

EXPERT INTERVIEW · RESEARCHER, BASQUE COUNTRY

"If you look at […] the Canary Islands and Andalusia […] they are a clear example of a very marked social gradient […] if you look at the figures for child poverty […] they correlate perfectly with childhood obesity."

EXPERT INTERVIEW · RESEARCHER, MADRID

As a result, where people live, as much as their clinical need, shapes the care and support they can access, reinforcing geographic and socioeconomic inequalities in obesity (Box 2).

6.4 Health systems and care access

Within the health system, there were barriers related to affordable care and the availability of appropriate HCPs to support their obesity care. Participants described the feeling of being in a diagnostic "limbo" due to the lack of disease recognition. Several participants described their situation as "pre, pre, pre" (prediabetes, overweight, but not yet having obesity), a grey area they described as an excuse by the system not to offer them the same care as if a formal diagnosis of the disease already existed.

"I've been quite frustrated from the start […] I have prediabetes, but I don't have diabetes […] everything is like pre, pre, pre."

PWLE FOCUS GROUP PARTICIPANT

Affordability of care

Affordability of care was highlighted as a key barrier within the health system by all stakeholder groups. Out-of-pocket payments were reported as the most common financing method for both pharmacological (91%) and lifestyle (81%) interventions by PWLE (Figure 8). This was particularly true in the case of pharmaceutical treatment, which is not covered by the SNS.

91%

of PWLE paid for medication mostly out of pocket

"The drugs cost 124 or 154 euros per dose […] going from 124 to paying 40% of that is still high."

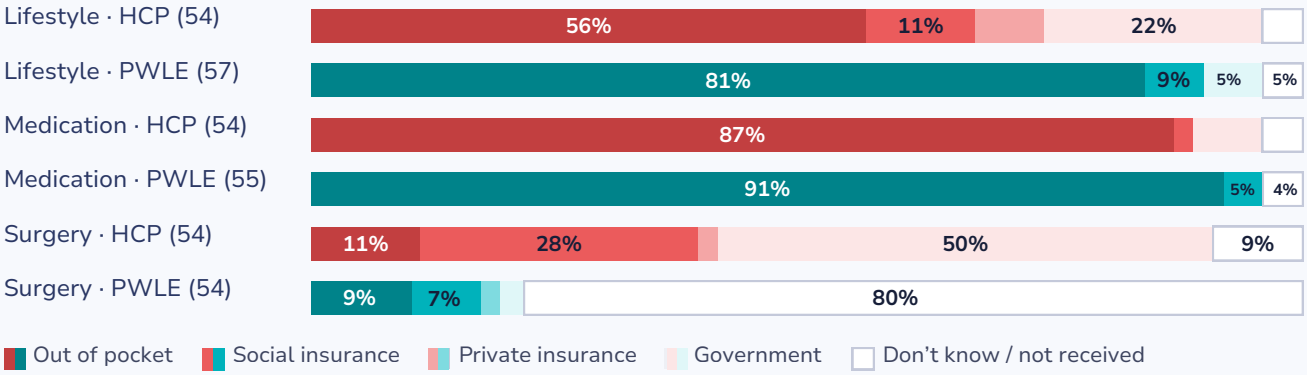
PWLE FOCUS GROUP PARTICIPANT

"Especially the financial aspect, even more so if you don't have a high salary. I think Social Security should cover at least part of it. In my case, I may have to stop the treatment because I can't afford it."

PWLE SURVEY PARTICIPANT

FIGURE 8

How obesity treatment is mostly paid for



PWLE (including parents and carers) were asked: "How did you fund your obesity treatment?"
HCPs were asked: " How is obesity treatment typically paid for in your country?" Answers are "mostly" paid by each source. Final category: "I don't know" for PWLE; "I did not receive this type of treatment" for HCPs

When describing facilitators to care, PWLE mentioned having the financial ability to access treatment through the private system, with a few participants explicitly describing their private insurance plans as facilitating their access to treatment.

These findings suggest that access to obesity treatment in Spain currently depends heavily on personal income (i.e. being able to pay out of pocket) and private insurance, risking a two-tier system in which those who are most able to pay receive timely care while others delay, ration or stop treatment.

"The first thing my parents did was to take me to the private sector, that is, to never think about the public sector…"

PWLE FOCUS GROUP PARTICIPANT

"Having a very good health insurance plan."

PWLE SURVEY · VALENCIAN COMMUNITY

Access to trained professionals and multidisciplinary teams

Lack of access to trained HCPs with a good understanding of obesity and how to treat it in a non-stigmatising way was cited as a key barrier to care by both HCPs and PWLE. Notably, access to obesity care through primary care (PHC) was limited, with only 18% of PWLE survey participants reporting that they had seen a general practitioner as part of their obesity care. PHC should be the first point of contact in the SNS and is free at the point of use (Bernal-Delgado et al., 2024). This places GPs and primary care nurses in a strong position to provide long-term obesity care and to refer patients to specialist services when needed. The GIRO guideline calls for an obesity lead in every primary care team and closer links between primary care and hospital obesity units, and some regions have begun to put this into practice (Box 1).

18%

of PWLE had seen a general practitioner as part of their obesity care

70%

of HCPs had no obesity training in their core training

It was suggested that obesity training for Spanish HCPs is currently inadequate and insufficient, leaving most professionals unprepared and unable to provide the standard of care expected of them. Of the survey participants, 70% of HCPs reported that they had received no obesity training in core training and 23% of HCPs reported specialist training as not available in Spain at all (though 53% felt that specialist training was available but only if you could self-fund). Overall, experts felt that obesity occupies barely one hour of the curriculum throughout the entire medical degree in Spain.

"An hour talking about obesity, the only thing they'd been getting about obesity in their entire career."

EXPERT INTERVIEW · CLINICAL ENDOCRINOLOGIST AND RESEARCHER, GALICIA

"In the end they do teach us about the condition, but I think in a rather outdated way, not with the new information we have or the new nutritional therapies, and always from a clinical point of view, without focusing on the patient. As for the rest, well, we've all been keeping ourselves up to date by finding our own way."

HEALTHCARE PROFESSIONAL FOCUS GROUP · NUTRITIONIST

Alongside the need for professionals trained in obesity, the desire for more multidisciplinary care and teams – especially professionals such as psychologists and nutritionists – throughout a patient's treatment journey was evident.

"Lack of time and lack of multidisciplinary resources, especially in social work and mental health. Lack of effective treatments that are publicly funded"

HCP SURVEY · SPECIALIST MEDICAL PRACTITIONER, CATALONIA

PWLE also cited lack of access to professionals who are trained in obesity and provide sufficient information to their patients about obesity.

"They explained to me that I was having stomach surgery, not brain surgery. I never had a psychologist present."

PWLE FOCUS GROUP PARTICIPANT

"I think there's a serious lack of information; it's not even about prevention anymore, it's just about information […] they don't tell you about the costs or the implications."

PWLE FOCUS GROUP PARTICIPANT

This lack of information leaves a void that the patients themselves fill with alternative resources, in some cases of dubious reliability. Participants highlighted the risk of misinformation and using less reliable sources of information, such as social media or AI, in the absence of adequate and reliable information from their HCP.

"…there is a great deal of ignorance about how to manage it, and people still pay a great deal of attention to myths."

PPCR SURVEY · PUBLIC HEALTH PROFESSIONAL, ANDALUSIA

From the perspective of HCPs, key barriers for HCPs in supporting treatment included insufficient time for consultations alongside an increased demand for specialist consultations. These barriers often result in personalised care not being prioritised, long waiting lists, and limited follow up. These factors alongside a lack of professionals, limited multidisciplinary resources, especially in social work and mental health, and poor coordination between professionals are all barriers to providing person-centred care.

"The barrier is human resources […] when you want to follow up, you find that you have a number of patients that don't fit in your schedule."

EXPERT INTERVIEW · CLINICAL ENDOCRINOLOGIST AND RESEARCHER, GALICIA

HCPs survey participants also reported that the availability of suitable obesity treatment professionals is lower in rural areas. When rating the availability out of 10, the average rating for urban areas was 5.74 versus 4.32 in rural areas (n=47), which may further exacerbate inequalities related to access. These findings confirm the need for enhanced professional training on obesity and access to multidisciplinary teams with sufficient time to provide holistic, person centred care.

6.5 Lived experience opportunities to influence decision-making

9.5/10

average importance PWLE place on involving lived experience voices in the development of obesity policy, prevention and research

This research found that there are limited opportunities for PWLE to influence decision-making in obesity policy, research and advocacy. PPCR survey participants reported that PWLE had limited engagement in policy, research and advocacy, with 47% of survey participants indicating that PWLE are not engaged at all and a further 22% reporting that they do not know (Figure 7). PWLE also highlighted the lack of awareness or existence of opportunities to influence healthcare policies, with 30% stating that there are no opportunities for PWLE to influence healthcare policies related to obesity in Spain and 58% not knowing if these opportunities exist (Figure 9). Despite this, PWLE indicated that they feel it is very important to involve lived experience voices in the development of obesity policy, prevention and research, with an average score of 9.5 out of 10. There is a clear gulf between the perceived value of PWLE involvement in obesity policymaking, and the knowledge of (and possibly existence of) opportunities for PWLE to do so.

FIGURE 9

Opportunities to influence healthcare policy

Views of PWLE



"Are there opportunities for you or the person you care for to influence healthcare policies related to obesity in your country?" (n=60).

Despite the broad agreement on the value of greater citizen participation, one expert warned of the risk that it will be exploited —by institutions, academia or pharmaceutical companies— without it subsequently resulting in real decisions.

"Anything that increases levels of citizen participation, including co-creation with citizens […] is fundamental if we want the measures to work […] my problem arises when that participation is used or instrumentalised […] that is not real participation."

EXPERT INTERVIEW · RESEARCHER, UNIVERSITY OF ALCALÁ

This together suggests that there are opportunities for enhanced PWLE participation in policy, research and advocacy, with caution that any participation needs to not be tokenistic and result in real participation and collaborative decision making.

6.6 Socio-cultural and environmental factors

Health and policy professionals who responded to the survey commonly referred to "cultural factors" as a barrier to obesity prevention, treatment and management, although most did not specify what these were.

Alongside this, these participants recognised that there was also an increase in the availability of ultra-processed foods and a lack of free time for families to prepare healthy meals due to long working hours.

"In Spain, eating and drinking well and enjoying food socially requires a gradual cultural change that is difficult to implement."

PPCR SURVEY · PUBLIC HEALTH PROFESSIONAL, VALENCIAN COMMUNITY

"Easy access to ultra-processed foods as a cheap, accessible and regular part of the diet, which makes it easier to balance family life"

PPCR SURVEY · PUBLIC HEALTH PROFESSIONAL, CASTILE AND LEÓN

"The lack of consistency between health messaging and practical reality (greater access to processed foods, lower prices, access to these products in healthcare settings…), and difficulties in reaching families (little time beyond work to be present in schools and hospitals and to access possible educational resources)"

HCP SURVEY · PSYCHOLOGIST, MADRID

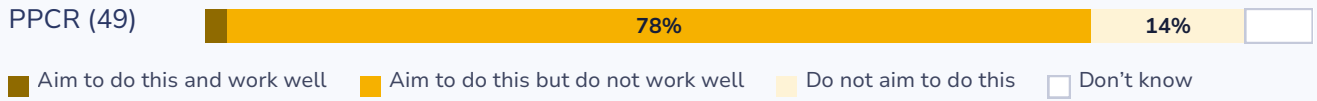
78%

of PPCR participants say policies aim to adapt environments for healthy lifestyles but do not work well

Participants also highlighted the lack of suitable outdoor spaces for physical activity, contributing to a sedentary lifestyle. PPCR survey participants felt that although current policies do aim to adapt environments to enable a healthy lifestyle, they do not work well (Figure 10).

FIGURE 10

How well policies adapt environments to enable a healthy lifestyle



"How well do current policies adapt environments to enable a healthy lifestyle?" Percentages may not sum to 100 due to rounding.

"In Valladolid, in my neighbourhood, all the streets are uphill, there are no facilities nearby where I can take him to do sports."

PWLE FOCUS GROUP PARTICIPANT · VALLADOLID

Despite these challenges, some participants recognised some cultural and environmental factors unique to Spain which could support in obesity prevention and treatment, including a favourable climate for outdoor exercise and the local diet. These findings point to an opportunity in Spain to harness the cultural factors that will support obesity prevention and treatment, and ensure accessibility.

07

Key priorities for obesity action

This research represents perspectives from 282 actors across the obesity care and prevention system in Spain. Findings provide insight into the challenges of, and opportunities for, system-level changes that could support improvements at the political, health system and individual levels.

Seven key priorities emerged from this research and were developed in partnership with the MAPPS II Spain Working Group.

1 Recognition of obesity as a disease

Whilst obesity is sometimes referenced as a chronic disease in policy documents, those working in and with lived experience of obesity do not perceive it to be recognised. Legal recognition of obesity as a disease is an important first step and needs to be accompanied by legislation which ensures stable funding independent of political cycles. This recognition should also be reflected in clinical practice, with official national guidance adopted by the SNS. Additionally, there is a need for an updated obesity strategy which addresses obesity across the life course.

2 Person-centred, multidisciplinary and life-course based management and care

There is a **need to ensure widespread availability of multidisciplinary teams** that include professionals, such as dietitians, nutritionists, and psychologists, in primary care and in obesity units, alongside the normalisation of person-centred care.

The system should ensure continuity of care both by promoting the continuity of the same reference professional throughout care and in the transition from paediatrics to adult care.

3 Equity in access to care

Measures are needed to **reduce dependence on out-of-pocket payments,** ensuring that access is determined by clinical need rather than ability to access private insurance or pay privately. The bureaucracy of referral and treatment authorisation processes should be simplified, and regional variability in waiting times reduced.

Particular attention should be given to rural areas, where fewer trained professionals are available, and to children and families in disadvantaged areas, where the social gradient in obesity is most marked.

4 Enhanced capacity for health professionals

Obesity should be integrated into undergraduate curricula, and accessible, publicly supported specialist training should be available, including on delivering care in a non-stigmatising way.

Training alone is not enough. HCPs described limited consultation time, rising demand and staff shortages as barriers to person centred care and follow-up. Ensuring sufficient workforce capacity and time within consultations is essential for trained professionals to provide the care people need.

5 Campaigns to address stigma and provide evidence-based dietary and physical activity advice

Stigma is present across all areas of Spanish life. Public awareness campaigns should challenge the perception of obesity as a matter of personal willpower and promote understanding of it as a complex, chronic disease. Campaigns should also address emerging "treatment stigma", countering misinformation and judgement towards people using medically prescribed treatment. Alongside this, people need clear, evidence-based information on food and physical activity that is accessible, realistic, and free from blame.

6 Multisectoral and regional collaboration

There is an opportunity for enhanced collaboration across sectors and autonomous communities. A "stable forum for the exchange" of good practices between autonomous communities would support the replication of promising practices in obesity prevention and care. Collaboration should also be truly multisectoral and include actors from across the system, such as education, agriculture, city planning, and others. In particular, people with lived experience of obesity are vital to the development of evidence-based policy.

7 Environments that enable healthy behaviours

Further **implementation of evidence-based fiscal measures,** such as taxes on sugary drinks and ultra-processed foods with revenue reinvested to make fresh, healthy food more affordable, could help shift the food environment.

Physical environments should support active lifestyles through accessible local facilities, safe outdoor spaces and public transport.

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Appendix 1: Detailed methodology

This research took a mixed-methods approach involving data collection through surveys, expert interviews and focus group discussions. This research was designed as a stakeholder consultation to capture experiences and perceptions of actors across the system. No attempt was made to achieve a representative sample. Detailed methodology for each element of the research can be found below:

1 Surveys

a. Data collection

Three global cross-sectional online surveys were designed by the World Obesity Federation with support from the MAPPS II Global Working Group. These were hosted on SurveyMonkey from May 2025 to August 2026 and were distributed to key Spanish stakeholders through the World Obesity Federation's member organisations and the global and Spanish working group's networks. Each survey was developed in collaboration with HCPs, PWLE, civil society and research experts. The surveys were designed for a specific audience: people with lived experience of obesity and their parents and carers; healthcare professionals and public health and policy professionals, researchers and civil society actors. An additional shorter version of the survey was designed to be distributed as part of the Spanish Roundtable which took place at SEEDO's annual congress in November 2025.

b. Data analysis

A mixed methods data analysis of all three surveys was undertaken in MaxQDA and Microsoft Excel.

i. Qualitative analysis

Qualitative responses to key survey questions were coded inductively to identify themes across the data set. The coding frameworks across all three surveys were reviewed by at least one member of WOF staff who provided feedback.

ii. Quantitative analysis

Quantitative responses were analysed descriptively, with results presented as averages and percentages. No statistical analysis was undertaken and quantitative results are therefore not generalisable.

2 Interviews and focus groups

a. Data collection

A series of interviews and focus groups were conducted by both Carla Montane (CM) and WOF staff to provide additional richness and depth to survey findings. Detailed information on method, researcher and participant profile can be found below:

b. Data analysis

All interviews and focus groups were conducted virtually using Zoom with verbatim transcripts generated using Zoom Transcript and MaxQDA to support analysis. Data was analysed using thematic analysis of interview and focus group transcripts (Braun and Clarke, 2006). An inductive thematic analysis was conducted by CM on all data collected by CM to identify themes. These themes were then applied deductively to all data collected by WOF. No new codes or themes were identified in the data collected by WOF.

Throughout the research, AI tools (Zoom AI for transcripts, Plaude Note, Google Translation, MaxQDA, Pronto translation and Claude PRO Sonnet 5.5) have been used to support data processing (transcription, analysis and translation). Interviews were fully anonymised before being processed and were processed fairly under CM's theoretical guidelines; every result was audited, verified, and interpreted manually for final delivery. The process adhered to strict standards of confidentiality and methodological rigour (World Obesity Federation, n.d).

3 Multisectoral roundtable

On 21 November 2025, the World Obesity Federation and the Spanish Society for the Study of Obesity (SEEDO) hosted a national MAPPS II roundtable in Toledo, Spain, bringing together experts, practitioners and lived experience organisations to examine where political intent does not translate into action, where care pathways break down, and how social, commercial and infrastructural determinants shape obesity outcomes.

Detailed notes from the discussion were used to sense check findings in this report and develop the key priorities.

4 Limitations

Both the survey and qualitative data is not representative and findings are not generalisable at the population level. Experiences of the system across regions of Spain are distinct and this research did not consult experts from across the country and may not represent the experiences of people living in different regions.

Appendix 2: Participant characteristics

2.1 Focus groups and interviews

METHOD	GROUP	RESEARCHER	PARTICIPANT PROFILE	N
In-depth interviews	Expert interviews	CM	Experts in clinical practice, public planning and management at the regional level, and research	**5**
	Expert interview	WOF	Researcher working in obesity	**1**
Focus groups with people with lived experience	G1	CM	Patients receiving pharmacological treatment	**5**
	G2	CM	Patients who have undergone bariatric surgery or are on the waiting list	**6**
	G3	CM	Patients managing their obesity through private or self-managed resources	**5**
	G4	CM	Parents of children living with overweight or obesity	**3**
Focus group with healthcare professionals	G5	WOF	Bariatric surgeon, endocrinologist, occupational medicine physician, pharmacist and nutritionist	**5**
Total				**30**

2.2 Where participants are based

Autonomous community of participants in each survey, shown as n (%). Darker cells show a larger share of that survey's participants (coral: HCP; teal: PWLE; gold: PPCR). This question was answered by 95 HCPs, 57 PWLE and 71 PPCR participants.

AUTONOMOUS COMMUNITY	HCP	PWLE	PPCR
Andalusia	23 (24%)	7 (12%)	15 (21%)
Aragon	0 (0%)	2 (4%)	1 (1%)
Asturias	2 (2%)	1 (2%)	0 (0%)
Balearic Islands	0 (0%)	3 (5%)	3 (4%)
Basque Country	2 (2%)	4 (7%)	0 (0%)
Canary Islands	7 (7%)	0 (0%)	2 (3%)
Cantabria	1 (1%)	4 (7%)	1 (1%)
Castile and León	2 (2%)	3 (5%)	2 (3%)
Castilla-La Mancha	0 (0%)	1 (2%)	0 (0%)
Catalonia	17 (18%)	17 (30%)	13 (18%)
Extremadura	2 (2%)	1 (2%)	3 (4%)
Galicia	6 (6%)	3 (5%)	17 (24%)
La Rioja	0 (0%)	0 (0%)	2 (3%)
Madrid	22 (23%)	5 (9%)	9 (13%)
Murcia	2 (2%)	0 (0%)	2 (3%)
Navarre	2 (2%)	0 (0%)	0 (0%)
Valencian Community	7 (7%)	6 (11%)	1 (1%)
Ceuta and Melilla	0 (0%)	0 (0%)	0 (0%)
Total	95	57	71

2.3 Participant characteristics by survey

Shares of each survey's participants, shown as % (n). Where given, n is the number of participants who answered the question. Autonomous community is shown in appendix 2.2.

Healthcare professionals

N = 101

Work setting (n = 48)

Urban	90% (43)
Rural	10% (5)

Care context † (n = 51)

Primary care	35% (18)
Secondary/tertiary care	43% (22)
Community-based healthcare	2% (1)
Community outreach	4% (2)
Other	16% (8)

Profession (n = 100)

Generalist medical practitioner	21% (21)
Specialist medical practitioner	52% (52)
Medical resident/junior doctor	0% (0)
Nurse or nurse practitioner	3% (3)
Physician assistant/associate	1% (1)
Dietitian	2% (2)
Nutritionist	10% (10)
Exercise therapist/scientist	0% (0)
Physiotherapist	1% (1)
Psychologist, counsellor or psychotherapist	1% (1)
Midwife	0% (0)
Community health worker	1% (1)
Dentist	0% (0)
Other	8% (8)

Specialty (specialist practitioners or those who did not specify profession) (n = 52)

Endocrinologist or diabetologist	48% (25)
Obesity specialist	13% (7)
Bariatric specialist	8% (4)
General surgeon	0% (0)
Cardiologist	6% (3)
Paediatrician	10% (5)
Obstetrician and gynaecologist	0% (0)
Psychiatrist	0% (0)
Other	15% (8)

People living with or at risk of obesity, parents and carers

N = 76, including 2 parents or carers

Age (years)

Median (IQR)	49.2
Under 18	1% (1)
18–24	0% (0)
25–34	5% (4)
35–44	25% (19)
45–54	45% (34)
55–64	20% (15)
65 and over	4% (3)

Sex (n = 73)

Female	85% (62)
Male	14% (10)
Prefer not to answer	1% (1)

Setting

Urban	74% (56)
Rural	26% (20)

Self-reported or carer-reported BMI category

Underweight	0% (0)
Healthy weight	4% (3)
Overweight	16% (12)
Obesity	46% (35)
Severe obesity	34% (26)
Don't know	0% (0)

Time living with or at risk of obesity (n = 75)

Less than 1 year	0% (0)
1–2 years	0% (0)
3–4 years	4% (3)
5 or more years	95% (71)
Prefer not to say	1% (1)

Education, training or employment (multi-select) (n = 76)

School	0% (0)
College	5% (4)
University	7% (5)
Vocational, apprenticeship or professional training	12% (9)
Full-time employment	55% (42)
Part-time employment	8% (6)
Caring for home or family	18% (14)
Other unpaid work	4% (3)
None of the above	14% (11)

Public health, policy, civil society and research

N = 75

Area of work (multi-select) (n = 75)

Public health	56% (42)
Policy making	0% (0)
Civil society	5% (4)
Research and/or academia	29% (22)
Other	31% (23)
No response	0% (0)

Education, training or employment and area of work are multi-select questions: percentages are of all participants in each survey (76 and 75) and won't add up to 100%.

Appendix 3: Detailed survey analysis methods

Questions analysed from each survey, by type of analysis. Each survey had additional questions which are not reported in this report.

Lived experience survey: Section A covers participants living with or at risk of obesity (Q1–32) and Section B covers parents and carers (Q33–61).

Eligibility criteria

PPCR SURVEY

Q1 Please read the following statements and confirm your understanding and consent to take part in this research:

Q2 Which country are you reporting on?

HCP SURVEY

Q1 Please read the following statements and confirm your understanding and consent to take part in this research:

PWLE SURVEY

Section A: living with or at risk of obesity

Q1 Please read the following statements and confirm your understanding and consent to take part in this survey:

Q2 Do you identify as living with or being at risk of obesity?

Q4 What is your country of residence?

Section B: parents and carers

Q34 What is the country of residence of the person you care for?

Descriptive analysis (MAXQDA / Excel)

PPCR SURVEY

Q3 Which of the following best describes your area of work?

Q4 Does your government officially recognise obesity as a disease?

Q6 Does your country have officially published national strategies for the following?

Q7 Please rate how well your country's national government is doing in terms of financial support in the following areas.

Q11 Does your national government have policies which do the following?

Q12 How well do current policies do the following:

Q15 To what extent are obesity policies monitored after implementation?

Q20 In your country, how do the following actors engage in obesity policy, research and advocacy?

HCP SURVEY

Q2 What is your country of residence?

Q3 Which of the following best describes where you work?

Q4 In what context do you work to prevent, manage and/or treat obesity?

Q5 Which category best describes your profession?

Q6 In which area do you specialise?

Q7 Does your government officially recognise obesity as a disease?

Q9 Compared to other health and social problems, how much of a priority is obesity prevention, management and treatment for your national government?

Q10 Do any of your national government or professional bodies have clinical guidelines on obesity prevention, management and treatment for adults or children?

Q11 In practice, if clinical guidelines on obesity prevention, management and treatment do exist, are they followed?

Q13 Please rate how well you think your country's national government is doing in terms of financial support in the following areas.

Q15 How is obesity treatment typically paid for in your country?

Q18 Please rate on a scale of 0-10 the availability of suitably qualified obesity treatment and prevention professionals in both rural and urban areas.

PWLE SURVEY

Section A: living with or at risk of obesity

Q3 What is your age in years?

Q5 Which of the following best describes where you live?

Q6 Which of the following best describes your body weight status as described by Body Mass Index (BMI)?

Q7 How long have you been living with obesity or at risk of obesity?

Q8 Are you a parent or carer of someone living with obesity or who is at risk of obesity? (also used for routing)

Q9 What is your sex?

Q10 Are you currently in any of the following

Q11 Has a health or medical professional ever told you that you have obesity or are at risk of obesity?

Q12 After this conversation with the health or medical professional, was there an offer of support or treatment provided?

Q13 Have you ever received obesity treatment?

Q15 Which of the following medical professionals have you seen for obesity treatment?

Q16 Outside of the health system, what support have you sought to manage obesity?

Q17 How long have you been actively receiving obesity treatment?

Q20 How did you fund your obesity treatment?

Descriptive analysis (MAXQDA / Excel) (continued)

PPCR SURVEY

HCP SURVEY

Q19 Are multidisciplinary teams to manage obesity care typically available in the following settings in your country?

Q20 How well do you think your country is doing on the three components of a primary care approach?

Q21 Was obesity prevention and management training included as part of your core training?

Q22 Is specialist obesity training readily available for healthcare professionals in your country?

Q23 To what extent do you feel weight bias affects the care people living with obesity receive in your setting?

Q24 How confident do you feel about treating and managing your patients living with obesity in a non-stigmatising way?

PWLE SURVEY

Q22 Based on your personal experience, please rate your health system's ability to prevent obesity and treat individuals living with obesity.

Q24 Do you consider obesity to be a disease?

Q25 Have you ever experienced stigma or prejudice related to your obesity?

Q26 In what areas of life have you experienced this stigma or prejudice?

Q27 To what extent do you think that stigma impacts the ability of people living with obesity to seek and access care?

Q28 How is obesity portrayed in the media in your country?

Q30 How important do you think it is to include the voices of people with lived experience in the development of obesity policy, prevention and research?

Q31 Are there opportunities for you to advocate for yourself and influence healthcare policies related to obesity in your country?

Section B: parents and carers

Q33 What is the age of the person you care for?

Q35 Which of the following best describes where the person you care for lives?

Q36 What is the sex of the person you care for?

Q37 Is the person you care for currently in any of the following

Q38 To the best of your knowledge, how would you describe the weight status of the person you care for?

Q39 How long has the person you care for been living with obesity or been at risk of obesity?

Q40 Has a health or medical professional ever told the person you care for that they have obesity or are at risk of obesity?

Q41 After this conversation with the health or medical professional, was there an offer of support or treatment provided?

Q42 Has the person you care for ever received obesity treatment?

Q43 Which of the following medical professionals has the person you care for seen for obesity treatment?

Q44 Outside of the health system, what support have you sought to manage obesity?

Q45 How long has the person you care for been actively receiving obesity treatment?

Q48 How did the person you care for fund your obesity treatment?

Q51 Based on your personal experience, please rate your health system's ability to prevent obesity and treat individuals living with obesity.

Q53 Do you consider obesity to be a disease?

Q54 Has the person you care for ever experienced stigma or prejudice related to their obesity?

Q55 In what areas of life have they experienced this stigma or prejudice?

Q56 To what extent do you think that stigma impacts the ability of people living with obesity to seek and access care?

Q57 How is obesity portrayed in the media in your country?

Descriptive analysis (MAXQDA / Excel) (continued)

PPCR SURVEY

HCP SURVEY

PWLE SURVEY

Q59 How important do you think it is to include the voices of people with lived experience in the development of obesity policy, prevention and research?

Q60 Are there opportunities for you or the person you care for to advocate for people living with obesity and influence healthcare policies related to obesity in your country?

Qualitative analysis of open-ended questions (thematic, MAXQDA)

PPCR SURVEY

Q8 Please share what you think your country is doing really well in terms of financial support in each area.

Q9 Please share what you think your country could do more of or do better in terms of financial support in each area.

Q10 Please share information about any other financial support available for obesity treatment, prevention and management in your country.

Q13 In your country, are there specific groups at a higher risk of obesity?

Q14 How well do existing policies serve those at higher risk?

Q16 How could current policies be improved?

Q17 What are the key barriers and facilitators to obesity prevention in your country?

Q18 In what way does the public perception of obesity impact the development and implementation of research and policy to prevent, treat and manage obesity in your country?

Q19 Please share any promising initiatives, programmes or practices in obesity prevention, treatment and/or management you are aware of in your country.

Q21 What key barriers and facilitators exist for effective coordination between sectors on obesity prevention?

HCP SURVEY

Q8 Please share a bit more about where your government is on the journey of recognising obesity as a disease. If relevant, please include what state or region you're located in.

Q12 What barriers and facilitators have impacted your ability to follow obesity prevention, management and treatment guidelines in practice?

Q14 Share any additional information about any other financial support available for obesity treatment, prevention and management in your country. Please mention any differences that exist at the state or regional level.

Q16 Why do people living with obesity usually enter and leave the health system for obesity treatment and management?

Q17 What are the key barriers to obesity prevention, treatment and management in your country?

Q25 Please share anything that has or would impact your confidence to provide non-stigmatising obesity care.

Q26 Please share any promising initiatives, programmes or practices in obesity prevention, treatment and/or management you are aware of in your country.

Q27 Please share anything else you feel we should be aware of about obesity prevention, treatment or management in your country.

PWLE SURVEY

Section A: living with or at risk of obesity

Q14 Please share anything which influenced your decision to delay or avoid obesity treatment.

Q18 Please share any factors which influenced your decision to discontinue obesity treatment.

Q19 What was your experience of receiving treatment?

Q21 What factors have made it easier or more difficult to access obesity treatment?

Q23 How well do you feel primary care services (e.g., GPs, family doctors, nurses or community clinics) support people with obesity in terms of prevention, management, and treatment?

Q29 Please share anything else you think is important for us to know about stigma, prejudice or the public perception of obesity in your country.

Section B: parents and carers

Q46 Please share anything which influenced their decision to discontinue obesity treatment.

Q47 What do you think worked well, didn't work at all or could have been changed to improve the experience of the person you care for when receiving obesity treatment?

Q49 Please share anything which influenced their decision to delay or avoid obesity treatment.

Q50 What factors have made it easier or more difficult for the person you care for to access obesity treatment?

Q52 How well do you feel primary care services (e.g., GPs, family doctors, nurses or community clinics) support people with obesity in terms of prevention, management, and treatment?

Q58 Please share anything else you think is important for us to know about stigma, prejudice or the public perception of obesity in your country.

Appendix 4: Roundtable participants

Toledo, Spain, 21 November 2025

NO.	NAME	ROLE AND AFFILIATION
1	**Maggie Wetzel (Moderator)**	Head of Policy and Advocacy, World Obesity Federation
2	**Susana Monereo (Moderator)**	Head of Endocrinology, Obesity and Metabolism, Hospital Ruber Internacional, Madrid; Professor, Complutense University of Madrid; Secretary General, Spanish Society for the Study of Obesity (SEEDO)
3	**Prof. Susana Aznar**	Professor of Physical Activity and Health and Director of the Promotion of Physical Activity for Health Research Group (PAFS), University of Castilla-La Mancha (UCLM); Member of the PASOS Consortium
4	**Sagrario Pérez Castellanos**	Deputy Director General for Healthy Lifestyles, Xunta de Galicia (Galician Regional Government)
5	**Federico Luis Moya**	President, National Association of People Living with Obesity (ANPO); Vice-President, European Coalition for People living with Obesity (ECPO)
6	**Xandra Alemany**	Vice-President, National Association for the Support of Obesity Treatment (ANATO); Expert Patient, Obesity Unit (UTIO), Vall d'Hebron University Hospital
7	**Sara Bernal Gutiérrez**	Secretary, National Association for the Support of Obesity Treatment (ANATO)
8	**Francisco Romero López**	Head of Communications, Spanish Society for the Study of Obesity (SEEDO) and Spanish Diabetes Society (SED)
9	**Prof. Fernando Fernández-Aranda**	Professor of Psychology, University of Barcelona; ICREA Academia; Director of the Eating Disorders Units, Bellvitge University Hospital (HUB); Research Lead, IDIBELL and CIBERobn
10	**Dr Julio Álvarez Pitti**	Head of Paediatrics, Valencia General University Hospital Consortium (CHGUV); Associate Professor of Paediatrics, University of Valencia; Researcher, CIBERobn, Carlos III Health Institute
11	**José Manuel Fernández García**	Family Doctor and Head of the Primary Care Service, Valga (Pontevedra); Associate Professor, University of Santiago de Compostela (USC); Coordinator of the Nutrition Group, Spanish Society of Primary Care Physicians (SEMERGEN)
12	**Josep Vidal**	Endocrinologist, Hospital Clínic de Barcelona; Associate Professor, University of Barcelona
13	**Paula Berruezo Torres Gómez de Cádiz**	Technical Coordinator of Research and Programmes, Gasol Foundation
14	**Diana Estévez Fernández**	Technical Officer, World Health Organization (WHO)
15	**Andreea Ciudin**	Specialist in Endocrinology and Nutrition and Coordinator of the Obesity Unit (EASO-COM), Vall d'Hebron University Hospital; Professor, Autonomous University of Barcelona; Treasurer, SEEDO
16	**Julia Díez**	Professor and Researcher in Epidemiology and Public Health, University of Alcalá
17	**Dr Violeta Moizé Arcone**	Researcher and Clinical Nutritionist, Hospital Clínic de Barcelona; Associate Professor, University of Barcelona; President, Spanish Scientific Society of Dietetics and Nutrition (SEDYN)
18	**Luis Cereijo**	Professor and Researcher in Physical Activity Epidemiology and Public Health, University of Alcalá
19	**Álvaro Hernando Freile**	Adviser to the Minister's Cabinet and Head of Service, Directorate-General for Public Health and Health Equity (DGSPES), Ministry of Health
20	**Delfina Boudou**	Programme Manager, Hepatic Public Health Group, Barcelona Institute for Global Health (ISGlobal)

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