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White Paper

The Obesity Landscape in Türkiye

Ecosystem, market dynamics and the impact of semaglutide LoE

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Executive summary

Obesity has emerged as one of the most critical and fast growing public health challenges globally and in Türkiye, with significant clinical, economic, and societal burden. Türkiye is among the countries with highest obesity prevalence in the world. More than one-third of adults are living with obesity today, and projections indicate that more than half of the adult population could be living with obesity by 2035. This trajectory is expected to significantly increase the burden of diabetes, cardiovascular disease and other non-communicable diseases while also creating substantial economic pressure on the healthcare system. This underscores the urgency of coordinated long-term policy and system responses.

This white paper presents a comprehensive assessment of the obesity ecosystem in Türkiye, combining epidemiology, public policy frameworks, healthcare delivery pathways, patient and healthcare professional insights, and market dynamics. It highlights obesity not only as a medical condition but also as a chronic disease with a substantial emotional and economic burden, characterized by delayed care seeking behaviors, fragmented treatment pathways, and high rates of treatment discontinuation.

Obesity is recognized as a chronic disease leading to a wide range of diseases and is considered a significant public health challenge by Ministry of Health. Türkiye has established a national action plan including a prevention infrastructure through primary care screening and awareness programs, supported with a network of Healthy Life Centers. The Ministry of Health’s obesity initiatives including nationwide outreach to approximately 10 million citizens demonstrate increasing institutional prioritization of obesity management. However, despite this preventive framework, many patients with obesity remain outside formal care pathways or enter care late, often after the development of comorbidities. Diagnosis continues to rely primarily on BMI, with variability in the use of broader metabolic risk assessment tools across specialties.

The treatment landscape in Türkiye is evolving rapidly, parallel to changes in global environment. Lifestyle interventions remain the cornerstone of obesity management, while pharmacological therapies particularly GLP-1 treatments are increasingly reshaping clinical practice. Physician insights reveal growing confidence in obesity medicines, supported by accumulated experience and emerging global guidelines. At the same time, affordability issues and limited post-prescription support remain key challenges affecting treatment initiation, adherence, and long-term continuation. Endocrinologists, internists and cardiologists are taking active role in the management of obesity while family physicians mainly focus on screening and referral. Obesity has a non-linear, multi-entry care pathway, with pharmacists emerging as increasingly important stakeholders within the obesity ecosystem due to frequent patient interaction and high accessibility. However, pharmacists currently operate within a structurally underdefined role despite their growing influence on treatment continuation and patient behavior.

Patient insights reveal that pharmacological treatments are not only valued for weight loss but also for the psychological relief they provide; however, gaps in guidance, affordability pressures, and fear of long-term sustainability drive dissatisfaction and switching behaviors.

The global obesity medicines market reached USD 66 billion in list-price sales in 2025 and is projected to grow to USD 92 billion in 2026. Türkiye is still in an early but accelerating phase of GLP-1 adoption. The launch of next-generation obesity therapies such as Wegovy and Mounjaro has accelerated market formation and patient demand, and uptake patterns in Türkiye are already comparable to several developed European markets despite the absence of public reimbursement. Market demand is being driven by combination of increasing epidemiology, rising disease awareness, physician experience and social media influence.

Looking ahead, the obesity market is expected to be shaped by multiple factors such as the introduction of oral formulations, evolving physician practices, and the loss of exclusivity (LoE) of semaglutide. Semaglutide's LoE represents a potential inflection point, with generics expected to improve affordability, enable longer treatment duration, and expand access in Türkiye.

Overall, addressing obesity in Türkiye requires a holistic, system level approach by aligning prevention, early diagnosis, sustainable treatment access, and long-term support. Coordinated action among policy makers, healthcare professionals, and the healthcare industry will be essential to translate therapeutic innovation into meaningful and equitable public health impact.

1. Obesity: A serious public health burden

Obesity is a major public health challenge for both globally and Türkiye. Overweight and obesity occur when fat accumulates in the body to a level that presents a health risk. Individuals with a body mass index (BMI) above 25 are classified as overweight, while those with a BMI exceeding 30 are considered as living with obesity. The prevalence of overweight and obesity has been increasing among both adults and younger populations. According to World Health Organization (WHO), the share of adults living with obesity rose from 7% in 1990 to 16% in 2022. Over the same period, obesity among children and adolescents aged 5–19 also grew significantly, with prevalence rising from 2% to 8%.[1]

Global prevalence and disease burden

Global estimates of overweight and obesity levels, according to data from the World Obesity Atlas 2023 indicate that more than 2.6 billion people were affected in 2020 and more than 4 billion people could be affected by 2035. It is expected to increase from 38% of the global population in 2020 to more than 50% in 2035 (Children under 5 years old are not included). The prevalence of obesity alone is expected to rise from 14% to 24% of the population during the same period, affecting approximately 2 billion adults, children, and adolescents by 2035. If current trends persist, the global economic impact of overweight and obesity could reach USD 4.32 trillion per year by 2035.[2]

Prevalence in Türkiye

Obesity has emerged as one of the most pressing public health challenges in Türkiye, with prevalence rates increasing over the past two decades. Based on WHO data, Türkiye is among the countries with the highest prevalence of overweight and obesity in the WHO European Region, with 32.1% of adults classified as living with obesity and 66.8% of adults classified as overweight including people living with obesity in 2016.[3] National data confirm the scale of the issue. According to Türkiye Nutrition and Health Survey (TNHS) 2017, 34.1% of adult population is classified as living with obesity, rising from 30.3% in 2010 reflecting an upward trend over time. Gender differences are particularly notable, indicating that obesity prevalence among women is significantly higher than men. TNHS 2017 suggests 42.6% of adult women and 26.3% of adult men in Türkiye are living with obesity.[4]

Obesity prevalence increases with age, with declining physical activity levels and metabolic changes. Childhood obesity is also becoming a growing concern. Estimates suggest that approximately 8% of children under five are overweight, while school-age children show rising overweight and obesity prevalence, reflecting early exposure to obesogenic environments. These trends indicate that obesity in Türkiye is increasingly affecting younger populations, raising concerns about the long-term burden of non-communicable diseases (NCDs).

Current epidemiological evidence demonstrates that obesity in Türkiye is widespread, growing, and unevenly distributed across gender and age groups, creating significant long-term health risks for the population. Looking forward, projections indicate a continued rise in obesity prevalence suggesting that 55% of the adult population in Türkiye could be living with obesity by 2035, underscoring the urgency of preventive interventions.[2]

The rising prevalence of obesity in Türkiye is driven by a combination of socioeconomic, behavioral, and environmental factors. Rapid urbanization, changes in dietary habits, and sedentary lifestyles have fundamentally altered the country's health risk landscape. One of the most significant drivers is the shift toward processed foods. Increased availability of inexpensive processed foods, sugary foods and beverages, and packaged snacks is linked to the growing obesity problem. Economic factors can reduce access to healthy foods such as fresh fruits, vegetables, and lean protein sources. Physical inactivity is another key contributor. According to OECD data, 44% of adults in Türkiye do not perform sufficient physical activity, higher than the OECD average of 30%.[5]

Emotional burden of obesity

Social intelligence data reveal that patients in Türkiye experience obesity as a long-term psychological and physical burden. Patient narratives describe years of repeated dieting cycles, weight fluctuations, and emotional exhaustion. Persistent guilt, shame, and stigma stemming from the perception of “not trying hard enough”. A turning point in treatment-seeking behavior that is often triggered not by aesthetic goals, but by emotional collapse, fear for health, or a sense of hopelessness.

Comorbidities

Excess weight not only contributes to physical limitations and psychological problems but also significantly raises the likelihood of developing several NCDs, such as cardiovascular disease, cancer, and diabetes. As body weight increases, the probability of experiencing comorbidity also rises. Additionally, carrying extra weight can cause musculoskeletal problems, such as osteoarthritis. Globally, an estimated 5 million NCD deaths were linked to having a high BMI level in 2019.[1] 78% of NCD-related deaths linked to overweight and obesity have been recorded in low and middle income countries, and by 2035 an estimated 79% of individuals with obesity will be living in LMICs.[6] Turkey is upper-middle-income country like China, Brazil and South Africa. This distinction influences healthcare infrastructure, spending capacity, and policy implementation.

Real-world evidence from Türkiye illustrates the scale of comorbidity among individuals with obesity. In the OBREDI-TR study, which evaluated more than 10,000 patients with obesity across multiple regions, the prevalence of key comorbidities was substantial. Among adults with obesity, 78% had hypertension, 75% had fatty liver disease, 35% had type 2 diabetes, 12% had dyslipidemia, and 10% had coronary artery disease highlighting the close relationship between obesity and metabolic disease burden.[7]

Economic burden

According to the WHO, obesity is estimated to account for 2–8% of total healthcare expenditures and 10–13% of overall mortality in WHO European Region.[8]

The high prevalence of obesity-related conditions contributes to a significant economic burden for the Turkish healthcare system. A modeling study estimated that the total economic cost of obesity in Türkiye was equivalent to 2.6% of the country’s gross national product in 2021. Direct medical costs account for a substantial share of this burden. Obesity-related healthcare expenditures represent approximately 8.4% of total health spending in Türkiye, reflecting increased demand for chronic disease management, pharmaceutical treatments, and hospital care. Indirect costs are also considerable. Reduced productivity, absenteeism, disability, and premature mortality all contribute to the broader societal impact of obesity. Studies indicate that indirect costs may exceed direct medical costs, emphasizing the importance of preventive strategies and early intervention.[9]

Taken together, obesity not only increases the risk of chronic disease but also imposes a substantial financial burden on the healthcare system and the broader economy.

Public policy and government actions in Türkiye

Obesity is recognized as a chronic disease leading to a wide range of diseases and is considered a significant public health challenge in Türkiye. In response, preventive healthcare has become increasingly important for the Ministry of Health (MoH) and other relevant stakeholders. Preventing obesity requires a comprehensive approach that promotes physical activity and emphasizes the adoption of healthy dietary habits. In this context, the development and implementation of a holistic roadmap for obesity prevention and management have been highlighted as key priorities. Relevant departments under the General Directorate of Public Health are implementing a range of programs and initiatives aligned with these objectives.

Activities aimed at increasing public awareness are carried out as part of MoH efforts to address obesity. “Learn Your Ideal Weight, Live Healthy” campaign has aimed to increase awareness through direct interaction with the public. Height and weight measurements have been carried out in high-traffic locations to inform individuals about their health status and to promote

utilization of Healthy Life Centers, where they can access free dietitian and physiotherapy services.

In 2025, MoH launched another intensive campaign to tackle obesity in Türkiye, sending SMS invitations to approximately 10 million citizens registered as having overweight or obesity in the family medicine system. The messages encourage individuals to visit Healthy Life Centers.

Educational programs delivered by dietitians in schools and community education centers focus on promoting healthy nutrition, increasing physical activity, and improving awareness of obesity and diabetes. Through these large-scale outreach initiatives, it is estimated that approximately 3.5–4 million individuals were reached in 2025.

Under the National Obesity Action Plan, coordination is carried out across multiple public institutions to ensure a multisectoral approach to obesity prevention. Key stakeholders include the Ministry of Education, the Ministry of Youth and Sports, and the Ministry of Agriculture. These collaborations play an instrumental role in promoting healthy lifestyle behaviors and supporting the development of nutrition and food-related policies to prevent obesity.

The National Nutrition Council convenes twice annually and plays a key role in shaping national nutrition policies. Decisions and recommendations emerging from these meetings inform policy development aimed at improving the food environment and supporting healthier dietary behaviors. Key policy areas discussed within the Council include front-of-pack color-coded nutrition labeling, the introduction of dedicated logos for compliant school food products, mandatory warning labels on certain food items, and measures to limit the availability of salt and sugar in mass catering settings. Collectively, these initiatives aim to foster a food environment that encourages healthier eating habits.[10]

Addressing this growing epidemic requires coordinated action from both governments and society. National policies should promote increased physical activity while improving the affordability, availability, and accessibility of healthier food options. In addition, effective responses should involve collaboration across multiple government sectors, civil society organizations, the private sector, and other relevant stakeholders.[8]

2. Obesity management ecosystem

2.1. Preventive policies

The fight against obesity and chronic diseases in Türkiye is gaining momentum through national policies and government-supported initiatives. In 2025, the General Directorate of Public Health under the Ministry of Health (MoH) published the "Obesity Prevention and Physical Activity Action Plan 2025–2028." Preventing obesity has become an increasingly important priority within Türkiye's public health agenda.

National strategies primarily focus on reducing lifestyle-related risk factors, particularly unhealthy diets and physical inactivity. Türkiye's policy framework includes initiatives such as the Healthy Nutrition and Active Life Program, public awareness campaigns promoting healthier lifestyles, and school-based nutrition programs aimed at improving dietary habits among children and adolescents. In addition, regulatory efforts have targeted food environments, including voluntary reformulation programs to reduce salt and sugar content in packaged foods.

WHO has highlighted Türkiye's integrated approach to preventing non-communicable diseases, which involves coordinated actions across the health, education, and food policy sectors.

In Türkiye, primary care services play a central role in the prevention and management of obesity. Training on obesity is included in the standard education curriculum for Family Physicians (FPs). In 2025, FPs carried out a large-scale screening program among the registered population aged 18 and above, identifying approximately 6.5 million individuals with overweight or obesity. Patients diagnosed with obesity are monitored up to four times a year, with assessments including BMI calculation, waist circumference measurement, and relevant laboratory tests when necessary. FPs also encourage individuals to visit Healthy Life Centers, where they can access free consultation services.

Türkiye has nearly 350 Healthy Life Centers nationwide, where dietitians and physiotherapists provide personalized guidance and support. Patients diagnosed with obesity by FPs are primarily referred to these centers, and when needed, further referred to secondary care institutions. In addition, MoH expanded outreach efforts by sending SMS messages to 10 million citizens registered in the family medicine system, encouraging them to benefit from the free services available at Healthy Life Centers.[10]

Preventive strategies also include community-based initiatives that promote physical activity, such as public exercise campaigns and municipal efforts to increase access to recreational spaces. These prevention policies are increasingly supported by clinical management approaches that recognize obesity as a chronic condition requiring sustained, long-term treatment.

2.2. Diagnostic framework

International clinical guidelines from organizations such as the WHO emphasize a comprehensive diagnostic approach to obesity, incorporating BMI, metabolic risk assessment, and the identification of obesity-related complications. Obesity management in clinical practice primarily follows the Obesity Diagnosis and Treatment Guideline published by The Society of Endocrinology and Metabolism of Turkey in 2024. According to physician insights, national guidelines along with international guidelines are among most commonly used knowledge source across specialties. Clinical practice in Türkiye generally aligns with these recommendations; however, certain gaps remain evident. In practice, obesity diagnosis in Türkiye largely relies on BMI, which continues to be the most widely used tool due to its simplicity and integration into routine clinical assessments. Additional measures such as waist circumference and waist-to-hip ratio are occasionally used to assess central obesity and associated cardiometabolic risk. Although these indicators are well established in international guidelines, their use in routine practice vary across healthcare settings. In primary care, BMI is typically recorded during general consultations, whereas more comprehensive metabolic evaluations are more common in specialist settings.

BMI is the primary diagnostic measure for obesity across specialties, but it is routinely complemented by additional indicators that vary by clinical context. According to physician interviews, endocrinologists commonly use waist circumference and waist-to-hip ratio, particularly near BMI thresholds, and may further apply tools such as body fat percentage or the Edmonton Obesity Staging System to better assess metabolic burden. Internists also consider waist circumference alongside risk factors, including family history and metabolic parameters like visceral fat accumulation. In such cases, individuals with lower BMI may still be classified as living with obesity when there is evidence of elevated metabolic risk, such as insulin resistance or excess visceral fat. For cardiologists, BMI remains a reference measure, but waist circumference is often viewed as a more relevant indicator of cardiovascular risk. At the primary care level, FPs systematically measure both BMI and waist circumference as part of routine screening. Integrated with national health information systems, these measures support earlier detection and documentation of obesity at the population level.

In practice, patients who receive a formal diagnosis and treatment for obesity generally fall into two groups: those presenting with obesity-related comorbidities and those actively seeking medical support for weight management. A substantial proportion of individuals with obesity remain outside the formal care pathway. Many people attempt weight loss independently through dieting or commercial wellness services without engaging healthcare professionals (HCPs), while others seek medical care only after developing obesity-related complications such as diabetes or cardiovascular disease. This pattern contributes to delayed treatment initiation and limits opportunities for early intervention.[11]

2.3. Treatment modalities

Obesity management in Türkiye encompasses multiple treatment pathways, ranging from lifestyle interventions to pharmacological and surgical options. These approaches often coexist within a fragmented ecosystem, where patients may move between different treatment modalities over time.

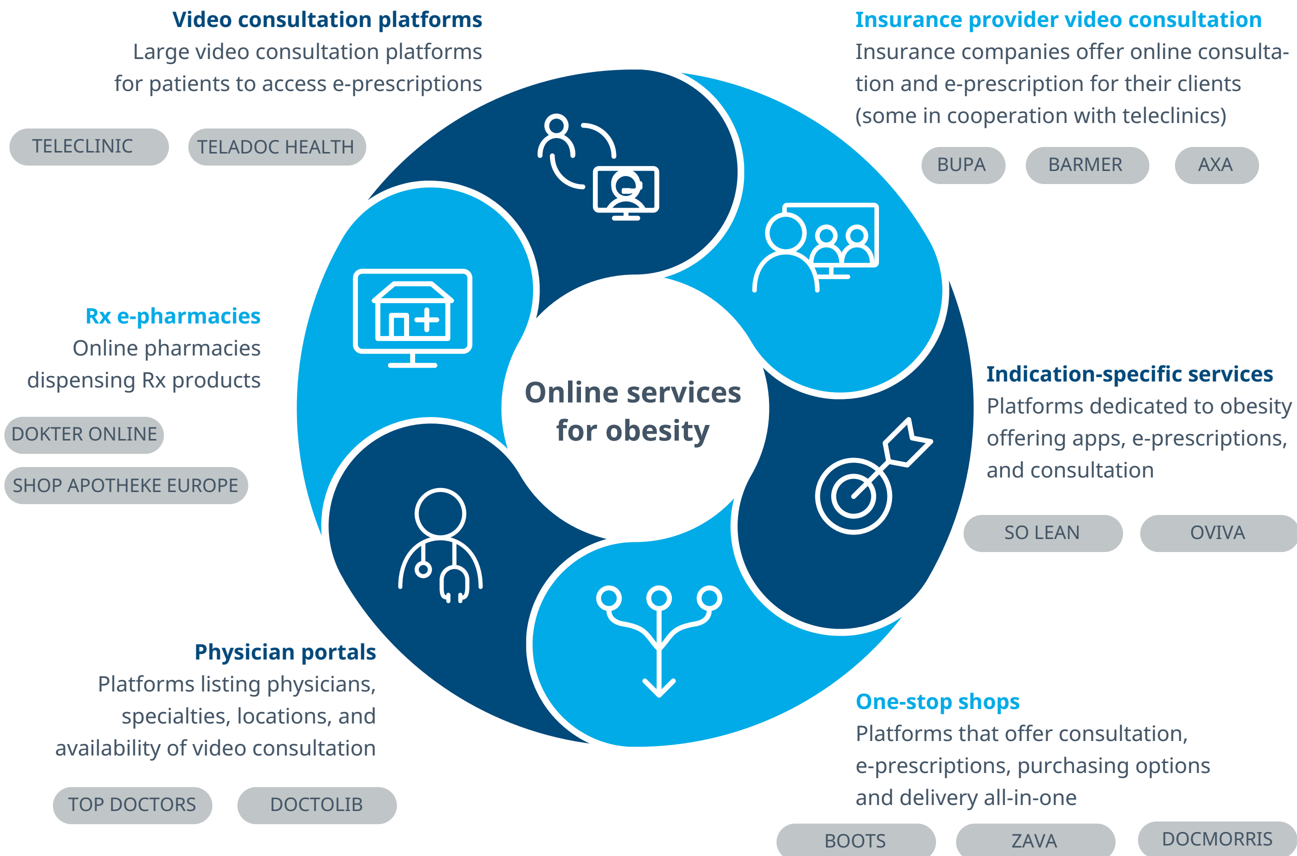
2.3.1. NON-PHARMACOLOGICAL LIFESTYLE MODIFICATIONS

Lifestyle interventions are typically the first step in patients' journey and remain the most commonly used approach to obesity management. These interventions include dietary programs and nutrition counseling, fitness and lifestyle coaching, commercial weight-loss programs, over-the-counter supplements and wellness products, as well as digital health platforms that provide remote coaching and activity or diet tracking.

2.3.2. DIGITAL SOLUTIONS IN OBESITY MANAGEMENT

A mature digital health ecosystem has emerged as a key enabler of direct-to-patient obesity treatment models in several European countries. In the UK and Germany, integrated platforms provide end-to-end services including video consultations, e-prescriptions, online dispensing, and tailored coaching support. For example, the UK pharmacy chain Boots provides comprehensive treatment packages for conditions such as obesity, combining virtual consultations, medication prescriptions,

Figure 1: Online services for obesity management in Europe



Source: The Potential for the Private Prescription Market in Europe (2025), IQVIA

and behavioral support. Similarly, Germany's DocMorris enables patients to access consultations and prescriptions entirely online, facilitating care from home.[12] These digitally enabled models not only improve continuity of care but also address critical gaps in post-prescription guidance and patient empowerment, particularly in the growing out-of-pocket obesity medication market.

A prerequisite for this proliferation of e-health offerings is the regulatory environment — not all countries allow online consultations and prescriptions. Even where online consultations are permitted, they may be possible only for already existing doctor-patient relationships or there may be other regulatory limitations.

The digital health ecosystem in Türkiye continues to develop within the framework of its national healthcare priorities and regulatory environment. In this context, the organization and delivery of digital health services differ from those observed in some European markets. The Regulation on the Remote Provision of Healthcare Services, introduced in 2022, enables licensed healthcare institutions to provide video or audio consultations through MoH approved systems. Telemedicine services in Türkiye are therefore progressing in line with defined regulatory principles, with a focus on ensuring patient safety, data security, and alignment with public health objectives.

Türkiye has established a strong national digital health infrastructure through widely adopted, state-led platforms such as e-Nabız and MHRS. These platforms serve as central access points for appointment scheduling, personal health record management, medication history review, and basic health risk tools such as BMI calculation. They are well integrated into the public healthcare system and are widely trusted by both citizens and healthcare professionals. At present, these platforms primarily support healthcare access, information continuity, and system coordination, rather than functioning as comprehensive digital treatment pathways that combine consultation, prescription, dispensing, and follow up within a single digital environment.

Prescription medicines in Türkiye are dispensed through licensed pharmacies, with in person collection reflecting the current structure of pharmaceutical care delivery. As digital health engagement and disease awareness continue to expand, particularly in areas such as obesity, discussions around the future evolution of care pathways and patient access models may increasingly come to the fore. In this context, Türkiye's digital health landscape is expected to continue evolving in a way that balances innovation, regulatory oversight, and the established strengths of its healthcare system.

Additionally, in Türkiye, digital health tools, including mobile applications and online nutrition programs, are becoming increasingly popular, particularly among younger and urban populations.

2.3.3. PHARMACOLOGICAL TREATMENT

Lifestyle interventions remain the foundational approach to obesity management, with pharmacological therapies and bariatric surgery typically introduced when lifestyle changes alone are insufficient. However, the increasing availability of effective obesity medications is gradually reshaping this treatment paradigm by establishing pharmacotherapy as an intermediate option between lifestyle modification and surgical intervention.

In December 2025, the WHO issued a global guideline on the use of GLP-1 medicines for obesity, including conditional recommendations for their use to support people living with obesity.

During treatment decision-making, physicians also assess obesity-related comorbidities, including type 2 diabetes, hypertension, dyslipidemia, and cardiovascular disease, to guide individualized treatment strategies. Pharmacological treatment options for obesity are expanding globally, particularly with the introduction of GLP-1 receptor agonists. The emergence of next-generation therapies with improved clinical efficacy is expected to further increase physician and patient interest in pharmacological treatment.

Orlistat-based medications have been available in the Turkish market for many years as part of obesity treatment landscape. GLP-1 therapies indicated for weight management were first introduced to Türkiye in 2018. More recently, next-generation GLP-1 agents indicated for weight management, such as Wegovy and Mounjaro, were launched in the Turkish market in 2025. (Please refer to Table 1 for detailed information).

Tendency to prescribe obesity medications in Türkiye

Physician readiness to prescribe pharmacological obesity treatments varies across specialties. Endocrinologists and metabolic disease specialists generally demonstrate greater familiarity with these therapies, while some physicians remain cautious due to historical safety concerns associated with earlier generations of weight-loss medications. The growing clinical evidence supporting newer pharmacological options is expected to gradually strengthen physician confidence in prescribing obesity medications.

Across interviews, GLP-1 therapies are consistently described as a widely used pharmacological option in obesity management. Patient awareness is often driven by social media and peer influence rather than structured clinical understanding, requiring physicians to clarify indications, treatment rationale, and potential side effects. Endocrinology perspectives are prominent, with GLP-1 therapies viewed positively and supported by extensive clinical experience rooted in diabetes care. Physicians emphasize strict adherence to appropriate indication and report declining requests for use in patients below clinical obesity thresholds, particularly for cosmetic purposes. Internists similarly cite the diabetes heritage of GLP-1 therapies as reinforcing confidence and report routine use in motivated patients over several months. Cardiologists also express favorable views, highlighting the role of weight loss in improving cardiovascular outcomes and simplifying overall disease management.

At the same time, clinicians acknowledge the existence of non-clinical access pathways, most commonly through pharmacies, leading to unsupervised initiation or discontinuation. This is viewed as a challenge to appropriate use and continuity of care, rather than a reflection of low patient acceptance.

2.3.4. BARIATRIC SURGERY

Bariatric surgery remains one of the most effective treatment options for severe obesity. Procedures such as sleeve gastrectomy and gastric bypass are commonly performed in Türkiye, which has also emerged as an important destination for bariatric surgery and medical tourism. Surgical intervention is typically considered for patients with a BMI ≥40, or ≥35 with obesity-related comorbidities, in line with international clinical guidelines. Although bariatric surgery delivers substantial weight loss outcomes, its invasive nature, risk of complications and associated costs limit its use to a relatively small proportion of eligible patients.

Insights from physician interviews highlight a variation in how bariatric surgery is perceived across specialties and individual clinical practices in Türkiye. While some physicians regard it as a highly effective treatment option, it appears to be positioned as a last-resort option for patients with severe obesity who do not achieve adequate results from lifestyle modification or pharmacological treatments. Across specialties, endocrinologists adopt a more conservative approach, primarily considering surgery for patients with very high BMI levels or persistent obesity-related comorbidities associated with elevated clinical risk. Cardiologists express a similar view, recommending surgery mainly for patients with high cardiometabolic risk who do not respond to medical therapy. Internists demonstrate more heterogeneous perspectives. Some emphasize the growing role of pharmacological treatments, particularly GLP-1 receptor agonists, while others consider bariatric surgery appropriate in cases where long-term adherence to lifestyle and medical therapy is unlikely, particularly among patients with severe obesity. FPs primarily play a supportive role, focusing on patient awareness and facilitating multidisciplinary evaluation. Overall, physician interviews suggest that bariatric surgery occupies a narrowly defined position within the obesity treatment pathway. While its clinical value is widely recognized, strict BMI thresholds and requirements may limit broader access to surgical intervention.

In Türkiye, reimbursement for bariatric surgery is defined under the Health Implementation Communiqué (SUT), establishing eligibility for public funding. Access to surgery is governed by stringent criteria, including multidisciplinary review and center-based eligibility requirements. This regulatory framework can extend evaluation and scheduling timelines, particularly in public institutions relative to private hospitals.

2.4. Patient journey

Patient awareness of obesity as a medical condition varies across Türkiye. Many individuals initially perceive weight gain as a lifestyle issue rather than a clinical condition requiring treatment. However, media coverage and social media discussions around weight-loss medications have contributed to growing awareness and interest in pharmacological treatment options. Common triggers for seeking treatment include the development of obesity-related comorbidities, physician recommendations during routine consultations, as well as social or aesthetic motivations. Patients typically enter the obesity treatment pathway through primary care or specialist consultations.

In Türkiye, there are 116 obesity centers operating under the General Directorate of Public Hospitals. These centers adopt a multidisciplinary approach and provide a range of services, including dietitian support, physiotherapy, medical and psychological counseling, and bariatric surgery options. They are typically accessed by individuals with a BMI above 30.

2.4.1. KEY SPECIALTIES IN OBESITY MANAGEMENT

Obesity care in Türkiye follows a non-linear, multi-entry pathway involving multiple stakeholders, with pharmacies also acting as continuous access points for support. Key specialties involved in obesity diagnosis and treatment in Türkiye include internal medicine, endocrinology, cardiology and family medicine. Endocrinologists typically lead pharmacological management, while FPs serve as the primary point of contact for most patients seeking medical advice. Despite the availability of a formal referral system, patients can directly access specialists such as internists and endocrinologists within the public healthcare system, enabling more immediate entry into obesity care.

Family physician

The pathway generally begins in primary care, where FPs play a central role in early identification and ongoing monitoring. This is supported by integrated health records via Disease Management Platform (HYP) and e-Nabız, which enable longitudinal tracking of key metrics such as height, weight, BMI, and waist circumference. Following the Family Physician Regulation updates, screening responsibilities for FPs were expanded to include obesity, cardiovascular risk, diabetes, and hypertension. Within this framework, patients with obesity can be referred to Healthy Lifestyle Centers, where multidisciplinary support is provided free of charge. FPs also conduct initial assessments supported by first-line laboratory testing (e.g., blood count, liver and kidney function, HbA1c, and insulin resistance markers). In cases of confirmed obesity with comorbidities or limited response to lifestyle interventions, patients are typically referred to internal medicine, and in some cases endocrinology.

Internal medicine

Internal medicine functions as a key transition point where obesity management shifts from lifestyle-focused care to pharmacological treatment. Internists frequently serve as the primary initiators of obesity diagnosis and treatment. Obesity is generally framed as a metabolic condition requiring medical therapy by internists, particularly given the high prevalence of prior unsuccessful weight-loss attempts among patients.

Endocrinology

Based on endocrinologists' insights, patients typically present with an existing awareness of obesity and a strong motivation to lose weight. Endocrinologists typically manage patients with higher disease complexity or prior treatment failures, often following referral or dietitian-led identification prior to endocrinology consultation. Their role is staged, requiring a close follow-up particularly in patients with other chronic metabolic comorbidities. Pharmacological treatment is widely used, particularly in patients with prior unsuccessful weight-loss attempts or higher disease burden, with lifestyle modification remaining a foundational component alongside medication.

Cardiology

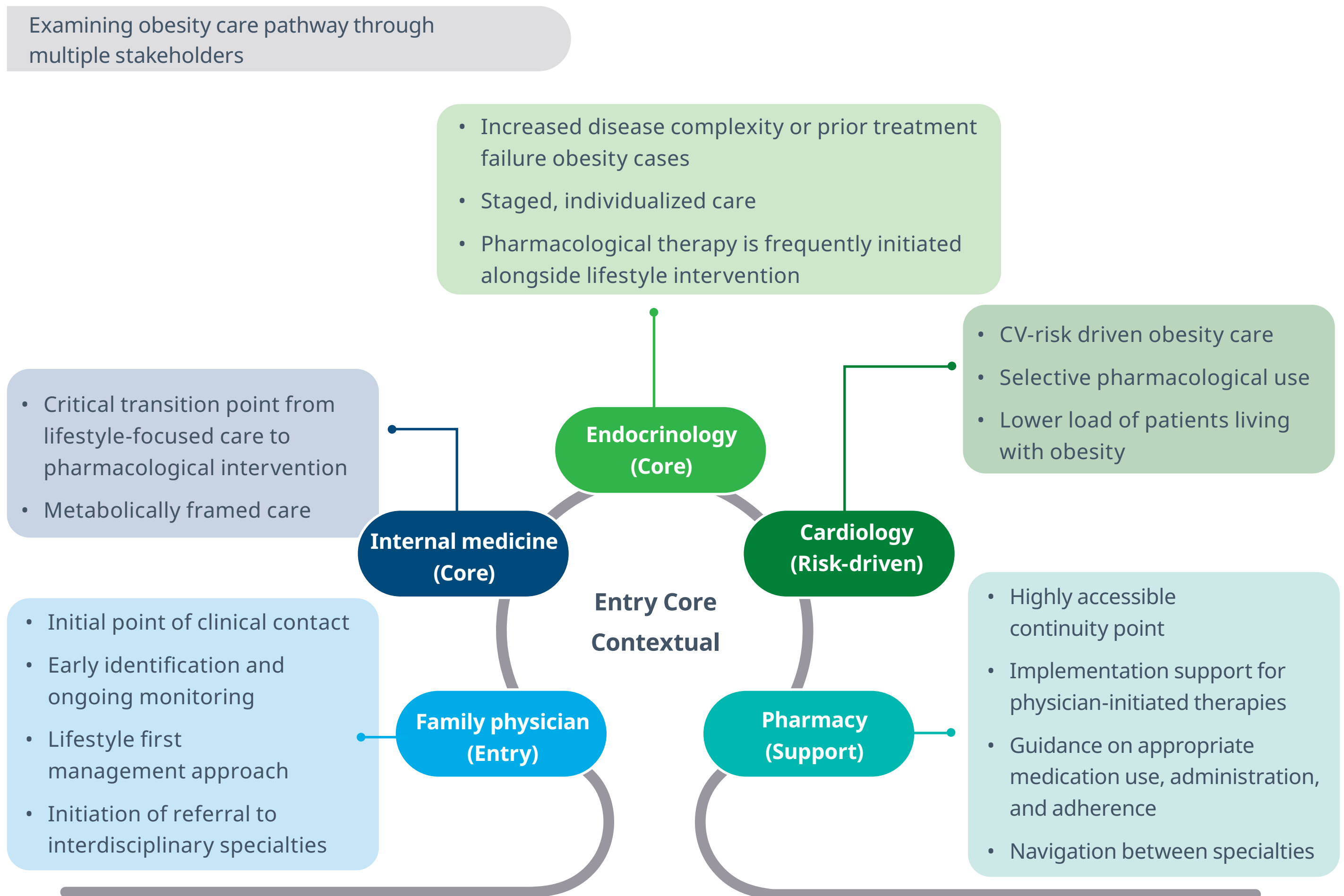
Cardiologists mostly frame obesity through the lens of cardiovascular risk. Pharmacological treatment is initiated more selectively, typically reserved for patients with high cardiometabolic risk, atherosclerotic disease, or impaired glucose metabolism. For lower-risk patients, lifestyle modification is generally preferred, although treatment decisions are strongly influenced by comorbidities, patient preference, and affordability considerations affecting treatment continuity.

Other specialties

Patients may also enter the obesity care pathway through other specialties, such as obstetrics and gynecology or orthopedics, typically presenting with related conditions like women's health issues or joint disorders.

Bariatric surgical procedures are performed by general surgeons with specialized expertise in obesity surgery. The care pathway is typically multidisciplinary, with endocrinology playing a key role in assessing patients' metabolic status and overall suitability, while surgery is ultimately carried out by the general surgeon.

Figure 2. Roles by multiple stakeholders in obesity care pathway



Source: Primary market research with HCPs, IQVIA

2.4.2. ROLE OF PHARMACISTS

Pharmacists play a significant role in patient education and ongoing guidance in obesity management. As highly accessible healthcare professionals, they frequently advise patients on weight-loss products, medication use, and lifestyle strategies, while also influencing brand selection, treatment adherence, and perceptions of safety and effectiveness. Pharmacists position themselves as central yet structurally underdefined stakeholders in obesity care. They report having frequent and sustained patient contact, particularly in chronic conditions such as obesity, diabetes, hypertension and respiratory diseases. Following physician's diagnosis and prescription, the day-to-day implementation of treatment including how a medication is used, continued, adapted or discontinued unfolds at the pharmacy level based on insights shared by pharmacists. Pharmacists consistently describe obesity management as a long-term, dynamic process and position themselves as key continuity points throughout the treatment journey.

Their role is particularly focused on:

- Supporting long-term treatment adherence
- Providing guidance on correct medication use
- Assisting with injection techniques and administration
- Identifying early patient concerns and facilitating referral when needed

Incretin-based therapies have become a prominent part of daily pharmacy practice, with pharmacists describing obesity treatment demand as rapidly accelerating rather than growing linearly. This growth is primarily attributed to word-of-mouth influence and social learning, as patients are increasingly motivated by visible outcomes observed within their close networks, further mentioned than social media impact. Pharmacists appears to characterize themselves as a "consultative interface" rather than a decision-maker. Patients typically seek pharmacists' input mostly on side effects, tolerability, dosing and titration, and administration technique. In this context, pharmacists provide practical guidance and reinforce physician-led treatment plans. However, several barriers limit their involvement in obesity care, including time constraints for structured patient counseling, lack of direct communication between physicians and pharmacist, and the absence of a formally defined consultative role of pharmacists within the regulatory framework. Pharmacists also highlight operational and commercial challenges associated with obesity treatments, including low profit margins, payment delays, commission structures, and cold-chain requirements. These challenges, combined with increasing patient-driven demand, raise concerns regarding the long-term sustainability of obesity care support at the pharmacy level.

2.4.3. PHARMACOLOGICAL TREATMENT APPROACH

Several factors influence prescribing decisions in obesity management, including clinical efficacy and safety, physician familiarity with specific molecules, patient affordability, and local market availability. Patient characteristics — such as comorbidities, cardiovascular risk, and prior treatment history — also play a critical role in treatment selection.

Across specialties, clinical efficacy (weight-loss) and tolerability emerge as the common key drivers of treatment choice. Physicians emphasize real-world patient response, side-effect profile (particularly gastrointestinal tolerability), and ease of administration. Brand loyalty remains limited; instead, decisions are guided by scientific evidence, peer experience, patient-specific factors, and the financial sustainability of long-term treatment. Patient affordability and long-term continuation are recurring considerations given the chronic nature of obesity management.

Endocrinologists primarily prioritize efficacy and safety/tolerability, with particular attention to mechanisms of action (e.g., dual GLP-1/GIP activity) and robust clinical weight-loss data. Treatment selection is individualized, supported by careful dose titration and preference for user-friendly delivery systems. While scientific evidence, peer experience and individual patient need guide decisions, patient budget sensitivity remains an important factor where physicians avoid costly therapies if long-term affordability is uncertain.

From internal medicine perspective, treatment choice is driven by a combination of efficacy, tolerability, and patient profile, often incorporating a patient-centered approach. Physicians frequently involve patients in decision-making, with gastrointestinal tolerability and affordability acting as key differentiators.

Cardiologists appear to prioritize evidence-based efficacy and peer recommendations. Therapies are prioritized considering cardiometabolic risk profile, safety, and anticipated cardiovascular benefit. In patients with heart disease, semaglutide's cardiovascular evidence may influence choice. Practical considerations such as drug interactions and weekly dosing convenience also factor into decisions.

FPs appear to focus on appropriate referral and patient guidance. Decision-making is strongly influenced by patient socioeconomic status. Physicians tend to avoid recommending expensive therapies to patients unlikely to sustain treatment, opting instead for metformin and lifestyle interventions, or referring to specialists if needed.

2.4.4. PATIENT INITIATED DEMAND FOR OBESITY PHARMACOTHERAPY

Interviews with pharmacists consistently indicate a high level of patient-initiated inquiry and demand for obesity treatments, often occurring at the pharmacy level prior to formal physician engagement. Pharmacists report that they routinely advise patients to seek medical consultation, while noting that patient interest and questioning are largely self-driven.
Across interviews, pharmacists describe that initiated treatments are perceived to be predominantly patient-led rather than physician-initiated, with pharmacy-based interactions representing a significant touchpoint in the patient journey. In this context, pharmacists highlight a recurring professional tension between their responsibility to promote appropriate clinical guidance and their awareness that patients may continue exploring alternatives within the broader healthcare ecosystem if unmet at the initial point of contact.

Patient motivation is primarily characterized by the pursuit of rapid weight reduction and visible physical change. Pharmacists consistently observe a clear differentiation between patient segments:

- Patients entering the pathway following physician referral tend to frame obesity treatment primarily around health-related outcomes, frequently in connection with existing metabolic or cardiovascular comorbidities.
- Patients who initially engage pharmacists are more likely to emphasize speed of effect and aesthetic considerations when discussing treatment expectations.

Despite these differences, pharmacists uniformly reinforce the understanding of obesity as a chronic, multifactorial disease, strongly associated with long-term metabolic and cardiovascular risk, and emphasize the importance of appropriate clinical oversight.

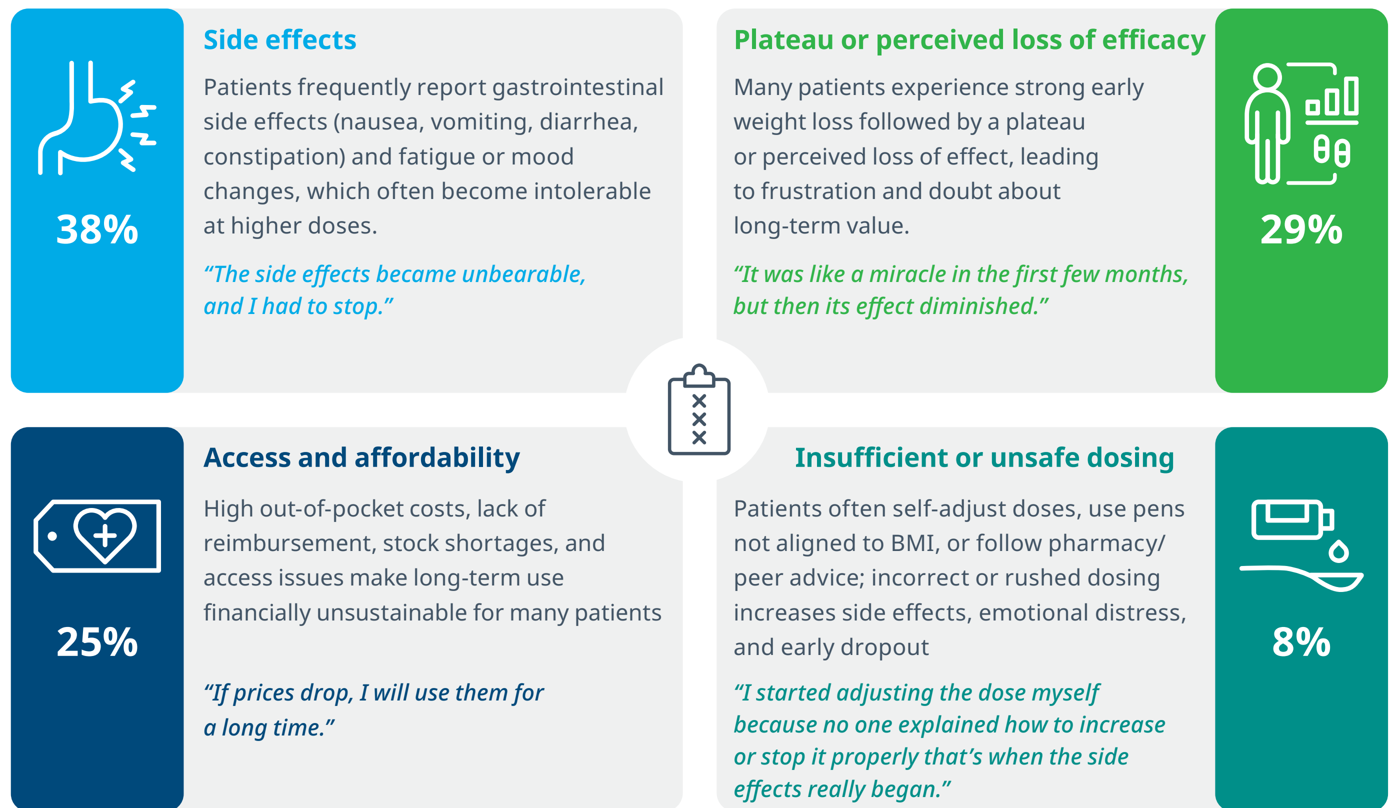
2.4.5. KEY CHALLENGES IN OBESITY MANAGEMENT AND PATIENT JOURNEY

People with obesity typically have difficult patient journeys due to stigmatization, deeply affecting their engagement with health systems and treatment. Some studies affirm that people living with obesity may be subject to medical assessments that disproportionately focus on their weight, which, in turn, predisposes patients and delays care-seeking behaviors. Establishing patient-centered models of care that prioritize empathetic communication, psychosocial support, and individualized treatment is vital to enhancing therapeutic relationships and optimizing clinical outcomes.[6]

Based on social intelligence analysis of Türkiye, patient perspectives on treatment experiences show that, obesity medications are valued not just for weight loss, but for the mental relief they provide — offering a sense of control and reducing guilt. The most significant challenge is not the side effects themselves, but the feeling of being left alone to manage them. Many patients report a lack of post-prescription guidance. This gap has led to the rise of social media and patient communities as informal but essential support systems.

Side effects, perceived loss of efficacy, and access or affordability issues accounted for 92% of negative patient experiences; unsafe dosing due to limited guidance was also reported.

Figure 3. Patients' reported negative experiences with obesity medications



Source: IQVIA Social Intelligence Analysis on Türkiye, March 2026 (*Based on sample analysis of 2,280 patient conversations. 567 data points relevant to the business questions*.)

Cost and affordability

Cost and access are consistently identified as the primary barriers to obesity pharmacotherapy, particularly by endocrinologists. Orlistat-based treatments may be reimbursed on a limited basis, subject to specific restrictions and eligibility criteria.

The lack of public reimbursement for GLP-1 therapies leads to widespread out-of-pocket payment, with some physicians estimating that over 90% of patients self-fund treatment and only a minority rely on private insurance. Even where private coverage exists, reimbursement criteria have become increasingly restrictive. Despite strong patient demand, including individuals willing to self-finance treatment for 3–12 months, a substantial subgroup remains unable to initiate or sustain therapy due to financial constraints. By way of example from GLP-1 therapies, as of May 2026, the monthly treatment cost of tirzepatide (Mounjaro) is approximately $272 at the initiation dose and ranges from $355 to $603 per month for maintenance doses, with the most commonly used 5 mg dose costing around $355 per month. Additionally, the monthly cost of semaglutide (Wegovy) varies from $236 to $354 depending on the dosage.

Insights from pharmacist interviews confirm that cost is a key determinant of both initiation and continuation of pharmacological obesity treatment. Out-of-pocket patients are highly price-sensitive, often modifying usage patterns or discontinuing therapy in response to affordability constraints. While lower-cost generic options are expected to improve access, they are also likely to increase patient-initiated demand, at sometimes outside physician oversight. Pharmacists anticipate an expanded role in supporting treatment journeys, particularly in ensuring appropriate use, adherence, and long-term maintenance.

Side effects and tolerability

Side effects are common but generally manageable and are rarely the primary reason for treatment discontinuation. The most frequently reported adverse events by physicians include nausea, vomiting,

constipation, and abdominal pain. Cardiologists report nausea-related adherence issues in approximately 20% of patients, with 10–15% discontinuing typically within the first 1–2 months. Persistence tends to improve once weight loss becomes evident. Severe adverse events such as pancreatitis are rare but lead to immediate cessation. From the caregiver perspective, physicians tend to prioritize safety, long-term risks, and the patient's daily functionality over weight loss.

Across specialties, tolerability is managed through similar strategies, including gradual dose titration, dietary counseling, injection-timing adjustments, and symptomatic treatments. With these measures, gastrointestinal side effects are usually transient, and injection-related concerns are generally resolved with in-clinic support and guidance.

Lifestyle factors are consistently highlighted, particularly by internists, as key determinants of both treatment outcomes and tolerability. Poor diet and low physical activity can exacerbate side effects and reduce effectiveness, while excessive appetite suppression raises concerns about protein deficiency and potential impact on muscle and bone health.Although a multidisciplinary approach, including dietetic and psychological support, is considered optimal, its implementation remains inconsistent in routine practice.

Efficacy

A small subgroup of patients (approximately 5-10%), mainly identified by endocrinologists, discontinues treatment due to inadequate weight loss despite dose escalation. Physicians across specialties also emphasize that visible weight loss in the early months is critical for perceived treatment benefit. Cardiologists note that lack of early response may increase the likelihood of discontinuation, while continued weight loss supports persistence. Internists describe treatment as effective when weight loss can be maintained over time, with interruption and re-initiation might be observed if weight regain occurs after stopping treatment.

Treatment adherence and persistence

Treatment persistence is widely recognized to fall short of the clinically optimal duration. Although physicians across specialties typically describe a treatment period

of 6–12 months to support sustained behavioral change, real-world adherence is considerably shorter. In primary care settings, treatment often lasts only 1–3 months, while patients managed by endocrinologists and internists tend to continue for approximately 5–6 months. FPs report particularly low persistence among older or more sedentary patients, whereas younger and highly motivated individuals are more likely to maintain treatment over longer periods. Across all specialties, financial burden emerges as the primary driver of discontinuation, with side effects cited as a secondary factor. Some physicians also indicate loss of follow-up as distinct pattern where patients discontinue care rather than treatment itself.

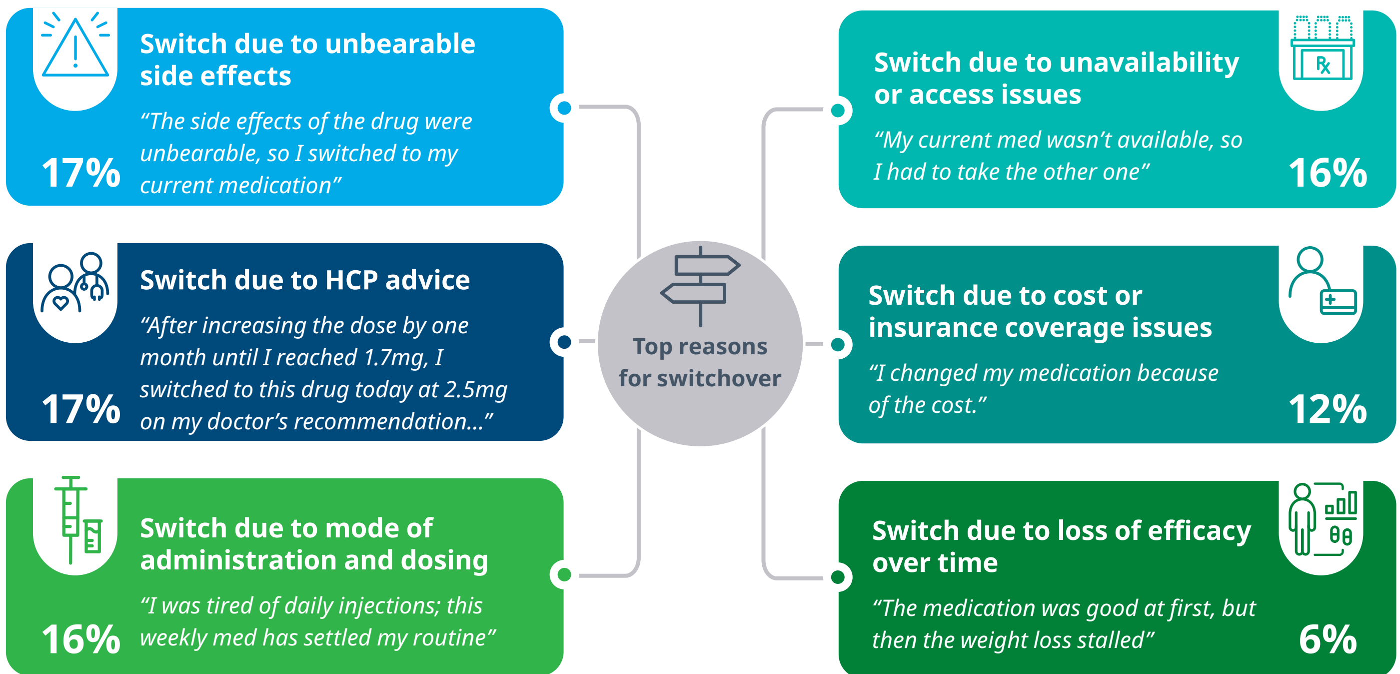
Injection

Pharmacists identify injectable formulations as a psychological barrier for a subset of patients, potentially limiting treatment initiation. The anticipated entry of oral options is expected to lower this barrier, enabling uptake among new patient segments and prompting some existing patients to switch formulations, thereby expanding the overall treated population. However, pharmacists consistently note that as access broadens, the need for guidance and ongoing support at the pharmacy level will intensify, particularly in the absence of close physician oversight.[11]

2.4.6. DRIVERS OF MEDICATION SWITCH

Patients switch obesity medications not because they give up, but because they are trying to find a balance between efficacy, tolerability, access, and fear of running out of options. Based on real-world patient narratives, key drivers of medication switching behavior among patients using obesity medications include side effects, HCP advise, dosing burden, access and cost concerns, and perceived decline in efficacy over time.

Figure 4. Patients' reported top reasons for switch of obesity medication



Source: IQVIA Social Intelligence Analysis on Türkiye, March 2026 (*Based on sample analysis of 2,280 patient conversations. 348 data points relevant to the business questions.*)

2.4.7. LONG-TERM CONTINUATION AND MAINTENANCE

Sustaining long-term ideal weight remains a key challenge in obesity treatment, with many patients experiencing cycles of weight loss and regain. Long-term treatment continuation is influenced by multiple factors, including treatment cost, perceived effectiveness, side effects, and lifestyle compatibility. Patient concerns during the maintenance phase increasingly reflect emotional and behavioral dimensions that affect adherence.

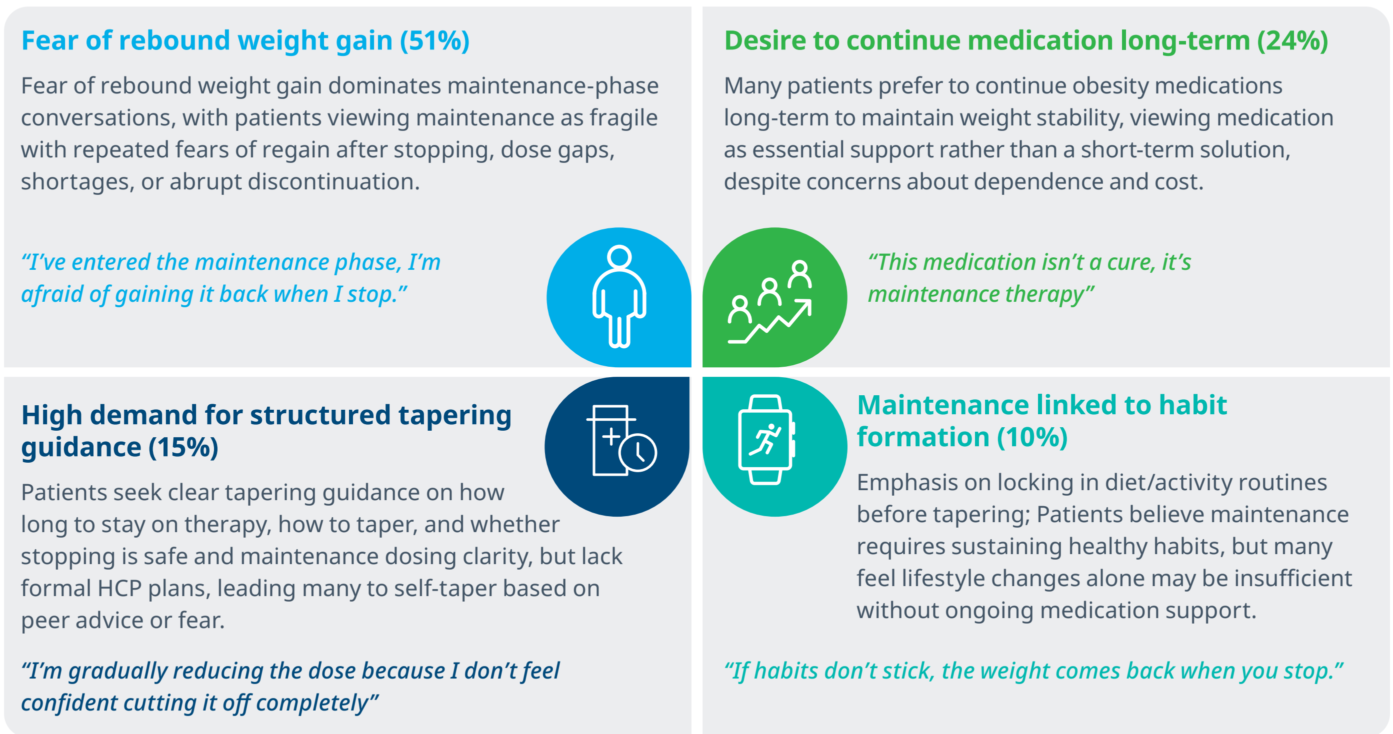
Although cost is rarely a barrier to initiation, financial stress often becomes more evident over time, particularly when weight loss slows or patients enter the maintenance phase. At this point, the question becomes: "How long can I sustain this?" Over time, the financial burden transforms into an emotional one, with patients expressing guilt over the cost and anxiety about long-term affordability.

Treatment modality also influences long-term perceptions. From the patient perspective, injections are often perceived as potent and clinically robust, while oral therapies are perceived as more acceptable for sustained use. Many patients conceptualize treatment as a staged journey, beginning with injectables for initial control and transitioning to oral options for longer-term maintenance.

Patient concerns observed during the maintenance phase, including fear of rebound weight gain, desire for long-term continuation, and demand for structured tapering guidance.[13]

From physicians perspective, long-term maintenance is more about sustaining achievable outcomes under real-world conditions. Physicians highlight that treatment interruption does not necessarily reflect loss of motivation, but rather practical constraints that accumulate over time. In this context, long-term obesity management is increasingly viewed as a dynamic process, where continuity, re-initiation, or adjustment of therapy may be required to support weight control across individual patient situations.

Figure 5. Expectations of patients during the maintenance phase



- ***Patients view maintenance as fragile and high-risk, with strong fear of rebound weight gain driving a preference for long-term medication continuation***
- ***Obesity medications are often seen as a supportive tool rather than a cure, while plateaus and regain after stopping reinforce discontinuation anxiety***
- ***Patients actively seek clarity on treatment duration, tapering, and maintenance dosing, but formal guidance is often lacking, leading to confusion and self-management***

Source: IQVIA Social Intelligence Analysis on Türkiye, March 2026 (*Based on sample analysis of 2,280 patient conversations. 353 data points relevant to the business questions.*)

2.4.8. UPCOMING CHANGE IN THE TREATMENT LANDSCAPE: ORAL FORMULATIONS

2026 is marking a major inflection point in global obesity medication accessibility and patient preference. After several years of injectable dominance, oral formulations are emerging as a game changer — not only because they eliminate the need for cold-chain storage, but also because they have the potential to improve adherence and unlock long-term maintenance opportunities.[14] Oral Wegovy, the first oral GLP-1 approved for obesity, was launched in the US in January 2026. Within the first eight weeks, the product accounted for roughly one-third of new-to-brand prescriptions. Additionally, about two-thirds of users are new to GLP-1 therapy, indicating an expansion in the overall market rather than primarily driving switches from injectables due to improved convenience and lower pricing. In parallel, Eli Lilly's orforglipron, entered the US market in April 2026, intensifying competition within oral GLP-1 class.[15]

The introduction of oral formulations in low and middle-income countries (LMICs) is expected to expand access to obesity therapies by improving affordability and reducing infrastructure dependencies. With more than one-third of clinical-stage assets focused on oral agents, these therapies offer the potential for clinically meaningful weight loss alongside greater patient convenience. Compared with injectable therapies requiring continuous cold-chain, oral formulations are more stable at room temperature, reducing logistical complexity and healthcare delivery costs. This is

particularly relevant in LMICs, where supply chain capacity and healthcare infrastructure may be variable, and where distribution to rural or underserved areas is often constrained.[6]

Based on Turkish physician insights, oral formulations are generally viewed as a complementary option rather than a replacement for injectable therapies. Awareness for upcoming oral therapies is present, particularly among core specialties, but detailed familiarity remains limited and is closely linked to real-world experience, efficacy data, and cost considerations. Physicians do not expect oral therapies to expand indications, but rather to be used within existing eligible patient groups.

The main perceived advantage is the removal of the injection barrier, particularly for patients with injection aversion and logistical challenges such as travel and cold-chain dependency. This may not always mean improved adherence, as physicians noting that daily dosing may create challenges for some patients compared to once-weekly injections. Some of the internists suggest oral therapies may primarily serve a small subgroup of injection-averse patients which are ~5–10% of patient population. Some anticipate modest increases in treated patients, while others note that meaningful expansion in treated patient pool depends largely on pricing, with the possibility of a substantial increase if affordability is achieved with oral options. Meaningful efficacy comparable to injectables and price advantages are expected to be the primary drivers of broader adoption of oral obesity medications.

Cardiologists view oral formulations as potentially improving adherence by reducing injection-related barriers, but express concerns regarding comparative efficacy versus injectables. They identify suitable use cases including injection fear, low adherence to injectables, BMI 27–30 populations, insulin resistance, and maintenance therapy, positioning oral agents more acceptable and practical alternative in these patient groups. Cardiologists also emphasize that cost will remain the dominant factor shaping uptake in potential patient groups.

FPs similarly recognize the practical advantages of oral formulations, particularly ease of use during travel,

but caution that daily dosing may not translate into improved adherence for all patients, especially those already managing high medication burdens. Some FPs highlight that some patients take 5–10 medications per day, and that introducing an additional daily pill could further compromise adherence. Accordingly, they suggest that meaningful uptake would depend primarily on clear cost advantages, with some indicating that substantial price reductions could significantly expand patient adoption, in line with other specialist opinions.

Overall, while oral therapies are seen as improving accessibility by addressing injection-related and logistical barriers, physicians consistently highlight cost, patient behavior, and regimen burden as key determinants of real-world adoption. Physicians also expect that side-effect management will remain a key aspect of obesity care following the introduction of oral therapies.

At a broader level, GLP-1 therapies have transformed the obesity treatment paradigm, shifting management from a predominantly lifestyle and surgery-based approach to one that includes pharmacological interventions capable of achieving more than 10-15% weight loss in clinical trials. In Türkiye, this therapeutic evolution has followed a similar trajectory but remains at an early stage of market development for pharmacologic obesity treatments. The landscape is expected to continue evolving with the anticipated entry of oral and generic options in the near future.

3. Obesity market dynamics

3.1. GLP-1 therapies: Market formation

The emergence of GLP-1 therapies represents a major inflection point in the treatment of obesity. Globally, these therapies are transforming obesity management from a lifestyle-focused approach into a pharmacologically treatable chronic condition. GLP-1 therapies were originally developed and approved as treatments for type 2 diabetes mellitus, due to their ability to improve glycemic control and stimulate insulin secretion. Over time, clinical trials demonstrated significant weight-loss effects associated with these therapies, which led to their repositioning as pharmacological treatments for obesity and chronic weight management. The therapeutic class includes agents such as liraglutide, semaglutide and tirzepatide, which act by mimicking endogenous incretin hormones that regulate appetite, satiety, and glucose metabolism. Their mechanism of action reduces caloric intake by delaying gastric emptying and suppressing appetite signals in the brain.

Obesity medicines have been integrated into the toolbox of solutions to address obesity, with their supply and use mostly confined to high-income countries where access is largely through out-of-pocket payments or very restrictive reimbursement policies. As a result, these therapies are usually only accessible to higher-income population segments.[6]

3.1.1. GLP-1 THERAPIES IN THE TURKISH PHARMACEUTICAL MARKET

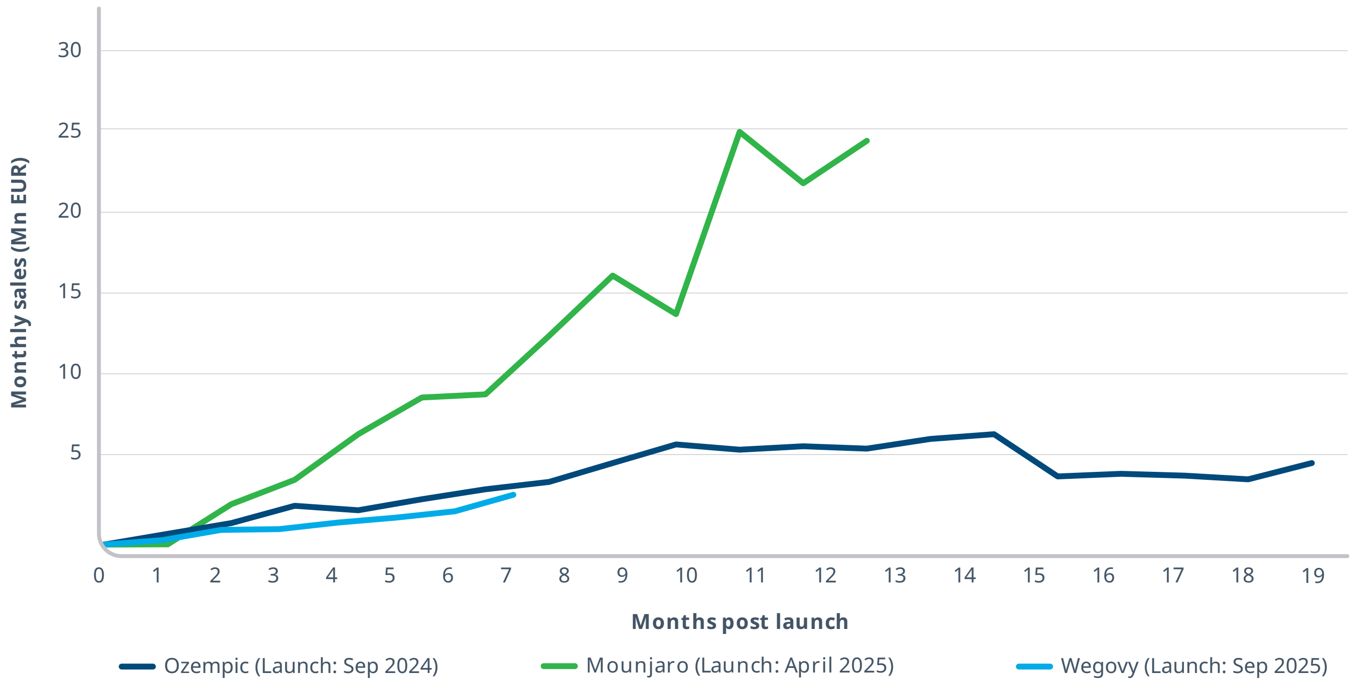
Growing public awareness of weight-loss medications and widespread discussion on social media platforms have accelerated interest in GLP-1 therapies. Demand for so-called “weight-loss injections” has increased significantly in Türkiye in recent years, particularly in large metropolitan areas. The perception of GLP-1 therapies has gradually shifted from a niche diabetes therapy to a mainstream metabolic health intervention, with increasing attention from physicians and patients. Also, the insights derived from social intelligence analysis illustrate the rapid transition of GLP-1 therapies into a consumer-driven treatment category.

Table 1. GLP-1 treatments with market authorization in Türkiye

MOLECULE	BRAND NAME	COMPANY	INDICATION	MA	LAUNCH
Exenatide	Byetta	Astrazeneca	Type 2 diabetes	Jul 2008	Feb 2010
Liraglutide	Victoza	Novo Nordisk	Type 2 diabetes Reduce the risk of major CV events	Oct 2012	Aug 2014
Liraglutide	Saxenda	Novo Nordisk	Weight management	June 2017	Apr 2018
Dulaglutide	Trulicity	Lilly	Type 2 diabetes	Jan 2018	Mar 2018
Semaglutide	Ozempic	Novo Nordisk	Type 2 diabetes Reduce the risk of major CV events	May 2022	Sep 2024
Semaglutide	Wegovy	Novo Nordisk	Weight management	Dec 2023	Sep 2025
Tirzepatide	Mounjaro	Lilly	Type-2 diabetes mellitus Weight management	Aug 2024	Apr 2025

Figure 6 shows the uptake of new generation GLP-1 therapies in Türkiye following launch, particularly for Mounjaro, which demonstrated a steep growth trajectory and reached EUR 24.6 million monthly sales in March 2026, after a year of its launch. Fast uptake of Mounjaro suggests continued patient interest and expanding treatment adoption in obesity landscape in Türkiye.[16]

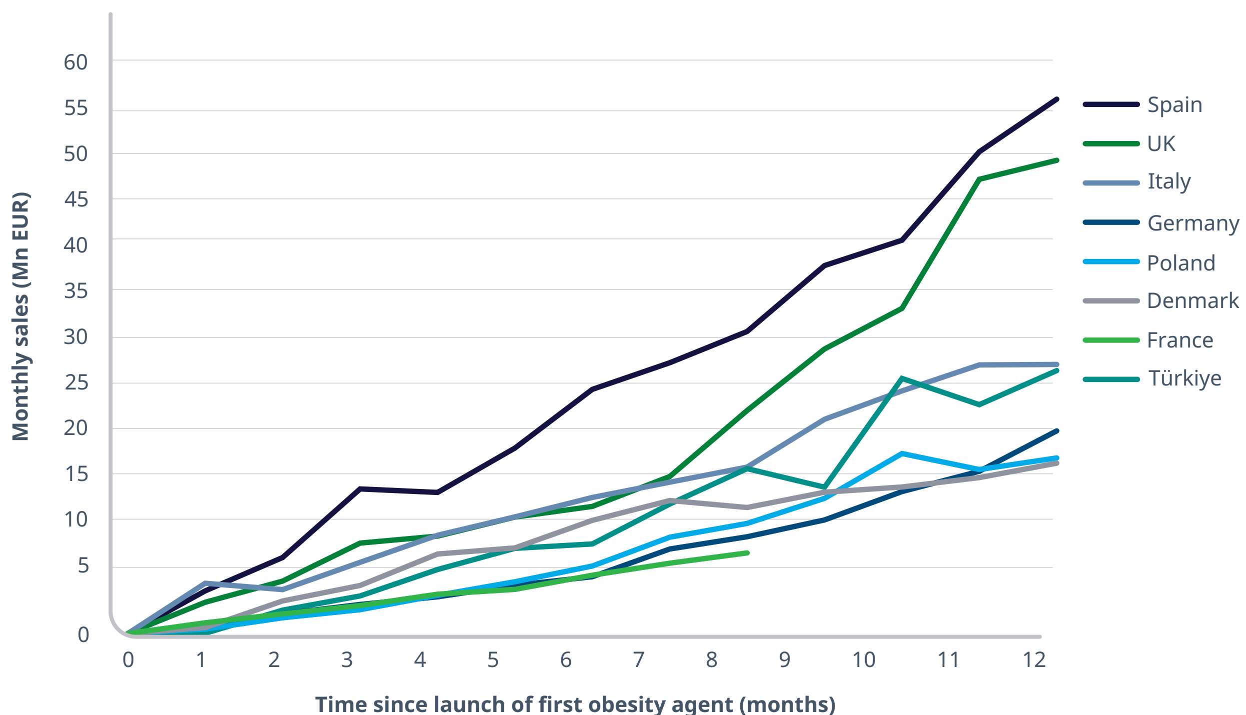
Figure 6. Monthly sales during post-launch for selected GLP-1 agents in Türkiye



Source: IQVIA Türkiye Retail Hospital Database (Sales in manufacturer prices), IQVIA analysis

Figure 7 demonstrates a comparison of the launch trajectory of leading new generation obesity medications Wegovy and Mounjaro across selected European countries. Looking at the sales uptake of Mounjaro and Wegovy, both launched in Türkiye over the past year, uptake has been strong and comparable to levels observed in developed European private markets.

Figure 7. Private market sales for Wegovy and Mounjaro by country



Source: IQVIA analysis

3.1.2. Brand awareness for obesity medications in Türkiye

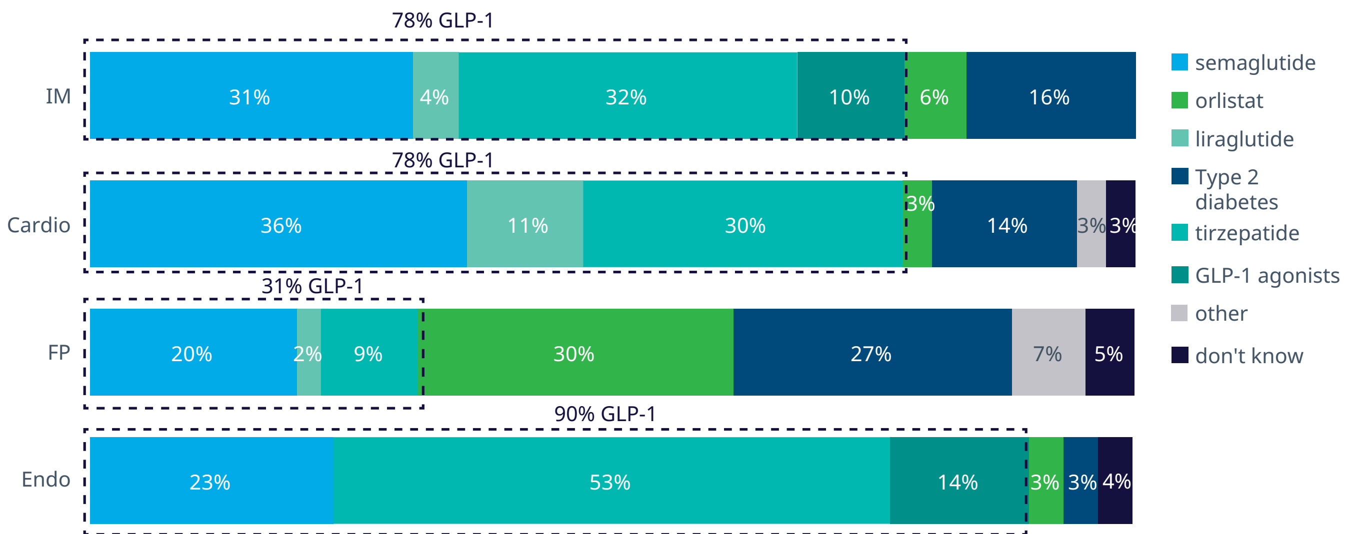
In Türkiye, commonly recognized treatment options include Mounjaro, Ozempic and Wegovy. Brand perceptions are primarily shaped by patient satisfaction and tolerability, which serve as key determinants of prescribing preference.

Top-of-mind awareness

Top-of-mind awareness of obesity treatments is split between orlistat and GLP-1 agonists among FPs, whereas it is predominantly driven by GLP-1 agonists among specialists. IQVIA primary market research was conducted through a total of 220 interviews across four specialities internal medicine, cardiology, family physician and endocrinology. When physicians were asked considering currently available treatments in obesity landscape which drugs/molecules come to mind at first question, it is seen that GLP-1 based treatments predominantly are recalled in all specialties except FPs. One third of FPs both recall orlistat and as a with similar ratio, it's GLP-1 agonists. Both semaglutide and tirzepatide are the most frequently cited GLP-1 molecules across internists and cardiologists, while half of endocrinologists have tirzepatide top of mind.

Most physicians name the brand name as top of mind, rather than molecule name. Across internists, cardiologists and endocrinologists, Mounjaro leads top of mind recall, whereas among FPs, Ozempic and metformin are more commonly first mentioned.

Figure 8. Top of mind awareness (first mention) by drug classes/molecules



Others = Non pharmacological treatment

Type 2 diabetes treatments refer to pharmacological treatments used in the management of type 2 diabetes include metformin, insulin therapies, SGLT2 inhibitors, and DPP-4 inhibitors.

Insights area

- Both semaglutide and tirzepatide are the most frequently cited GLP-1 agonists across internists and cardiologists.
- Half of endocrinologists have tirzepatide as top of mind molecule.

Source: Primary market research with HCPs, IQVIA

3.2. Future outlook for obesity market

GLP-1 therapies represent one of the fastest-growing segments in the pharmaceutical industry both globally and in Türkiye. The rapid market expansion is driven by rising obesity prevalence, increasing recognition of obesity as a chronic disease, clinical experience associated with GLP-1 therapies, and expansion into additional indications such as cardiovascular risk reduction. These trends have positioned GLP-1 therapies as one of the most commercially transformative drug classes in pharmaceutical markets.

3.2.1. GLOBAL OBESITY MARKET FORECAST

The global obesity medicines market reached USD 66 billion in list-price sales in 2025 and is projected to grow to USD 92 billion in 2026. For 2027 onward, estimates range from USD 105 billion to USD 200 billion. 2026 is a changing year for the obesity treatment landscape, as the drivers of long-term, sustainable market growth become more clearly defined. Key developments shaping the sector include the oral therapies and the impact of off-patent semaglutide. Additionally, innovation is broadening the focus of obesity treatment beyond weight reduction alone, with growing emphasis on comorbidity outcomes, long-term weight maintenance, and preservation of muscle mass.[15]

3.2.2. TÜRKİYE PERSPECTIVE: GROWTH DRIVERS AND BARRIERS FOR GLP-1 MARKET

In Türkiye, the GLP-1 market is currently in an early adoption phase but characterized by growing awareness. Over the next decade, the trajectory of GLP-1 adoption will likely depend on regulatory approvals of new treatments (new agents, oral formulations, generic competition etc.), expansion of obesity treatment guidelines, changes in physician perception and prescription behaviour. No matter what, GLP-1 therapies are expected to play a key role in the future management of obesity in Türkiye. Although Türkiye currently represents a relatively small share of the global GLP-1 market, several factors suggest significant long-term growth potential.

Table 2. Growth drivers for GLP-1 market in Türkiye

Driver	Description
RISING OBESITY PREVALENCE AND LARGE POPULATION BASE	Türkiye already ranks among countries with the highest obesity prevalence globally. Looking ahead, obesity rates are projected to continue rising, with estimates suggesting that up to 55% of the adult population could be living with obesity by 2035. When combined with Türkiye's large adult population, this demographic trend translates into tens of millions of individuals potentially eligible for pharmacological obesity treatment.
INCREASING AWARENESS	Public awareness of GLP-1 medications has increased rapidly, largely driven by social media platforms, online health communities, and media coverage. The influence of digital platforms appears particularly strong, contributing to increased demand for weight-loss injections among urban populations.
RISING OUT-OF-POCKET SPENDING	While Türkiye is classified as an upper middle-income country overall, approximately 20–25% (considering upper and upper middle SEC groups) of the population belongs to higher-income segments, corresponding to more than 17 million individuals. Over recent years, out-of-pocket healthcare spending has increased, partly reflecting limited reimbursement for innovative therapies. According to the OECD, OOP payments account for roughly 17–18% of total health expenditure. This sizeable and affluent population segment accounts for a disproportionate share of OOP spending and demonstrates a higher willingness to pay for non reimbursed, innovative treatments, supporting the adoption potential of GLP-1–based obesity therapies, particularly among higher-income and urban populations.
EXPANSION OF TREATED PATIENTS DRIVEN BY ANTICIPATED PRICE REDUCTIONS	Future market expansion may be supported by patent expirations and the subsequent introduction of generic or biosimilar versions of GLP-1 therapies, which are expected to drive price competition. Price reductions following LoE may significantly expand access to GLP-1 treatments by enabling the inclusion of more price sensitive patient segments. In parallel, the introduction of oral GLP-1 formulations is likely to further enhance affordability and uptake by reducing treatment related costs and lowering barriers associated with injectable therapies, such as administration burden and patient reluctance. Together, price erosion post LoE and improved convenience through oral alternatives are expected to increase the number of treated patients and accelerate broader adoption of GLP-1–based obesity treatments over time.

Despite growing interest in GLP-1 therapies, access might remain constrained by several structural and economic factors. While awareness and demand for GLP-1 therapies are rising in Türkiye, access could remain constrained by reimbursement gaps, affordability concerns, evolving disease landscape and supply shortages.

Table 3. Current barriers for GLP-1 market in Türkiye

LACK OF PUBLIC COVERAGE	PRICE SENSITIVITY AND AFFORDABILITY CONCERNS	EVOLVING CLINICAL INFRASTRUCTURE AND PHYSICIAN AWARENESS	SUPPLY SHORTAGES
Like many healthcare systems globally, obesity medications are not reimbursed by public or private insurance programs in Türkiye. This creates a significant reliance on out-of-pocket spending, limiting access primarily to higher-income patients.	Lack of public coverage means patients must bear treatment costs themselves, making price sensitivity a key market constraint. GLP-1 medications could represent a substantial cost burden for patients paying out of pocket.	Pharmacological obesity management is still an emerging field in Türkiye, and treatment guidelines and physician familiarity continue to evolve.	Although regulatory approvals have been granted for certain products, global demand for GLP-1 medications has led to supply shortages in several markets, which can affect distribution and widespread availability in Türkiye.

4. What to expect after Semaglutide's LoE?

The expiration of patents for certain GLP-1 therapies could significantly alter prescribing dynamics. Generic competition is expected to reduce treatment costs and expand patient access, particularly for price-sensitive patients. Lower prices may also increase physicians' willingness to prescribe pharmacological obesity treatments earlier in the patient journey rather than reserving them only for advanced disease stages. Price sensitivity and confidence in manufacturers are cited as key factors shaping future openness to generic alternatives. Pharmacists indicate that meaningful price differentiation would be required for generics to shift behavior, particularly among patients motivated by aesthetic outcomes, where brand loyalty is expected to remain stronger.

In 2026, Novo Nordisk's semaglutide will lose exclusivity in several key markets — including Brazil, Canada, China, India, and Türkiye – where about a third of the world's adults with obesity are currently located. The entry of generic competitors (notably from India and China) is expected to drive down costs significantly, improving affordability and access to these therapies in many low-middle income countries.[6] Following the expiration of Novo Nordisk's semaglutide patent in India on March 2026, several domestic manufacturers — including Natco, Sun Pharma, Dr. Reddy's, Zydus, and Eris — launched generic versions for obesity and comorbidities, type 2 diabetes and MASH, and are available across multiple forms such as oral tablets, vials, prefilled and reusable pens. While Novo Nordisk implemented price reductions ahead of loss of exclusivity, generic manufacturers positioned their products at 20–40% discounts versus the innovator significantly intensifying price competition and expanding patient access.

Semaglutide's LoE in Türkiye holds the potential to transform obesity care into a more sustainable chronic disease management model. Future price reductions following generic entry could expand treatment access to more price-sensitive patient groups. However, realizing this potential depends not only on price reductions but also on ensuring continuity of care, structured guidance, and an improved patient experience. Social intelligence insights suggest that semaglutide's LoE is not primarily seen as a price event, but as a psychological and structural turning point. Patients are not asking "Will I start?" but rather "How far can I continue?"

LoE's primary impact will be enabling long-term treatment continuation, not just expanding initial access. Generic semaglutide is not perceived as a downgrade. Instead, it is framed as relief from monthly moral accounting and freedom to plan life without constant financial calculations. Trust in generics is conditional on physician endorsement and system-level support.

Physicians' perspectives on generics in obesity: Trust, experience, and cost as key drivers
Physician views on the anticipated entry of generics into the obesity treatment landscape are broadly cautious yet pragmatic, shaped by the complexity of treatment, trust in manufacturers, and strong cost pressures. Across specialties, injectable GLP-1 therapies are regarded as more sensitive than conventional therapies, leading to higher expectations for evidence and reliability. Confidence in generics is primarily driven by demonstrated bioequivalence, company credibility, clinical experience, peer validation, and patient outcomes.

Endocrinologists show the highest level of awareness, particularly regarding off-patent semaglutide, while maintaining a cautious stance. Their prescribing behavior reflects mixed prior experiences with generics in other areas — less favorable in antibiotics but more positive in oral diabetes therapies. In obesity care, they emphasize the need for generics to be as similar as originals, especially for injectable formulations. At the same time, they recognize the potential of generics to significantly expand access in a high-prevalence, price-sensitive market such as Türkiye, with expectations of substantial patient growth if meaningful cost reductions are realized.

Internists demonstrate relatively moderate awareness on LoE, perceiving generics as a way to improve accessibility. Physicians' confidence could be influenced by company reputation, regulatory oversight by the Ministry of Health, and early patient feedback. An increased uptake is anticipated, particularly among younger patients, with overall treatment volumes rising under lower-cost scenarios. Cardiologists could take a more conditional approach, prioritizing proven efficacy, bioequivalence, and production by trusted companies with established cardiovascular portfolios. While acknowledging that some patients may continue to prefer originator brands, they expect generics to play a key role in improving access, with cost reductions likely to drive a meaningful increase in prescribing. FPs demonstrate lower awareness but frame GLP-1 therapies as advanced biotechnology treatments, contributing to a more cautious approach. Their prescribing decisions rely heavily on clinical experience and peer guidance. Nevertheless, they also highlight the high price sensitivity of obesity care and expect improved affordability to gradually increase the number of patients receiving treatment, even if initial preference for originators persists.

Overall, the adoption of generics in obesity treatment is expected to be gradual and trust-based, with affordability acting as the primary catalyst. Lower-cost alternatives are likely to expand access significantly, while clinical confidence and real-world experience will determine the pace and extent of uptake. Physicians anticipate a meaningful expansion of the treated population following generic entry with some expecting moderate patient volumes to double under favorable and affordable pricing conditions.

Explanations

The study employed a hybrid research design, integrating quantitative, qualitative, and social media intelligence methodologies to generate a comprehensive multi-stakeholder view of obesity management in Türkiye.

The quantitative phase included a total of 220 physicians across four specialties: Internists (n=68), Cardiologists (n=36), Family Physicians (n=86), and Endocrinologists (n=30). All participants reported actively managing patients with overweight (BMI 25–29.9) and obesity (BMI ≥30) within the preceding month. Data were collected through a 10-minute online survey conducted between 14 January and 15 February 2026. The survey captured information on total and obesity-related patient load, active pharmacological obesity management, treatment awareness (top-of-mind and spontaneous), brand familiarity, and key information sources related to the obesity treatment landscape.

The qualitative phase consisted of in-depth/online interviews lasting approximately 60 minutes each. Interviews were conducted with physicians actively managing patients with obesity across Endocrinology (n=3), Internal Medicine (n=3), Cardiology (n=2), and Family Physicians (n=3). In addition, pharmacy perspectives were captured through interviews with Independent Pharmacies (n=3) and Key Opinion Leader (KOL) Pharmacies (n=3). In total, 17 qualitative interviews were completed. Fieldwork for the qualitative phase took place between 16 February and 17 March 2026. Discussions explored clinical and pharmacy-level perspectives on obesity management, treatment approaches and stakeholder roles in the obesity care pathway.

In parallel, a social media intelligence analysis was conducted using a validated obesity and weight management keyword taxonomy to extract relevant conversations from Türkiye on February 2026. A total of 6,789 conversations were screened, with insights derived from 2,280 patient and caregiver conversations. Analysis focused on identifying patient perspectives, treatment experiences, and emerging themes aligned with the study objectives.

For detailed insights derived from primary market research interviews with healthcare professionals and social intelligence analyses, please contact the authors.

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Abbreviations

ABBREVIATION	FULL FORM
BMI	Body Mass Index
Cardio	Cardiologist
Endo	Endocrinologist
FP	Family Physician
GLP-1	Glucagon-Like Peptide-1
HCP	Healthcare Professional
HYP	Disease Management Platform
IM	Internal Medicine
LMIC	Low-middle-income Country
LoE	Loss of Exclusivity
MA	Market Authorization
MASH	Metabolic Dysfunction-Associated Steatohepatitis
MHRS	Central Physician Appointment System
MoH	Ministry of Health
NCD	Non-communicable Disease
OECD	Organization for Economic Co-operation and Development
OOP	Out-of-Pocket
SEC	Socio-Economic Class
SUT	Health Implementation Communiqué
TNHS	Türkiye Nutrition and Health Survey
WHO	World Health Organization

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