



FOCUS GROUP SUMMARY REPORT

Stigma and its Impact on Obesity Care

Patient-informed insights on barriers to obesity care, stigma, treatment access, and system-level opportunities for action.

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1. Executive Summary

Key Findings

Lived experience is essential to better health outcomes – Participants identified barriers often invisible in clinical and policy discussions, from delayed diagnosis and fragmented care to unaffordable treatment, inadequate psychological support and missing long-term outcome data.

Stigma blocks access to care and rights – Stigma discouraged care-seeking, led clinicians to dismiss symptoms or attribute unrelated conditions to weight, left participants feeling they had to prove they were not “*drug seeking*”, and reduced their confidence to ask for treatment, accommodations or protection from discrimination.

Obesity is not recognised as a chronic disease – Misdiagnosis, delayed care and moral judgement were common. In the rare cases where care was coordinated, respectful and monitored, participants described better outcomes.

Inequitable access to effective treatment – Comprehensive, multidisciplinary bariatric care was rarely accessible; GLP-1 medications were unaffordable or unavailable in several countries; eligibility criteria were inconsistent; and multidisciplinary care was rare.

Cultural norms shape experience – Perceptions ranged from acceptance to shame. In some contexts, weight signalled status or prosperity.

Weight loss does not resolve stigma – Participants were judged for losing too little or too much, sometimes leading to self-isolation, depression and loss of identity.

Stigma affects professional life and advocacy – Participants faced hiring discrimination, credibility challenges in health professions and judgement within weight-loss communities. Advocates from low-resource settings faced additional inequities.

Research is respectful in conduct but insufficient in output – Participants described non-stigmatising trials and genuine co-creation, but percentage weight loss is the only outcome routinely published, leaving them without data on chronicity, relapse or treatment switching.

Why This Matters

Stigma reduction is part of improving access to obesity care. Stigma delays diagnosis, discourages care-seeking, undermines trust in clinicians and limits access to treatment. When people living with obesity are treated as experts in their own experience, and lived experience informs medical education, treatment pathways, research and policy, systems are better equipped to deliver respectful chronic-disease care.

2. Background & Objectives

Background

Obesity is recognised as a chronic, relapsing disease, yet participants described systems that still treat it as a personal failing – in families, schools, workplaces, clinics and research design. The consequences include delayed diagnosis, depression linked to stigma rather than weight itself, withdrawal from social and professional life, and treatment that is unaffordable, unavailable or unexplained. Stigma shapes whether people seek care, whether clinicians investigate symptoms, whether policymakers invest in treatment, and whether people living with obesity are recognised as authorities on their own condition.

Objectives

The focus group aimed to:

- Understand lived experiences related to obesity including stigma
- Identify unmet needs and challenges for access to treatment
- Gather patient-informed ideas for improvement
- Strengthen patient-centred advocacy and programming

3. Methodology

This report draws on a 90-minute, in-person focus group with twelve people living with obesity from ten countries across North America, Latin America, Europe, Africa, Asia, the Caribbean and Oceania. Participants had a range of treatment experience, from nutrition counselling and exercise programmes to pharmacotherapy and bariatric surgery, and several also work as advocates, health professionals, researchers or community leaders. A semi-structured, qualitative discussion explored experiences of stigma, access to treatment, cultural and social influences, and recommendations for change. The findings offer rich lived-experience insight rather than a statistically representative picture. Full details of the methodology, participants and limitations are provided in the appendix.

4. Key Findings & Themes

Theme 1: Managing Stigma

Stigma was a central, cross-cutting theme, experienced in families, schools, workplaces, clinical settings and even within the obesity community. Asked where the stigma that most shaped them came from, participants responded immediately: *“Family. Family. And school. Professional colleagues.”* Family-based stigma was long-running and often formative. A participant from Oceania recalled: *“My mum started making fun of me... From being an extrovert, I became an introvert... I stopped going out, developed depression, suicidal thoughts.”* Another, from Europe, said simply: *“My mother bullied me.”* A participant from Asia described her mother-in-law attributing two years of infertility to her weight: *“That was very heartbreaking for me.”* Around five participants described depression linked to stigma rather than to weight itself; as one reflected, *“When I was suffering, I didn’t know it was related to the weight... now I understand it has to do with it.”*

Cultural framings were contradictory rather than uniformly negative. In Oceania, *“A beautiful woman is chubby... our leaders would be big”*, and in Africa, weight can signal status – *“that you’re eating well, and life is easy for you.”* Elsewhere, obesity was framed as shameful or neglectful: *“a lack of willpower and neglecting”* (Europe); *“Obesity is shameful. Very shameful for almost the family”* (Asia); *“If you’re fat... the first thing that walks through the door is your weight, not you as a person”* (Europe). Expectations also shifted with gender and life stage. A participant from the Caribbean described *“a schizophrenic approach... chubby children are loved... and at the same time, there’s a whole sector that wants everybody to be slim,”* while in Asia, women *“in the marriage market”* are judged harshly for any weight, whereas men are *“expected to gain weight.”*

Stigma also shaped professional life and public discourse. An advocate working in Europe observed: *“Hardly any other chief executive woman is overweight or obese... If I was not representing an organisation focusing on obesity, perhaps I wouldn’t be getting a job in that senior role.”* A participant from North America was shaken to hear a supervisor disparage a colleague living with obesity *“while she was giving excellent examples”*, and in Latin America, *“People expect a dietitian or a nutritionist to look slim.”* A participant from Africa uses his own platforms to counter a prominent social media figure who blames individuals rather than the food environment. Stigma persisted even in spaces meant to support people living with obesity, and did not end with weight loss: one participant faced negativity from her bariatric surgery community because *“I was losing too much.”*

Theme 2: Access to Treatment

Effective treatment exists but reaches people unevenly. For some, cost was an absolute barrier: *“I have no access to the medication. The GLP-1 medications are very expensive,”* said a participant from Africa. Participants from Asia and Europe stated that obesity medications are not covered – *“it’s very much used as cosmetic”* – and eligibility criteria calibrated to diabetes excluded people who were already unwell. A participant living with hypertension, type 2 diabetes and stage 3 chronic kidney disease, was told by his GP: *“you’re not eligible... because your HbA1c is only 6.5.”* He eventually obtained treatment through relatives who are doctors in a country in Asia, an informal route unavailable to most. Even in strong systems, waits were long: *“It took a little bit over two years for me to have access to treatment”* (Europe).

Access did not guarantee good care. One participant who obtained medication through a direct-to-consumer telehealth service said: *“You basically never speak to anyone... The understanding of the disease is not there.”* A participant who moves between Asia and Europe described the opposite problem – *“every specialist I go to... everybody is saying, get on with it. And they would hand you the medical representative’s number”* – in contrast to *“a very measured, monitored approach and very respectful treatment”* in Europe. Access could also depend on who was asking: a participant from North America felt she had to insist *“I am not drug seeking”*, while her husband was offered a GLP-1 *“immediately. Just like that.”*

Inequity also bred guilt and silence among those with access. *“I didn’t want to tell anybody I was on the medication... I felt it was unfair that I could access these drugs and my colleagues and friends could not,”* said a participant, while another advocate noted that campaigning *“in a country where there are no resources”* brings *“an additional layer of stigma.”* Where participants described good care, it was coordination rather than product availability that made the difference. In a bariatric preparation pathway (in a country in Europe), *“You speak with both the endocrinologists and dietitians,”* and a participant from Oceania described a new GP who *“has started referring me to specialists - helping me in the real sense.”*

Theme 3: Policy Recommendations

Participants offered practical guidance for medical educators, schools and workplaces, focused on formal structures on the premise that institutional obligations can be mandated but attitudes cannot. In medical education, lived experience should come first: *“The first class... I would let the first class be a person living with obesity.”* Curricula should teach obesity as a chronic disease – *“It is chronic, metabolic, lifelong, genetic... so it is not a lifestyle”* – and the evidence behind that classification, because *“you can’t force someone to change what they think.”* A participant from Europe called for clinicians to confront their own prejudices, questioning why *“the medical*

professional's own opinion is allowed to stand," while a participant from Oceania stressed coordination: *"The doctors, the nutritionist - they should all come together."*

In schools, participants prioritised training teachers – *"the child spends almost eight hours in the school"* (Oceania) – and making sport and extracurricular activity inclusive. How to frame obesity for children was contested. A physician participant warned that labelling a child with obesity as a diseased person may actually stigmatise the child more, and recommended directing disease framing at parents and teachers instead, while a participant from the Caribbean suggested presenting obesity as one difference among many: *"Perhaps what we're introducing is that we're all different."*

In workplaces, participants called for obesity to be recognised as a disease in policy and for anti-stigma provisions to be written into manuals and policies: *"Even colleagues make comments... sometimes it comes as a light comment, but the effect is enormous."*

5. Unmet Needs & Challenges

Participants identified persistent, structural challenges that prevent obesity from being treated as a chronic disease in practice:

- **Obesity is classified as a disease but not practised as one** – Clinicians attributed unrelated symptoms to weight, documented obesity without discussing it, or returned responsibility to the individual: *“Rather than understanding it as a chronic condition, it was a blame game.”*
- **Coordinated care is more claimed than delivered** – Specialists worked in silos, leaving patients to carry their own clinical history between rooms: *“I’ve never been seen by the team.”*
- **Access fails at four points: cost, eligibility, coverage and the clinical relationship** – Those without access relied on cross-border or personal workarounds; those with access often received medication without explanation, monitoring or follow-up.
- **Psychological support is largely absent** – Fewer than half had accessed food-specific psychological counselling, and one participant named it as the support she most needed but had never been offered. Provision is limited even in high-income settings.
- **Patients lack information about the long term** – There was no guidance on relapse, switching treatment or what happens when medication stops working, and no published outcomes beyond percentage weight loss.
- **Weight loss is misread as cure** – Families and clinicians withdrew recognition of an ongoing condition precisely when continuity of care mattered most.
- **Inequity silences the community itself** – Participants with access concealed it from peers without; advocates in low-resource settings described an additional layer of stigma, and even shame in asking for support for their campaigns.

These unmet needs contribute to:

- **Avoidance of healthcare** from childhood into adulthood, with diagnostic delay as a direct consequence. One participant's stress fractures were discovered only by chance.
- **Depression linked to stigma** rather than weight, sometimes alongside suicidal ideation and self-isolation.
- **Erosion of self-identity through** cycles of praise and criticism: *"You don't know where you are... you lose who you think you are."*
- **Reduced professional visibility** and, in participants' assessment, exclusion from senior opportunities altogether.
- **A weakened advocacy position:** without data on chronicity, relapse and outcomes beyond weight, patients and organisations must argue for long-term treatment using the one metric that can make treatment appear complete.

6. Opportunities & Patient-Informed Recommendations

One principle recurred across the opportunities participants identified: lived experience should shape the systems intended to improve health outcomes, and anti-stigma protections are part of access to care.

Programme & Support Improvement

- **Multidisciplinary care standards** – Participants described a consistent model of good care: coordinated endocrinology, nutrition and mental health support, respectful language and monitoring beyond weight, as in the bariatric preparation pathway in a European country. *“Any time people have experience actually working with people that live with obesity, their approach is different. It’s kinder.”*

This model is replicable and should be documented as a care standard rather than left as a national exception.

- **Close the psychological support gap** – Current care is weighted towards diet and pharmacotherapy, and psychological support is rarely offered.
- **Build on existing NCD infrastructure** – Expand NCD-related workplace and community programmes rather than creating parallel systems.

Advocacy & Policy Opportunity

- **Calibrate eligibility criteria to obesity** – Eligibility must reflect obesity as a chronic disease, not diabetes thresholds, as the participant refused treatment with an HbA1c of 6.5 illustrates.
- **Pair under-treatment and over-supply** – Being denied treatment and being pushed towards it without explanation are the same systemic failure: obesity managed without real understanding of the disease. Presenting both strengthens advocacy with all stakeholders.
- **Make outcome reporting an advocacy target** – Reporting only percentage weight loss leaves patients unable to justify continued treatment or relapse management.
- **Provide operable policy text** – The intent already exists, but institutions lack enforceable, adaptable language they can implement.

Education & Awareness Needs

- **Lived experience first in medical education** – the most emphatic educational recommendation.

- **Teach the evidentiary basis and practitioner prejudice** – how obesity came to be classified as a chronic disease, and how clinician prejudice affects patient care.
- **Train teachers before identifying children** – while resolving how to name obesity in schools without labelling the child. The disagreement itself is a finding.

Participants emphasised the importance of:

- **Being heard and involved in decision-making** – being consulted during research design rather than receiving conclusions afterwards.
- **Clear, accessible information** – on how medication works, its expected course, relapse and what happens if treatment stops.
- **Ongoing engagement beyond one-time events** – more sessions of this kind, with wider representation, including people from settings without treatment.

7. Conclusion

Fighting obesity stigma is not an optional communications activity but a core health, access and rights strategy. Stigma begins early, is reinforced by families, schools, workplaces, health systems, media and even patient communities, and affects whether people seek care, whether clinicians listen, whether treatment is offered and whether people living with obesity are recognised as experts in their own condition.

People with lived experience already know where systems fail. Hearing them earlier, training clinicians differently, giving schools and workplaces usable policy tools and measuring outcomes that matter beyond weight loss would challenge stigma where it causes the most harm.

Appendix: Methodology and Participants

Methodology

Date:	16 July 2026
Duration:	approximately 90 minutes
Format:	in-person in Mexico City
Facilitated by:	Catalyst Consulting Group

- The session was facilitated by World Obesity Federation and Catalyst Consulting Group.
- A semi-structured discussion guide explored stigma, access to treatment, interactions with health systems, cultural and social influences, and recommendations for future advocacy.
- The discussion was qualitative, designed to generate insight and identify recurring themes; it was not intended to reach data saturation or produce representative findings.

Ethical and Participation Considerations

- Participants gave informed consent, and findings are reported thematically to protect confidentiality.
- Participants received honoraria or support in recognition of their time and expertise.
- Facilitation aimed to create a respectful environment in which participants were not asked to justify their condition or treatment choices.
- Sponsors were invited to observe the focus groups to deepen their understanding of participants' lived experiences and the real-world challenges they face. Their role was strictly observational: sponsors had no involvement in defining the research objectives, selecting participants, or facilitating the sessions. This separation helped ensure that the discussions remained independent and participant-led, keeping participants' experiences and perspectives at the centre of the conversation.

Participants

- Twelve people took part, selected for their lived experience of obesity and of navigating stigma in personal, professional, community or healthcare settings.

- Lived experience represented: Adults living with, or with a history of, obesity. Several also hold professional or advocacy roles in health.
- Several brought additional perspectives as advocates, health professionals, researchers or community leaders, but all contributions were grounded in lived experience.
- Participants were identified through World Obesity networks, partner organisations and advocacy contacts, prioritising lived experience, geographic and cultural spread, and demographic diversity. All continents were represented aside from Antarctica.
- As several participants held advocacy, professional or leadership roles, the findings should be read as rich qualitative insight rather than a complete representation of people living with obesity.

Need for Broader Future Engagement

The group's lived experience and cultural diversity showed how stigma is created and reinforced across families, communities, schools, workplaces, healthcare and public discourse. As participants themselves emphasised, future engagement should include people outside advocacy networks, lower-income and rural communities, caregivers, young people, and those whom stigma has discouraged from seeking care or speaking openly.

Limitations

These findings are based on a small qualitative focus group and should not be interpreted as statistically representative of all people living with obesity or of entire national health systems. Participants were geographically diverse, but many also brought advocacy, professional, or community leadership experience, which may shape both their access to information and the perspectives shared. Country examples are therefore best understood as lived-experience accounts that identify important barriers and design questions, rather than as definitive assessments of national policy or practice.

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