

Navigating Obesity Management and Treatment: **A Patient Resource Guide for Women**



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SWHR acknowledges that there are valued groups of people that may benefit from our materials who do not identify as women. We encourage those who identify differently to engage with us and our content.

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About SWHR

The Society for Women's Health Research (SWHR) is a national nonprofit and thought leader dedicated to advancing women's health through science, policy, and education while promoting research on sex differences to optimize women's health. Founded in 1990 by a group of physicians, medical researchers, and health advocates, SWHR is making women's health mainstream by addressing unmet needs and research gaps in women's health. Thanks to SWHR's efforts, women are now routinely included in major medical research studies, and more scientists are considering sex as a biological variable in their research. Visit www.swhr.org for more information.

SWHR's Obesity Program

SWHR Programs identify research gaps and address unmet needs in diseases and conditions that exclusively, disproportionately, or differently affect women. The Obesity Program explores the impact of obesity on women's health with a focus on health care disparities, cultural influences and stigma, comorbidities, and barriers to prevention and treatment interventions for women across the lifespan.

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Background

Obesity, defined as an excessive or abnormal accumulation of body fat, is a complex chronic disease. Obesity is affected by many different factors including a person's sex, genetics, health conditions, and mental health as well as their environment and financial situation. Obesity is also associated with over 220 other diseases and conditions, like type 2 diabetes and heart disease.¹ Additionally, due to the long-term and recurring nature of the disease, obesity is associated with increased health care costs, reduced quality of life, disability, and even early death.^{2,3}

Managing obesity is a lifelong process. While obesity is a treatable disease, its management and treatment require maintainable, holistic, and personalized strategies. Obesity remains chronically undertreated, and the longer that the condition is left untreated, the more significant the potential negative health impacts. Fortunately, there are many treatment options available, including

lifestyle changes, behavioral therapies, obesity medications, surgeries, or a combination of these options.

Each woman living with obesity experiences a unique journey over her lifespan.

There are distinct sex and gender differences in the mechanisms of obesity. Accordingly, it is important to learn about treatment options that are responsive to biological sex, lifestyle, needs, and resources. For women seeking treatment for obesity, it is important to speak with a qualified health professional about treatment and management options. It may take a combination of approaches to fully address the disease; however, obesity is treatable, and support is available throughout the care process.

In the United States, two in five women are living with obesity.⁴

2 in 5

Seeking Care for Obesity



Understanding Obesity in Women

While the number of men and women who are living with obesity in the United States is similar, more women are diagnosed with severe (**class III**) obesity (**Body Mass Index (BMI)** ≥ 40 kg/m²) than men.⁴ There are differences in body fat distribution and function with women having higher overall **adipose tissue** (body fat), more subcutaneous adipose tissue (SAT) (fat under the skin), and more SAT in the abdominal and thigh areas.⁵ Structural, chemical, and functional changes in the brain which can influence food intake, eating behavior, and food choices also differ between men and women.⁶ Women also experience unique changes in adipose tissue function across their lifespan during hormonal milestones like puberty, pregnancy, perimenopause (the menopause transition), and menopause. Most relevant for those seeking care for obesity, there are sex differences in treatment responses, **comorbidities**, and health outcomes.^{7,8,9}

In the United States, there are significant racial, ethnic, and socioeconomic disparities in obesity. Non-Hispanic Black and Hispanic women experience higher rates of obesity than White and Asian women with non-Hispanic Black women having the highest prevalence of obesity (56.9%).¹⁰ Ethnic differences have been observed in body image, **weight perception**, and motivation for weight loss. In comparison to non-Hispanic White women, non-Hispanic Black women and Mexican-American women with obesity demonstrated higher weight misperception, or a mismatch between their actual weight and their believed weight.¹¹ Notably, there are also racial and ethnic differences in treatment outcomes that may be due to social determinants of health.¹²

Diagnosing Obesity in Women

Currently, only about 41% of patients with class III obesity receive a formal diagnosis, with many people living with obesity being underdiagnosed and undertreated.¹⁴ Rates of underdiagnosis are higher for marginalized groups and patients with less severe obesity.¹⁵ The simplest and most common way to diagnose obesity is by measuring body mass index (BMI), but this is a limited tool. BMI does not accurately capture the type of body fat, body composition, or the impact of excess body fat on your health. A BMI $\geq$ (greater than or equal to) 30 kilograms per square meter (kg/m²) alone does not always need to be treated.

If you are experiencing any or all of the following, consider talking to your provider about your weight:

- ▶ Struggling to manage your weight, particularly after modifying diet and physical activity levels
- ▶ A diagnosis of common comorbid conditions of obesity like type 2 diabetes, **dyslipidemia**, metabolic dysfunction-associated steatotic liver disease (MASLD), or hypertension
- ▶ Experiencing comorbid symptoms of obesity like joint pain (back/knees), shortness of breath, or gastroesophageal reflux disease (GERD)
- ▶ Family history of obesity or other chronic diseases, such as obstructive sleep apnea, type 2 diabetes, or heart disease

Obesity is classified as a **chronic disease**, defined as a condition that lasts for 1 year or more and requires ongoing medical attention or impacts daily life or both.¹³



Once your provider confirms you are a candidate for obesity treatment, your journey should begin with a comprehensive assessment of medical and weight history, family history, lifestyle behaviors, environment, and current physical and psychosocial health. It is important to speak with a professional to ensure that treatment recommendations are evidenced-based and appropriate for your specific needs and goals.

Understanding Risk Factors and Comorbidities

When seeking care for obesity, it is essential to recognize that obesity is a complicated disease with multiple risk factors, contributors, and comorbidities, some of which are beyond individual control. The underpinnings of obesity are complex with multiple causes, some which begin *in utero* (before birth). Environmental and societal factors like access to healthy food, access to childcare, poverty, and discrimination also play a role in obesity. As a woman, your experience with obesity is also influenced by your age and life stage. There are unique challenges associated with pregnancy, perimenopause, and menopause. Before meeting with a provider, understanding your risk factors can assist you identify the appropriate provider and care plan for you.

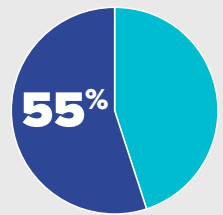
Common risk factors for obesity are:

- ▶ Certain medications
- ▶ Environmental factors and exposures
- ▶ Family history
- ▶ Genetics
- ▶ Medical conditions
- ▶ Mental health (e.g., stress, depression, anxiety)
- ▶ Physical inactivity
- ▶ Poor sleep habits or sleep disorders
- ▶ Social factors
- ▶ Unhealthy eating habits or excessive caloric intake

To investigate your unique risk factors, use the [Risk Factor Tracker](#) at the end of this toolkit.

People living with obesity are more likely to have multiple health conditions and complications than those without obesity, which can lead to worse health outcomes and increased care costs.¹⁶ Common comorbidities of obesity include type 2 diabetes, cancer, depression, heart disease, kidney disease, MASLD, and obstructive sleep apnea. Women living with obesity are at a heightened or unique risk of specific medical diseases and conditions including endometrial and ovarian cancer, polyendocrine metabolic ovarian syndrome (PMOS), and bothersome symptoms of menopause.^{17,18,19}

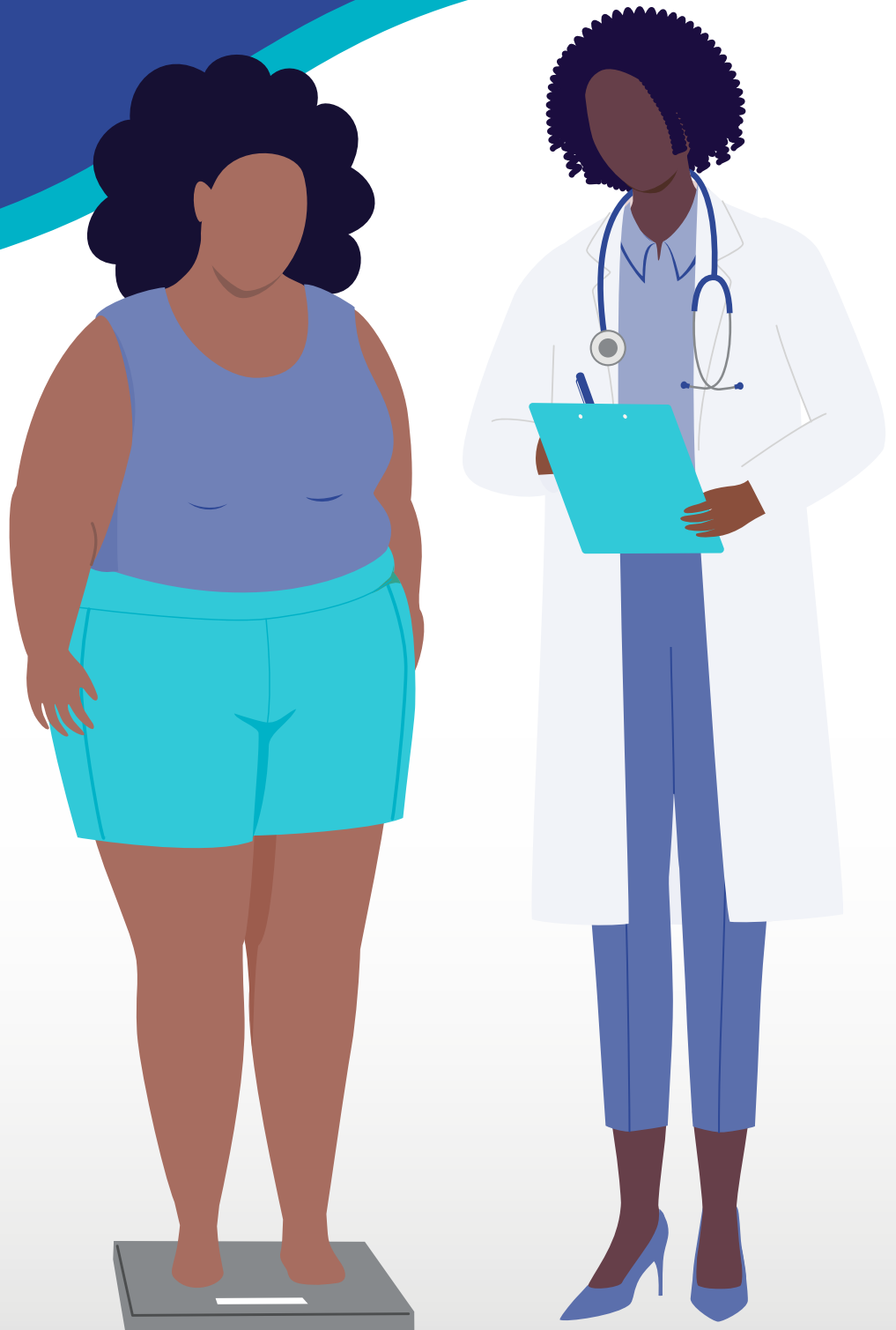
About 55% of cancers diagnosed in women are **overweight- and **obesity-related** cancers compared to only 24% of those diagnosed in men.²⁰**



Around 50% of women with PCOS (now known as PMOS) are living with obesity.²¹



Medical Support for Obesity



Identifying Your Obesity Care Providers

Depending on your life stage, treatment goals, and your network of providers, you may want or need to seek obesity care from different types of providers. Consider your personal risk factors, comorbidities, and treatment goals when building your obesity care team. A comprehensive approach that considers your unique situation is the most effective approach for care. Providers you may consider for your obesity concerns and treatment include:

- ▶ **Bariatric Surgeon/Bariatrician:** A provider who specializes in medical treatment of obesity and comorbidities of obesity.
- ▶ **Endocrinologist:** A provider who specializes in diagnosing and treating disorders of the organs and glands that produce hormones (the endocrine system).
- ▶ **Nurse Practitioner or Advanced Practice Registered Nurse (NP or APRN):** A registered nurse with advanced training in administering patient care. A Women's Health Nurse Practitioner (WHNP) is an APRN who specializes in the care of women.

- ▶ **Physician Assistant (PA):** A health care professional who practices across different specialties and health care settings with physician supervision. PAs may support lifestyle modifications, behavioral interventions, and prescription medication management.
- ▶ **Obesity Medicine Specialist:** A provider trained to treat obesity and obesity-related conditions.
- ▶ **Primary Care Provider (PCP):** A provider who diagnoses and treats general health and common conditions over time.
- ▶ **Registered Dietitian (RD or RDN):** A certified health professional who specializes in diet and nutrition.

You may also consider seeking care from mental health providers (psychologists, psychiatrists, social workers), cardiologists, exercise specialists, and physical therapists. If you are of reproductive age, pregnant, or trying to become pregnant, you should also consider consulting an obstetrician-gynecologist, reproductive endocrinologist, or maternal-fetal medicine specialist.

Many women avoid seeking care for obesity and comorbidities due to **weight stigma** and bias. Multiple studies have shown that patients living with overweight or obesity can experience stigma and discrimination from their providers due to their weight. This stigma can lead women to avoid or delay care for obesity and other conditions and contribute to internalized weight stigma.^{22,23}

You have the right to safe, effective, and respectful care in all health care settings. If you feel like you are being treated differently due to your weight, advocate for yourself – be vocal about your needs, seek support from others, and if necessary, find a new provider.



Talking to Your Care Team

When you meet with your provider, you may want to bring information about your risk factors and have questions prepared. The questions below can be tailored to your situation, medical history, and goals. General questions to consider are:

- ▶ What is my current weight and BMI?
- ▶ What is a healthy weight for me?
- ▶ How is my weight affecting my overall health right now?
- ▶ Are there other health-related issues that might be affecting my weight?
- ▶ What is a healthy and realistic weight loss goal for me? How long will it take to achieve this goal?
- ▶ Is there a specific obesity management program you would recommend for me? Should I consider: lifestyle changes, medication, surgery?
- ▶ What other strategies would you recommend for my obesity management?
- ▶ How can you support me during my care journey?
- ▶ Are there any other health care professionals I should contact to help me with my care?

Deciding on a Care Plan

Your personalized care plan should be developed with your health care providers. The process of collaboratively planning your care alongside your provider, also known as shared-decision making, can result in better health outcomes and increased weight loss. Some important things to consider when selecting your plan are:

- ▶ **Cost and Coverage:** For coverage of your treatment, key questions to consider are: Does my insurance policy cover my treatment plan? Are there certain medical requirements for my treatment to be covered? Is there a time limit on how long my treatment may be covered?

Many patients will consider costs of treatments covered or not covered by insurance, but it is also important to consider additional care costs like groceries and transportation to care.

- ▶ **Employment:** Obesity has been associated with loss of workdays or productivity at work.²⁴ A care plan may help reduce these workplace disruptions, but you should be clear about how a treatment plan fits in your work life. Will you need to go to additional doctors' appointments during work hours? Do you need to schedule time during your workday to prepare healthy meals?
- ▶ **Impact on Daily Living:** Engaging in a care plan will require lifelong changes to your day-to-day living. What amount of change feels reasonable and sustainable in your life?
- ▶ **Recovery:** Treatments like bariatric surgery may require recovery time in the hospital and at home. Consider that you may need to take time off work or require assistance with caregiving or housework.
- ▶ **Social Support:** A support network can have meaningful impacts on weight loss.²⁵ Think about who in your community can provide support during your treatment journey or if you should find a support group.
- ▶ **Sustainability:** The sustainability of a treatment plan is one of the most important and challenging considerations. Be honest with yourself about what you can imagine doing six months, one year, two years, or five years from now.
- ▶ **Obesity and other health conditions:** Your provider should counsel you on what care plan is most appropriate for you given your health history, current weight, medical conditions, and risk for complications. You should also consider what beyond weight loss is a relevant treatment outcome for you.

Exploring Treatment Options

Treatment goes far beyond weight loss. For women living with obesity, goals of treatment may also include the prevention and/or improvement of comorbidities or complications and enhancing physical function and quality of life.²⁶ Obesity treatment is not about short-term solutions but about effective long-term management. Treatment options for obesity are commonly broken down into three categories: **lifestyle modifications, obesity medications, and metabolic and bariatric surgery.**

For people living with obesity, even moderate weight loss (5-10%) from obesity treatment can have clinically meaningful benefits for comorbidities such as reduction in cardiovascular risk factors, improvements in depression, and improvements in menstrual regularity.²⁷



Lifestyle Modification

Lifestyle modification is a part of every obesity treatment plan and is often the entry point for care. For some patients living with obesity, lifestyle modifications alone are not effective in achieving their treatment goals. Lifestyle modification can be completed alone, in a care setting with your primary care provider, in a commercial setting, online, or in a specialty practice like an obesity medicine clinic. Current clinical guidelines recommend that the most effective behavioral weight loss treatment is an in-person, high-intensity program delivered by a trained interventionist.²⁸ Key features of a lifestyle modification care plan include²⁶:

- ▶ **Nutrition and dietary recommendations:** A tailored nutrition plan is essential for weight loss. Treatment may include speaking with a dietitian or other qualified health care provider and receiving guidance on appropriate portion sizes, reading nutrition labels, preparing healthy foods, meal timing, and grocery shopping.
- ▶ **Physical activity:** Physical activity is a key component of any obesity management plan, long-term weight maintenance, and general well-being. There are many types of exercise, so try to find one that fits not only your needs but also that you enjoy. Strength training along with aerobic exercise may be recommended based on your other treatments. If you have not exercised before or recently, be sure to speak to your provider prior to starting a new routine and build your routine slowly.
- ▶ **Behavioral therapy:** Behavior modification is a type of therapy that aims to replace undesirable behaviors with positive ones and can be provided individually or in groups. This therapy may be combined with other types of therapy like Cognitive-Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), and motivational interviewing.

Other types of lifestyle modifications include community-based weight loss programs and commercial weight loss programs. Studies have shown that individuals who engage in commercial weight loss programs have greater reductions in weight compared to those who try to lose weight on their own.^{29,30} Ask your provider about these resources and check out your local health department, hospital, or YMCA for available programs. Your employer or health plan may also include coverage or incentives for participating in these types of programs.

Obesity Medications

Over the past few decades, considerable progress has been made in the safety and success of obesity medications. There are medications for chronic weight management, short-term weight loss, and medications for treating the comorbidities of obesity. Recent attention has focused on obesity medications like **GLP-1 receptor agonists** (GLP-1s) which mimic a hormone (GLP-1) in the body, but there are additional types of medications that you and your providers may consider. Some obesity medications have also been indicated (approved) for the treatment of other health conditions like type 2 diabetes, cardiovascular disease risk reduction, chronic kidney disease, MASH (metabolic dysfunction-associated steatohepatitis), and obstructive sleep apnea.^{31,32} While medications do not all have the same efficacy, some research shows that women have greater weight loss from GLP-1s compared to men.^{33,34,35}

When identifying your treatment plan, you and your provider should focus on medications that will help you achieve your goals while also considering access, cost, health status, risk, and preferences. While there are limited studies on sex differences in obesity medication outcomes, some evidence suggests that side effects from these medications occur more often in women.^{36,37}

As of spring 2026, the U.S. Food and Drug Administration (FDA) has approved seven obesity medications for long-term obesity management that can be prescribed when a patient meets certain criteria. These medications are from different classes of drugs and work through different mechanisms like appetite suppression, reduced fat absorption, controlled cravings, and slowing the emptying of the stomach. The seven medications approved for long-term use and their drug classes are:

- ▶ Orlistat (lipase inhibitor)
- ▶ Phentermine-topiramate (anorectic + anticonvulsant)

- ▶ Naltrexone-bupropion (opiate antagonist + antidepressant)
- ▶ Liraglutide (GLP-1 receptor agonist)
- ▶ Semaglutide (GLP-1 receptor agonist)
- ▶ Tirzepatide (dual GLP-1/GIP receptor agonist)
- ▶ Orforglipron (GLP-1 receptor agonist)

Additional FDA approved medications include a drug (Setmelanotide) approved for limited use in individuals with specific rare genetic conditions, and medications approved for short-term use only. Several other medications with weight-reducing benefits may be prescribed for off-label use to treat obesity.³⁸ You should always consult with your doctor before using a new medication.

Due to high demand for weight loss medications, supply problems, and cost barriers, some



patients have considered or taken counterfeit (fake) or compounded (custom-made) versions of popular medications. It is important to note that many of these medications are different from the manufactured version and have not been tested for safety, effectiveness, or quality.

You should always consult your provider before taking medication to learn about potential risks.

Visit <https://www.fda.gov/medwatch> for additional information.

Metabolic and Bariatric Surgery

Metabolic and bariatric surgery works by making changes to the digestive system to reduce the number of calories your body can absorb and consume. Surgery also impacts certain hormones in the gastrointestinal system, improving metabolism, and affecting appetite. While evidence shows minimal difference between men's and women's outcomes from bariatric surgery, there are important considerations for women considering surgery, particularly for those who intend to become pregnant following surgery.^{39,40} There are four main types of metabolic and bariatric surgery⁴¹:

- ▶ **Roux-en-Y gastric bypass:** This surgery reduces how much food the stomach can hold (from about 3 pints before surgery to 1 oz directly after surgery) and reduces caloric absorption. The bypass created in the small intestine also impacts hormone levels in the gastrointestinal system, which can reduce feelings of hunger and increase feelings of fullness.
- ▶ **Sleeve gastrectomy:** In this procedure, about 75-80% of the stomach is removed, leaving a tube- or banana-shaped section. This surgery restricts how much food the stomach can hold and impacts the hormones in the gastrointestinal system, which impacts metabolism and can decrease hunger and increase feelings of fullness.
- ▶ **Biliopancreatic diversion with duodenal switch (BPD/DS):** This type of surgery includes two separate procedures, beginning with a sleeve gastrectomy, where a portion of the stomach is removed. The second procedure divides the small intestine and reattaches the section on distinct parts of the intestine. This restricts how much food the stomach can hold and reduces the absorption of calories and nutrients. More than gastric bypass or a sleeve gastrectomy alone, this procedure impacts hormones that decrease hunger, increase fullness, and improve blood sugar control.
- ▶ **Single-anastomosis duodeno-ileal bypass with sleeve gastrectomy (SADI-S):** This surgery begins with a sleeve gastrectomy with a portion of the stomach removed. The first section of the small intestine, the duodenum, is then closed off and connected to a lower part of the small intestine, the ileum. This surgery restricts how much food the stomach can hold and reduces the absorption of calories and nutrients.
- ▶ Additional procedures include *adjustable gastric banding* and or non-surgical options like the *intra-gastric balloon*.

Utilizing Coverage for Obesity Treatments



For women living with obesity, access to care can be difficult due to limited or no insurance coverage, limited access to qualified providers, stigma or weight bias from providers, and lack of appropriate care settings. For insured women, navigating insurance coverage for obesity can feel overwhelming and confusing. As you begin this journey, there are important things to consider about qualifying for care and navigating insurance coverage.

Qualifying for Care

Current guidelines recommend that providers screen for obesity, at minimum, annually and counsel patients with BMI ≥ 25 kg/m² on weight loss. All women for whom weight loss is recommended should be directed to lifestyle modifications (behavioral therapy, diet, and physical activity). If a woman has been unable to lose or sustain weight loss with lifestyle modifications, or if she has BMI ≥ 30 kg/m² or BMI ≥ 27 kg/m² with comorbidities or additional risk factors, additional interventions may be considered.^{28,42} There are several specific factors which may qualify or disqualify a woman for prescribed obesity care. These qualifications may be similar to medical requirements for coverage by your insurance provider. For example, women who are eligible for bariatric surgery are women with a BMI ≥ 35 kg/m² or a BMI ≥ 30 kg/m² with metabolic disease (with adjusted thresholds in Asian populations of BMIs ≥ 27.5 kg/m² and ≥ 25 kg/m², respectively).⁴³ Women with a BMI ≥ 30 -34.9 kg/m² who show they cannot achieve meaningful or durable weight-loss or co-morbid improvement using other methods can also become candidates for surgery. A woman may not qualify for surgery if she has an insufficient BMI (too low), severe psychological comorbidities, uncontrolled medical conditions, or is pregnant or planning for pregnancy soon.

Similarly, clinical guidelines recommend prescription medication for adults with obesity (typically defined as BMI ≥ 30 kg/m²) or overweight (BMI ≥ 27 kg/m²) with comorbidities, with specific recommendations

based on comorbidities.²⁶ Guidelines recommend management of heart disease risk factors and obesity-related conditions regardless of engagement in obesity treatment.²⁸ Speak more to your provider about current guidelines for treatment and how or why you might qualify for different types of care.

Navigating Insurance Coverage

Coverage varies significantly depending on where you live, work, and what kind of health insurance plan you have. Most women in the United States ages 19-64 receive their health insurance through private-employer based plans. Alternatively, women may receive coverage from public insurance plans like **Medicaid** or **Medicare**.⁴⁴ When considering your treatment options, review the details of your policy and contact your insurance provider with questions. If you receive insurance through your job, you may want to talk to your benefits personnel about coverage and other benefits like reimbursement accounts. Pay close attention to whether your insurance plan has specific inclusion or exclusion criteria for obesity treatment. There also may be specific requirements in your plan for obesity care like showing that past medical treatments for obesity have failed before trying a new treatment (sometimes called **step therapy**).

The Affordable Care Act (ACA) requires most private health insurance plans, and some Medicaid plans, to cover preventive services related to healthy diet and obesity prevention. Behavioral interventions are also available to individuals with a BMI ≥ 30 kg/m². Other treatment coverage is highly variable, often requiring failed weight-loss attempts, **prior authorization** (review and approval prior to prescription), and step therapy (requirements to try and “fail” a lower cost treatment). To increase your chances of obtaining coverage, review your policy, collect necessary documentation, and inquire about prior authorization for your selected treatment plan.

Generally, Medicaid programs differ from state to state, and states can include obesity treatment services under several different benefit categories, which may be mandatory or optional. Recently, some states have stopped providing insurance coverage under Medicaid for obesity medications when prescribed solely for weight loss.

Medicare coverage of obesity services and treatments currently includes obesity screening, behavioral therapy, some bariatric surgical procedures, and some obesity medications. If you qualify for Medicare, there are many coverage options and benefits to consider. More information for Medicare beneficiaries can be found in SWHR's *Savvy and 65: A Woman's Guide to Understanding Medicare Toolkit* at www.medicareforwomen.org.

Private and public insurance providers are investigating new ways to make obesity care accessible. For example, from July 1, 2026, through December 31, 2027, CMS will launch the Medicare GLP-1 Bridge, a short-term test program that will provide eligible Medicare Part D beneficiaries with access to certain GLP-1 drugs. The program is intended to serve as a pathway to the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model, which is designed to expand access to GLP-1s and lifestyle support for eligible Medicare Part D and Medicaid beneficiaries.



The STOP Obesity Alliance offers a Comprehensive Obesity Benefits Checklist for patients to review their plans compared to recommended benefits. Check it out at stop.publichealth.gwu.edu.



Appendix



Glossary

Adipose tissue: Fat tissue or body fat that can be found throughout a person's body including under the skin (subcutaneous adipose tissue) or between internal organs (visceral fat)

Bariatrics: The field of medicine that focuses on the causes, prevention, and treatment of obesity

Body Mass Index (BMI): A measure of body fat based on height and weight, this number is calculated by dividing a person's body weight in kilograms (kg) by the square of their height in meters (m²)

Chronic disease: A condition that lasts for one year or more and requires ongoing medical attention or impacts daily life or both

Comorbidity/Comorbidities: A disease or medical condition that occurs at the same time as one or more other conditions in a patient

Dyslipidemia: A condition when a person has abnormal levels of lipids (fats) in their blood, impacting the gastrointestinal system. High cholesterol is a type of dyslipidemia

Glucagon-like peptide-1 (GLP-1): A hormone naturally produced by the body primarily in response to food intake that plays an important role in regulating blood sugar, slowing stomach emptying, and regulating appetite. The medication, GLP-1 receptor agonist, mimics this hormone

Medicare: A federal health insurance program for people 65 and older, and some individuals under 65 with certain disabilities and conditions. Individuals entering Medicare choose between Original/traditional Medicare (**Part A and Part B**) or Medicare Advantage (**Part C**). Individuals can also choose extra coverage including **Medicare Part D** (drug coverage) or **Medicare Supplement Insurance** (Medigap)

Medicaid: A joint federal and state insurance program that provides free or low-cost health coverage to certain low-income individuals, families and children, pregnant people, the elderly, and individuals with disabilities; program qualifications, benefits, and names differ by state

Obesity: A disease defined by having excessive body fat. Obesity is measured by BMI, with obesity defined as a BMI ≥ 30 kg/m² with three classifications:

Class I obesity: BMI = 30 to 34.9 kg/m²

Class II obesity: BMI = 35 to 39.9 kg/m²

Class III obesity: BMI = 40 kg/m² or greater

Overweight: A condition defined by having too much body fat. Overweight is measured as a BMI ≥ 25 to 30 kg/m²

Prior authorization: A process used by some health insurance companies that requires the review and approval of a specific procedure, drug, or treatment before it is paid for, even if it has been recommended or prescribed by a provider

Step therapy: A health insurance strategy that requires patients to try and "fail" on one or more lower cost medications before a more expensive option

Weight misperception: A mismatch between a person's actual weight and their believed weight (higher or lower)

Weight stigma: Negative attitudes, beliefs, stereotypes, and misconceptions associated with a person's weight and size

Additional Resources

For more resources and information, check out these organizations:

- ▶ **American Society for Metabolic and Bariatric Surgery**, www.asmb.org
- ▶ **Obesity Action Coalition**, www.obesityaction.org
- ▶ **Obesity Association**, www.obesityassociation.org
- ▶ **Obesity Care Advocacy Network**, www.obesitycareadvocacynetwork.com
- ▶ **Obesity Medicine Association**, www.obesitymedicine.org
- ▶ **National Institute of Diabetes and Digestive and Kidney Diseases**, www.niddk.nih.gov
- ▶ **Society for Women's Health Research**, www.swhr.org/health_focus_area/obesity/
- ▶ **Stop Obesity Alliance**, stop.publichealth.gwu.edu

References

- 1 Yuen, M. M. A. (2023). Health Complications of Obesity: 224 Obesity-Associated Comorbidities from a Mechanistic Perspective. *Gastroenterology Clinics of North America*, 52(2), 363–380. <https://doi.org/10.1016>
- 2 Cawley, J., Biener, A., Meyerhoefer, C., Ding, Y., Zvenyach, T., Smolarz, B. G., & Ramasamy, A. (2021). Direct medical costs of obesity in the United States and the most populous states. *Journal of Managed Care & Specialty Pharmacy*, 27(3), 354–366. <https://doi.org/10.18553/jmcp.2021.20410>
- 3 Ward, Z. J., Willett, W. C., Hu, F. B., Pacheco, L. S., Long, M. W., & Gortmaker, S. L. (2022). Excess mortality associated with elevated body weight in the USA by state and demographic subgroup: A modelling study. *eClinicalMedicine*, 48. <https://doi.org/10.1016/j.eclim.2022.101429>
- 4 Emmerich, S. D., Fryar, C. D., Stierman, B., & Ogden, C. L. (2024). Obesity and Severe Obesity Prevalence in Adults: United States, August 2021–August 2023. *NCHS Data Brief*, (508). <https://doi.org/10.15620/CDC/159281>
- 5 Karastergiou, K., Smith, S. R., Greenberg, A. S., & Fried, S. K. (2012). Sex differences in human adipose tissues - The biology of pear shape. *Biology of Sex Differences*, 3(1). <https://doi.org/10.1186/2042-6410-3-13>
- 6 Kroll, D. S., Feldman, D. E., Biesecker, C. L., McPherson, K. L., Manza, P., Joseph, P. V., Volkow, N. D., & Wang, G. J. (2020). Neuroimaging of Sex/Gender Differences in Obesity: A Review of Structure, Function, and Neurotransmission. *Nutrients*, 12(7), 1942. <https://doi.org/10.3390/NU12071942>
- 7 Christensen, P., Meinert Larsen, T., Westertorp-Plantenga, M., Macdonald, I., Martinez, J. A., Handjiev, S., Poppitt, S., Hansen, S., Ritz, C., Astrup, A., Pastor-Sanz, L., Sandø-Pedersen, F., Pietiläinen, K. H., Sundvall, J., Drummen, M., Taylor, M. A., Navas-Carretero, S., Handjieva-Darlenska, T., Brodie, S., ... Raben, A. (2018). Men and women respond differently to rapid weight loss: Metabolic outcomes of a multi-centre intervention study after a low-energy diet in 2500 overweight, individuals with pre-diabetes (PREVIEW). *Diabetes, Obesity and Metabolism*, 20(12), 2840–2851. <https://doi.org/10.1111/DOM.13466>
- 8 Tramunt, B., Smati, S., Grandgeorge, N., Lenfant, F., Arnal, J. F., Montagner, A., & Gourdy, P. (2020). Sex differences in metabolic regulation and diabetes susceptibility. *Diabetologia*, 63(3), 453–461. <https://doi.org/10.1007/S00125-019-05040-3>
- 9 Faulkner, J. L., & Belin De Chantemèle, E. J. (2018). Sex Differences in Mechanisms of Hypertension Associated with Obesity. *Hypertension*, 71(1), 15–21. <https://doi.org/10.1161/HYPERTENSIONAHA.117.09980>
- 10 Hales, C.M., Carroll, M.D., Fryar, C.D., & Ogden, C.L. (2020). Prevalence of obesity and severe obesity among adults: United States, 2017–2018. *NCHS Data Brief*, (360).
- 11 Min, J., Goodale, H., Xue, H., Brey, R., & Wang, Y. (2021). Racial-Ethnic Disparities in Obesity and Biological, Behavioral, and Sociocultural Influences in the United States: A Systematic Review. *Advances in Nutrition*, 12(4), 1137–1148. <https://doi.org/10.1093/ADVANCES/NMAA162>
- 12 Byrd, A. S., Toth, A. T., & Stanford, F. C. (2018). Racial Disparities in Obesity Treatment. *Current Obesity Reports*, 7(2), 130–138. <https://doi.org/10.1007/s13679-018-0301-3>
- 13 Centers for Disease Control and Prevention (2026). About Chronic Diseases. Centers for Disease Control and Prevention. www.cdc.gov/chronic-disease/about/index.html
- 14 Szymanski, R., Abraham, M., Childs, W., Le, K., Velez, C., Vaughn, I., Lamerato, L., & Budzynska, K. (2024). Factors associated with receiving an obesity diagnosis and obesity-related treatment for patients with obesity class II and III within a single integrated health system. *Preventive Medicine Reports*, 46. <https://doi.org/10.1016/j.pmedr.2024.102879>
- 15 Bajaj, S. S., Zhong, A., Khunte, M., & Stanford, F. C. (2025). Trends and Disparities in Clinician Diagnosis of Overweight and Obesity. *Journal of General Internal Medicine*, 41(6), 1565–1572. <https://doi.org/10.1007/S11606-025-09633-0>
- 16 Bae, J. P., Nelson, D. R., Boye, K. S., & Mather, K. J. (2025). Prevalence of complications and comorbidities associated with obesity: a health insurance claims analysis. *BMC Public Health*, 25(1). <https://doi.org/10.1186/S12889-024-21061-Z>
- 17 Liu, Y., Metzinger, M. N., Lewellen, K. A., Cripps, S. N., Carey, K. D., Harper, E. I., Shi, Z., Tarwater, L., Grisoli, A., Lee, E., Slusarz, A., Yang, J., Loughran, E. A., Conley, K., Johnson, J. J., Klymenko, Y., Bruney, L., Liang, Z., Dovichi, N. J., ... Stack, M. S. (2015). Obesity contributes to ovarian cancer metastatic success through increased lipogenesis, enhanced vascularity, and decreased infiltration of M1 macrophages. *Cancer Research*, 75(23), 5046–5057. <https://doi.org/10.1158/0008-5472.CAN-15-0706>
- 18 Ollila, M. M. E., Piltonen, T., Puukka, K., Ruokonen, A., Järvelin, M. R., Tapanainen, J. S., Franks, S., & Morin-Papunen, L. (2016). Weight Gain and Dyslipidemia in Early Adulthood Associate With Polycystic Ovary Syndrome: Prospective Cohort Study. *The Journal of Clinical Endocrinology & Metabolism*, 101(2), 739–747. <https://doi.org/10.1210/JC.2015-3543>
- 19 Namgoung, S., Chang, Y., Woo, C. Y., Kim, Y., Kang, J., Kwon, R., Lim, G. Y., Choi, H. R., Kim, K. H., Kim, H., Hong, Y. S., Zhao, D., Cho, J., Guallar, E., Park, H. Y., & Ryu, S. (2022). Metabolically healthy and unhealthy obesity and risk of vasomotor symptoms in premenopausal women: cross-sectional and cohort studies. *BJOG: An International Journal of Obstetrics and Gynaecology*, 129(11), 1926–1934. <https://doi.org/10.1111/1471-0528.17224>
- 20 Steele, C. B., Thomas, C. C., Henley, S. J., Massetti, G. M., Galuska, D. A., Agurs-Collins, T., Puckett, M., & Richardson, L. C. (2023). Vital Signs: Trends in Incidence of Cancers Associated with Overweight and Obesity — United States, 2005–2014. *Morbidity and Mortality Weekly Report*, 66(39), 1052–1058. <https://doi.org/10.15585/MMWR.MM6639E1>
- 21 Lim, S. S., Davies, M. J., Norman, R. J., & Moran, L. J. (2012). Overweight, obesity and central obesity in women with polycystic ovary syndrome: a systematic review and meta-analysis. *Human Reproduction Update*, 18(6), 618–637. <https://doi.org/10.1093/HUMUPD/DMS030>
- 22 Mensinger, J. L., Tylka, T. L., & Calamari, M. E. (2018). Mechanisms underlying weight status and healthcare avoidance in women: A study of weight stigma, body-related shame and guilt, and healthcare stress. *Body Image*, 25, 139–147. <https://doi.org/10.1016/J.BODYIM.2018.03.001>
- 23 Schroeder, M., Roscoe, R. A., & Ramseyer Winter, V. (2025). Weight Stigma and Implicit Bias in Healthcare: Investigating the Impact of Women's Body Size on Continuity of Care and Communication About Sexual and Reproductive Health. *Women's Reproductive Health*, 12(3), 873–889. <https://doi.org/10.1080/23293691.2025.2524377>
- 24 Cawley, J., Biener, A., Meyerhoefer, C., Ding, Y., Zvenyach, T., Smolarz, B. G., & Ramasamy, A. (2021). Job Absenteeism Costs of Obesity in the United States: National and State-Level Estimates. *Journal of Occupational and Environmental Medicine*, 63(7), 565–573. <https://doi.org/10.1097/JOM.0000000000002198>
- 25 Wang, M. L., Pbert, L., & Lemon, S. C. (2014). Influence of family, friend and coworker social support and social undermining on weight gain prevention among adults. *Obesity*, 22(9), 1973–1980. <https://doi.org/10.1002/oby.20814>
- 26 American Diabetes Association Professional Practice Committee for Obesity (2026). Pharmacologic Treatment of Obesity in Adults: Standards of Care in Overweight and Obesity. *Diabetes, Obesity, and CardioMetabolic CARE*, 1(1), 5–36. <https://doi.org/10.2337/DOC125-0008>

- 27 Ryan, D. H., & Yockey, S. R. (2017). Weight Loss and Improvement in Comorbidity: Differences at 5%, 10%, 15%, and Over. *Current Obesity Reports*, 6(2), 187–194. <https://doi.org/10.1007/s13679-017-0262-y>
- 28 Jensen, M. D., Ryan, D. H., Apovian, C. M., Ard, J. D., Comuzzie, A. G., Donato, K. A., Hu, F. B., Hubbard, V. S., Jakicic, J. M., Kushner, R. F., Loria, C. M., Millen, B. E., Nonas, C. A., Pi-Sunyer, F. X., Stevens, J., Stevens, V. J., Wadden, T. A., Wolfe, B. M., & Yanovski, S. Z. (2014a). 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: A report of the American college of cardiology/American heart association task force on practice guidelines and the obesity society. *Journal of the American College of Cardiology*, 63(25 PART B), 2985–3023. <https://doi.org/10.1161/01.cir.0000437739.71477.ee>
- 29 Tate, D. F., Lutes, L. D., Bryant, M., Truesdale, K. P., Hatley, K. E., Griffiths, Z., Tang, T. S., Padgett, L. D., Pinto, A. M., Stevens, J., & Foster, G. D. (2022). Efficacy of a Commercial Weight Management Program Compared With a Do-It-Yourself Approach: A Randomized Clinical Trial. *JAMA Network Open*, 5(8), e2226561–e2226561. <https://doi.org/10.1001/JAMANETWORKOPEN.2022.26561>
- 30 Marrero, D. G., Palmer, K. N. B., Phillips, E. O., Miller-Kovach, K., Foster, G. D., & Saha, C. K. (2016). Comparison of commercial and self-initiated weight loss programs in people with prediabetes: A randomized control trial. *American Journal of Public Health*, 106(5), 949–956. <https://doi.org/10.2105/AJPH.2015.303035>
- 31 Nauck, M. A., Quast, D. R., Wefers, J., & Meier, J. J. (2021). GLP-1 receptor agonists in the treatment of type 2 diabetes – state-of-the-art. *Molecular Metabolism*, 46, 101102. <https://doi.org/10.1016/J.MOLMET.2020.101102>
- 32 Preshy, A., Fernandez, C. J., Nedai, M. H., & Pappachan, J. M. (2026). Anti-Obesity Pharmacotherapy and Emerging Multimodal Interventions for Obstructive Sleep Apnea. *Chronic Diseases and Translational Medicine*. <https://doi.org/10.1002/cdt3.70040>
- 33 Anichini, R., Cosimi, S., di Carlo, A., Orsini, P., de Bellis, A., Seghieri, G., Franconi, F., & Baccetti, F. (2013). Gender difference in response predictors after 1-year exenatide therapy twice daily in type 2 diabetic patients: a real world experience. *Diabetes, Metabolic Syndrome and Obesity*, 6, 123–129. <https://doi.org/10.2147/DMSO.S42729>
- 34 Jastreboff, A. M., Kaplan, L. M., Frías, J. P., Wu, Q., Du, Y., Gurbuz, S., Coskun, T., Haupt, A., Milicevic, Z., & Hartman, M. L. (2023). Triple–Hormone-Receptor Agonist Retatrutide for Obesity — A Phase 2 Trial. *New England Journal of Medicine*, 389(6), 514–526. doi.org/10.1056/NEJMoa2301972
- 35 Onishi, Y., Oura, T., Matsui, A., Matsuura, J., & Iwamoto, N. (2017). Analysis of efficacy and safety of dulaglutide 0.75 mg stratified by sex in patients with type 2 diabetes in 2 randomized, controlled phase 3 studies in Japan. *Endocrine Journal*, 64(5), 553–560. <https://doi.org/10.1507/ENDOCRJ.EJ16-0552>
- 36 Kantowski, T., Schulze zur Wiesch, C., Aberle, J., & Lautenbach, A. (2024). Obesity management: sex-specific considerations. *Archives of Gynecology and Obstetrics*, 309(5), 1745–1752. <https://doi.org/10.1007/S00404-023-07367-0>
- 37 Joung, K. I., Jung, G. W., Park, H. H., Lee, H., Park, S. H., & Shin, J. Y. (2020). Gender differences in adverse event reports associated with antidiabetic drugs. *Scientific Reports*, 10(1). <https://doi.org/10.1038/s41598-020-74000-4>
- 38 Hendricks, E. J. (2017). Off-label drugs for weight management. *Diabetes, Metabolic Syndrome and Obesity*, 10, 223–234. <https://doi.org/10.2147/DMSO.S95299>
- 39 Hider, A. M., Bonham, A., Carlin, A., Finks, J., Ghaferi, A., Varban, O., & Ehlers, A. P. (2024). Association of Sex Differences on Weight Loss and Complications Following Bariatric Surgery. *Journal of Surgical Research*, 299, 359–365. doi.org/10.1016/j.jss.2024.04.050
- 40 Johansson, K., Cnattingius, S., Näslund, I., Roos, N., Trolle Lagerros, Y., Granath, F., Stephansson, O., & Neovius, M. (2015). Outcomes of Pregnancy after Bariatric Surgery. *New England Journal of Medicine*, 372(9), 814–824. doi.org/10.1056/NEJMoa1405789
- 41 Crossan, K., & Sheer, A. J. (2023). Surgical Options in the Treatment of Severe Obesity. *StatPearls*. <https://www.ncbi.nlm.nih.gov/books/NBK576372/>
- 42 Apovian, C. M., Aronne, L. J., Bessesen, D. H., McDonnell, M. E., Murad, M. H., Pagotto, U., Ryan, D. H., & Still, C. D. (2015). Pharmacological Management of Obesity: An Endocrine Society Clinical Practice Guideline. *The Journal of Clinical Endocrinology & Metabolism*, 100(2), 342–362. <https://doi.org/10.1210/JC.2014-3415>
- 43 Eisenberg, D., Shikora, S. A., Aarts, E., Aminian, A., Angrisani, L., Cohen, R. v., de Luca, M., Faria, S. L., Goodpaster, K. P. S., Haddad, A., Himpens, J. M., Kow, L., Kurian, M., Loi, K., Mahawar, K., Nimeri, A., O’Kane, M., Papasavas, P. K., Ponce, J., ... Kothari, S. N. (2022). 2022 American Society of Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) Indications for Metabolic and Bariatric Surgery. *Obesity Surgery*, 33(1), 3–14. <https://doi.org/10.1007/S11695-022-06332-1>
- 44 KFF (2024). Women’s Health Insurance Coverage. KFF. <https://www.kff.org/womens-health-policy/womens-health-insurance-coverage/>

Risk Factor Worksheet:

Track Your Obesity Risk Factors

Patient Name:

Date Range Completed:

MEDICATIONS (prescription and non-prescription)
Create a list of your current medications, including vitamins and supplements.



ENVIRONMENTAL FACTORS AND EXPOSURES
Note what items in your immediate environment may be impacting your health. This could include your food environment, neighborhood, work setting, and exposure to toxins.



FAMILY HISTORY
Record your family's history of medical conditions, especially diagnoses of diabetes, heart disease, and obesity.



DIAGNOSED CONDITIONS
Prepare a list of any currently diagnosed conditions, especially diagnoses of hypertension, type 2 diabetes, dyslipidemia, coronary heart disease, and respiratory problems.

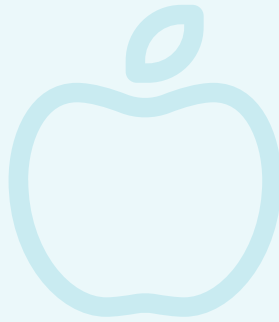


PHYSICAL ACTIVITY
Track all your physical activity for a week.



CURRENT EATING HABITS AND CALORIC INTAKE

Write down what you eat and drink for a week



PSYCHOLOGICAL FACTORS

Record stressors, feelings of anxiety or sadness, feelings of guilt or shame, or low self-esteem.



SLEEP HABITS

Record the amount and quality of your sleep for a week. It may be useful to note how you feel upon waking up regardless of the amount of sleep you get



SOCIAL DETERMINANTS

Note your current access to healthy food, health care, and spaces/ opportunities for safe physical activity.



SOCIAL SUPPORT

Consider who in your community may support you in your weight loss journey or if there are ways you can find additional support like joining a local support group.



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