

Mapping weight stigma in food-based dietary guidelines across thirteen countries in Latin America and the Caribbean: a qualitative analysis



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Summary

Background Weight stigma is a growing public health concern with documented harms to physical, mental and social well-being. Food-Based Dietary Guidelines (FBDGs), central to nutrition education and policy, may unintentionally reinforce stigmatising narratives. In the Latin America and the Caribbean (LAC), where the obesity is shaped by complex determinants, this study aims to uncover the presence and patterns of weight stigma in national FBDGs and inform the development of more inclusive, person-centred nutrition policies.

Methods A content analysis was performed. We used the Weight Stigma Heat Map (WSHM) to assess thirteen national FBDGs and four technical documents from LAC countries. Ten thematic areas focused on language, imagery, behavioural framing, and representations of health were analysed. Inter-evaluator agreement was evaluated using Bangdiwala's test.

Findings Most FBDGs contained explicit or implicit weight-stigmatising content. Common patterns included portraying weight loss as a universal health goal, using alarmist language around obesity, and framing body weight as fully modifiable through individual behaviour, often without acknowledging individual variability or clinical context. Thinness was often linked to physical activity, while higher weight was associated with sedentarism and poor choices. Structural determinants were rarely acknowledged. Only Saint Vincent and the Grenadines adopted a more inclusive, environmentally focused approach. Inter-evaluator agreement was high (Bangdiwala's $B = 0.93$), supporting the reliability of the coding process.

Interpretation National FBDGs across LAC frequently reflect moralising and reductionist narratives that may perpetuate weight stigma. Revising these documents through a person-centred lens, grounded in human rights, social justice, and a multifactorial understanding of obesity is essential to promote equitable public health nutrition.

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Introduction

Latin America and the Caribbean (LAC) are undergoing a significant epidemiological transition, marked by a rising prevalence of diet-related non-communicable diseases (NCDs).¹ This shift reflects broader transformations in food systems, urbanisation, physical activity patterns, and the social determinants of health.² Among the contributing factors is the increasing rate of overweight and obesity, shaped by complex and

interrelated influences that extend beyond individual behaviour.^{3,4}

This evolving health landscape is placing growing pressure on public health systems,⁵ as metabolic conditions such as type 2 diabetes, cardiovascular diseases, and certain cancers become more widespread. Recent estimates suggest that over 67% of adults in the region are living with overweight or obesity, while abdominal adiposity, an important marker of cardiometabolic risk,

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Research in context

Evidence before this study

Weight stigma has been widely documented in high-income countries as a significant risk factor for physical, mental, and social health. Studies show that it is associated with adverse health outcomes, psychological distress, avoidance of physical activity, and reduced use of healthcare services. We searched PubMed, Scopus, and SciELO for articles published in English, Spanish, and Portuguese up to June 2025 using terms such as “weight stigma”, “dietary guidelines”, “nutrition policy”, and “Latin America”. Most studies focused on clinical or interpersonal manifestations of weight stigma, with limited attention to its presence in national Food-Based Dietary Guidelines (FBDGs). No prior research systematically mapped or qualitatively analysed weight-related language across dietary guidelines in Latin America and the Caribbean. This study addresses that gap by examining how weight stigma is embedded in nutrition recommendations.

Added value of this study

This is the first study to systematically map content related to weight stigma in the FBDGs of 13 countries across Latin America and the Caribbean, using a structured tool (Weight

Stigma Heat Map). The analysis reveals recurring patterns, including the presentation of weight loss as a health goal, the association of larger bodies with “unhealthy” behaviours, and the use of alarmist language to describe obesity. In contrast, the social and structural determinants of body weight are rarely addressed. The findings suggest that dietary recommendations may, unintentionally, reinforce bias and stereotypes about body size and health.

Implications of all the available evidence

The findings of this study could contribute to the development of public nutrition policy. It is essential that FBDGs adopt a person-centred approach grounded in human rights and social justice. Reviewing the language, imagery, and explanatory frameworks used in dietary recommendations can enhance their effectiveness, scientific integrity, and social acceptance. Such transformation may foster trust, inclusion, and health equity. This study also offers a foundation for updating FBDGs in the region and for training nutrition and public health professionals to provide care that is free from weight stigma.

affects up to 62% of the population, depending on the diagnostic criteria applied.^{6,7}

In parallel, weight stigma has become increasingly visible in health-related discourse and practice. Defined as negative attitudes, stereotypes, and discriminatory behaviours directed at individuals based on body size or weight status, weight stigma often stems from harmful assumptions, such as the belief that people in larger bodies lack motivation, self-discipline, or competence. These biases can lead to social exclusion, devaluation, and discrimination across multiple domains.^{8,9}

The health consequences of weight stigma are well documented. Individuals who experience weight-based discrimination are more likely to report psychological distress, disordered eating, social withdrawal, and avoidance of healthcare services.^{9–12} Chronic exposure to stigma may also trigger physiological stress responses that adversely affect metabolic health and body weight over time.^{13,14}

Although most research on weight stigma has been conducted in high-income countries, emerging evidence from non-Western contexts confirms its global relevance. A recent scoping review identified 130 studies on weight stigma across 33 countries and territories outside the Global North, while a narrative review of cultural beauty ideals found that thinness is increasingly promoted in many non-Western societies.¹⁵ In LAC and other low- and middle-income regions, weight stigma is an emerging public health concern, manifesting in healthcare, employment, and

education settings, and contributing to physical, psychological, social, and financial harm.¹⁶

The Organisation for Economic Co-operation and Development (OECD) has further documented that individuals living with obesity face poorer labour market outcomes, lower earnings, and higher rates of social exclusion, even after controlling for education and work experience.^{1,17} These effects not only diminish quality of life but also reinforce cycles of marginalisation and perpetuate structural barriers to effective obesity care and treatment.

Food-Based Dietary Guidelines (FBDGs) are central to national nutrition strategies and serve as key tools for shaping public health messaging.¹⁸ Developed using rigorous scientific evidence and shaped by each country’s unique cultural, agricultural, and health landscape, FBDGs typically offer recommendations on foods and dietary patterns to promote overall health and prevent chronic disease.¹⁹ In recent years, many nations have begun to broaden their guidelines to include considerations such as meal composition, eating practices, food safety, sustainability, and lifestyle behaviours.²⁰

While progress has been made toward a more inclusive and comprehensive understanding of nutrition, the language, imagery, and framing used in nutrition education tools and public health messaging, particularly when focused narrowly on individual behaviour change, can unintentionally reinforce weight bias.¹⁵ Messages that emphasise personal responsibility for food intake and physical activity, without

acknowledging broader social and environmental influences, may stigmatise individuals in larger bodies and compromise the fairness and inclusivity of public health initiatives.^{21,22}

Yet, there remains a notable gap in the literature regarding the extent to which FBDGs may perpetuate weight stigma, particularly within the LAC context. To address this gap, the present study applies the Weight Stigma Heat Map (WSHM), a structured tool designed to identify and classify weight stigma in public health and health promotion materials.²³ Through a qualitative, Following qualitative reporting standards,²⁴ we conducted a content analysis of national FBDGs across the region. This study aims to uncover the presence and patterns of weight stigma and to inform the development of more inclusive, person-centred nutrition policies.

Methods

Study design

A qualitative content analysis was conducted to examine FBDGs and their accompanying technical documents from LAC. The analysis followed a deductive approach,²⁵ guided by a preestablished framework developed by Willer F.,²³ rather than generating categories inductively from the data. Four methodological steps were undertaken: i) selection of units of analysis, ii) application of predefined categories, iii) identification and extraction of relevant content, and iv) assessing coding reliability.

Selection of units of analysis

LAC region comprises a total of 33 countries. The study employed a census sampling strategy, whereby the entire accessible population relevant to the research question was included (all FBDGs updated within the past ten years). This approach was selected to enable a comprehensive examination of all recently revised dietary guidelines at a time when discussions on obesity stigma were gaining prominence within the scientific community. By incorporating the full universe of eligible cases, the sampling strategy ensured analytical completeness within the defined study parameters. In total, FBDGs from 13 countries met the inclusion criteria. The analysis included FBDGs from South America (Argentina,²⁶ Chile,²⁷ Colombia,²⁸ Ecuador,²⁹ Paraguay,³⁰ Peru,³¹ and Uruguay³²); North America (Mexico³³); and the Caribbean (Barbados,³⁴ Grenada,³⁵ Guyana,³⁶ Jamaica,³⁷ and Saint Vincent and the Grenadines³⁸).

Additionally, four technical documents were included from Argentina,³⁹ Chile,⁴⁰ Colombia,⁴¹ and Saint Vincent and the Grenadines.⁴²

Application of predefined categories

To classify and evaluate weight stigma, we applied the Weight Stigma Heat Map (WSHM) developed by Willer

F. The WSHM identifies ten thematic areas relevant to weight-related discourse, including pictorial or photographic representation, beliefs regarding weight and health, body weight modifiability, and financial implications.

Each theme was assessed across four appraisal categories: Weight Stigma, characterised by negative stereotyping, prejudice, or discrimination that restricts access to opportunities or services; Weight Bias, represented through depictions of smaller bodies as the norm, or as being inherently healthy, desirable, or good; Bias Neutral, defined by the inclusive representation of diverse body sizes and the provision of balanced, evidence-based health information; and Anti-Stigma, which encompasses narratives that emphasise strengths, celebrate diversity, and positively portray larger-bodied individuals, including their leadership and agency.

Themes were then scored on a scale from +2 (anti-stigma) to -2 (weight stigma), allowing for a cumulative score per FBDGs or technical document. Lower scores indicated more stigmatising content.

A heat map was created to visually display the findings. The least stigmatising category (bright blue) reflects an overtly anti-stigma and strengths-based approach for larger-bodied people (e.g., 'people with larger bodies deserve excellent health care'). The first of the stigmatising categories (pale orange), is for elements that express a preference for a Body Mass Index (BMI) of 18.5–25 kg/m². The most stigmatising category (bright orange) is for elements that directly take a deficit-based or pathologising approach towards larger-bodied people and their assumed behaviour, intentions and health status. For example, stating or inferring that the cost of delivering good quality health care to larger-bodied people is an avoidable burden.

Identification and extraction of relevant content

The first phase of analysis involved and extracted content related to weight stigma. This includes identifying the content and its impact on the concept of weight stigma, considering the narrative and analysing the messages related to the health consequences of various body types. The narratives were then analysed using content analysis approaches to assess the weight modifiability evidence presented and its relation to interventions that may affect body weight or body shape. Content related to weight stigma was identified within the documents, and relevant textual citations and illustrative examples were extracted and organised following a deductive structure (themes and sub-themes) to capture emerging patterns and meanings. In the next step, we discussed what were considered images that negatively portrayed people with larger body sizes. This included depictions of individuals with larger bodies as unkempt, incompetent, or emotionally distressed (e.g., sad or angry expressions, holding or

grabbing body parts, especially areas with visible fat). These were categorised based on their alignment with the WSHM themes and stigma levels. The final phase involved synthesising the results (narratives and visual representations) that contributed to or countered weight stigma.

Assessing coding reliability

To ensure consistency and credibility of the findings, two independent coders, both qualified nutritionists with expertise in analysing nutritional education materials, undertook the coding process. Before analysis, a training phase was conducted by the first author to familiarise coders with the WSHM tool, resolve initial discrepancies, and ensure a minimum inter-coder agreement of 90% before proceeding. Coders met regularly to discuss themes and clarify any questions regarding the coding structure. Final scores, total and per theme of each food guideline and technical document, were obtained with the final decision of the principal investigator when there were discrepancies.

The Bangdiwala weighted statistic was used to evaluate the concordance between the two coders. This index measures the agreement between two ways of evaluating, adjusting the observed concordance for that which could occur by chance.⁴³ More specifically, the function computes a statistic that measures the strength of agreement by accounting for ordered ratings and assigning weights to off-diagonal cell frequencies in its calculation. Then, we performed an agreement chart, a two-dimensional method for visually assessing the agreement between two measures, rating the same n units into the same k discrete ordinal categories (score quartiles of each coder).

For interpreting the measures of agreement, Bangdiwala weighted statistic values can be classified as follows: 0.01–0.20 (very low), 0.21–0.40 (low), 0.41–0.60 (moderate), 0.61–0.80 (good), and ≥ 0.81 (almost perfect).⁴³

To conduct the Bangdiwala analysis, we categorised the scores into quartiles, where the first quartile represents the lowest scores (less stigmatising content) and the fourth quartile represents the highest scores (more stigmatising content). Quartiles were used because they provide a structured way to visualise concordance and discordance across meaningful categories.

All statistical analyses were performed in R version 4.1.1.

Ethical approval

Ethics approval was not required because the study analysed publicly available documents and involved no human participants.

Role of the funding source

There was no funding source for this study.

Results

We analysed thirteen national FBDGs from LAC countries and, where available, their corresponding technical documents ($n = 4$) to assess the presence and extent of weight-stigmatising content. The overall findings are summarised in Figs. 1 and 2 (Heat Maps) and Tables 1 and 2 (Categorisation Notes and Scores).

Global weight stigma scores across FBDGs

As shown in Table 1 and Fig. 3, the global score of the documents ranges from -14 (documents that strongly promoted weight stigma) to 1 (the least stigmatising document). The least stigmatising document was the Saint Vincent and the Grenadines' technical document, then the FBDGs from Argentina and Guyana (score: -4).

This less weight-stigma appraisal has a clearer exposition of the relationships between health-promoting living environments, health behaviours, and body weight, and the use of less stigmatising terminology for larger bodies.

In contrast, stigmatising content was frequently observed across multiple dimensions. Key elements contributing to weight stigma included the promotion of weight modifiability as a core strategy for improving health, the tendency to equate high body weight with unhealthy eating and physical inactivity, and the framing of fatness as intrinsically unhealthy, often without considering contextual or individual variability (Table 1).

Weight stigma scores by themes

Most FBDGs and technical documents feature a positive depiction of larger-bodied individuals, but with a proportionally limited number. Only a few of them have simply smaller-bodied people pictured with no representation of larger-bodied people (Table 1).

Several FBDGs, including those from Barbados, Chile, Colombia, Grenada, Jamaica, Mexico, Paraguay, and Saint Vincent and the Grenadines, associated larger body size with heightened health risks. Moreover, documents from Uruguay, Peru, Guyana, Ecuador, and Argentina employed alarmist terminology, such as "obesity epidemic" and "health challenge", about population body size trends (Table 1).

Nearly all documents framed a high body mass index (BMI) as a modifiable risk factor for chronic disease. They often conveyed the assumption that adopting a "healthy" lifestyle naturally results in a BMI below 25 kg/m^2 , reinforcing a simplistic, linear relationship between weight and behaviour. The Barbados FBDGs was the only one that did not explicitly present weight as modifiable (Table 1).

Weight loss was commonly promoted as synonymous with health. Pervasive narratives implied that larger-bodied individuals possess poor health habits

Themes	Argentina	Barbados	Chile	Colombia	Ecuador	Grenada	Guyana	Jamaica	Mexico	Paraguay	Peru	Saint Vincent and the Grenadines	Uruguay
1. Negative imagery													
2. High BMI as a problem													
3. Weight modifiability													
4. Weight loss = health													
5. Overgeneralising and misinformation													
6. Weight = dietary habits													
7. Weight = physical activity													
8. Mental health and cognitive capacity													
9. Environment frame													
10. Financial burden													
Overall score	-4	-8	-9	-7	-8	-13	-5	-9	-11	-11	-10	-11	-14

Fig. 1: Weight stigma heat map for food guidelines of thirteen countries in Latin America and the Caribbean.

Themes	Argentina	Chile	Colombia	Saint Vincent and the Grenadines
1. Negative imagery				
2. High BMI as a problem				
3. Weight modifiability				
4. Weight loss = health				
5. Overgeneralising and misinformation				
6. Weight = dietary habits				
7. Weight = physical activity				
8. Mental health and cognitive capacity				
9. Environment frame				
10. Financial burden				
Overall score	-14	-15	-11	1

Fig. 2: Weight stigma heat map for technical documents of food guidelines of thirteen countries in Latin America and the Caribbean.

Theme	Argentina	Score
Imagery		0
High body mass as a problem		0
Weight modifiability	Weight modifiability is not mentioned explicitly but is implied from the context that higher body weight is avoidable and modifiable at both population and individual levels	-2
Weight loss = health		0
Overgeneralising and Misinformation		0
Weight = dietary habits	Narratives recommending the reduction of foods high in sugar, fat, or salt, consistent with established health guidelines, implicitly assume that these foods lead to increased body weight: "Limit consumption of sugared drinks and foods with high fat, sugar and salt content ... Excessive consumption of these foods predisposes to obesity, hypertension, diabetes and cardiovascular diseases, among others". "The frequent and excessive consumption of cookies, Argentine pastries, cakes and other bakery products can cause overweight and obesity."	-2
Weight = physical activity		0
Mental health and cognitive capacity		0
Environment frame		0
Financial frame		0
Overall score		-4
Data based on Ministerio de Salud de la Nación. Guías alimentarias para la población Argentina. ²⁶		
Theme	Barbados	Score
Imagery	Images are pictorial, all uniform shape, not rounded, BMI <25	-1
High body mass as a problem	High body mass as a problem is not mentioned specifically but implied from context that people with small bodies have fewer health problems and a lower risk of chronic diseases because of their body size.	-1
Weight modifiability		0
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation		0
Weight = dietary habits	Narratives that demonise nutrients or foods, based on the assumption that they lead to fatness: "Excessive sugar consumption can lead to weight gain, diabetes and heart disease" and "Excess fat is linked to obesity and chronic noncommunicable diseases such as heart disease, diabetes and certain types of cancer."	-2
Weight = physical activity	Larger bodies are inactive: "The root causes of overweight and obesity are complex and deeply embedded in the way we live"	-2
Mental health and cognitive capacity		0
Environment frame		0
Financial frame		0
Overall score		-8
Data based on Ministry of Health Barbados. National Nutrition Centre. Food-based dietary guidelines for Barbados. ³⁴		
Theme	Chile	Score
Imagery	Positive representation of larger people, but a proportionally limited number.	1
High body mass as a problem	Frame BMI 18.5–25 kg/m ² as healthy weight: "The body needs these foods and vitamins that help: Maintain a healthy weight in adults, boys and girls."	-2
Weight modifiability	The body is presented as an easily modifiable risk factor for chronic diseases.	-2
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation	Report associations between BMI and various outcomes without correcting for covariates such as age, lifestyle patterns, socioeconomic factors, internalised weight stigma, history of weight fluctuation, degree of discrimination in health care	-1
Weight = dietary habits	Narratives that demonise nutrients or foods, based on the assumption that they lead to fatness: "Frequent consumption of stamped or ultra-processed products is associated with obesity, cardiovascular diseases ..." and, "fried foods are associated with heart disease and weight gain".	-2
Weight = physical activity		0
Mental health and cognitive capacity		0
Environment frame	Present a justification for creating social and physical environments that help current and future populations live well (access to safe, nutritious and enjoyable food, connection and fitness, sustainability) in the bodies they have.	1
Financial frame		0
Overall score		-7
Data based on Ministerio de Salud de Chile. Guías alimentarias para Chile. ²⁷		

(Table 1 continues on next page)

Theme	Colombia	Score
(Continued from previous page)		
Imagery	Positive representation of larger people but proportionally limited in number.	1
High body mass as a problem	Frame a higher BMI as an unhealthy weight.	-2
Weight modifiability		0
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation		0
Weight = dietary habits	Packaged products: "These products favour the appearance of diabetes, hypertension and heart disease, overweight and obesity, dental caries and bone demineralization". Harmful fats: "... they also produce overweight and obesity."	-2
Weight = physical activity	Assumes that a smaller body size is evidence of a physically active lifestyle.	-2
Mental health and cognitive capacity		0
Environment frame		0
Financial frame		0
Overall score		-7
Data based on Instituto Colombiano de Bienestar Familiar. Guías alimentarias basadas en alimentos para la población colombiana mayor de 2 años: rotafolio para facilitadores. ²⁸		
Theme	Ecuador	Score
Imagery	Positive representation of larger people but proportionally limited in number.	1
High body mass as a problem	Use of terms overweight, obesity and variations. Reports high body mass as a complex and recurrent disease/condition: "... doctor diagnosed him with obesity, and informed him of all the risks that this high weight brings to his health"	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation		0
Weight = dietary habits	Narratives that demonise nutrients or foods, based on the assumption that they lead to fatness: "Ultra-processed food consumption is associated with obesity, heart disease, cancer, gastrointestinal diseases, among others."	-2
Weight = physical activity	Assumes that a smaller body size is evidence of a physically active lifestyle: "Benefits of physical activity: controlling overweight and obesity".	-2
Mental health and cognitive capacity		0
Environment frame	Presents a rationale for creating social and physical environments that help current and future populations live well in the bodies they have.	1
Financial frame		0
Overall score		-8
Data based on Ministerio de Salud Publica del Ecuador. Manual para Facilitadores de las Guías Alimentarias Basadas en Alimentos (GABA) del Ecuador. ²⁹		
Theme	Grenada	Score
Imagery	Images are pictorial, all uniform shape, not rounded, BMI <25	-1
High body mass as a problem	Crisis language: use of terms overweight, obesity and variations.	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation	Report associations between BMI and various outcomes without correcting for covariates such as age, lifestyle patterns, socioeconomic factors, internalised weight stigma, history of weight fluctuation, degree of discrimination in health care, etc.	-1
Weight = dietary habits	Weight positioned as a matter of food selection.	-2
Weight = physical activity	Narratives that state that larger people are sedentary: "Relationship between overweight/obesity and sedentary lifestyle".	-2
Mental health and cognitive capacity		0
Environment frame		0
Financial frame	Presents a weight bias position reporting that Grenada Hospital Services, in its 2012–2013 cost estimate, projected a substantial increase in admissions for chronic noncommunicable diseases	-1
Overall score		-13
Data based on Government of Grenada. Ministry of Agriculture and Lands. Grenada food based dietary guidelines 2020: technical document. St George's (Grenada), 2020. ³⁵		

(Table 1 continues on next page)

Theme	Guyana	Score
(Continued from previous page)		
Imagery	Images are pictorial, all uniform shape, not rounded, BMI <25	-1
High body mass as a problem	Crisis language: use of terms overweight, obesity and variations.	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health		0
Overgeneralising and misinformation		0
Weight = dietary habits		0
Weight = physical activity		0
Mental health and cognitive capacity		0
Environment frame		0
Financial frame		0
Overall score		-5
Data based on Food and Agriculture Organisation of the United Nations. Ministry of Public Health—Food Policy Division (Guyana). ³⁶		
Theme	Jamaica	Score
Imagery	Positive representation of larger people, but a proportionally limited number.	1
High body mass as a problem	Infer that people with small bodies have fewer health problems and a lower risk of chronic diseases because of their body size.	-1
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Weight loss presented as a way to achieve health: "enable people living with obesity to access early and appropriate support and treatment to improve health"	-2
Overgeneralising and misinformation		0
Weight = dietary habits	Narratives that demonise nutrients or foods, based on the assumption that they lead to fatness: "... it helps control conditions such as diabetes, hypertension, overweight/obesity and heart disease."	-2
Weight = physical activity	Assumes larger bodied people are all sedentary.	-2
Mental health and cognitive capacity		0
Environment frame		0
Financial frame		0
Overall score		-8
Data based on Ministry of Health Jamaica. Food based dietary guidelines for Jamaica 2015. Kingston (Jamaica). ³⁷		
Theme	Mexico	Score
Imagery	Positive representation of larger people, but a proportionally limited number.	1
High body mass as a problem	"These three problems (obesity, malnutrition and climate change), currently affect the majority of the world's population and may have significant consequences for individuals, societies and the natural systems on which life depends."	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Weight loss presented as a way to achieve health	-2
Overgeneralising and misinformation	Narrative imputes a significant value in being healthy and maintaining health throughout life, this includes a healthy weight.	-1
Weight = dietary habits	Weight positioned as a matter of food selection: "... reduce our overconsumption of food and drinks, including unhealthy options, and resulting weight gain."	-2
Weight = physical activity	Assumes larger bodied people are all sedentary.	-2
Mental health and cognitive capacity	Claim that weight loss will improve mental health: "an inactive and sedentary lifestyle is associated with an increased risk of mortality and disease, such as diabetes, hypertension, depression and anxiety, and lower psychological well-being, life satisfaction and happiness."	-2
Environment frame	Presents a rationale for creating social and physical environments that help current and future populations live well in the bodies they have.	1
Financial frame		0
Overall score		-11
Data based on Secretaría de Educación Pública (Mexico). Guías alimentarias saludables y sostenibles para la población mexicana 2023. ³³		

(Table 1 continues on next page)

Theme	Paraguay	Score
(Continued from previous page)		
Imagery	Images are pictorial, all uniform shape, not rounded, BMI <25	-1
High body mass as a problem	Objective: "Controlling weight, avoiding obesity."	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Weight loss presented as a way to achieve health	-2
Overgeneralising and misinformation		0
Weight = dietary habits	Weight positioned as a matter of food selection: "The consumption of fats and fried foods favours the appearance of overweight and obesity". "Excessive consumption of oils and fats can cause obesity"	-2
Weight = physical activity	Assumes larger bodied people are all sedentary.	-2
Mental health and cognitive capacity		0
Environment frame		0
Financial frame		0
Overall score		-11
Data based on Instituto Nacional de Alimentación y Nutrición. Ministerio de Salud Pública y Bienestar Social (Paraguay). Guías alimentarias del Paraguay: segunda actualización. Asunción. ³⁰		
Theme	Peru	Score
Imagery	Positive representation of larger people, but a proportionally limited number.	1
High body mass as a problem	It states that BMI >30 kg/m ² is a disease state: "These new eating patterns have caused an increase in overweight and obesity in the last two decades, being a problem in all population groups, causing diseases related to overweight, such as diabetes, cardiovascular diseases, hypertension and various cancers."	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Weight loss presented as a way to achieve health	-2
Overgeneralising and misinformation		0
Weight = dietary habits	Weight positioned as a matter of food selection: "Watch your weight by consuming rice, bread and noodles in moderation" and "Excessive sugar consumption contributes to overweight and increases the risk of cardiovascular disease, obesity and diabetes."	-2
Weight = physical activity	Assumes larger bodied people are all sedentary.	-2
Mental health and cognitive capacity		0
Environment frame	A rationale for creating social and physical environments that help current and future populations live well according to the bodies they have: "Food guides are also an instrument to promote the implementation of public policies for food security and agriculture".	1
Financial frame		0
Overall score		-8
Data based on Lázaro-Serrano ML, Domínguez-Curi CH. Instituto Nacional de Salud (Perú). Guías alimentarias para la población peruana. ³¹		
Theme	Saint Vincent and the Grenadines	Score
Imagery	There are few images, all uniform shape, not rounded, BMI <25	-1
High body mass as a problem	High BMI as a problem not mentioned specifically but implied from context that people with small bodies have fewer health problems and a lower risk of chronic diseases because of their body size.	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Weight loss presented as a way to achieve health	-2
Overgeneralising and misinformation		0
Weight = dietary habits	Weight positioned as a matter of food selection: "The benefits of avoiding highly processed foods and snack foods, as they are high in fat, sugars and salt ..."	-2
Weight = physical activity	Assumes larger bodied people are all sedentary.	-2
Mental health and cognitive capacity		0
Environment frame		0
Financial frame		0
Overall score		-9
Data based on Ministry of Health, Wellness and the Environment. Nutrition Unit. Food based dietary guidelines for St. Vincent and the Grenadines; Facilitators Guides. Kingstown. ³⁸		

(Table 1 continues on next page)

Theme	Uruguay	Score
(Continued from previous page)		
Imagery	Only smaller-bodied people are represented, with no representation of large-bodied people.	-1
High body mass as a problem	Use of crisis terms to refer to the distribution of the body mass of the population: "The effects are manifested in the obesity epidemic, whose consequences have already become the biggest public health problem in many countries, including Uruguay," and "Its frequent consumption has become a major public health problem in many countries, including Uruguay".	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation	Report associations between BMI and various outcomes without correcting for covariates such as age, lifestyle patterns, socioeconomic factors, internalised weight stigma, history of weight fluctuation, degree of discrimination in health care, etc.	-1
Weight = dietary habits	Assumes that heavier people eat inadequately: "Two out of three Uruguayans are at risk of suffering serious consequences due to being overweight or obese, hypertension and complications derived from eating inadequately." and "non-communicable diseases related to inadequate nutrition are the most common cause of death".	-2
Weight = physical activity	Physical activity: "Physical activity helps to control overweight, obesity and body fat percentage"	-2
Mental health and cognitive capacity		0
Environment frame	Frame the need for social and physical environments that lead populations to have a lower BMI: "To inform Uruguayan citizens, so that they seek changes in themselves and in their environment, and demand compliance with the human right to adequate and healthy food."	-2
Financial frame		0
Overall score		-14
Data based on Ministerio de Salud Pública (Uruguay). Guía alimentaria para la población uruguaya: para una alimentación saludable, compartida y placentera. ³⁸		
Note: Narrative examples illustrating each theme in the food guides are presented in quotation marks and have been translated into English.		

Table 1: Food guidelines- categorisation notes and scores.

and require behavioural correction. An example from one guide stated: "Incorporate vegetables and fruits in all your meals. It will help you feel good and maintain a proper weight." Such language reinforces the idea that wellness is contingent on weight loss.

Concerns about associations between BMI and various outcomes without correcting for covariates such as age, lifestyle patterns, and socioeconomic factors, internalised weight stigma, weight fluctuation history, degree of health care discrimination, or factors likely to affect outcomes such as energy restriction, nutrition status, distress, eating disorders and self-stigmatisation are frequent in some food guides and technical documents (Colombia, Grenada, Mexico, Uruguay, Chile). Also, there are incorrect or unfounded statements about the superior health status of smaller-bodied people (Table 1).

Nutritional messages frequently demonise specific foods or nutrients for their presumed role in contributing to fatness. Larger-bodied individuals were implicitly framed as habitually overconsuming energy. Notably, Guyana's FBDG made no explicit connections between dietary patterns and body weight.

Most FBDGs and technical documents have narratives that state or insinuate that a smaller body size is evidence of a physically active lifestyle, or more specifically, the relationship between overweight/obesity and sedentary lifestyle. Few of them do not make

connections between body weight and physical activity (Table 1).

Mental health was addressed in only one guide—Mexico—and the discussion perpetuated weight-stigmatising messages. It implied that larger body size leads to mental health problems and that weight loss would enhance psychological well-being: "... is associated with an increased risk of mortality and disease, such as diabetes, hypertension, depression and anxiety, and lower psychological well-being, life satisfaction and happiness" (Table 1).

Themes related to social and physical environments, such as access to nourishing food, community connectedness, and sustainability, were mentioned in 9 of the 13 countries. Five FBDGs (Uruguay, Paraguay, Colombia, Chile, and Argentina) framed these environments as contributors to "unhealthy lifestyles," which were implicitly linked to body weight. The remaining documents encouraged supportive environments that promote well-being across all body sizes (Table 1).

The topic of financial issues is explicitly included in the Grenada FBDGs. This guideline presents a weight bias position reporting that Grenada Hospital Services, in its 2012–2013 cost estimate, projected a substantial increase in admissions for chronic noncommunicable diseases (Table 1). The Chilean technical document has a score of weight stigma in this point because it

Theme	Argentina	Score
Imagery	Images are pictorial, all uniform shape, not rounded, BMI <25	-1
High body mass as a problem	Crisis language: "Epidemic of overweight and obesity primarily in children and adolescents."	-2
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation	Report associations between BMI and various outcomes without correcting for covariates such as age, lifestyle patterns, socioeconomic factors, internalised weight stigma, history of weight fluctuation, degree of discrimination in health care, etc.	-1
Weight = dietary habits	Narratives that demonise nutrients or foods, based on the assumption that they lead to fatness: "Limit consumption of sugared drinks and foods with high fat, sugar and salt content ... Excessive consumption of these foods predisposes to obesity, hypertension, diabetes and cardiovascular diseases, among others". "The frequent and excessive consumption of cookies, bills, cakes and other bakery products can cause overweight and obesity."	-2
Weight = physical activity	Larger bodies are inactive: "The root causes of overweight and obesity are complex and deeply embedded in the way we live"	-2
Mental health and cognitive capacity		0
Environment frame	The influence of food environments is mentioned, currently characterised by the high availability and accessibility of foods of high energy density and low nutritional quality: "the environment is characterised by offering at hand and as a priority, candy, packs of cookies, chips, sugary drinks such as flavoured water and soft drinks, and other food products whose formulation gives them a taste accentuated".	-2
Financial frame		0
Overall score		-14
Data based on Ministerio de Salud de la Nación. Manual para la aplicación de las guías alimentarias para la población Argentina. ³⁹		
Theme	Chile	Score
Imagery	Positive representation of larger people but proportionally limited in number.	1
High body mass as a problem	Infer that people with small bodies have fewer health problems and a lower risk of chronic diseases because of their body size.	-1
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation	Report associations between BMI and various outcomes without correcting for covariates such as age, lifestyle patterns, socioeconomic factors, internalised weight stigma, history of weight fluctuation, degree of discrimination in health care, etc.	-1
Weight = dietary habits	Narratives that demonise nutrients or foods, based on the assumption that they lead to fatness: "Drinks, juices, sports drinks and energy drinks, most of which contain sugar, increasing the number of calories and sugars in the diet, favouring obesity."	-2
Weight = physical activity	Assumes that a smaller body size is evidence of a physically active lifestyle.	-2
Mental health and cognitive capacity		0
Environment frame	The influence of food environments is mentioned, currently characterised by the high availability and accessibility of foods of high energy density and low nutritional quality: "Obesity, is determined by multiple environmental and social elements that complexify the scenario, the current obesogenic environments"	-2
Financial frame	Calculates the costs of obesity using a comparison of population with no obesity: "Studies with Chilean workers indicate that people diagnosed with obesity and severe obesity have a 25% to 57% higher absenteeism from work than people with normal weight" and "Costs due to absenteeism from work due to obesity and overweight were estimated for Chile at 32.7 million dollars in 2014".	-2
Overall score		-13
Data based on Ministerio de Salud de Chile. Subsecretaría de Salud Pública. División de Políticas Públicas Saludables y Promoción. Departamento de Nutrición y Alimentos. Plan de implementación de las Guías Alimentarias para Chile. ⁴⁰		
Theme	Colombia	Score
Imagery	Positive representation of larger people but proportionally limited in number.	1
High body mass as a problem	Frame BMI 18.5-25 kg/m2 as normal weight.	-1
Weight modifiability	Weight modifiable not mentioned specifically but implied from context that higher weight is avoidable and modifiable in population and individuals	-2
Weight loss = health	Obesity treatment or weight loss recommendations are presented as a path to health	-2
Overgeneralising and misinformation	Report associations between BMI and various outcomes without correcting for covariates such as age, lifestyle patterns, socioeconomic factors, internalised weight stigma, history of weight fluctuation, degree of discrimination in health care, etc.	-1
Weight = dietary habits	Narratives that demonise nutrients or foods, based on the assumption that they lead to fatness: "To maintain a healthy weight, reduce consumption of packaged products, fast foods, soda and sugary drinks." "The replacement of conventional foods with ultra-processed foods is the main determinant of the rapid increase in obesity worldwide, and is associated with other diseases and malnutrition." "Animal fats generate overweight, obesity and associated diseases."	-2

(Table 2 continues on next page)

Theme	Colombia	Score
(Continued from previous page)		
Weight = physical activity	Physical activity: <i>"Reduces the risk of becoming overweight or obese and improves your figure"</i>	-2
Mental health and cognitive capacity		0
Environment frame	The influence of food environments is mentioned, currently characterised by the high availability and accessibility of foods of high energy density and low nutritional quality: <i>"Girls, boys and young people are the most affected by the consumption of these products, influenced by the large number of advertisements of this type of products in the mass media and the advertising hooks with which they promote them."</i>	-2
Financial frame		0
Overall score		-11
Data based on Instituto Colombiano de Bienestar Familiar. Organización de las Naciones Unidas para la Alimentación y la Agricultura. Guías alimentarias basadas en alimentos para la población colombiana mayor de 2 años: manual para facilitadores. ⁴¹		
Theme	Saint Vincent and the Grenadines	Score
Imagery	Positive representation of larger people but proportionally limited in number.	1
High body mass as a problem		0
Weight modifiability		0
Weight loss = health		0
Overgeneralising and misinformation		0
Weight = dietary habits		0
Weight = physical activity		0
Mental health and cognitive capacity		0
Environment frame		0
Financial frame		0
Overall score		1
Data based on Ministry of Health Wellness and the Environment. Nutrition Unit. National Food Based Dietary Guidelines Task Force. Food based dietary guidelines for St. Vincent and the Grenadines. ⁴²		
Note: Narrative examples illustrating each theme in the technical documents are presented in quotation marks and have been translated into English.		

Table 2: Technical documents- categorisation notes and scores.

calculates the 'costs of obesity' using a comparison of population with 'no obesity': "Studies with Chilean workers indicate that people diagnosed with obesity and severe obesity have a 25%–57% higher absenteeism from work than people with normal weight" and "Costs due to absenteeism from work due to obesity and overweight were estimated for Chile at 32.7 million dollars in 2014".

The analysis of FBDGs provides an opportunity to evaluate the extent to which they address diversity (by age, ethnicity and disability) as well as the concept of food sovereignty. Most of the FBDGs considered in this study address age and ethnic diversity. With respect to age, 13 of the 17 included documents (76 per cent), comprising both FBDGs and technical documents, take into account different stages of the life course, offering differentiated recommendations and graphically representing various age groups. Ethnic diversity is also reflected through the positive use of imagery and text, being incorporated in nearly half of the analysed documents (47 per cent). Disability inclusion is present, though less consistently: only 35 per cent of the documents include it, primarily represented through indistinct or marginally visible images. Finally, food sovereignty as an explicit concept is not directly addressed in any of the guidelines; however, it is incorporated indirectly through related concepts or its

pillars, with emphasis on local production, self-consumption and biodiversity (see [Supplementary Table S1](#)).

Comparison between food guides and technical documents

The technical documents publicly available were from only four countries (Argentina, Chile, Colombia, and St. Vincent and the Grenadines). Generally, they mirrored the content of their respective food guides but exhibited more pronounced weight-stigmatising content—especially in Colombia, Chile, and Argentina (scores: -11 to -14) ([Fig. 2](#) and [Table 2](#)). Saint Vincent and the Grenadines' technical document remained the least stigmatising.

Technical documents more frequently included framing heavier individuals as being at higher health risk, placing strong emphasis on weight modifiability, promoting weight loss as a health goal, drawing direct connections between body weight and dietary or physical activity behaviours, and presenting simplistic BMI-health outcome associations without considering relevant covariates.

Inter-evaluator agreement

According to the Bangdiwala weighted statistic, the level of agreement between the two evaluators was 0.93,

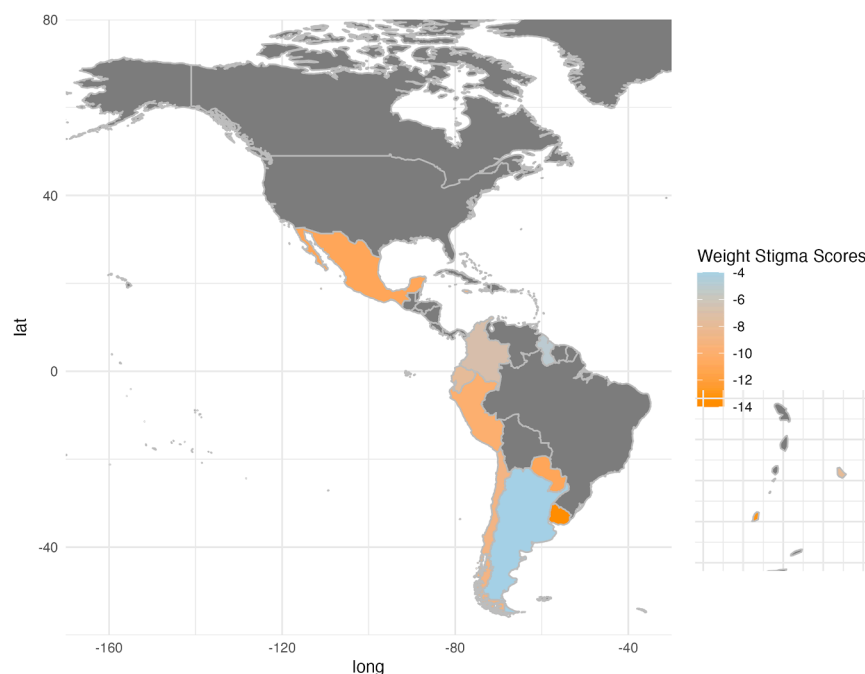


Fig. 3: Weight stigma heat map by country.

indicating strong concordance. Thus, an examination of the agreement chart can help uncover issues and patterns of disagreement that affect the reliability and validity of cross-classified data. The chart shows the amount of agreement quantification noticed by the B-statistic. In the chart, blackened square areas within the rectangles represent exact agreement, while shaded regions indicate partial agreement. Finally, the diagonal line indicates non-bias and equal marginal distributions. In our analysis, the agreement chart corroborated the high level of agreement, as evidenced by the large, blackened areas and the alignment of most rectangles with the diagonal line. Notably, this alignment was consistent across all quartiles except the second, suggesting minimal bias in the marginal distributions. We observed a slight bias among the evaluators toward the lower quartiles of the scores, as indicated by the “path of rectangles” falling below the diagonal line of no bias in quartiles 1 and 2. This pattern suggests that the bias occurred primarily in categories associated with lower levels of weight stigma, where no bias was evident when the FBDGs exhibited higher levels of stigma (Fig. 4).

Discussion

Our findings reveal that the national FBDGs and technical documents from the 13 analysed countries reproduce multiple forms of weight stigma, both explicitly and implicitly. These stigmatising

representations reinforce reductionist narratives that attribute body weight primarily to individual choices, overlooking structural, social, and biological determinants. This is particularly concerning given the growing body of evidence demonstrating the harmful effects of weight stigma on the physical, mental, and social health of affected individuals.⁴⁴ In line with qualitative reporting standards,²⁴ our analysis considered how the emphasis on individual responsibility in many FBDGs may shape representations of weight and health.

A consistent pattern observed in the analysed documents was the promotion of weight loss as a universal health goal, the portrayal of BMI as fully modifiable, and the direct association between larger bodies, unhealthy dietary habits, and sedentary lifestyles. This oversimplified narrative neglects robust scientific evidence indicating that body weight regulation is not entirely under voluntary control, and that genetic, epigenetic, and environmental factors play pivotal roles in the development and persistence of obesity.⁴⁵ Beyond being scientifically inaccurate, such a framing perpetuates social bias and leads to misguided public health policy.

The FBDGs also tended to directly equate thinness with physical activity and higher weight with sedentarism. This assumption has been challenged by recent studies showing that weight stigma can act as a significant barrier to engaging in physical activity. Among individuals with higher weight, stigma has been

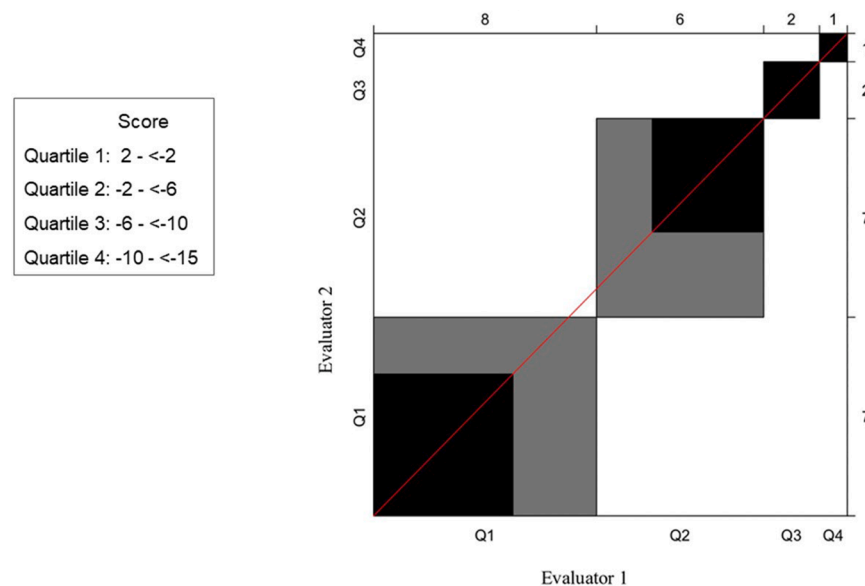


Fig. 4: Agreement chart of evaluators- Bangdiwala statistic.

associated with lower self-efficacy, increased exercise avoidance, and more sedentary behaviours.^{46,47} Therefore, representing body size as a direct reflection of physical activity levels reinforces an unsubstantiated causal relationship that may ultimately undermine public health efforts.

Another noteworthy observation was the frequent use of alarmist language when describing obesity, often referring to it as an “epidemic” or a “public health threat”, without contextualising the social or structural determinants that contribute to it. This risk framing, especially when not adjusted for relevant variables such as age, socioeconomic status, or mental health, that can exacerbate stigmatisation and contribute to discriminatory practices within health systems.⁴⁴

While obesity is associated with adverse health outcomes, including a reduction in life expectancy of up to 13 years among individuals with severe obesity,⁴⁸ such information requires careful contextualisation to avoid reinforcing stigmatising narratives. In 2019, an estimated 5.0 million deaths (95% UI: 3.2–7.1 million) and 160.3 million disability-adjusted life years (DALYs) (95% UI: 106.0–218.9 million) were attributable to excess body weight (EBW) globally. Although the age-standardised mortality rate attributable to EBW remained relatively stable between 1990 and 2019 (a 4.9% change; 95% UI: –7.3 to 24.6), the age-standardised DALY rate increased by 18.0% (95% UI: 2.2–42.3) during the same period.⁴⁹

These global estimates reflect the significant health burden associated with EBW, including in LAC region, where nutrition transitions, urbanisation, and social inequities intersect to shape obesity trends. However,

the use of DALYs in public health messaging must be approached with caution. When presented without adequate context, such metrics can inadvertently reinforce moralising narratives that attribute disease burden to individual failure. These framing risks obscuring the structural determinants, such as poverty, food insecurity, and systemic discrimination, that underpin disparities in health outcomes across the region.

In addition, weight stigma, whether perceived or internalised, has been strongly associated with increased risk of anxiety, depression, and reduced psychological well-being,⁵⁰ as well as with maladaptive behaviours, such as higher consumption of ultra-processed foods following stigmatising experiences.⁴⁶

These findings raise the question of whether the influence of these narratives stems from direct readership of FBDGs or from the wider systems they shape. Although FBDGs target both health professionals and the public, evidence on their use by lay populations in LAC is limited, and FAO reports note that implementation, reach, and uptake remain poorly documented.⁵¹ Nevertheless, FBDGs play a key upstream role in national nutrition discourse, informing professional training, school curricula, food assistance programmes, media campaigns, and community materials. Thus, even with low direct readership, their narratives circulate widely through derivative channels. Addressing weight-stigmatising content is therefore crucial to prevent harmful framings from being reproduced in materials more commonly accessed by the public.

On the other hand, the emphasis on the economic costs of excess weight, as observed in the Chilean and

Grenadian documents, is also problematic. While economic considerations are relevant in public policy, portraying people with obesity as a societal "burden" raises ethical concerns and may contribute to utilitarian narratives that diminish the dignity and rights of individuals living with obesity. By contrast, the technical document from Saint Vincent and the Grenadines adopted a more balanced approach, highlighting health-promoting environments without reinforcing direct associations between weight and behaviour. This aligns with evidence showing that a nuanced understanding of the multifactorial causes of obesity is associated with lower levels of weight bias and blame.^{52,53}

Representation in imagery also warrants attention. The limited inclusion of diverse body types and the dominance of thin bodies reinforce aesthetic and societal norms deeply embedded in public discourse. As Kilby and Mickelson (2025) have shown,⁵⁴ exposure to weight-stigmatising content, particularly through social media, has a stronger negative impact on body image and mood than traditional media. National FBDGs, as authoritative tools in public health and education, have an ethical obligation to challenge, rather than reinforce, such stereotypes.

Most dietary guidelines consider and address different age and ethnic groups, recognising that recommendations must be adapted to the characteristics of individuals within a diverse and multicultural context, with efforts to include indigenous groups and respect their food cultures. In this regard, Mexico is notable for acknowledging the participation of indigenous groups in the validation of these documents.⁵⁵ For effective accessibility, guidelines and nutritional education materials must be culturally appropriate, respecting the varied food consumption patterns and cultural contexts of the national population.⁵⁶ Coverage of disability is limited; fewer than half of the analysed guidelines take it into account, which presents a challenge for its incorporation in future versions. These findings demonstrate an intention towards demographic inclusivity and cultural contextualisation to foster representativeness. This approach should also be extended to body diversity and the stigmatisation of obesity, which is often perceived as an individual and modifiable characteristic.

Finally, the role of the social and physical environment in shaping dietary behaviour must be carefully addressed. While some FBDGs acknowledged structural barriers such as access to healthy foods or community cohesion, others used these factors to subtly reinforce individual responsibility. A genuinely inclusive public health framework must recognise that obesogenic environments not only influence food choices, but also shape public perceptions of health, weight, and moral worth.⁴⁴

While these dynamics are evident within LAC region, similar concerns have been documented in other

regions, making it valuable to situate our findings within a broader international context. Recent applications of the WSHM framework outside LAC provide useful points of comparison. For example, studies in the United Kingdom have examined welfare stigma and political values,⁵⁷ while critiques of nutritional guidelines related to "healthy weight" and obesity have highlighted similar tendencies to frame body size through moralising and reductionist narratives.⁵⁸ These analyses reveal both parallels and distinctions: while LAC FBDGs frequently equate thinness with health and larger bodies with behavioural failure, comparable documents in other regions also risk perpetuating stigma by overemphasising individual responsibility and neglecting structural determinants.

Complementary literature further underscores the global relevance of this issue, including evidence on the health impacts of weight stigma across diverse populations and recommendations for reducing bias in dietetic practice.⁵⁹ International precedents also illustrate that alternatives are feasible. Brazil's and Canada's national dietary guidelines demonstrate that evidence-informed guidance can emphasise environments, cultural practices and equity without relying on weight-centric framings, while paradigms such as *Health At Every Size* (HAES)⁶⁰ reject weight loss as the sole indicator of health and instead promote body acceptance, intuitive eating and respectful care. Although these models align with no stigmatising principles, none has been evaluated for its impact on weight stigma following implementation, which highlights an important gap in current guideline development and monitoring. Drawing from these examples, revising FBDGs in LAC will require removing weight-based targets, avoiding alarmist language, and integrating structural determinants, diversifying representation and adopting participatory processes. Together, these measures can guide the development of dietary guidelines that are both scientifically robust and socially inclusive, aligning with rights-based and person-centred approaches to public health nutrition.

This study offers a robust and systematic analysis of weight-stigmatising content embedded within national FBDGs across 13 LAC countries. Several methodological strengths underpin its rigour such as the application of the WSHM tool, a structured, theory-informed analytical framework that enabled consistent evaluation across varied textual sources. The high level of inter-evaluator agreement (The Bangdiwala weighted statistic $B = 0.93$) enhances the credibility of the coding process. The inclusion of technical documents, where available, offered further insight into the development processes underpinning the FBDGs. These documents are intended to outline the evidence base and methodology applied to formulate the guidelines, as well as to present and discuss the recommendations, and to propose follow-up steps for testing and

implementation. Although possible policy implications, including legislation, are briefly addressed, the tone of these documents often exhibited more overt stigmatising narratives. Likewise, the regional approach allows meaningful comparisons, revealing recurring themes and country-specific nuances rather than quantifiable trends.

Nonetheless, several limitations should be acknowledged. A further point concerns the analytic lens through which the coding was conducted. As all coders were trained nutritionists, their interpretation is inevitably shaped by disciplinary traditions that emphasise behavioural risk management, diet-related responsibility, and weight regulation as core clinical priorities. Within this paradigm, long-standing normative messages in nutrition (such as the linkage between “healthy eating” and maintaining a “proper” weight) may appear technically unproblematic, thereby obscuring their potential to reproduce weight-stigmatising narratives. Conversely, sociocultural, economic and structural determinants of body weight, central to stigma research, may be under-recognised when viewed through a predominantly biomedical frame. Importantly, our deductive content analysis applied pre-established categories from the WSHM tool, which provided a structured framework to guide coding and reduce subjectivity. Nevertheless, future assessments would benefit from interdisciplinary teams that incorporate social scientists and individuals with lived experience, ensuring that diverse perspectives inform the identification and interpretation of stigma.

Other limitations include the limited access to technical documents in most countries; the qualitative nature of stigma assessment carries an element of subjectivity despite strong evaluator concordance; and the fact that findings have limited generalisability even within the LAC region, given the restricted number of countries included. Moreover, the assessment remains focused on content analysis rather than the lived experiences of individuals affected by these guidelines. Therefore, further research should seek to incorporate qualitative data from communities engaging with national FBDGs, to more fully understand the real-world impact of stigmatising discourse within public health nutrition policy. Given that FBDGs aim to provide context-specific, evidence-based recommendations rooted in a country’s unique public health priorities, dietary habits, sociocultural dynamics, and food systems, understanding how individuals experience and interpret these guidelines is crucial. As FBDGs increasingly adopt more holistic approaches such as encompassing meal patterns, eating modalities, lifestyle factors, and sustainability, capturing lived experiences will help ensure that these policies foster inclusivity, reduce stigma, and support equitable and culturally sensitive nutrition practices.

In summary, our findings underscore the urgent need to revise and reframe the conceptual and discursive foundations of FBDGs in LAC region. Incorporating human rights, social justice, and current scientific evidence is essential. Addressing weight stigma is not merely an ethical imperative, it is foundational to the effectiveness and equity of public health nutrition policy.

Contributors

All authors participated in the development and critical review of the manuscript, approved the final version of the manuscript submitted. Concept and design: IP-G. Analysis and interpretation: MV, MA. Drafting of the manuscript: SL-A, IP-G, KB, CT, CE. Critical revision of the paper: IP-G, SL-A, MV, MA, KB, CT, CE. IP-G made the decision to submit the manuscript.

Data sharing statement

This study is based on publicly available national Food-Based Dietary Guidelines and technical documents. The analysed materials are accessible through official government or institutional websites. The coding framework and content analysis outputs are available from the corresponding author upon reasonable request. Due to the qualitative nature of the study, no individual-level or confidential data were collected or generated.

Editor note

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Declaration of interests

The authors declare no conflicts of interest.

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Appendix A. Supplementary data

Supplementary data related to this article can be found at <https://doi.org/10.1016/j.lana.2026.101438>.

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