



Obesity policy in Portugal: epidemiology, sociology and the limits of prevention

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Abstract

Obesity prevention has become a prominent public health priority in Portugal, yet policy responses continue to engage unevenly with the social conditions through which obesity is produced and distributed. This paper examines Portuguese obesity policy through an integrated sociological and epidemiological perspective, arguing that its limitations are fundamentally sociopolitical rather than technical. Drawing on sociological theories of embodiment, class, gender, stigma, and power, it conceptualises obesity as an embodied expression of social inequality rather than solely an outcome of individual behaviour. The paper has three interrelated aims: first, to examine how epidemiological and sociological perspectives conceptualise obesity and its determinants, and the implications of these perspectives for prevention policy in Portugal; second, to analyse how recent obesity policies frame responsibility and address structural determinants through their strategies and instruments; and third, to explore how class, gender, and stigma shape the implementation and effects of these policies, and how alternative sociological framings might support more equitable prevention. Using Portugal as a case study, the paper analyses how welfare arrangements, political dynamics, and institutional framings shape national obesity strategies, including recent regulatory and environmental interventions. While these policies signal a shift towards upstream action, dominant discourses still prioritise personal responsibility, often misaligned with the economic, temporal, and social realities that structure everyday practices, particularly among women and socio-economically marginalised groups. The analysis shows that obesity-related stigma arises not simply from interpersonal attitudes, but from institutional and political processes that legitimise culpability narratives and depoliticise structural determinants of health. More equitable obesity prevention requires moving beyond technical policy instruments towards a Health in All Policies approach that challenges moralised framings of responsibility and addresses the broader social, economic, and political conditions shaping obesity risk and lived experience

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Introduction

The epistemology of obesity has evolved considerably over recent decades. Initially framed as a risk factor, obesity was later considered as a chronic disease and, more recently, as a global public health pandemic, reflecting both its growing prevalence and increasing political relevance (Poulain 2024). This evolution has been largely driven by epidemiological evidence demonstrating strong associations between high body mass index (BMI), morbidity, and premature mortality (Phelps et al. 2024; World Health Organization (WHO), 2022; Zhou et al. 2024).

Historically obesity was conceptualised through a simplistic energy-balance model (Poulain 2009), but now it is widely recognised as a complex, multifactorial, and relapsing condition shaped by an interplay of genetic, epigenetic, behavioural, but also environmental, cultural, socioeconomic, and structural determinants (Frühbeck et al. 2019). As Crossley (2004) notes, while weight gain operates through biological mechanisms, social factors are central in activating and sustaining these processes (Crossley 2004). However, policy approaches continue to frame body weight primarily as a matter of personal responsibility and lifestyle change (Frühbeck et al. 2019). Obesity prevalence is socially patterned, disproportionately affecting women and individuals in lower socioeconomic positions, yet these inequalities remain insufficiently addressed in policy design (Anekwe et al. 2020).

Portugal offers an instructive case for examining obesity policy scenario. Over the past decade, obesity has become an explicit public health priority, with the launch of National Programme for the Promotion of Health Eating (PNPAS) in 2012, the adoption of cross-sectoral “Health in All Policies” strategies, and, more recently, Portugal’s participation in the WHO Acceleration Plan to STOP Obesity (Graça et al. 2021; Gregório, 2019; Direção-Geral da Saúde, 2025). These initiatives signal growing institutional commitment; yet persistent gender- and social-related inequalities in obesity prevalence suggest that prevailing policy approaches remain limited in their capacity to address structural determinants (World Health Organization, 2022).

While epidemiology has been highly effective in documenting obesity trends, identifying population-level risk factors, and informing policy agendas, sociological perspectives remain underutilised in policymaking (Warin et al. 2016). Yet these perspectives are essential for understanding how social structures, power relations, and embodied practices shape obesity and its distribution (Power 1999). Integrating sociological theory allows obesity to be conceptualised not only as an individual or socially patterned condition, but as a structural phenomenon produced and reproduced through political, institutional, and economic arrangements (Warin et al. 2016).

This paper addresses this gap by examining obesity prevention policy in Portugal through a sociological lens. Drawing on theories of embodiment, class, gender, stigma, and power, it situates obesity policy within the broader context of the Portuguese welfare state, political field, and health system. Specifically, it pursues three interrelated aims. First, it examines how epidemiological and sociological perspec-



tives conceptualise obesity and its determinants, and the implications of these perspectives for prevention policy in Portugal. Second, it analyses how recent obesity policies frame responsibility and address structural determinants through their strategies and instruments. Third, it explores how class, gender and stigma shape the implementation and effects of these policies, and how alternative sociological framings might support more equitable prevention.

We argue that, despite increasing recognition of structural determinants, obesity policy in Portugal remains shaped by individualised and moralised framings that constrain its preventive potential and contribute to the reproduction of social inequalities. In this sense, the limits of current policy approaches are fundamentally sociopolitical, rooted in how responsibility, stigma, and power are organised and reproduced through institutions, political representation, and dominant class-based understandings of health. By analysing obesity policy in this way, and applying Bourdieu's theory of classed embodiment, Goffman's theorisation of stigma, and feminist scholarship on the gendered politics of care and responsibility, the paper shows how contemporary welfare states govern obesity through classed and gendered moral regulation and clarifies how "prevention" discourses allocate responsibility, legitimise specific interventions, and reproduce social inequalities.

Methods

A qualitative documentary analysis of Portuguese obesity-related policies and strategic documents was conducted. We examined the National Health Plans (NHP) 2012–2020 and 2020–2030, the National Programme for the Promotion of Healthy Eating (PNPAS) plans 2012–2020 and 2022–2030, the Action Plan to Accelerate the Prevention and Control of Obesity in Portugal 2025–2027, obesity-related content on the National Health Service (SNS) and PNPAS websites, and two national legislative instruments specifically addressing obesity (one parliamentary resolution and one ministerial dispatch). The period covered was 2012–2025, corresponding to the introduction and consolidation of obesity and nutrition as explicit public health priorities in Portugal. Documents were identified through searches of the Ministry of Health, Directorate-General of Health and SNS/PNPAS websites, complemented by snowballing from references and cross-references within policy and legislative texts. We included documents that explicitly addressed obesity prevention, treatment or management at the national level and excluded purely clinical guidelines without a population-level or preventive focus.

All documents were read in full and examined to identify if and how obesity was mentioned, with particular attention to references to prevention, treatment and management. We then assessed how these documents framed obesity, responsibility and risk, and how class, gender and broader social determinants were represented or omitted. The analysis was interpretive rather than formally coded and was informed by the theoretical framework outlined below, drawing on sociological concepts of embodiment, class, gender, stigma and neoliberal governance to characterise dominant policy framings and tensions between upstream structural measures and individualising narratives.



Theoretical framework

Sociological theories conceptualise obesity as an embodied expression of social structures, power relations and inequality. The proposed framework provides analytical tools for understanding the limitations of obesity prevention strategies and how stigma and moralisation become embedded in policy and practice.

Embodiment, class and temporality

Pierre Bourdieu's conceptualisation of the body as a sociological object is central to understanding obesity as a socially structured phenomenon. Through the concept of *habitus*, Bourdieu describes how social conditions are internalised as durable, embodied dispositions that shape perceptions, preferences, and practices, often operating below conscious awareness (Bourdieu 1980; Power 1999). Eating practices, physical activity, and relationships with the body are thus patterned by class-based experiences rather than freely chosen behaviours.

Habitus is transmitted intergenerationally through everyday family practices - what Bourdieu terms "pedagogic action"- embedding social inequalities within bodies from early life onward (Bourdieu 1980). While *habitus* can evolve, early-life social conditions exert a lasting influence, helping explain the persistence of class-based obesity inequalities over time (Bourdieu 1980). This perspective challenges public health strategies that assume individuals can readily adopt healthier behaviours once informed, regardless of their social context.

Class-based embodiment is also shaped by temporal orientations. Bourdieu's notion of temporal ethos demonstrates how economic insecurity fosters present-oriented practices, whereas more privileged social positions enable long-term investments in the body (Bourdieu 1980). Wacquant (2016) and Shilling (2012) further show that sustained bodily work, such as regular exercise or dietary planning, requires economic stability and predictable time – resources that are unevenly distributed across social classes (Shilling 2012; Wacquant 2016). Therefore, health promotion initiatives that emphasise future-oriented health benefits may resonate more strongly with middle- and upper-class groups, but risk alienating lower-class groups whose everyday circumstances constrain future-oriented planning. We use this Bourdieusian notion of *habitus* to analyse how obesity prevention policies presuppose a reflexive, future-oriented subject and how this presupposition clashes with the classed and gendered dispositions that structure everyday food practices and body management.

Gender, morality and bodily regulation

Class-based inequalities intersect with gender to intensify embodied disadvantage and further differentiate *habitus* across social groups. Patriarchal social structures subject women to heightened scrutiny of body size and appearance, positioning thinness as a moral and social ideal (Bourdieu 1998). Across social classes, women face greater pressure to engage in bodily self-regulation, yet access to resources for body management is unequally distributed. Working-class women often experience constraints related to economic precarity, time scarcity, and unpaid care work, limiting



their capacity to engage in preventive health practices (Nettleton 2020). These constraints produce “temporal-corporeal inequalities,” in which health practices become reactive rather than preventive (Nettleton 2020). Skeggs (1997) further demonstrates how working-class women’s bodies are read as markers of moral worth or failure, reinforcing classed and gendered stigma. In this context, obesity is not only a health condition but a moralised social identity (Skeggs 1997).

Stigma and moral hierarchies

In contemporary societies, obesity is often framed as a moral failing, attributed to perceived deficits in self-discipline and responsibility (Broom and Warin 2011). In Bourdieusian terms, these moral judgements can be understood as evaluations of differently classed and gendered *habitus*, in which some bodily dispositions are valorised as legitimate while others are devalued as deficient. Such framings generate stigma by positioning people living with obesity as morally deficient, evoking emotions such as disgust, fear, or contempt (De Brún et al. 2014; Lupton 2013). Thinness, by contrast, is valorised as a symbol of virtue and self-control. Goffman’s concept of stigma as a “spoiled identity” illustrates how these moral judgements operate relationally, through social interactions that impose negative meanings on certain bodies, reflecting broader power relations rather than individual attributes (Goffman 1968). Disgust, as Lupton (2015) and Nussbaum (2004) argue, functions as a social boundary-making mechanism, legitimising exclusion and reinforcing hierarchies of worth (Lupton 2015; Nussbaum 2004).

When applied to body weight, stigma involves several dimensions. Weight stigma refers to the social devaluation of individuals with higher body weight, expressed through negative attitudes, stereotypes, and prejudice, often framing people with overweight or obesity as lacking self-discipline and personally responsible for their condition (Rubino et al. 2020). Weight discrimination captures the behavioural expression of this bias through unfair treatment, while internalised weight bias refers to the incorporation of these stereotypes into self-understandings, producing self-blame and self-devaluation (Rubino et al. 2020). These dimensions operate explicitly, through conscious attitudes, and implicitly, through automatic and often unconscious associations.

Knowledge, power, and disciplinary tensions

Sociological and epidemiological approaches to obesity often diverge in their conceptualisation of the body. While epidemiology prioritises measurable health outcomes, sociological approaches emphasise lived experience, embodiment, and power (Warin 2015). Poulain (2024) characterises this divergence as a productive scientific controversy, highlighting the need for dialogue rather than disciplinary dominance (Poulain 2024). The framework adopted here takes this controversy as a starting point, using sociological concepts to challenge reductionist framings, expose the political dimensions of obesity policy, and support non-stigmatising, equity-oriented approaches to prevention and care.



The Portuguese context: a case study

In Portugal, welfare, political, and health system arrangement's structure obesity prevention policies and shape the ways responsibility, risk, and care are defined, governed, and experienced.

Welfare state

Following the 1974 Carnation Revolution, Portugal established a welfare state aligned with other capitalist democracies in Europe guided by principles of decolonization, democracy, and socioeconomic development (Calado et al. 2019). Portuguese welfare state evolved through alternating cycles of economic growth and welfare expansion vs. austerity and economic stagnation. After joining the European Economic Community (EEC) in 1986, the country benefited from European funds directed at professional development, employment, infrastructure and institutional innovation (Arnold and Rodrigues, 2015; Calado et al. 2019; Rodrigues and Andrade, 2020). Between 1986 and 2001, despite persistent poverty and inequality, Portugal experienced economic growth and social convergence with Europe, supported by significant investment in healthcare, education and social policies (Arnold and Rodrigues, 2015; Calado et al. 2019; Rodrigues and Andrade, 2020). However, economic vulnerabilities emerged during international crises (1993, 2002/3), when neoliberal ideas gained momentum, leading to attempts to cut social spending, deregulate labour markets and increase privatization of public services (Arnold and Rodrigues, 2015; Calado et al. 2019; Rodrigues and Andrade, 2020). The 2010s marked a critical juncture, as the 2008 global financial crisis triggered severe austerity measures, resulting in cuts in social policies, further privatization and labour deregulation and rising inequality, reflecting broader global neoliberal trends (Wacquant 2023). In 2015, a political shift occurred with a left-wing alliance that reversed some austerity measures, restoring social benefits and contributing to poverty reduction and economic recovery (Calado et al. 2019). Despite these changes, challenges such as labour precarization, wage stagnation and continued reliance on lower labour costs limited the welfare state's capacity to address structural inequalities (Veiga et al. 2024).

Political field

The Portuguese Parliament, known as the Assembly of the Republic, comprises 230 members (Veiga et al. 2024). Despite mandates lasting four years, political instability has been recurrent, with most governments ending their terms prematurely since 1976 (Veiga et al. 2024). The political landscape has been predominantly dominated by the alternated governance of the Socialist Party (PS, centre-left) and the Social Democratic Party (PSD, centre-right) (Veiga et al. 2024). Other longstanding parties include the Portuguese Communist Party (Partido Comunista Português, PCP), the Left Bloc (Bloco de Esquerda, BE) and the Democratic and Social Centre - Popular Party (CDS-PP) (Veiga et al. 2024). In 2019, three additional political forces emerged, namely the progressive and pro-European LIVRE (L) on the left, and on the right, the liberal-libertarian Liberal Initiative (Iniciativa Liberal, IL) and the far-



right Chega party (CH)(Veiga et al. 2024) The 2025 legislative elections marked a turning point, breaking with the country's longstanding bipartisan pattern, with CH becoming the third largest political force, one of the strongest performances by a third party in the Portuguese democratic history (Magalhães and Cancela 2025). This reflects a fragmented parliament, with increased representation from emerging parties and a shifting balance of power, particularly on the right of the political spectrum. According to the partisan theory, political parties shape economic and social policies according to their ideologies and the interests of their social bases: left-wing governments tend prioritise expansionary fiscal policies, income redistribution, tackling poverty and unemployment; while right-wing typically emphasise inflation control and market competitiveness (Hibbs 1977, 1987). As a result, the ideology of the party in power plays a crucial role in shaping policy decisions in democratic systems (Hibbs 1977, 1987).

National health system

The Portuguese National Health Service (NHS), created in 1979, is a key component of the welfare state, reflecting the constitutional right to universal, comprehensive, and largely free healthcare (Böhm et al. 2013; Law No. 56/79, 1979). Funded mainly through general taxation, public expenditure accounts for two-thirds of total health spending, complemented by out-of-pocket payments and voluntary insurance (De Almeida et al. 2017). The NHS was formalised by Law No. 56/79, passed in June 1979 (Law No. 56/79, 1979), with strong support from left-wing parties (PS, PCP, UDP), abstention from the PSD, and opposition from the CDS-PP (Veiga et al. 2024). The law reflected the constitutional principle of the right to health protection, while recognising the supplementary role of the private sector (Simões et al. 2021). It also allowed private entities to assist in healthcare delivery until the NHS could fully meet demand, through contractual arrangements or direct reimbursement to patients (Simões et al. 2021). The NHS is delivered through the intersection of three sectors: the State, which regulates, coordinates and finances most care; the social sector, which is prominent in long-term care; and the private sector, which plays a complementary role in specialised and outpatient services (De Almeida et al. 2017). Over time, political cycles have shaped the balance among these sectors. Right-wing governments have generally expanded private sector participation and public-private partnerships (PPPs), while left-wing governments have reinforced the NHS's public character (Simões and Fronteira 2019). The 1990 Basic Health Law enabled privatisation and private management of public services (Law No. 48/90, 1990), whereas the 2019 revision reaffirmed the NHS as the main pillar of healthcare provision, preserving its mission of ensuring fair access to quality healthcare for all citizens regardless of where they live or their social or economic status (Simões et al. 2021). In 2024, a nationwide reform created 39 Local Health Units (ULS) integrating hospitals and primary care centres and decentralising the coordination of healthcare delivery at the regional level (República Portuguesa, 2023). Nevertheless, persistent challenges remain, including regional inequalities that might amplify barriers to healthcare access among lower socioeconomic groups (De Almeida et al. 2017).



Obesity policy in Portugal

In Portugal, the organisation of the welfare state, the political field, and the health system structures obesity prevention policies and shapes how responsibility, risk, and care are defined, governed, and experienced.

Trajectory of obesity as a public health priority in Portugal

Secular trend data for young Portuguese men in the Lisbon district show that the prevalence of overweight ($\text{BMI} \geq 25 \text{ kg/m}^2$) more than doubled between 1960 and 1990, increasing from 8.1% to 18.0% (Jácome De Castro et al., 1998). At the national level, obesity prevalence rose from 11% to 17% among men and from 11% to 15% among women between 1998 and 2019 (Valente et al. 2025). Across these 21 years, obesity remained consistently concentrated among individuals in lower socioeconomic positions, with women in these groups bearing the greatest burden of obesity (Valente et al. 2025). Among children, data from Childhood Obesity Surveillance System (COSI) show an obesity prevalence of 15.3% in 2007/2008 and a slight decrease to 13.5% in 2022 (Rito et al. 2023).

Obesity was formally defined as a chronic disease by the Directorate-General of Health in 2004 and the National Platform Against Obesity was created in 2008. These initiatives were later consolidated by the launch of the National Programme for the Promotion of Healthy Eating (PNPAS) in 2012 and the Integrated Strategy for the Promotion of Healthy Eating (EIPAS) in 2017, which established obesity and nutrition as explicit public health priorities and created the conditions for more upstream, food-environment-oriented interventions (Graça et al. 2021). In 2025, Portugal's trajectory of obesity prevention was recognised by the United Nations and the World Health Organization, which honoured the country for its multi-sectoral measures to prevent and control obesity, in particular the work led by the Directorate-General of Health to promote healthy eating and mobilise actors across sectors to reshape eating environments, protect children, and support healthier choices in the population (República Portuguesa | XXV Governo, 2025).

Institutional framework

Understanding obesity governance in Portugal requires examining the institutional arrangements that shape health policy design, implementation, and evaluation. The Ministry of Health oversees NHS and public health policy, with the Directorate-General for Health (DGS) responsible for planning and implementing the National Health Plans (NHPs) and the National Institute of Health Dr Ricardo Jorge (INSA) for its evaluation (Assembleia da República, 2019). Within this governance structure, institutional definitions of obesity play a central role in framing policy priorities and intervention strategies, and in shaping societal understandings of obesity. On the NHS website, obesity is defined as: “(...) a chronic disease characterised by excessive fat accumulation in the body. It results from an imbalance between calorie intake, through food, and the number of calories expended through physical activity or daily activities. When a positive energy balance persists over time, weight



increases, leading to the development of obesity. A healthy diet and regular physical activity help maintain a healthy weight. (...)" (SNS 24, 2023).

National Health Plans

Obesity has been progressively incorporated into Portugal's NHPs as a public health priority. The 2012–2020 and 2020–2030 NHPs define the strategic guidelines and objectives of national health policy (Graça Freitas et al. 2022; Direção-Geral da Saúde, 2015). The earlier NHP framed obesity as a risk factor for non-communicable diseases (NCDs) and a health determinant. The plan outlines prevention strategies primarily focused on children and adolescents. Although equity and adequate access to healthcare across different social, geographic, and demographic groups are acknowledged, the concrete recommendations are limited to strengthening equitable access to paediatric prevention programmes and intersectoral strategies aimed at minimising obesity-related risk factors (Direção-Geral da Saúde, 2015). In terms of monitoring, the plan proposes controlling the incidence and prevalence of overweight and obesity in the paediatric population (Direção-Geral da Saúde, 2015).

The later plan identified obesity as one of the twelve priority public health needs. Beyond its framing as a risk factor NCDs, obesity was presented as biological determinant of health (da Graça Freitas et al. 2022). Furthermore, the plan explicitly recommends adopting an integrated approach to tackle the main determinants of NCDs, including obesity, recognizing the synergistic interactions among these determinants with and socioeconomic determinants. Following the identification of health needs, several intervention strategies were proposed. Although only one strategy explicitly mentions obesity, some measures address its prevention and management, directly or indirectly, such as the prescription of physical activity and the promotion of healthy eating, as well as the legislative initiatives and fiscal measures aimed at modifying dietary consumption patterns. (da Graça Freitas et al. 2022; Direção-Geral da Saúde, 2015).

The national program for the promotion of healthy eating (PNPAS)

Under the DGS, PNPAS marked Portugal's first coordinated food and nutrition policy with a strong focus on obesity prevention (Graça and Gregório 2016). From 2012 to 2020, PNPAS adopted a preventive and cross-sectoral approach aligned with WHO and European Commission guidance, combining actions to improve knowledge on dietary intake and its determinants, empowering the population to make healthier food choices (particularly groups living in vulnerable socioeconomic contexts), and strengthen the capacity of health and other professionals to influence dietary behaviours. During this period, PNPAS implemented a range of evidence-based interventions, including the monitoring of dietary patterns and nutrition-related health outcomes, improvements in food availability in schools, workplaces, and public spaces, along with nutrition education initiatives, and nationwide public health campaigns (Graça et al. 2021). While education and empowerment measures remained integral to the programme, increasing emphasis was placed on interventions targeting food environments: fiscal measures, food reformulation, and regula-



tion of food provision. These policy shifts reflect a growing recognition that structural changes to food environments were likely to yield greater population-level impact on obesity prevention.

This strategic orientation is further consolidated in the PNPAS 2022–2030, in which obesity prevention is addressed through complementary intervention axes targeting behaviours, healthcare, and food environments, with a systemic focus on upstream dietary determinants. The “Inform and Empower” and “Identify and Care” axes prioritise behavioural and early preventive action through public communication campaigns (e.g.: “I Choose to Eat Well”) (Direção-Geral da Saúde, 2023), open-access nutrition education resources (e.g.: “10 Steps for a Healthy Nutrition” guide) (Direção-Geral da Saúde, n.d.), and nutrition education in early childhood settings and schools, with targeted interventions for socioeconomically vulnerable groups and priority life-course stages (the first 1,000 days of life, childhood, and adolescence). Within the health system, these axes also include early identification of unhealthy dietary patterns, brief nutritional counselling in primary care, and improved access to multidisciplinary prevention and care pathways for people living with obesity. These actions are reinforced by the “Protect and Support” axis, which addresses population-level prevention through structural measures aimed at modifying food environments, and focus on strengthening its regulation, fiscal policies to improve access to healthy foods and limit unhealthy options, food reformulation with reductions in salt, sugar, and trans fatty acids, as well as restrictions on marketing and sale of unhealthy foods in schools, hospitals, and public health centres. Additionally, nutritional labelling improvement, and definition of nutritional standards for food provision and public procurement are also established. These measures were set to support a national target of a 5% reduction in paediatric obesity by 2030 (Direção-Geral da Saúde, 2022).

Action plan to accelerate the prevention and control of obesity in Portugal

In 2025, DGS launched the Action Plan to Accelerate the Prevention and Control of Obesity in Portugal (2025–2027), a three-year strategy within the WHO Acceleration Plan to STOP Obesity, reinforcing obesity as public health priority (Direção-Geral da Saúde, 2025). It adopts a life-course approach, prioritising interventions in infancy and childhood, such as the new National School Health Programme aimed at promoting healthy eating and physical activity, new nutrition criteria for food procurement in the public sector, supported by nutrition education campaigns and best practice guides. In healthcare, it establishes an Integrated Care Pathway for People Living with Obesity and expands primary care capacity through nutritional counselling. The plan also promotes municipal partnerships and international collaboration to accelerate progress in obesity prevention and management (Direção-Geral da Saúde, 2025).

Legislative developments

Recent legislation complements these strategic frameworks. Resolution No. 195/2021 outlined thirteen strategic actions addressing obesity prevention, treatment, and social determinants of obesity through health literacy, food reform, and improved access to care (Assembleia da República, 2021). It highlighted the need for cross-government



coordination, societal collaboration, public health investment and engagement with the food industry to improve product composition. Then, Dispatch No. 12634/2023 introduced an Integrated Care Model for the Prevention and Treatment of Obesity (Saúde - Gabinete da Secretária de Estado da Promoção de Saúde, 2023). This model prioritises personalised, multidisciplinary care for individuals with pre-obesity and obesity within ULS, linking primary and hospital care. It also includes a structured 24-month “Specialised and Multidisciplinary Obesity Consultation” intervention programme and reinforces counselling on diet and physical activity. These developments are being implemented within a reorganised NHS structure based on ULS, some of which operate under PPP arrangements, creating heterogeneous organisational and financial conditions for obesity prevention and care across regions (Saúde - Gabinete da Secretária de Estado da Promoção de Saúde, 2023).

Critical analysis

Portugal’s obesity policies reflect a gradual shift toward upstream and regulatory interventions, yet they remain constrained by individualised and moralised framings of responsibility. These constraints are sociopolitical, reflecting how stigma and power are built into obesity policy and how responsibility is assigned and reproduced. Measures such as sugar-sweetened beverage taxation, food reformulation, and restrictions on food marketing address commercial determinants of health and signal policy innovation (Heller et al. 2024; World Health Organization 2018). At the same time, public health narratives frequently emphasise personal choice, self-control, and behavioural change. Moralising language and imagery, risk reinforcing stigma and obscuring the socioeconomic constraints that shape food practices and health behaviours and, as framing studies suggest, can also erode public support for structural obesity policies when they personalise responsibility and centre treatment over prevention (Hagenaars et al. 2026; Hill et al. 2021; Lupton 2013).

Bourdieu’s concept of *habitus* helps explain why educational interventions focusing on behaviour change often fail to resonate with populations facing economic insecurity and time scarcity. Practices related to food, physical activity, and body management are socially conditioned, embodied and reproduced over time, rather than freely chosen or easily modified through information alone (Bourdieu 1979; Power 1999). These embodied differences are subject to social evaluation and moral judgement. Goffman’s framework of stigma illuminates how policy discourses and institutional practices can translate embodied social differences into moral hierarchies by distinguishing between bodies deemed responsible and irresponsible (Goffman 1968). Building on these individual and organisational processes, Scambler’s “jigsaw model” situates weight stigma within broader class-based power structures, demonstrating how responsibility attribution becomes politicised and institutionalised in contexts marked by growing social inequality (Monaghan 2017; Puhl and Heuer 2010; Scambler 2006).

In Portugal, official definitions of obesity and strategic documents continue to prioritise biomedical and behavioural explanations that implicitly attribute responsibility onto individuals. The NHS definition of obesity frames it as an energy imbal-



ance (SNS 24, 2023), while the 2012–2020 and 2020–2030 NHPs largely retain an individualised biomedical orientation, with limited engagement with structural determinants like poverty, gender inequality, and unequal access to health-promoting environments (da Graça Freitas et al. 2022; Direção-Geral da Saúde, 2015). Furthermore, neither plan establishes measurable prevalence targets nor outlines concrete accountability mechanisms to address the social conditions shaping obesity distribution (Graça et al. 2021).

At the same time, through PNPAS, Portugal has progressively incorporated more upstream population-level interventions. Public health campaigns, fiscal measures, food reformulation and marketing restrictions move beyond traditional education-focused approaches and address aspects of the food environment (Graça et al. 2021). However, a persistent tension remains between contextual policy measures and individualising public messaging. Narratives around “junk food” (in Portuguese, “lixo alimentar,” a term with a strongly pejorative connotation) and campaigns encouraging people to “choose to eat well”, rely on culpability-based narratives of personal agency while downplaying material constraints on food access, affordability and time (PNPAS et al., 2020). Such messages implicitly assume a way of life oriented towards long-term planning and active body work, which aligns more closely with middle-class routines than with the crisis-driven time pressures experienced by many working-class women. While intended to promote health, these framings may stigmatise people living with obesity who face limited options, thereby reinforcing moralisation and social distinction (Farrell et al. 2016a; Lupton 2013; Poulain 2024).

Narrative messages can effectively communicate causal information about societal issues and foster support for policy solutions (Niederdeppe et al. 2014; Puhl and Heuer 2010). Short, carefully designed stories are particularly well suited to integrating individual and societal causes of obesity, thereby promoting more complex understandings of its root causes. Consequently, they have the potential to increase policy support among adults, including those with conservative political views, when obesity is framed as involving no or only moderate personal responsibility and when societal determinants are emphasised (Niederdeppe et al. 2014). However, recent work on political framing goes further, arguing that the currently dominant framing of obesity as a chronic “but individually treated disease” along with the message that “we need to both prevent and treat” can undermine public and political support for upstream measures, whereas framings that emphasise the influence of the food industry and food environments on obesity elicit stronger support for structural interventions (Hagenaars et al. 2026; Niederdeppe et al. 2014). Weight stigma is a key mechanism through which these policy discourses are experienced and translated into harm. In Portugal, a study among women with obesity found that stigma mediates the relationship between physical health and adverse emotional outcomes (Vilhena et al. 2014). Weight self-stigma has been linked to a tendency to avoid or suppress distressing thoughts and emotions, unhealthy eating behaviours, binge eating, and diminished obesity-related quality of life, particularly among women with binge-eating symptoms (Palmeira et al. 2016, 2018). Internalised weight stigma is fuelled by pervasive stigmatising messages, including those present in healthcare settings, where weight-biased attitudes have been documented among professionals (R. M. Puhl and Heuer 2009). Individuals who are more vulnerable to internalising



such messages appear particularly at risk of adverse psychological outcomes, lower adherence to nutritional and exercise recommendations, and poorer treatment outcomes, including reduced post-surgical weight loss (Palmeira et al. 2016, 2018; Puhl et al. 2026; Romano et al. 2026). Studies from Italy, France, Spain, Australia, and Brazil similarly show that internalised weight bias mediates the relationship between experienced stigma and adverse psychosocial outcomes, while stigmatising beliefs remain widespread across everyday settings (Bidstrup et al. 2026; Lecube et al. 2025; Lemoine et al. 2025; Ramsamy et al. 2026; Viola et al. 2026). Weight stigma appears to be patterned by ethnicity; findings from the United States show different levels of prejudice, experienced stigma, and internalised bias among Hispanic, non-Hispanic White, and non-Hispanic Black adults with obesity (Galindo et al. 2026). The accumulation of clinical harms and negative day-to-day lived experiences associated to weight stigma highlights the need for leadership and structural changes that explicit prohibit weight-based discrimination policies (Pearl et al. 2015; R. M. Puhl and Heuer 2009; Rubino et al. 2020) and support the use culturally attuned communication rather than generalistic “one-size-fits-all” approaches (Galindo et al. 2026). Given that weight stigma is ingrained in contemporary societies, such changes and policies should be applied to all sectors of society (Rubino et al. 2020). Specifically within healthcare settings, weight discrimination is perceived by patients as a disrespectful treatment and poorer quality care, that erodes trust, generates feelings of unsafety and reduces satisfaction with services (Baile et al. 2026). Discriminatory interactions held by healthcare professionals lead to a vicious cycle of suboptimal care and worse health outcomes, which in turn reinforce prejudiced views (Baile et al. 2026; Marchesi et al. 2026). For instance, weight discrimination and implicit weight bias are particularly harmful among women, since those living with overweight or obesity tend to communicate less with healthcare providers about contraception and family planning, compromising reproductive autonomy (Meisenbach 2025), and have higher odds of having out-of-date cervical and breast cancer screenings (Gerend et al. 2026; Ross and Solinger 2017). These examples demonstrate how stigma and gender intersect to shape health, potentially intensifying existing inequalities.

Given that the physical and psychosocial effects of weight stigma are not evenly distributed across population groups, universal prevention strategies, particularly those centred on nutrition education and behaviour change, tend to resonate more strongly with middle- and upper-class groups, for whom health-promoting practices align with available economic, temporal, and symbolic resources (Farrell et al. 2016b; Zivkovic et al. 2015). In contrast, for lower-income groups, the structural constraints related to temporality, affordability, availability, and the social and emotional meaning of food shape food practices limit the effectiveness of such nutrition-education interventions (Farrell et al. 2016b; Power 1999; Warin 2015; Zivkovic et al. 2015). Labelling foods as “bad” and promoting avoidance may intensify feelings of deprivation, particularly where food plays a central social and affective role (Warin 2023). Additionally, the reduction of food to nutritional values and of health to individual choice (the “black boxing” of nutrition) depoliticises obesity by masking the social and economic conditions through which it is produced and sustained (Guthman 2014; Poulain 2024; Yates-Doerr 2012). Ethnographic research from Australia shows that, on one hand, individuals from lower socioeconomic groups tend to foreground eco-



conomic constraints and support measures such as food subsidies and marketing restrictions. On the other hand, higher socioeconomic groups more often attribute obesity to knowledge deficits and endorse labelling and educational campaigns, reinforcing moral distinctions between “responsible” and “uninformed” citizens while leaving structural determinants largely unchallenged, a pattern described as “wilful ignorance” (Farrell et al. 2016a; Warin 2023).

Weight stigma permeates all age groups and appears to emerge early in the life course. In a nationally representative survey of Portuguese adolescents (11–16 years), those with overweight reported poorer self-perceived health and signs of social isolation compared with their peers, suggesting that stigma and exclusion are already shaping wellbeing in youth (Fonseca & Gaspar de Matos, 2005). Negative perceptions of larger body sizes, and their association with unhealthiness, lack of agency, bullying, and social exclusion, have also been observed among young children, who are influenced by family narratives as well as media and social media content activities (Lorenc et al. 2026). In this way, children can become active perpetrators of stigma, potentially deterring peers with overweight or obesity from participating in physical and social activities (Lorenc et al. 2026). When children and adolescents who have already experienced the negative consequences of weight stigma undergo paediatric obesity treatment, clinical encounters that focus heavily on diet, weight monitoring, and individual responsibility risk reinforcing internalised stigma, particularly when communication is experienced as excluding or judgemental (Palad et al. 2019).

International recognition of Portuguese obesity policy reflects the progress achieved during the last two decades, in a political and institutional landscape marked by post-financial crisis austerity, political instability and the widespread adoption of neoliberal policies by major parties. After 2008, austerity policies have further constrained the capacity of health systems to invest in obesity prevention, by reducing public health and primary care funding, hiring freezes, and workforce cuts limiting staff for preventive services, shorten consultation times, and curtail the capacity to invest in public health and preventive care, leading to a widespread deterioration in access to care, particularly for vulnerable populations (McDaid et al. 2013; Quaglio et al. 2013). This, alongside societal consequences such as unemployment, poverty, and housing insecurity, exposed lower income groups to several determinants that shape obesity risk (Stuckler et al. 2017; Stuckler and Basu 2014).

Despite the austerity influence, obesity policy has evolved under alternating centre-right and centre-left governments, but the trajectory of the Portuguese health system reform is more complex than a simple left–right divide. The PPP model in hospital management was formally introduced in 2001 under a Socialist government, through a new legal regime for healthcare PPPs and a dedicated Mission Structure of Health Partnerships, and subsequent administrations across the political spectrum alternated between launching, renewing, and ending hospital PPP contracts (Asensio and Popic 2019; Pereira et al. 2021). Evaluations highlight complex tenders, frequent renegotiations and limited value gains for the public sector, suggesting that PPP expansion has been largely driven by political choices and contributing to the embedding of market-oriented governance logics across party lines (Pereira et al. 2021). Although there is limited empirical evidence on how increased private sector



participation has reshaped the framing of obesity within the Portuguese NHS specifically, experience from other European health systems suggests that commercial involvement in obesity care tends to foreground individualised, treatment-focused approaches (Thomson et al. 2015). Industry-funded programmes and partnerships have often prioritised weight-loss pharmacotherapy and commercial weight management services, while devoting less attention to upstream structural determinants and the regulation of obesogenic environments, raising concerns that such initiatives risk functioning as “marketing by another name” and failing to address root causes (Griffin 2022; Harrison 2023). In this context, growing private sector participation in obesity pathways—whether through PPP-managed services or commercial partnerships—may reinforce framings of obesity as a matter of individual behaviour amenable to pharmaceutical and behavioural “solutions,” narrowing clinical pathways around biomedical treatment and lifestyle counselling and amplifying responsibilising and stigmatising discourses at the expense of more structural, population-level interventions (De Vogli 2011; Schorb 2013; Schrecker 2016). From a political-sociological perspective, such developments are consistent with broader neoliberal patterns in which responsibilisation, market-oriented governance and austerity intersect to individualise risk and legitimise conditional or fragmented provision of care.

The recent restructuring of the NHS into ULS, some of which are now managed through public-private partnership arrangements, further complicates the implementation and coherence of obesity prevention. By devolving substantial discretion to ULS and allowing heterogeneous governance models, this reform risks producing territorially fragmented approaches to obesity, with variation in how responsibility, prevention, and treatment are framed and resourced across regions. In practice, such fragmentation may exacerbate existing geographical inequalities in obesity (Alves et al. 2017). This decentralisation is also embedded in neoliberal governance logics—fiscal constraints, performance metrics, and partnership with commercial actors—that have been shown to shift responsibility from collectivities to individuals in European health systems (De Vogli 2011; Schrecker 2016). In this context, local discourses that emphasise personal responsibility and “lifestyle choices” as conditions for accessing support may further intensify weight-related stigmatisation, echoing broader patterns in which responsibilisation and austerity intersect with stigma to legitimise conditional or fragmented provision of care (Sánchez-Carracedo 2022; Schorb 2013). The incremental policy change within the Portuguese political and institutional frameworks described above implicitly reflects healthism and lifestylism, whereby ideals of individual choice and self-management are projected onto the body and used to judge people’s worth by distinguishing those seen as actively pursuing health from those deemed negligent (Hartlev 2014; Krieger 2001). These framings are particularly detrimental for people in lower socioeconomic groups, who are more exposed to structural health determinants yet are still held individually accountable for outcomes shaped by inequality (Wacquant 2022; Warin 2023). This pattern of incremental policy change is better understood by examining how dominant narratives of responsibility and blame are sustained within neoliberal governance structures (Poulain 2024; Rubino et al. 2020), consistent with broader analyses showing that neoliberal globalisation and austerity have constrained redistributive and structural health policies in Europe and that dominant “obesity as a chronic disease requiring individual



treatment” framings crowd out political space for prevention and align with food and pharmaceutical industry interests (De Vogli 2011; Hagenaars et al. 2026; Schrecker 2016). In this sense, obesity-related stigma and policy neglect, in a context where obesity prevalence and related harms fall disproportionately on women and lower socioeconomic groups, can be understood as a form of “slow violence,” involving the accumulation of harm that remains politically marginal and insufficiently addressed (Warin 2023). Not less important is the influence of political representation in policy agenda setting. The social composition of the Portuguese Parliament remains dominated by white men from larger urban areas graduated in law, economics or management (Mineiro 2019). Thus, obesity-related policymaking appears to occur within a socially homogeneous setting that is distant from the material constraints associated with obesity risk. Furthermore, the increasing presence of populist radical-right politics, which tend to prioritise security, nationalism, and moral order over redistributive social policy, may further marginalise structural health interventions (Mendes 2021; Magalhães and Cancela 2025). This social and political configuration of obesity governance becomes even more important in a context of increasing migration, where racialised and migrant communities are likely to face greater exposure to structural determinants of obesity and weight stigma, yet remain under-represented in political and policy-making arenas (OECD, 2025).

The attribution of individual responsibility and the moralisation of bodies limits the capacity of policy to address structural determinants of health. From a public health ethics perspective, health inequalities that arise from structural and social factors beyond individual control—such as socioeconomic position, access to education, or neighbourhood and built environments—are widely regarded as unjust, yet calls for greater social justice in health require a clear and robust conception of justice if they are to be translated into practice (Weidinger et al., 2026). More equitable and effective obesity prevention therefore requires not only technical health policy solutions, but also participatory and democratic governance processes grounded in a genuine Health in All Policies (HiAP) perspective (Doetsch et al. 2025; Heller et al. 2024; Hill et al. 2021). This perspective recognises that policies not traditionally framed as health interventions, such as those addressing poverty, labour precarity, housing conditions, and discrimination, are fundamental to shaping health opportunities and outcomes.

Although HiAP has been formally endorsed in Portugal, its operationalisation remains limited, characterised by weak cross-sectoral accountability, fragmented implementation, and a lack of binding mechanisms to integrate health equity goals into non-health policy domains (Doetsch et al. 2025). As a result, the potential of HiAP to address the structural drivers of obesity and health inequalities remains largely unrealised, and obesity policies risk reproducing the very inequalities they seek to reduce. Socioecological causes of obesity and barriers to its prevention are complex and multidirectional, involving cascading relationships between structural, community, organisational, and individual factors (Chung et al. 2026). Accordingly, successful responses require broad, multilevel interventions that combine public policy, multisector action, healthcare leadership, and community participation to support long-term, population-level change (Chung et al. 2026). These arguments extend beyond the policy arena to the organisation of research itself: researchers and funders



can either perpetuate or challenge weight stigma depending on how obesity-related research is framed, prioritised, and conducted (Kite et al. 2026). When research systems overlook the impact of stigma, they risk reinforcing weight-centric models of practice and narratives of personal responsibility that subsequently inform policies, whereas a more reflexive and participatory research culture, developed in collaboration with people with lived experience, can help reframe weight and obesity in ways that support equity rather than cause harm (Doetsch et al. 2025; Heller et al. 2024; Hill et al. 2021).

Conclusion

Portugal's approach to obesity prevention policy has increasingly targeted food environments, commercial determinants of health and healthcare interventions; however, dominant policy discourses continue to place responsibility on individuals, implicitly assuming equal agency and capacity for change across socially and economically diverse groups. These narratives actively obscure the social conditions through which obesity is produced, reproduce stigma, and constrain the capacity of policy to confront persistent social and gender inequalities in obesity prevalence.

By integrating sociological theory with epidemiological evidence and public health policy, this paper argues that the fundamental limits of obesity policy are sociopolitical rather than technical. Concepts such as habitus, stigma, and power reveal how food practices, body size, and health behaviours are structured by classed, gendered, and temporal inequalities that cannot be addressed through individual behaviour change alone. Obesity-related stigma emerges here as an institutional outcome, sustained through policy framings that legitimise culpability and depoliticise structural determinants of health. More equitable obesity prevention therefore requires a reorientation of governance beyond technical policy instruments, towards a Health in All Policies approach that challenges moralised narratives of responsibility and confronts the social, economic, and political conditions shaping obesity risk and lived experience.

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Data availability No datasets were generated or analysed during the current study.

Declarations

Competing interests The authors declare no competing interests.

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