Exercise and Physical Activity in the Era of Obesity Pharmacotherapy

A call for integrated, multidisciplinary models of care to ensure safe, equitable and effective use of GLP-1 and related weight-management medications

Issued jointly by:

ESSA Exercise & Sports Science Australia

BIOKINETICS SA LIFE THROUGH MOVEMENT

CSEP SCPE CANADIAN SOCIETY FOR EXERCISE PHYSIOLOGY — SOCIÉTÉ CANADIENNE DE PHYSIOLOGIE DE L'EXERCICE

CASES The Chartered Association of Sport and Exercise Sciences

CEPA Clinical Exercise Physiology Association ACSM Affiliate Society

CEPNZ Clinical Exercise Physiology New Zealand Ratonga Haumanu Whaiaroaro Aotearoa

CEP-UK Clinical Exercise Physiology UK

ECSS EUROPEAN COLLEGE of SPORT SCIENCE

ICSESP INTERNATIONAL CONFEDERATION OF SPORT & EXERCISE SCIENCE PRACTICE

IRISH SPORT AND EXERCISE SCIENCES ASSOCIATION

NFHT NORSK FORENING FOR HELSE- OG TRENINGSFYSIOLOGER

SESNZ SPORT & EXERCISE SCIENCE — NEW ZEALAND —

Executive summary

The Joint Statement

The International Joint Statement, *Exercise and Physical Activity in the Era of Obesity Pharmacotherapy*, calls for integrated, multidisciplinary models of care to ensure the safe, equitable and effective use of GLP-1 and related weight-management medications. Issued jointly by exercise and sport science organisations across Australia, New Zealand, North America, the United Kingdom, Europe and South Africa, it supports these medications as a major advance in obesity care while establishing that structured exercise, delivered by clinical exercise physiologists, is an essential clinical component for preserving muscle, strength and physical function during weight loss and sustaining outcomes after treatment. It calls on governments, regulators, funders and medical, allied health and international health bodies to match the rapid expansion of obesity pharmacotherapy with equitable access to that care.

The issue

Obesity now affects more than one billion people worldwide and is among the leading drivers of chronic disease and premature death, with a global economic impact exceeding USD 2 trillion a year[1]. Glucagon-like peptide-1 receptor agonists (GLP-1) and related incretin-based obesity pharmacotherapies* represent a landmark advancement in the management of obesity and metabolic disease. Clinical trials demonstrate that semaglutide achieves mean weight reductions of approximately 15% at 68 weeks[2] and tirzepatide up to 21% at 72 weeks[3]. More recently, oral GLP-1-based therapies have been approved in the United States[4,5,] with more modest weight-loss efficacy than the highest-efficacy injectable agents, highlighting that treatment response varies by agent, formulation and individual. These medications are explicitly indicated as adjuncts to physical activity and dietary modification, not stand-alone treatments[6]. Yet, despite growing recognition that obesity should be managed through comprehensive multidisciplinary care, GLP-1-based therapies are still frequently prescribed without structured exercise, dietary and behavioural support.

A critically important and under-recognised consequence of pharmacologically induced weight loss is the concurrent loss of lean body mass. Current evidence from systematic reviews and meta-analyses indicates that 20–40% of total weight lost during treatment with GLP-1-based therapies may come from lean tissue, including skeletal muscle, although the precise magnitude of muscle loss is not yet well characterised[7,8]. With the most potent agents - semaglutide 2.4 mg and tirzepatide 15 mg weekly - a greater share of the weight lost appears to come from lean tissue than when weight is lost through lifestyle change[7]. Skeletal muscle is not simply structural tissue. It is the body's primary site of insulin-mediated glucose disposal and a major determinant of whole-body insulin sensitivity[9]. It is also a key endocrine organ, releasing myokines that help regulate metabolism and inflammation[10], and it underpins physical strength, functional independence and healthy ageing[11]. Skeletal muscle loss during substantial weight loss is therefore a clinically important consideration that warrants further investigation and strategies to minimise lean tissue loss and reduce the risk of functional decline.

For older adults and those with pre-existing low muscle reserve or chronic disease, unmanaged loss of lean mass may increase the risk or accelerate sarcopenia and frailty, leading to declines in mobility and independence[12,13]. The World Health Organization calls for these medicines to be delivered within comprehensive chronic obesity care programmes that combine pharmacotherapy with behavioural support, physical activity and long-term follow-up[14]. Despite this vision, multidisciplinary obesity care remains inconsistent across many health systems. This statement is the exercise and sport science community's response to that call.

* Throughout this statement, the term "GLP-1 therapy" is used as a collective shorthand for GLP-1 receptor agonists and other approved incretin-based pharmacotherapies used in the treatment of obesity and type 2 diabetes, including dual GIP/GLP-1 receptor agonists such as tirzepatide. These agents are also described as incretin mimetics or, increasingly, nutrient-stimulated hormone (NuSH) therapies, reflecting a broadening class of single, dual and triple agonists acting on GLP-1, GIP, glucagon and related nutrient-stimulated hormone pathways. For readability and consistency with current policy and clinical usage, GLP-1 therapy is retained as the collective shorthand.

Purpose and audience

This statement sets out the shared position of the signatory exercise and sport science organisations around the globe on the role of exercise and physical activity in the safe and effective use of GLP-1 and related obesity medications. The signatory organisations support these medications as an important advance in obesity care; this statement addresses the clinical role of exercise, and of the clinical exercise physiologists who deliver it, in ensuring the benefits of these medications are realised and sustained.

This Statement is grounded in current research and clinician input and informed by consultation with researchers and prescribing clinicians. It is intended for governments, health ministries, regulators, funders, medical and allied health bodies, universities and international health institutions whose decisions shape how obesity care is delivered, subsidised and supported. Its purpose is to ensure that the rapid expansion of obesity pharmacotherapy is matched by equitable access to the multidisciplinary care, including clinical exercise physiologists, needed to protect patient safety and long-term health and function.

This statement concerns the role of clinical exercise physiology within multidisciplinary obesity care in the era of obesity pharmacotherapy. The discipline is delivered by university-qualified practitioners whose professional titles differ internationally, including Accredited Exercise Physiologists (Australia), Clinical Exercise Physiologists (United States, New Zealand and the United Kingdom), Certified Exercise Physiologists (Canada) and Biokineticists (South Africa). Unless referring to a specific profession or jurisdiction, these practitioners are collectively referred to throughout this statement as clinical exercise physiologists.

Why clinical exercise physiologists are essential for this cohort

Obesity is a complex, chronic and relapsing condition, not a simple matter of willpower or 'eating less and moving more'. Its causes are a multifactorial interplay of genetic, epigenetic, neurobiological, environmental, psychological, physiological, behavioural and sociocultural influences (see Figure 1), and obesity management should reflect that complexity. For this reason, physical activity for people on obesity pharmacotherapy cannot be reduced to generic advice to 'move more'. It should be individually assessed, prescribed and progressed by a clinical exercise physiologist who can account for each patient's comorbidities, medications and risk profile.

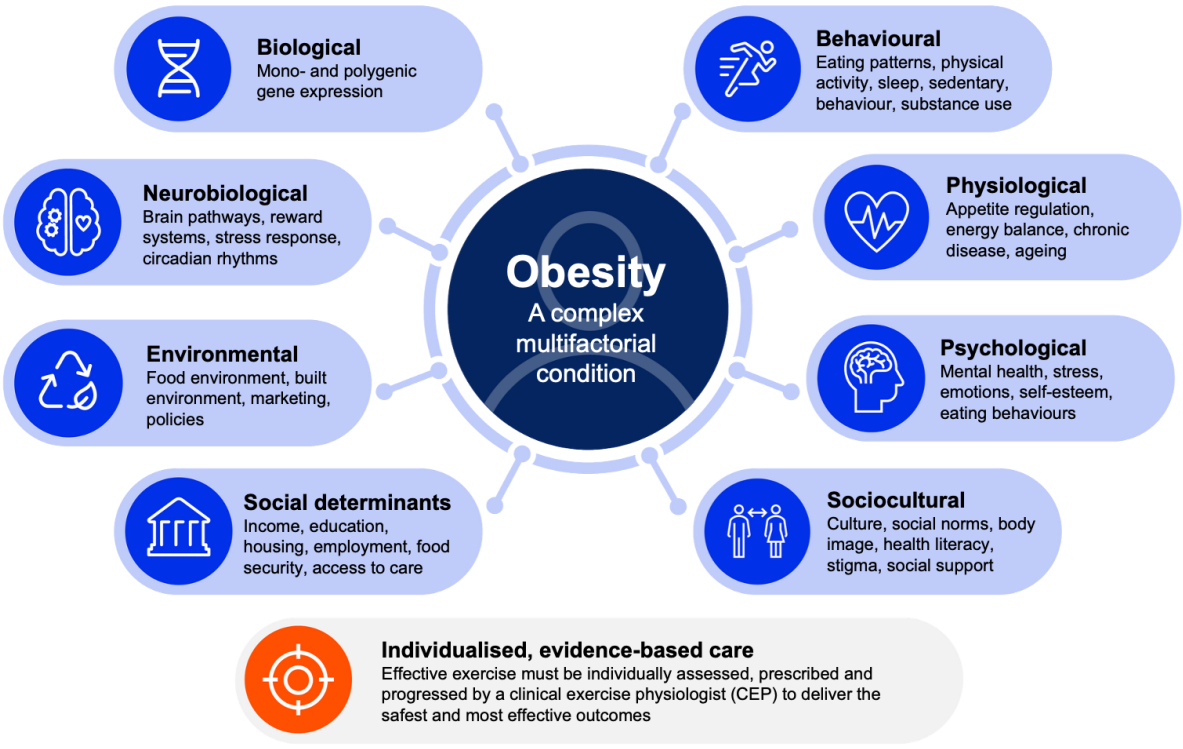

Figure 1. Multifactorial drivers of obesity

Structured exercise, particularly progressive resistance training, is among the most effective evidence-based interventions available for attenuating skeletal muscle loss and maintaining strength during weight loss[11,15]. Its benefits, however, extend well beyond muscle preservation. Regular exercise also improves physical function and independence, cardiorespiratory fitness, mental health, quality of life, and metabolic and cardiometabolic health, with many of these benefits occurring independently of weight or body-composition change[16,17]. Maintaining lean tissue, strength and physical capacity remain important clinical considerations during GLP-1 therapy, where a substantial proportion of rapid weight loss may comprise lean mass[7]. This effect is not uniform across patients and is most likely to be clinically significant in susceptible individuals, including older adults and those with low muscle reserve or chronic disease[12].

Evidence indicates that resistance training performed alongside GLP-1 therapy attenuates lean-mass loss, improves physical function and results in more favourable changes in body composition than pharmacotherapy alone[15]. The S-LiTE randomised controlled trial and its one-year post-treatment follow-up demonstrated better weight-loss maintenance when supervised exercise was combined with liraglutide 3.0 mg. Participants in the combined intervention were more likely to maintain a clinically meaningful (≥10%) weight loss and regained less weight during the year after treatment cessation than those who received liraglutide alone[18,19]. Whether similar maintenance benefits extend to the higher-efficacy agents now in widespread use - semaglutide 2.4 mg and tirzepatide - remains to be established in adequately designed trials and is an important evidence gap.

The durability of GLP-1 treatment outcomes remains uncertain in the context of high rates of treatment discontinuation. The positive effects of GLP-1 pharmacotherapy, including weight loss, improvements in metabolic health and reductions in cardiometabolic risk, are largely contingent on continued treatment. However, real-world discontinuation rates are high, with approximately half of individuals prescribed a GLP-1 receptor agonist for obesity ceasing therapy within 12 months[20]. Both trial and real-world data show that much of the weight lost is regained within a year of treatment cessation[21,22,23]. Sustained participation in physical activity and exercise is therefore important for maintaining lean tissue, strength, physical function and cardiometabolic health, and may improve the durability of treatment outcomes when pharmacotherapy is reduced or discontinued.

Achieving and maintaining these exercise behaviours, however, requires more than general lifestyle advice. Participants who completed a supervised exercise intervention continued to report substantially higher levels of physical activity 12 months after the program had ended, whereas no such effect was observed among those receiving pharmacotherapy alone[18]. These findings suggest that long-term exercise adherence is best supported through structured clinical intervention. This is particularly important because patients prescribed obesity pharmacotherapy commonly present with multiple comorbidities, including cardiovascular disease, type 2 diabetes, musculoskeletal disorders, mental health conditions and complex polypharmacy regimens[24]. Prescribing, progressing and monitoring exercise safely in this population is both a clinical and a practical challenge. It requires practitioners who can manage clinical risk, tailor exercise to each patient's other conditions, and protect physical function, strength and long-term health during rapid weight loss.

The signatory organisations represent clinical exercise physiologists who are specifically trained to deliver evidence-based clinical exercise interventions for people living with chronic and complex conditions. These are registered allied health practitioners whose university-level clinical training equips them to assess risk and to prescribe, supervise and progress exercise in the presence of comorbidities, polypharmacy and medication-related physiological change, consistent with recognised international standards for clinical exercise physiology practice[25]. This depth of clinical training positions clinical exercise physiologists as essential members of the multidisciplinary team delivering obesity pharmacotherapy. Their scope encompasses the following:

- Risk stratification to ensure the safety of physical assessment and individualised exercise prescription and supervision.
- Assessment of functional capacity and cardiometabolic risk in clinical populations.
- Individualised exercise testing, prescription, progression and supervision.
- Management of comorbidities, polypharmacy and medication-related factors affecting exercise participation and adaptation.
- Monitoring of muscle strength, fatigue, mobility and physical capacity throughout pharmacotherapy.
- Modification of exercise programs to accommodate musculoskeletal limitations, complex chronic disease presentations and clinical risk factors.
- Support for sustained behaviour change and long-term adherence to optimise health outcomes and weight maintenance.

Integrating these professionals into GLP-1 care pathways is not optional; it is a clinical imperative. Exercise prescription and programming delivered by clinical exercise physiologists must be recognised as a core clinical component of comprehensive obesity care, not a lifestyle add-on[17]. It is integral to protecting muscle mass, physical function and the durability of outcomes rather than a precondition for medication efficacy.

A call to global governments & international institutions

The undersigned organisations call on governments, health ministries, regulatory agencies, universities, medical regulatory bodies and international health institutions to act with urgency across six priority areas. Acting now, while prescribing patterns and models of care are still taking shape, can reduce the risk of avoidable functional decline, ease downstream demand and cost across health systems, and help protect community health and productivity. Delay risks locking in higher long-term costs and poorer clinical and community outcomes.

1. Embed integrated, multidisciplinary care within obesity pharmacotherapy pathways

GLP-1 and related medications should be prescribed optimally within coordinated models of care that include clinical exercise physiology, dietetics, medical oversight and psychological support. Regulatory frameworks, prescribing guidelines and reimbursement arrangements should fund and incentivise structured access to clinical exercise physiologists so that this care is genuinely available to all patients, regardless of geography or capacity to pay.

2. Address equity and access

The benefits of obesity pharmacotherapy, and the wraparound care required to use it safely, must not be limited to those who can afford private care. Obesity disproportionately burdens populations already facing systemic disadvantage, such as Indigenous and First Nations people, culturally and linguistically diverse communities, women, people in low- and middle-income countries, and those experiencing socioeconomic hardship[26]. Consistent with the United Nations Sustainable Development Goals and international human rights frameworks, governments must ensure that access to both pharmacotherapy and integrated clinical support, including clinical exercise physiologists, is designed around equity, not ability to pay[27].

3. Counter weight stigma

Weight stigma is pervasive, including within health systems and among health professionals, and acts as a direct barrier to care-seeking, diagnosis and appropriate clinical management; it is associated with poorer physical and mental health and undermines the effectiveness of treatment, including obesity pharmacotherapy[28]. Governments, regulators and health services should embed weight-stigma reduction into clinical guidelines, professional education, public messaging and the design of care environments, so that people living with obesity are met with respect and evidence-based care rather than blame. This includes recognising that physical activity messaging has itself historically contributed to weight stigma where it has been framed around personal responsibility or weight control rather than health. Clinical exercise physiologists are trained to deliver supportive, patient-centred care that is free of weight bias, and to frame movement around function, health and wellbeing rather than weight alone.

4. Align health and economic policy

The global economic impact of overweight and obesity is already around USD 2 trillion a year and is projected to exceed USD 4.3 trillion by 2035, close to 3% of global GDP[29]. The burden falls disproportionately on low- and middle-income countries, where costs are projected to increase up to 25-fold by 2060[29]. Investing in integrated care models, including clinical exercise physiology alongside pharmacotherapy, can help reduce functional decline, support the effectiveness of pharmacotherapy, lower long-term medication dependency and improve workforce participation. A 5% annual reduction in obesity prevalence could generate global savings of approximately USD 430 billion per year[29]. Economic evaluations indicate that, at current prices and over standard evaluation periods, GLP-1 medications often exceed conventional cost-effectiveness thresholds for obesity without diabetes, with favourable cost-effectiveness emerging mainly in specific subgroups and over longer time periods[30]. The value of these medications to health systems therefore depends heavily on the durability of weight loss and the prevention of rebound after treatment stops, factors that sustained exercise may help support, though this remains to be confirmed in adequately designed trials with contemporary agents[23]. Funding mechanisms should support whole-of-care approaches rather than medication-only pathways.

5. Establish national and international clinical guidance and referral pathways

Governments and institutions should work with professional bodies to develop, endorse and implement clinical guidelines for multidisciplinary pharmacological obesity management, including formal referral pathways to clinical exercise physiologists. Minimising the loss of lean and muscle tissue, while supporting physical function, cardiometabolic health and overall well-being, should be recognised as core clinical objectives of obesity treatment alongside weight reduction[16,18].

6. Invest in research, surveillance and data sharing

Longitudinal evidence on the functional, psychological and health-economic outcomes of integrated versus medication-only care models remains limited[9]. Governments and funders should prioritise long-term research and international data collaboration, including consistent measurement of body composition that distinguishes lean mass from skeletal muscle, muscle quality and function, weight maintenance and quality of life, and research identifying which patients benefit most from different types and intensities of exercise support during obesity treatment. They should also support shared data standards and registries that track outcomes across populations. Embedding data collection within funded care pathways will allow models of care to be refined as the evidence base grows, at the pace that clinical need demands.

Shared commitments

In launching this statement, the signatory organisations commit to:

1. Informing policy with evidence. Engaging in policy consultation, contributing to clinical guideline development, and sharing evidence and international best practice to inform decisions on care-pathway design, workforce planning and funding for obesity pharmacotherapy.

2. Collaborate internationally to build a shared evidence base and professional standards. Working across our organisations, and with researchers, clinicians and allied health bodies, to generate and translate evidence on integrated clinical exercise physiology within pharmacotherapy pathways into actionable clinical guidance.

3. Advocate for equitable access to clinical exercise physiologists as foundational obesity care globally. Working to ensure that access to clinical exercise physiologists as part of obesity pharmacotherapy care is equitable across populations, including Indigenous and First Nations people, culturally and linguistically diverse communities, women, people in low- and middle-income countries, and those experiencing socioeconomic disadvantage. Consistent with the UN Sustainable Development Goals, advocate against weight stigma and for care models designed around equity, not ability to pay.

4. Advance recognition of exercise and physical activity as a clinical - not lifestyle - component of obesity pharmacotherapy. Engaging health systems, policymakers and public communicators to embed this understanding in clinical practice, professional education and public policy, while recognising that effective, lasting physical activity engagement depends on individualised, person-centred and sustainable approaches delivered within that clinical framework.

5. Hold our member organisations and professions to the highest standards of practice, education and accountability. Investing in the clinical training, professional development and quality assurance of our members to ensure they are equipped and recognised to meet the complex needs of patients on obesity pharmacotherapy. This includes continuing education that evolves with the emerging evidence on obesity pharmacotherapy and the developing therapeutic pipeline.

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Appendix A

Signatory organisations

Exercise & Sports Science Australia (ESSA)

Title: Accredited Exercise Physiologist (AEP)

Credentialling body: Exercise and Sports Science Australia

Regulatory basis: Self-regulating health profession with accreditation by Exercise & Sports Science Australia. ESSA is a full member of the National Alliance of Self-Regulating Health Professions.

Web address: https://www.essa.org.au

Biokinetics Association of South Africa (BASA)

Title: Professional Association representing Biokineticists in South Africa

Credentialling body: Health Professions Council of South Africa (HPCSA)

Regulatory basis: Regulated Under the Health Professions Act, 56 of 1974, through the HPCSA, governed by the Professional Board for Physiotherapy, Podiatry, and Biokinetics (PPB)

Web address: https://biokineticssa.org.za/

Canadian Society for Exercise Physiology (CSEP)

Title: CSEP Clinical Exercise Physiologist®

Credentialling body: Canadian Society for Exercise Physiology (CSEP)

Web address: https://csep.ca (English) or https://scpe.ca (French)

Chartered Association of Sport & Exercise Sciences (CASES)

Title: Clinical Exercise Physiologist

Credentialling body: CASES

Regulatory basis: Academy for Healthcare Science (AHCS)

Web address: https://www.cases.org.uk/

Clinical Exercise Physiology Association (CEPA)

Title: Clinical Exercise Physiology Association (CEPA)

Credentialling body: N/A

Regulatory basis: N/A

Web address: https://acsm-cepa.org

Clinical Exercise Physiology New Zealand (CEPNZ)

Title: Professional Clinical Exercise Physiologist

Credentialling Body: Clinical Exercise Physiology New Zealand

Regulatory Basis: Clinical Physiologists Registration Board

Web address: https://www.cepnz.org.nz

Clinical Exercise Physiology UK (CEP-UK)

Title: Registered Clinical Exercise Physiologist

Credentialling body: Academy for Healthcare Science

Regulatory basis: Non-statutory but essential for employment in healthcare

Web address: https://www.clinicalexercisephysiology.org.uk/

European College of Sport Science (ECSS)

Title: Not applicable

Credentialling body: Not applicable

Regulatory basis: Not applicable

Web address: https://sport-science.org/

International Confederation of Sport and Exercise Science Practice (ICSESP)

Title: Sport and Exercise Scientist, Clinical Exercise Physiologist, Sport Scientist

Credentialling body: Relevant National Bodies

Regulatory basis: Variable

Web address: www.icsesp.global

Irish Sport and Exercise Sciences Association (ISESA)

Title: Accredited Sport and Exercise Scientists

Credentialling body: Irish Sport and Exercise Sciences Australia

Regulatory basis: Self-regulating

Web address: www.isesa.ie

Norwegian Association for Clinical Exercise Physiologists (NFHT)

Title: Clinical Exercise Physiologist (CEP)

Credentialling body: Norwegian Association for Clinical Exercise Physiologists (NFHT)

Regulatory basis: Bachelor's and master's degree in Health and Exercise Physiology (not an accredited profession in Norway)

Web address: https://www.nfht.no

Sport & Exercise Science New Zealand (SESNZ)

Title: Sport & Exercise Science New Zealand (SESNZ)

Credentialling body: SESNZ

Regulatory basis: Self-regulated

Web address: www.sesnz.org.nz