WHO guideline on the use of glucagon-like peptide-1 (GLP-1) therapies for the treatment of obesity in adults.

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World Health Organization (WHO)

World Health Organization (WHO). WHO guideline on the use of glucagon-like peptide-1 (GLP-1) therapies for the treatment of obesity in adults. Geneva (Switzerland): World Health Organization (WHO); 2025 Dec 1. 49 p. [78 references]

View Original Guideline

Overview

Guideline Objective

To provide evidence-informed recommendations on the use of glucagon-like peptide-1 (GLP-1) receptor agonists and glucose-dependent insulinotropic polypeptides (GIP)/GLP-1 dual agonists as part of chronic care for adults living with obesity

Patient Population

Adults (>19 years) with obesity, defined as body mass index (BMI) ≥30 kg/m^2

Recommendations

Recommendation Statements

Obesity is a chronic complex disease that requires lifelong care beginning with clinical assessment and early diagnosis. Once diagnosed, individuals should have access to comprehensive chronic care programmes offering sustained behavioural and lifestyle interventions. When appropriate, pharmacological, surgical or other therapeutic options may be used to support effective disease management. In parallel, care should address the prevention and treatment of obesity-related complications and comorbidities. (**Good Practice Statement**)

Remarks:

- Chronic care requires a capacitated health system to ensure essential functions are in place, including supporting governance, training of health workers, monitoring and evaluation, referral systems, procurement and supply chain, and financial coverage.
- In the context of obesity chronic care programmes, personalized periodic monitoring of treatment response and side effects/adverse events is essential to ensure sustained adherence and achieve optimal health outcomes.

In adults living with obesity, glucagon-like peptide-1 (GLP-1) receptor agonists or glucose-dependent insulinotropic polypeptides (GIP)/GLP-1 dual agonists may be used as long-term treatment for obesity. (**Conditional recommendation for; Moderate certainty evidence**)

Remarks:

- The evidence for two GLP-1 receptor agonists (liraglutide and semaglutide) and one GIP/GLP-1 dual agonist (tirzepatide) was evaluated for the purpose of this recommendation.
- This recommendation was derived from clinical trials in which treatment with a GLP-1 receptor agonist was administered from 26 weeks to 240 weeks (median 52 weeks).
- Obesity is a complex chronic disease characterized by excessive adiposity that can impair health and is defined by WHO as a body mass index (BMI) greater than or equal to 30 kg/m^2.
- While the randomised control trials (RCTs) that informed this recommendation included populations without specific BMI thresholds for overweight and obesity, with overweight and obesity defined per study, this recommendation applies to people with obesity (BMI ≥30 kg/m^2) but does not include people with BMI between

27 kg/m^2 and 30 kg/m^2 in association with one or two obesity-related diseases and disorders.

- The critical outcomes evaluated to inform this decision were weight, quality of life, adverse events, major adverse cardiovascular events and mortality.
- The trial follow-up times were i) 6 months to less than 24 months; and ii) 24 or more months, with higher certainty of evidence for those with less than 24 months of follow-up.
- Long-term treatment refers to the continued use of a medication for six months or longer, as per existing regulatory guidance (see the glossary in the original guideline for a more complete definition).
- Limited data are currently available to inform practice around decisions about, or the health impact of, discontinuation of GLP-1 receptor agonists and GLP-1/GIP dual agonists.
- In the process of establishing obesity chronic care programmes, consideration may be given to prioritizing those at higher risk of morbidity and mortality, while ensuring health equity across populations and settings.

People living with obesity should receive context-appropriate counselling on behavioural and lifestyle changes - including, but not limited to, physical activity and healthy dietary practices - as an initial step toward more structured behavioural interventions. For individuals who are prescribed GLP-1 receptor agonists or GIP/GLP-1 dual agonists, counselling on behavioural and lifestyle changes should be provided as a first step to intensive behavioural therapy to amplify and support optimal health outcomes. (**Good Practice Statement**)

Remarks:

- Recommendations and good practice statements for physical activity are included in the *WHO guidelines on physical activity and sedentary behaviour*, which highlight that all age groups should limit the amount of time being sedentary and should incrementally increase the frequency, intensity, and duration of physical activity, including muscle strengthening.
- According to the *Food and Agriculture Organization of the United Nations and the World Health Organization*, the core principles of a healthy diet apply to all population groups. The four core principles of a healthy diet are: 1) that they need to be adequate and provide enough essential nutrients to prevent deficiencies and

promote health, without excess; 2) be balanced in energy intake, and energy sources (fats, carbohydrates and proteins); 3) be moderate in consumption of foods, nutrients or other compounds associated with detrimental health effects; and 4) be diverse and include a wide variety of nutritious foods within and across food groups. In people living with obesity, additional considerations are necessary to support weight loss, including lowering daily energy intake. However, this should be prescribed and monitored in conjunction with a trained health care provider, whenever possible.

In adults living with obesity who are prescribed GLP-1 receptor agonists or GIP/GLP-1 dual agonists, intensive behavioural therapy (IBT) may be provided as a co-intervention within a comprehensive multimodal clinical algorithm. (**Conditional recommendation for; Low certainty evidence**)

Remarks:

- In the trials informing this recommendation, IBT, alongside GLP-1 receptor agonists or GIP/GLP-1 dual agonists, entailed goal-setting on physical activity and diet, restriction of energy intake, counselling (e.g., weekly, 30-45 minutes), and periodic assessment of goal attainment.
- The critical outcomes evaluated to inform this decision were weight, quality of life, and adverse events. Limited data were available on major adverse cardiovascular events and there were no data on mortality for the effects of IBT alongside GLP-1 receptor agonists or GIP/GLP-1 dual agonists.
- The data from the RCTs were limited to follow-up durations between 6 months and less than 24 months. There was no direct evidence for outcomes at or beyond 24 months.
- The systematic review identified lifestyle counselling, IBT, meal replacement and a lead-in phase with lifestyle changes as possible co-interventions. The analysis did not include any other co-interventions outside what was identified in the trials.

Evidence Rating Scheme

The Four Categories of Certainty of Evidence According to Grading of Recommendations Assessment, Development and Evaluation (GRADE)

Certainty	Definition
High	We are very confident that the true effect lies close to that of the estimate of the effect.
Moderate	We are moderately confident in the effect estimate; the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low	Our confidence in the effect estimate is limited; the true effect may be substantially different from the estimate of the true effect.
Very Low	We have very little confidence in the effect estimate; the true effect is likely to be substantially different from the estimate of the effect.

Recommendation Rating Scheme

With GRADE you have 2 strengths of recommendations: Weak (also called conditional) or Strong (with alternative labels: Recommended/Not recommended).

Recommendation Strengths and What They Mean

Strong Recommendation

Benefits outweigh harms for almost everyone. All or nearly all informed patients would likely want this option.

A strong recommendation essentially means "just do it" and there is good reason to believe all informed patients would want this option. The evidence should be of high/moderate quality, but in some instances you can issue strong recommendations based on low/very low quality evidence. Some organizations use the labels Recommended/ Not recommended for strong recommendations.

Weak/Conditional Recommendation

Benefits outweigh harms for the majority, but not for everyone. The majority of patients would likely want this option.

A weak/conditional recommendation does not necessarily mean that the guideline panel did not find sufficient evidence to support the suggested course of action. Indeed, there are two fundamental reasons for a weak recommendation: i) the evidence is low quality, so it's hard to be sure of the right course of action OR ii) there is a fine balance between benefits and harms of treatment alternatives. Other drivers for weak recommendations are variability in patients values and preferences or issues related to resource-use, feasibility, or equity. The implications of a weak - also called conditional - recommendation may be difficult to understand for clinicians without further explanation. In general clinicians should "think twice" and consider individual patient factors when applying weak recommendations. For example, patients' values and preferences, comorbitities, polypharmacy, burden of medical care, or personal limitations may result in the alternative course of action being the preferred option. Shared decision-making would be mandated for most weak recommendations.

Good Practice Statement

Good practice statements represent the guideline panel's view of optimal practice, but are not graded. Panels should use good practice statements when high quality indirect evidence is available, but it would not be a good use of the panel's limited resources to conduct formal evidence summaries. Good practice statements, if used appropriately, are consistent with official GRADE guidance.

Related Content

Supporting Documents

- Web Annex A: GRADE Evidence Profiles.
- Web Annex B: GRADE-CERQual Evidence Profile Table.
- Liraglutide for Adults Living with Obesity (Cochrane Review); 2025 Oct 30.
- Semaglutide for Adults Living with Obesity (Cochrane Review); 2025 Oct 30.
- Tirzepatide for Adults Living with Obesity (Cochrane Review); 2025 Oct 30.
- Effect of Discontinuation of Weight-lowering Medications on Weight Trajectories and Metabolic Outcomes in Adults with Obesity: A Systematic Review and Pairwise

Meta-analysis (Protocol); 2025 Mar 11.

  - Search Strategy.

- Values and Preferences, Acceptability, and Impact on Health Equity Around the Use of Glucagon-like Peptide-1 Receptor Agonists (GLP-1 RAs) in Adults with Obesity: A Rapid Qualitative Evidence Synthesis (Protocol); 2025 Mar 17.

  - Search Strategy.

- WHO Handbook for Guideline Development, 2nd Edition; 2014.

Implementation Tools

- MAGICapp Version of the Guideline.

Patient Education

No patient education materials available.

Disclaimer

TRUST Scorecard

Composition of Guideline Development Group (GDG)

Multidisciplinary GDG Members	**Yes**
Methodologist Involvement	**Yes**
Incorporation of Patient and Public Perspective	★★★★★

Systematic Review of Evidence

Literature Search	★★★★★
Study Selection	★★★★☆
Evidence Synthesis	★★★★☆

Foundations for Recommendations

Strength of Evidence Grade	★★★★☆
Description of Benefits and Harms of Recommendations	★★★★☆
Summary of Evidence Supporting Recommendations	★★★☆☆
Strength of Recommendations Rating	★★★★☆
Clear Articulation of Recommendations	★★★★★

Funding Source	**Yes**
Disclosure and Management of Financial Conflicts of Interests	★★★★★
External Review	★★★★★
Updating	★★★★★