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Addressing weight stigma in clinical guidelines for obesity treatment: a systematic review

Abordagem do estigma do peso nas diretrizes clínicas para o tratamento da obesidade: uma revisão sistemática

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ABSTRACT

Objective
This study aimed to evaluate how weight stigma is addressed in national and international clinical guidelines for the treatment of obesity.

Methods
A systematic review with qualitative synthesis was conducted, analyzing recommendations from clinical guidelines published between 2000 and 2022. Both national and international documents were included, with the goal of identifying the presence, emphasis, and treatment given to the topic of weight stigma. The search yielded 713 publications, of which only 26 met the inclusion criteria established for this study.

Results
The findings revealed that most of the analyzed guidelines do not meaningfully address weight stigma in their recommendations. Despite the importance of this issue for improving the quality of care for individuals with obesity, it remains underexplored, highlighting persistent gaps in the ethical and humanized approach to treatment.

Conclusion
The results underscore the urgent need to incorporate the discussion of weight stigma into clinical guidelines for obesity. Such incorporation is essential to foster an epistemological shift in how obesity is understood and managed in clinical contexts. This transformation requires coordinated efforts at multiple levels – individual, community, and systemic – and entails a reconfiguration of societal relations with fat bodies, as well as a redefinition of the very notion of healthcare.

Keywords: Obesity. Practice guideline. Weight prejudice.

RESUMO

Objetivo

O presente estudo teve como objetivo avaliar de que maneira o estigma do peso é abordado nas diretrizes clínicas nacionais e internacionais voltadas ao tratamento da obesidade.

Métodos

Para tanto, foi realizada uma revisão sistemática com síntese qualitativa das recomendações presentes em diretrizes publicadas entre os anos de 2000 e 2022. A análise contemplou documentos nacionais e internacionais, com o intuito de identificar a presença, a ênfase e o tratamento conferido à temática do estigma do peso. A busca resultou na identificação de 713 publicações, das quais 26 atenderam aos critérios de inclusão estabelecidos para este estudo.

Resultados

Os resultados revelaram que a maioria das diretrizes analisadas não contempla de forma significativa o estigma do peso em suas recomendações. Embora o tema seja essencial para a qualificação do cuidado à pessoa com obesidade, ele permanece pouco explorado, evidenciando lacunas persistentes na abordagem ética e humanizada do tratamento.

Conclusão

Conclui-se que há uma necessidade premente de incorporar a discussão sobre o estigma do peso nas diretrizes clínicas de obesidade. Tal incorporação é crucial para promover uma transformação epistemológica na forma como a obesidade é compreendida e manejada nos contextos clínicos. Essa mudança requer esforços coordenados em múltiplos níveis – individual, comunitário e sistêmico – e implica uma reconfiguração nas relações sociais com corpos gordos, bem como uma ressignificação da noção de cuidado em saúde.

Palavras-chave: *Obesidade. Guia de prática clínica. Preconceito de peso.*

INTRODUCTION

Since 1980, obesity has gained prominence in the public agenda when it was considered a "world epidemic" [1,2]. It has been placed in a position where it must be fought and, in the face of the war against obesity and the accountability of individuals for their condition, there is a war against fat people, based on discriminatory and stigmatizing actions [3].

From the perspective of the improvement of care, the development of clinical guidelines helps professionals and patients in decision making regarding the most appropriate alternative for care in specific clinical circumstances [4]. These guidelines are built on the basis of systematic reviews of scientific evidence, and on the assessment of the benefits and harms of different options in health care. Considering the complexity of obesity, characterized by the intersectionality of biological, behavioral, socioeconomic, cultural, political, historical and environmental dimensions, it is necessary that clinical guidelines for caring for people with obesity address these dimensions within the scope of their recommendations [5].

However, it is observed that the incorporation of a broader vision of the obesity phenomenon is still a difficult task that surrounds the scientific production and the operationalization of care practices. What we experience are constructs still based on the biomedical paradigm that emphasizes the relationship between body fat accumulation and health risks; weight loss as a marker of treatment success; and blaming the individual for their condition [6,7]. In this direction, most guidelines are centered on information about etiology, diagnosis, and different types of treatment: dietary, cognitive behavioral, physical activity, pharmacological and surgical [4,8,9].

Among the challenges of caring for people with obesity, the importance of reflecting on and overcoming weight stigma stands out. People who live with a fat body suffer various forms of prejudice and social devaluation because they do not fit the body standards established by society [10,11].

Studies show that weight stigma, more than obesity itself, harms mental health and is associated with higher levels of anxiety, depression and perceived stress, low self-esteem, social isolation, and excessive use of harmful substances. It can also lead to dysfunctional eating behaviors such as binge eating, use of extreme practices for weight loss, excessive emotional eating and increased sedentary behaviors [11].

Weight stigma, and the stereotypes associated with it, are very present in health spaces and contaminate care practices within these spaces. Health professionals are among the main actors in the process of reinforcing and perpetuating stigma, adopting negative practices towards people with obesity, resulting in a decrease in the quality of care provided to individuals [12,13]. Such practices, which are judgmental, discriminatory and marginalizing, in addition to subtracting the dignity of people with obesity and perpetuating their invisibility, make them avoid health services and move away from care actions [11]. It is also worth reflecting on the importance of ensuring that the health service environment is suitable for the care of people with obesity, with equipment and furniture that support the body size of all users.

Given this context, the present study aims to evaluate how the issue of weight stigma is addressed in clinical guidelines for the treatment of obesity.

METHODS

This is a systematic review with a qualitative synthesis of the recommendations from national and international clinical guidelines for the treatment of obesity published between 2000 and 2022. The guidelines were retrieved from the Guidelines database International Network, Medline, Scopus and Web of Science, as well as the pages of health institutions and professional societies available on the internet.

To identify the clinical guidelines in the databases, the following search strategies were used: 1) For Medline: guideline [Title] AND "obesity" [MeSH Terms]; practice guideline [Publication Type] AND "obesity" [MeSH Terms]. 2) For Scopus: Title (practice guideline) AND Title (obesity); Title (clinical practice guideline) AND Title (obesity). 3) For Web of Science: Title: (practice guideline) AND Title: (obesity); Title: (clinical practice guideline) AND Title: (obesity). In the Guideline International Network the term "obesity" was used.

Inclusion criteria were: 1) clinical guidelines for obesity; 2) that present recommendations for the treatment of adults; 3) developed by government agency and/or national-level societies of health professionals, to allow greater comparability between guidelines in terms of scope and resources; and 4) published from 2000 to 2022. Exclusion criteria were: 1) clinical guidelines that dealt exclusively with obesity associated with another health condition; 2) clinical guidelines that focused exclusively on obesity at specific stages of life other than adulthood; and 3) not including treatment recommendations for adults. There was no language limitation of any language.

To describe and evaluate the guidelines and recommendations, the following steps were implemented: (a) For each country, the target audience, year of publication, actors involved in the preparation of the material, conflicts of interest and the approach to multidisciplinary care were described; (b) The recommendations related to weight stigma were divided into five analysis classifications, constructed by the authors of the text. This definition was based on discussions about weight stigma available in the literature [5,10,11,13], and the criteria considered for its definition were: the quality of the studies, the depth of the topic, the accountability of health professionals in delivering care, and information on the impacts of weight stigma on the lives of individuals with obesity. The 'A' rating was constructed for guidelines that address stigma more broadly and

provide recommendations aimed at making professionals accountable for the need to broaden their focus on care, as well as guidelines for users; the 'B' classification was assigned when the material addresses stigma and provides recommendations aimed only at professionals; the classification 'C' was attributed to those documents in which the stigma of weight was addressed superficially and no recommendations were described for its reduction, nor the accountability of professionals or without demonstrating the impacts on the lives of users; the classification 'D' was assigned to guidelines that, despite addressing aspects of stigma, reinforce themes centered on weight loss in their recommendations, with blaming and stigmatizing views; and an 'E' rating was given to guidelines that do not mention any aspect of the topic.

We declare that there was no need for the approval of this study by the Institutional Review Board.

RESULTS

Seven hundred and thirteen papers were identified, of which 687 were excluded for not meeting the inclusion criteria (Figure 1). Twenty-six clinical guidelines were included and independently evaluated by a pair of reviewers/authors. Only in cases of discrepancy, a third evaluator was called. Data were extracted from the summary of recommendations, when available, or from the general text of the guideline, when a summary was not provided. The sources were last consulted in July 2023.

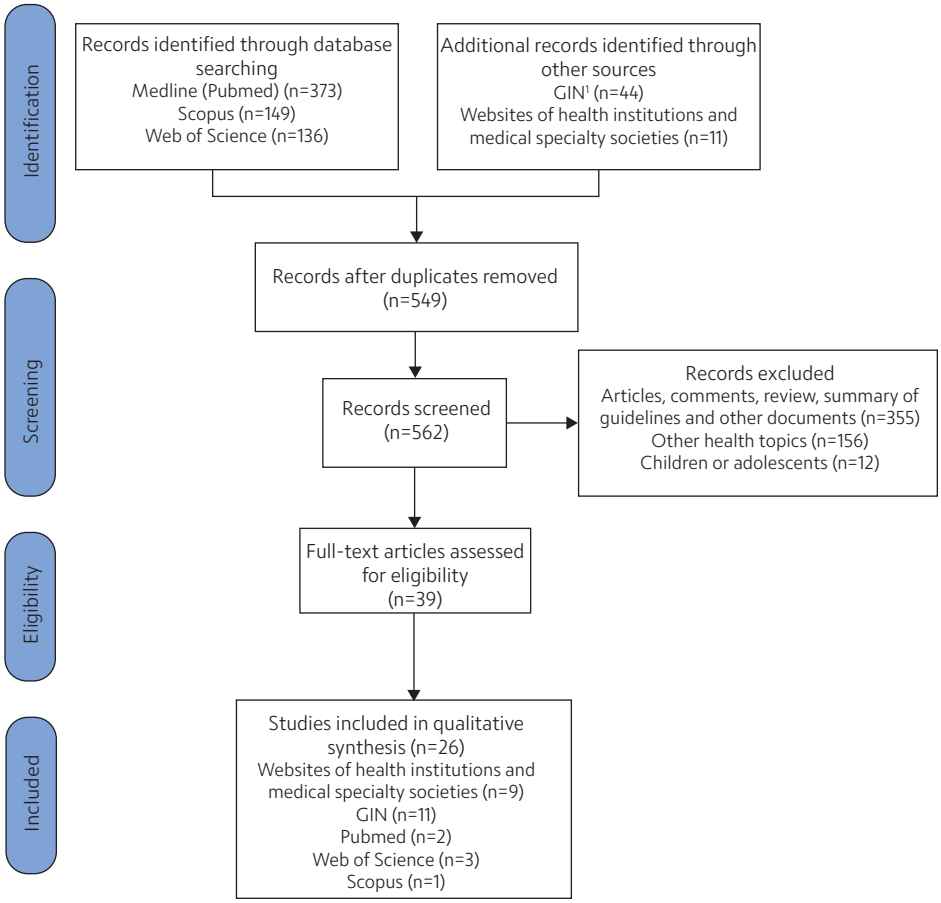

Figure 1 – Flow diagram of the search for clinical guidelines.
Note: [1]Guidelines International Network (http://www.g-i-n.net/).

Twenty-six clinical guidelines [4,8,9,14-36] for the treatment of obesity, published between 2004 and 2020, were evaluated. Of these, six were published in 2020 (Brazil – MH/PCDT, Canada [8], Qatar [25], Korea [16], Finland [31], USA (Department of Defense [32]). The oldest were from the years 2004 (Malaysia [24]) and 2006 (Belgium [34]).

The guidelines originate from twenty-one countries around the world, distributed as follows: 11 (42.3%) from countries located on the continent of the Americas (North, Central and South), 9 (34.6%) from countries in Europe and only 5 (19.2%) from Asia, and 1 (3.8%) in Oceania. The total absence of documents from African countries stands out (Chart 1).

Regarding classification, 12 guidelines (46.15%) were classified at level 'E', that is, they make no mention of weight stigma. It is noteworthy that four of the five U.S. guidelines are at this classification level (Chart 1). The guideline from Australia (p. 18) states in its body of text that it will not include broader reflections on obesity: "[...] The guidelines do not include: discussion of broader societal issues associated with overweight and obesity, including social norms of body shape and size, media and community discrimination and stigma, and how this affects lifestyle and behavioral change in individuals [...]" [15].

Regarding the awareness and accountability of professionals regarding the stigma of weight, it is noteworthy that the Canadian guideline was the only one that was classified at level 'A', bringing recommendations both for professionals, with a focus on the multidisciplinary team, and for the population, as described in the following excerpt: "Health professionals should assess their own attitudes and beliefs regarding obesity and consider how their attitudes and beliefs may influence the delivery of care (Level 1A; Grade A). [...] Health professionals should avoid the use of judgmental words (level 1A, grade A), images (level 2B, grade B) and practices (level 2A, grade B) when working with people living with obesity" [8, p. 5].

The guideline also presents key messages for people with obesity, informing, for example, that weight bias can affect the quality of health care and harm their health and well-being, as well as encouraging conversation with health professionals about how to address internalized weight bias and focus on improving healthy habits and quality of life rather than losing weight [8].

The guidelines classified in the 'D' dimension, despite mentioning the existence of weight stigma, do not contextually reflect its consequences. The Belgian document discusses the impact of weight on body satisfaction: "There is a relationship between weight loss and improved body image, but it is not linear. In other words, greater weight loss is not correlated with greater improvement in body image. On the other hand, a small weight gain can already mean a significant relapse" [34, p. 122].

The Brazilian guideline by ABESO (p. 164) presents the experience of stigma as one of the parameters for the indication of bariatric surgery; however, it does not reflectively address the impacts on the lives of fat individuals: "Apparently a resolution that intends, on the one hand, to increase zeal in the indication of surgery, can in practice trivialize the surgical indication, when it lists comorbidities that are difficult to document through exams (social stigmatization, depression, infertility) and others that, or did not have their severity mentioned in the Resolution, or may not necessarily be related to obesity in all cases (depression, dilated cardiomyopathy, osteoarthritis, erectile dysfunction, varicose veins and hemorrhoidal disease, social stigmatization)" [4].

Chart 1 – Description and classification of guidelines.

Country	Year	Actors involved in the elaboration	Conflict of interests	Multidiciplinary care	Physical structure	Classification	Assessment
Asia - 5 (19,2%)							
Korea	2020	TFP	No	Yes	Not described	E	
Malaysia	2004	MT	No	Yes	Not described	E	
Qatar	2020	TFP + GOV	No	Yes	Not described	C	It emphasizes respect for the patient and outlines appropriate strategies for treatment, ensuring a safe environment for discussion and that the patient's decisions will be respected. It also mentions "cultural acceptance" as a risk factor for obesity.
Saudi Arabia	2016	TFP	No	No	Not described	C	The term "stigma" is mentioned in a table within the psychological subsection, which addresses the consequences of obesity. It outlines care strategies focused on assessing readiness for behavioral change.
Singapore	2016	MT	No	Yes	Not described	E	
Oceania - 1 (3,8%)					Not described		
Australia	2013	TFP + GOV	No	Yes	Not described	E	
America - 11 (42,3%)							
Argentina	2014	MT + GOV	No	Yes	Not described	B	It points out that obesity is a stigmatized disease and a cause of discrimination in the workplace.
Brazil (ABESO)	2016	MT	No	No	Not described	D	It presents social stigmatization as one of the possible conditions for the indication of bariatric surgery, without reflectively addressing its impacts.
Brazil MH/PCDT	2020	MT	Yes	Yes	Not described	C	It discusses stigma, fatphobia, and their impacts, highlighting psychological aspects and other strategies as part of the treatment approach.
Canada	2020	MT	Yes. Pharmaceutical industry	Yes	Not described	A	A comprehensive approach that raises awareness among professionals about the importance of non-stigmatizing practices and highlights the need for policies to combat stigmatizing actions in healthcare.
Colombia	2016	INTERSECTORAL	Yes	Yes	Physical structure for adequate surgery for obese patients	E	
Mexico	2018	TFP	No	Yes	Not described	E	
USA – (Department of Defense)	2020	MT	Yes	No	Not described	B	Presents the stigma, its impacts on the individual's life, how it should be treated in the therapeutic conduct, and the responsibility of health professionals in the care that does not generate stigma.
USA (American Association of Clinical Endocrinologist)	2016	TFP	Yes. Pharmaceutical industry	Yes	Infrastructure for consultations, transport and security	E	
USA (American College of Cardiology)	2013	MT	Yes. Pharmaceutical industry	Yes	Not described	E	
USA (National Heart, Lung, and Blood institute)	2013	MT	Yes. Pharmaceutical industry	Yes	Not described	E	

Chart 1 – Description and classification of guidelines.

Country	Year	Actors involved in the elaboration	Conflict of interests	Multidiciplinary care	Physical structure	Classification	Assessment
USA (World Gastroenterology organization)	2011	TFP	Not describe	Yes	Not described	E	
Europe - 9 (34,6%)							
Belgium	2006	MT	No	Yes	Not described	D	It links weight loss to improved body image and weight gain to dissatisfaction.
England	2014	MT + User	Yes. Industry	Yes	Not described	B	It does not address stigma but focuses on non-discriminatory care that is built through respectful dialogue with the patient.
Finland	2020	MT	Yes. Pharmaceutical industry	Yes	Not described	E	
France	2011	MT	Yes	Yes	Not described	B	It discusses the experienced stigma, its impact on their lives, and its social consequences. It holds the medical profession largely responsible for perpetuating stigma, encourages professionals to alter their practices, and links the use of medication to stigma.
Germany	2014	MT	Yes	Yes	Not described	C	It explains the concepts of stigma and self-stigmatization, highlighting their effects on the clinical progression of the disease and social life. It also discusses media-driven stigma and its harmful impact on an individual's mental health.
Italy	2016	MT	No	Yes	Infrastructure, furniture and equipment suitable for the patient with obesity	C	The healthcare professional plays a crucial role in combating stigma, emphasizing its impact on the individual's life at personal, psychological, and social levels.
Netherlands	2010	MT	No	Yes	Not described	C	The term is mentioned only once in the text, providing a detailed discussion of the negative impacts on the life of the individual with obesity.
Norway	2011	MT + USER	Not describe	Yes	Not described	C	The term is mentioned only once, highlighting its impact on the individual's life and emphasizing the importance of mutual respect during treatment.
Scotland	2010	MT	Yes	Yes	Not described	E	

Note: 'A': Broad stigma coverage, with recommendations for both professionals and users; 'B': Stigma addressed with recommendations for professionals only; 'C': Superficial stigma mention, no recommendations or user impact; 'D': Reinforces weight loss focus with stigmatizing views; 'E': No mention of stigma. MT: Multidisciplinary Team; TFP: Team Formed by Physicians; GOV: Government Organizations; USERS: General Population; INTERSECTORIAL: Different Areas of Activity (education, technology, agriculture, social assistance); PGP: Public and General Population.

The French guideline [19] attributes responsibility for producing stigma to the medical profession, encouraging them to change their care practices. A similar recommendation is made by the Departments of Defense in the USA [32], which reinforces the need for care on the part of health professionals in their clinical approach so as not to generate stigma in their patients. The Argentine [9] guideline addresses the issue by focusing on the inclusion of individuals living with obesity in the labor market and states that it is necessary to think about spaces for approaching and assisting this problem in order to generate communication and awareness strategies.

The guideline from England (p. 2), on the other hand, addresses, without mentioning the term "stigma", the promotion of equal opportunities and the reduction of inequalities in health, in addition to pointing out that "when exercising their judgment, professionals are expected to take this guideline fully into account, together with the individual needs, preferences and values of its patients or the people who use its services" [27]. Therefore, these four guidelines were classified at level 'B'.

The recommendations from the Netherlands [33], Norway [20], Germany [14], Italy [30], Brazil-MH/PCDT [23] and Qatar [25] were more generic and superficial. They sometimes demonstrated in just one paragraph that prejudice and stigma have negative impacts on the individual's life, as is the case in the Netherlands [33], sometimes linking media and mental health problems to the stigma of weight. Some guidelines, such as the one from Germany [14], also mention the term "self-stigmatization", but do not go into depth in explaining the term. Norway [20], on the other hand, presents the word "respect" in its guideline as one of the ways to deal with the process of clinical, psychological and social treatment of the issue. Another guideline that talks about respect is from Qatar [25], reminding the health professional that the user's decisions must be accepted. The Italian guideline [30] places the health professional as an important actor in the fight against weight stigma, demonstrating its repercussions in different areas of life. Similarly, the Brazilian MH/PCDT e 23 presents the impacts of weight stigma and fatphobia, in addition to indicating Integrative and Complementary Practices as a treatment strategy.

It was also evaluated whether the guidelines mentioned environmental stigma, that is, regarding the adequate physical structure to accommodate people with obesity. Of the twenty-six guidelines analyzed, 88.5% (n=23) made no mention of this issue. Colombia [35] presents a brief excerpt mentioning the importance of adequate physical structure for the surgery of patients with obesity; Italy30 mentions adequate furniture and equipment for hospitalization and outpatient care for people with obesity; and the American guideline of the American Association of Clinical Endocrinologists [18] talks about infrastructure for consultations, transport and patient safety.

With regard to the target audience, most guidelines (Malaysia [24], Scotland [29], France [19], Norway [20], Australia [15], Germany [14], USA - National Heart, Lung, and Blood Institute [26], Argentina [9], Saudi Arabia [36], Singapore [22], Colombia [35] , Mexico [28] and Qatar [25]) describe that they are intended for the multidisciplinary team. Only the guideline from Finland [31] declared itself to be for use by health professionals and the general population. The American guidelines of World Gastroenterology Organization [17] and Brazilian MH/PCDT [23] do not describe their target audience. Meanwhile, Belgium [34], Netherlands [33], USA - American College of Cardiology [21], Brazil – ABESO [4], USA – American Association of Clinical Endocrinologists [18], Italy [30] and Korea [16] state that their guidelines are for the medical public.

Australia [15] and Qatar [25] had physicians and government actors participate in the development of their guidelines. Norway [20] and England [27] report having had the support of multidisciplinary teams and users for the construction of their guidelines. On the other hand,

countries like the USA – World Gastroenterology Organization [17] and American Association of Clinical Endocrinologists [18], Saudi Arabia [36], Mexico [28] and Korea [16] had only medical professionals in this elaboration. It is worth mentioning that the guideline in Colombia [35] was the only one built in an intersectoral way (health professionals, government agencies and other sectors such as social protection/social insurance, science and technology).

Multidisciplinary care, which is the existence of recommendations in the guidelines indicating that the individual with obesity receives comprehensive care through a team of multidisciplinary professionals, is present in almost all recommendations, except in Saudi Arabia [36], Brazil – ABESO [4] and USA – Department of Defense [32].

The guidelines that declare that there is no conflict of interest in their recommendations were those of Malaysia [24], Belgium [34], Netherlands [33], Australia [15], Argentina [9], Saudi Arabia [36], Brazil-ABESO [4], Singapore [22], Italy [30], Mexico [28], Qatar [25] and Korea [16]. Some declare that there are conflicts of interest, but without explaining them, such as: Scotland [29], France [19], Germany [14], Colombia [35] and the USA – Department of Defense [32]. The guidelines of the USA – American College of Cardiology [21], American Association of Clinical Endocrinologists [18] and National Heart, Lung, and Blood Institute [26], from England [27], Canada [8] and Finland [31] say that there may be conflicts of interest for the industry, especially the pharmaceutical industry. Finally, with no mention of conflicts of interest are Norway [20] and the USA - World Gastroenterology Organization [17].

DISCUSSION

Most clinical guidelines do not emphasize the theme of body weight stigma in their recommendations. Given the impact of obesity as a public health issue in several countries around the world, it is concerning that there are only 26 guidelines focused on this phenomenon. Of these, from the perspective of humanized and adequate care, only 46.2% deal with weight stigma and more empathetic health practices that consider this aspect. It is noteworthy that among those that address it, only five (19.2%) discuss the topic more broadly, considering the perspective of the health professional and the user with obesity.

This analysis is important since the prevalence of overweight and obesity has been increasing in recent decades, and the measures taken have not been very success in achieving the goal of the World Health Organization to prevent further increases in these levels among the elderly [7].

It is known that weight-related stigma and discrimination, although unacceptable, are present in our society and have caused significant negative impacts on the lives of people with obesity. The narrative about obesity found in the media, in political discourse, in the organization of care actions, in professional training and even in scientific production, is based on personal responsibility for the condition of obesity, strongly contributing to the reinforcement of stereotypes and to the centrality of weight in the care process for people with obesity [11]. This discourse contributes to people, when experiencing stigma, seeking health services less and less distancing themselves from self-care practices, as they do not feel welcomed and belonging to these spaces, which can aggravate their condition.

It is noteworthy that health professionals play a prominent role as a reinforcers agent of stigma related to weight and fatphobia [37]. The literature indicates that health professionals treat people with obesity disrespectfully; attributing all the health problems presented by them to their excess weight, making assumptions about weight gain and building barriers to the use of health care [11].

The practice of health professionals should be based on guidelines that guide care decisions for prevention, promotion and organization of services for health conditions of sanitary relevance, developed from the expanded understanding of the health-disease process and based on robust scientific evidence [38]. The perspective of a comprehensive health care process should include respect and acceptance of the individual, placing them at the center of the process in an individual and gentle way, in a perspective of co-responsibility. In this direction, stigmatizing statements present in guidelines spark an important alert. The existence of guidelines that reinforce stigma makes comprehensive, humane and empathetic health care extremely difficult, which places people with obesity in situations of vulnerability and embarrassment [5].

Empathy and compassion make health care for the patient more effective, favoring adherence to therapy [3]. Therefore, knowing what the clinical guidelines present on the subject of weight stigma is essential to understand what supports the clinical practice of these professionals in their fields of activity [39,40]. In this sense, it was observed that the Canadian guideline is the broadest on the subject, presenting important aspects that must be considered in clinical practice regarding the responsibility of health professionals for their attitudes. In addition, it places the user at the center of attention, providing recommendations that empower this individual regarding the care that is due to them [5]. In this direction, Gudzune et al. [37] demonstrated that patients who received respectful treatment, compared to those who felt judged by health professionals, were more likely to achieve a weight loss greater than or equal to 10%.

The vast majority of guidelines do not mention environmental stigma, demonstrating a lack of concern and information about the relevance of this aspect in the comprehensive care of individuals living with obesity. In this context, it is worth noting that, in addition to offering respectful individual care, the service environment should welcome individuals equally and with quality [41]. Therefore, equipment, furniture and infrastructure must be adequate to accommodate people with obesity. The health service needs to be a 'place that fits' everyone who demands it. Only in this way can integrate health care be enabled, guaranteeing the universality and comprehensiveness of care [41].

The guidelines that most addressed the theme of weight stigma were those that had a multidisciplinary team in their composition. This fact indicates that multiple perspectives on the subject favor the issue to be seen in its entirety, reducing the biomedical focus on care, which is limited to curative actions and reduced to weight loss [5].

The guidelines in Norway [20] and England [27] had the sensitivity to add users in the construction of the material, making it even more powerful, by giving voice to subjects with obesity in the process of building their care process. A study by Reis et al. [42], on the quality of clinical guidelines for the treatment of obesity, confirms that this is not a very common practice in the development of guidelines, and points out that, of the 21 guidelines evaluated, seven did not include representatives of the users in developing the guidelines or revising them.

Furthermore, concerning the publication years of the guidelines in question, it can be observed that more recent guidelines (Canada [8] and USA – Department of Defense [32], 2020) adopt a broader approach to addressing weight stigma. However, despite being a topic of more recent discussion, earlier guidelines (France [19], Argentina [9], and England [27], 2011–2014) also acknowledge this important issue.

It is also worth noting that, in Brazil, the Ministry of Health has made progress in addressing weight stigma, promoting an inclusive and respectful approach to the care of individuals with overweight and obesity. In recent years, resources such as the "Guidelines for Individual and Collective

Approaches to Obesity Management" and the "Manual for Primary Health Care of People with Overweight and Obesity in the *Sistema Único de Saúde* (SUS, Unified Health System)" have been published [42,43]. These materials provide health professionals with guidance on the importance of combating discriminatory attitudes, valuing the subjectivity of users, and adopting strategies that consider the complexity of obesity. These initiatives reflect a commitment to addressing stigma as a barrier to healthcare access, fostering humane and equitable care within the SUS. However, these guidelines have yet to be incorporated into national clinical protocols.

This study presents some limitations, such as the reliance on publicly available guidelines, which may have excluded internal or unpublished documents, and the broad timeframe analyzed (2000–2022), which could include outdated guidelines. It is assumed that the lack of criteria for the development and analysis of guidelines, particularly with a focus on issues related to weight stigma, is a factor that requires attention. Nevertheless, this text proposes that ideal recommendations for the care of individuals with obesity should address stigma comprehensively, providing clear guidelines for professionals and society, based on reflections from the literature. Additionally, we acknowledge that there may be some degree of subjectivity in the classification of recommendations, even with the methodological rigor of the analysis being upheld by two researchers, and in case of divergence, a third reviewer was involved to minimize this issue. Finally, the limited mention of stigma, as well as the differences in the development processes and target audiences of the guidelines, hinder comparability, highlighting the need for greater transparency and uniformity in the development of these recommendations.

CONCLUSION

Over the years, it has been possible to observe changes in the discourse presented in clinical guidelines for obesity, with the incorporation of recommendations that consider its multicausality, the complexity of care, and the impacts of weight stigma on the lives of individuals with obesity. The inclusion of these reflections contributes to the establishment and consolidation of care practices that encompass the individual in their entirety, without discrimination or individualized blame for excess weight, recognizing and valuing their potential. However, a significant path needs to be traversed in constructing this new epistemological narrative of obesity. This transformation demands coordinated efforts at individual, community, and systemic levels, requiring shifts in how society understands obesity and, importantly, the experience of living in a larger body.

It is necessary to move beyond the focus on weight loss as the primary objective of care and work towards building a praxis that embodies respect, empathy, protection, and social justice. This entails ensuring comprehensive, timely, and dignified care that meets the needs of individuals with obesity and their families, while also respecting their histories and social contexts.

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