

Patterns of Obesity Management and Use of Lifestyle Interventions in Primary Care: A Narrative Review with Focus on Qatar

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Abstract

Review Article

Background: Obesity is a chronic, relapsing, multifactorial disease that places a substantial burden on health systems worldwide and is highly prevalent in Gulf countries, including Qatar. Primary care is strategically positioned to identify excess adiposity, assess obesity-related risk, initiate lifestyle treatment, coordinate multidisciplinary care, and provide longitudinal follow-up. **Objective:** This narrative review examines contemporary patterns of obesity management in primary care, with particular attention to lifestyle interventions, structured programmes, pharmacotherapy, implementation barriers, and the evolving model of obesity care in Qatar. **Methods:** A focused narrative synthesis was undertaken using recent international guidelines, national policy documents, systematic reviews, and primary-care literature relevant to adult overweight and obesity. Particular emphasis was placed on evidence and guidance published from 2023 to 2026 and on sources describing Qatar's primary healthcare system. **Results:** Current evidence supports comprehensive lifestyle intervention as the foundation of obesity care. Effective programmes combine individualized dietary energy reduction, progressive physical activity, behavioural strategies, goal setting, self-monitoring, and repeated follow-up. Brief primary-care counselling can facilitate behaviour change, but isolated advice is generally less effective than structured, intensive, multidisciplinary support. Qatar has developed Healthy Lifestyle clinics, Wellness Centres, health-coaching services, and national clinical guidance, yet implementation challenges remain, including time constraints, variable referral uptake, cultural and language considerations, and the need to integrate newer anti-obesity medications within long-term care pathways. **Conclusion:** Obesity management in primary care should move beyond episodic advice toward a chronic-disease model that combines systematic identification, risk stratification, comprehensive lifestyle treatment, appropriate pharmacotherapy, structured referral, and longitudinal monitoring. Strengthening referral pathways, behavioural support, multidisciplinary coordination, and implementation of national strategy may improve obesity care in Qatar and similar healthcare systems.

Keywords: Obesity; overweight; primary care; lifestyle intervention; behavioural therapy; weight management; Qatar; pharmacotherapy.

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INTRODUCTION

Obesity has become one of the most consequential chronic diseases of the twenty-first century. The World Health Organization reports that the global prevalence of obesity has more than doubled since 1990 and that hundreds of millions of adults now live with obesity [3]. This growth reflects complex interactions among food environments, urbanisation, socioeconomic conditions, reduced occupational and transport-related physical activity, sleep and stress patterns, biological susceptibility, and commercial determinants of health. Obesity is associated with type 2 diabetes mellitus, hypertension, dyslipidaemia,

cardiovascular disease, obstructive sleep apnoea, osteoarthritis, several cancers, reproductive disorders, and impaired quality of life. The clinical burden therefore extends beyond body weight itself and requires a long-term, risk-based approach rather than episodic advice alone.

The Gulf Cooperation Council region has experienced particularly rapid increases in overweight and obesity in parallel with economic development, dietary transition, motorised transport, sedentary lifestyles, and climatic conditions that may discourage outdoor physical activity [4,5]. Qatar illustrates this

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challenge clearly. National data indicate a high prevalence of overweight and obesity among adults, and the associated economic burden is substantial [1,2,6]. Obesity prevention and treatment have consequently become central to national health planning, non-communicable disease control, and the organisation of primary healthcare services.

Primary care is uniquely positioned to address obesity because it provides repeated contact across the life course and allows weight-related care to be integrated with management of diabetes, hypertension, dyslipidaemia, cardiovascular risk, mental health, and other comorbidities. Primary-care clinicians can identify excess adiposity, assess complications and readiness for change, provide brief counselling, initiate or coordinate comprehensive lifestyle treatment, prescribe evidence-based pharmacotherapy when appropriate, and refer selected individuals for specialist or surgical assessment. The longitudinal nature of primary care also makes it suitable for relapse prevention and repeated re-engagement, both of which are essential in a chronic disease that commonly follows a fluctuating course.

Qatar has developed a number of service-level responses to this need. The Primary Health Care Corporation (PHCC) has established Wellness Centres, Healthy Lifestyle clinics, and Health Coach Clinics, while national clinical guidance provides recommendations for screening, lifestyle treatment, pharmacotherapy, and referral for bariatric surgery [7-10]. Despite these developments, the central implementation question remains how consistently evidence-based interventions are translated into routine clinical practice. This review synthesizes current knowledge on obesity management in primary care, focusing on lifestyle intervention, structured programmes, medication, barriers to implementation, and opportunities to strengthen the care pathway in Qatar.

OBJECTIVES OF THE REVIEW

The primary objective of this narrative review is to describe contemporary evidence-based approaches to the management of overweight and obesity in adult primary care, with emphasis on the practical use of dietary intervention, physical activity, behavioural therapy, structured lifestyle programmes, and pharmacotherapy. The review also considers the role of primary-care clinicians in screening, risk stratification, referral, longitudinal follow-up, and coordination with multidisciplinary services.

A secondary objective is to examine the relevance of this evidence to the Qatari healthcare context. Particular attention is given to national obesity guidance, PHCC lifestyle and wellness services, barriers that may affect implementation, and health-system strategies that can improve continuity between routine

primary-care counselling and more intensive obesity treatment.

REVIEW METHODOLOGY

This article was developed as a narrative review rather than a systematic review or meta-analysis. A focused synthesis was undertaken using the clinical guidelines, national reports, systematic reviews, and peer-reviewed studies identified for the topic of obesity management in primary care. Priority was given to recent sources, particularly those published from 2023 to 2026, while earlier concepts were incorporated where they remained consistent with current guidance. Sources were selected for their relevance to adult overweight and obesity, lifestyle treatment, primary-care delivery, pharmacological management, and the healthcare context of Qatar and the Gulf region.

The evidence was organized thematically around: the burden of obesity; the role of primary care; assessment and risk stratification; dietary intervention; physical activity; behavioural treatment; structured lifestyle services; pharmacotherapy; barriers to care; implementation strategies; and priorities for future research. Because the review was narrative, no pooled effect estimate was calculated and no formal risk-of-bias meta-analysis was undertaken. The purpose is therefore interpretive and practice-oriented: to integrate guidance and recent evidence into a coherent framework for primary-care obesity management rather than to provide a quantitatively exhaustive evidence synthesis.

OBESITY AS A CHRONIC DISEASE IN PRIMARY CARE

Contemporary obesity care increasingly treats obesity as a chronic, relapsing disease rather than as a simple consequence of individual behaviour. This conceptual shift has important consequences for clinical practice. It reduces reliance on one-time advice, acknowledges biological adaptation that can promote weight regain, and supports ongoing treatment intensity according to clinical risk and response. The primary-care pathway should therefore resemble the management of other chronic conditions: identify the condition, assess complications, define therapeutic goals, initiate treatment, monitor response and adverse effects, escalate therapy when needed, and maintain long-term follow-up.

Body mass index (BMI) remains the most widely used screening metric, but BMI alone does not fully describe cardiometabolic or functional risk. Clinical assessment should consider waist circumference where appropriate, blood pressure, glycaemic status, lipid profile, liver disease risk, sleep-related symptoms, mobility, reproductive health, medications associated with weight gain, eating patterns, psychological factors, and the presence of obesity-related complications. The severity and urgency of treatment are influenced not only by the degree of adiposity but also by comorbidity burden, functional impairment, previous treatment

attempts, patient preferences, and access to appropriate services [9,17,19].

Communication style is also clinically relevant. Weight stigma can reduce engagement, delay care-seeking, and undermine the therapeutic alliance. Primary-care teams should use respectful, person-centred language, ask permission before discussing weight, and emphasize health goals, functional improvement, and risk reduction rather than appearance. Shared decision-making is particularly important because treatment options differ in intensity, cost, expected benefit, adverse effects, and long-term commitment.

LIFESTYLE INTERVENTION AS THE FOUNDATION OF TREATMENT

Comprehensive lifestyle intervention remains the foundation of obesity management across major clinical guidelines [9,15,17,19]. However, “lifestyle advice” should not be equated with a brief generic recommendation to eat less and exercise more. Effective intervention is structured, individualized, behaviourally informed, and repeated over time. Its core components are dietary modification, physical activity, behavioural strategies, and ongoing monitoring. The intensity of contact and the degree of multidisciplinary input generally increase with obesity severity, associated complications, previous treatment failure, and the complexity of psychosocial barriers.

A realistic primary-care goal is often an initial clinically meaningful reduction in body weight accompanied by improvement in metabolic health, physical function, or quality of life. Even when large weight loss is not achieved, dietary quality, physical activity, sleep, and cardiometabolic risk factors can improve. Treatment goals should therefore include both weight-related and non-weight outcomes. Periodic review is essential because an intervention that is acceptable and effective at one stage may become less suitable as health status, medications, work patterns, family responsibilities, or motivation change.

DIETARY INTERVENTIONS

Dietary therapy aims to create a sustainable energy deficit while preserving nutritional adequacy and aligning the eating pattern with medical conditions, culture, preferences, and household context. Reviews of lifestyle prescription commonly describe an individualized energy deficit of approximately 500-750 kcal per day as a practical framework for weight reduction, although rigid calorie targets are not necessary for every patient [15]. The quality of the diet is also important. Dietary patterns emphasizing vegetables, fruits, whole grains, legumes, lean protein, minimally processed foods, and appropriate portion control can improve cardiometabolic health even when weight loss is modest.

No single dietary pattern is universally superior for all individuals. Lower-carbohydrate, lower-fat, Mediterranean-style, higher-protein, and other structured approaches can be effective when they produce sustained energy reduction and are acceptable enough to maintain. In primary care, the most useful strategy is often to identify a small number of high-impact dietary behaviours: frequent sugar-sweetened beverages, large portions, energy-dense snacks, fast-food consumption, irregular meal timing, or excessive intake of refined carbohydrates and saturated fat. Practical substitutions and environmental restructuring may be more sustainable than highly restrictive plans.

In Qatar and other Gulf settings, dietary counselling should take account of local food culture, social eating, hospitality practices, Ramadan and other religious observances, family meal structures, and the widespread availability of calorie-dense restaurant food. Dietitian referral can be particularly valuable for individuals with diabetes, dyslipidaemia, renal disease, gastrointestinal disorders, pregnancy planning, or repeated unsuccessful self-directed dieting.

PHYSICAL ACTIVITY AND REDUCTION OF SEDENTARY BEHAVIOUR

Physical activity contributes to weight management by increasing energy expenditure, preserving cardiorespiratory fitness and muscle function, improving insulin sensitivity, and supporting long-term weight maintenance. Exercise alone often produces less weight loss than dietary energy reduction, but its broader health effects are substantial. For many adults, a progressive combination of aerobic activity and resistance training is appropriate, with intensity adapted to baseline fitness, age, musculoskeletal limitations, cardiovascular risk, and personal preference [15,17].

Primary-care counselling should translate general recommendations into an achievable progression. For a sedentary individual, the initial goal may be regular walking, breaking up prolonged sitting, and increasing daily steps before advancing toward guideline-level moderate-intensity activity. Resistance exercise is particularly important for preserving lean mass during weight loss and for older adults. Referral to physiotherapy, exercise specialists, or supervised programmes may be required when pain, deconditioning, disability, or fear of injury limits independent activity.

Environmental barriers are highly relevant in Qatar, where extreme heat during parts of the year can limit outdoor activity. Indoor walking venues, gyms, Wellness Centres, home-based exercise, mall walking, and structured supervised sessions can provide alternatives. Health systems can improve adherence by matching physical-activity prescriptions to the patient's actual environment rather than relying on generic advice.

BEHAVIOURAL THERAPY AND SELF-MANAGEMENT SUPPORT

Behavioural therapy links dietary and physical-activity goals to the routines, cues, emotions, and environments that shape daily behaviour. Core strategies include goal setting, self-monitoring, stimulus control, problem solving, relapse planning, motivational interviewing, feedback, and social support [15,17]. These elements distinguish comprehensive lifestyle treatment from simple health education. Self-monitoring of weight, food intake, physical activity, or specific target behaviours can increase awareness and allow timely adjustment of the treatment plan.

Primary-care clinicians do not need to provide a full behavioural programme during every consultation. Brief interventions can identify readiness, agree on one or two specific goals, and arrange follow-up. More intensive behavioural work can then be delivered by trained nurses, dietitians, health coaches, psychologists, or multidisciplinary obesity services. The key is continuity: advice is more likely to translate into durable behaviour change when patients receive reinforcement, troubleshooting, and reassessment rather than a single counselling episode.

Stress, sleep disturbance, depressive symptoms, emotional eating, and family dynamics may interfere with weight management. These factors should be assessed when progress is limited. Where clinically indicated, treatment may require integration with mental-health services, sleep assessment, or family-based support. Such integration is particularly important because repeated “non-adherence” may actually reflect unaddressed psychological, environmental, or socioeconomic barriers.

STRUCTURED LIFESTYLE PROGRAMMES AND MULTIDISCIPLINARY CARE

Structured lifestyle programmes offer a mechanism for delivering higher-intensity treatment than is usually possible within a standard primary-care consultation. They can combine dietetic care, exercise supervision, behavioural support, risk-factor monitoring, and regular follow-up. Systematic review evidence indicates that primary-care-based weight-management interventions can achieve clinically meaningful weight reduction, especially when programmes provide repeated contact and structured behavioural support [13,14].

Qatar has developed service models that are well suited to this approach. PHCC Wellness Centres and Healthy Lifestyle clinics provide access to multidisciplinary lifestyle intervention, while Health Coach Clinics can support ongoing behaviour change and continuity after referral [7,8]. These services create an escalation pathway from routine primary-care counselling to more intensive intervention. Their potential impact depends, however, on consistent

eligibility criteria, clinician awareness, timely referral, patient uptake, and communication back to the referring primary-care team.

Referral alone should not be considered the endpoint of care. A high-quality pathway includes confirmation that the patient was contacted, attendance tracking, shared care plans, feedback on progress, and a clear route for re-referral or escalation. Digital support, telephone follow-up, text reminders, and telehealth may reduce practical barriers and allow programmes to maintain contact with individuals who cannot attend frequent in-person sessions.

PHARMACOTHERAPY IN PRIMARY-CARE OBESITY MANAGEMENT

Pharmacotherapy is increasingly important in obesity treatment and should be viewed as an adjunct to, not a substitute for, comprehensive lifestyle management. Current guidance generally considers anti-obesity medication for adults who meet BMI and comorbidity thresholds after individualized clinical assessment, particularly when lifestyle intervention alone has not produced sufficient benefit or when the degree of obesity-related risk justifies earlier escalation [17-19]. Choice of medication should consider expected efficacy, contraindications, adverse effects, interactions, comorbidities, reproductive plans, cost, availability, and patient preference.

The therapeutic landscape has changed rapidly with the availability of incretin-based agents that can produce substantially greater average weight loss than older medications. Their use has increased the need for primary-care clinicians to understand appropriate selection, dose escalation, gastrointestinal adverse effects, gallbladder and pancreatitis precautions where relevant, the importance of maintaining protein intake and resistance exercise during weight loss, and the high likelihood of weight regain after treatment discontinuation. Medication therefore fits most logically within a chronic-care model with long-term monitoring rather than as a short course.

Metformin may contribute to modest weight reduction in selected patients, particularly in the presence of diabetes or insulin resistance, but it is not primarily an anti-obesity drug. Orlistat remains an established option but may be limited by gastrointestinal adverse effects and adherence. Newer agents can offer greater efficacy but also raise issues of cost, access, supply, long-term safety surveillance, and equitable prioritization. Qatar’s national obesity and diabetes guidance provides an important framework for integrating pharmacological treatment with lifestyle services and specialist referral [9,18,20].

BARIATRIC AND METABOLIC SURGERY: THE PRIMARY-CARE INTERFACE

Bariatric and metabolic surgery can provide substantial and durable weight loss and metabolic benefit for appropriately selected individuals with severe obesity. Although surgery is delivered in specialist settings, primary care has a central role in identifying candidates, optimizing comorbidities before referral, supporting informed decision-making, and providing long-term postoperative follow-up. Referral decisions should follow national or internationally accepted criteria and should consider both BMI and obesity-related disease burden [9,19].

Long-term follow-up after bariatric surgery includes nutritional supplementation, monitoring for micronutrient deficiency, assessment of gastrointestinal symptoms, medication review, reproductive counselling where relevant, and attention to psychological health and weight recurrence. Effective communication between bariatric services and primary care is therefore essential. A fragmented pathway can undermine the long-term benefits of surgery even when the procedure itself is successful.

BARRIERS TO EFFECTIVE OBESITY MANAGEMENT IN PRIMARY CARE

Implementation barriers occur at patient, clinician, service, and policy levels. Clinicians frequently report limited consultation time, competing

priorities, uncertainty about referral pathways, lack of training in behaviour-change techniques, and discomfort initiating conversations about weight. Qatar-based literature has also highlighted language barriers and gaps between knowledge and practice in dietary counselling [11,12]. These barriers may lead to under-documentation, inconsistent follow-up, and variation in the intensity of treatment offered.

Patients may face work demands, caregiving responsibilities, transportation limitations, cost, low confidence after previous weight-loss attempts, cultural expectations, limited access to healthy food or exercise environments, and stigma. Behavioural recommendations that ignore these constraints may be clinically sound in theory but ineffective in practice. The intervention therefore needs to be adapted to the person's living conditions, resources, schedule, family context, and health literacy.

At the health-system level, the most important gap is often the transition from identification to sustained treatment. Screening rates can be high while referral, programme attendance, medication follow-up, or long-term weight monitoring remain inconsistent. A successful obesity pathway requires explicit ownership of follow-up, shared documentation, clear escalation criteria, and performance measures that evaluate not only whether counselling occurred but whether patients actually gained access to effective ongoing care.

Table 1: Common barriers to obesity management and practical health-system responses

Level	Common barrier	Potential primary-care response
Patient	Time constraints, work demands, previous unsuccessful attempts, stigma, language or cultural mismatch	Flexible follow-up, culturally adapted counselling, health coaching, digital contact, realistic goal setting
Clinician	Short consultations, limited obesity training, therapeutic inertia, uncertainty about referral or medication	Clinical pathways, training, decision support, standardized documentation and referral tools
Service	Limited continuity between routine primary care and intensive services; missed referrals or follow-up	Closed-loop referral, shared care plans, attendance tracking, multidisciplinary case coordination
Environment	Heat, sedentary transport patterns, food environment, limited convenient activity options	Indoor activity options, home-based plans, community partnerships, environment-specific counselling
Policy/system	Variable access, cost, medication supply, insufficient outcome measurement	Equitable eligibility criteria, formulary planning, quality indicators, population-level monitoring

IMPLEMENTATION STRATEGIES FOR QATAR

Qatar's existing infrastructure provides a strong platform for strengthening obesity care. The National Health Strategy 2024-2030 and related action planning on obesity, diabetes, and modifiable cardiovascular risk factors emphasize prevention, screening, and coordinated management [10]. Translating these objectives into routine primary care requires standardized workflows that reduce reliance on individual clinician initiative.

Electronic medical records can support this process through automated BMI flagging, prompts for obesity-related risk assessment, standardized documentation templates, referral order sets, medication monitoring, and recall systems. Decision support should be concise enough to function within routine consultations. Referral criteria for Healthy Lifestyle clinics and Wellness Centres should be transparent and easy to apply, and referrals should ideally include structured clinical information so that multidisciplinary teams can tailor treatment efficiently.

Workforce development is equally important. Primary-care physicians, nurses, and allied-health professionals benefit from training in person-centred obesity communication, motivational interviewing, anti-obesity pharmacotherapy, and recognition of eating disorders or psychological barriers. Expanding health-coaching models can shift part of the behavioural workload away from short physician visits while maintaining continuity within the primary-care team.

Finally, programme evaluation should track clinically meaningful outcomes. Useful indicators

include the proportion of eligible individuals offered treatment, successful referral completion, retention in structured programmes, changes in cardiometabolic risk, medication persistence and adverse effects, patient-reported experience, and equity across nationality, language, sex, age, and socioeconomic groups. Such measures can identify where the pathway loses patients and where targeted quality improvement is most needed.

SUMMARY OF MAJOR PRIMARY-CARE INTERVENTIONS

Table 2: Summary of major obesity-management interventions in primary care

Intervention	Core components	Primary-care role	Key implementation considerations
Dietary intervention	Individualized energy reduction; improved dietary quality; portion control; culturally appropriate meal planning	Brief assessment, goal setting, dietitian referral, monitoring of cardiometabolic response	Sustainability, cultural practices, family context, comorbidities, food environment
Physical activity	Aerobic activity, resistance exercise, reduced sedentary time, progressive activity goals	Assess readiness and limitations; prescribe gradual progression; refer when supervision is needed	Heat and climate, pain, disability, access to indoor facilities, baseline fitness
Behavioural therapy	Self-monitoring, goal setting, problem solving, motivational interviewing, relapse planning	Provide brief behaviour-change support and link to health coaches or behavioural services	Requires repeated contact; address stress, sleep, emotional eating and social support
Structured lifestyle programmes	Multidisciplinary diet, exercise and behavioural treatment with repeated follow-up	Identify eligible patients, refer, track attendance, integrate feedback into ongoing care	Referral completion, programme retention, communication between services, digital follow-up
Pharmacotherapy	Evidence-based anti-obesity medication combined with lifestyle intervention	Select appropriate candidates; prescribe/monitor or coordinate specialist care	Contraindications, adverse effects, cost, supply, long-term treatment, weight regain after discontinuation
Bariatric/metabolic surgery	Specialist assessment and operative treatment for selected patients with severe obesity	Identify candidates, optimize comorbidities, provide long-term postoperative monitoring	Shared care, nutritional surveillance, micronutrient supplementation, psychological support

CLINICAL IMPLICATIONS

For clinicians, the central practical message is that obesity care should be staged according to clinical risk and treatment response. Routine visits provide opportunities to identify obesity, discuss health implications respectfully, screen for complications, and initiate focused behaviour change. Patients requiring greater intensity should move promptly into structured lifestyle programmes rather than receiving repeated low-intensity advice without escalation. Pharmacotherapy should be considered when guideline criteria are met and should be integrated with nutrition, physical activity, and behavioural support.

For primary-care organizations, continuity is as important as the content of the initial intervention. Care pathways should make it easy to move between primary care, dietetics, exercise services, health coaching,

specialist obesity clinics, and bariatric services. Shared documentation and planned follow-up can reduce duplication and improve accountability. The goal is not simply to record that weight was discussed, but to create a sustained therapeutic pathway that can adapt over time.

RESEARCH GAPS AND FUTURE DIRECTIONS

Several areas require further study in Qatar and the wider Gulf region. Large prospective studies are needed to determine which primary-care pathways achieve the best long-term weight, metabolic, functional, and patient-reported outcomes. Research should compare the effectiveness and cost-effectiveness of brief counselling, multidisciplinary lifestyle programmes, health coaching, digital interventions, pharmacotherapy, and combined treatment models in routine practice.

Implementation research is particularly important. Studies should examine referral completion,

programme retention, reasons for discontinuation, clinician adoption of guidelines, and the effect of electronic decision support. Cultural adaptation deserves attention, including language-specific counselling, family involvement, dietary traditions, gender-related preferences for exercise environments, and the impact of Ramadan on treatment planning. Equity should be evaluated explicitly so that services do not disproportionately benefit individuals with greater time, mobility, income, or health literacy.

The rapid expansion of incretin-based obesity pharmacotherapy also creates new research priorities. Real-world studies should evaluate long-term effectiveness, safety, persistence, weight regain after discontinuation, effects on body composition, integration with resistance training and dietary protein, and the budget impact of broad use within publicly funded systems. These questions are directly relevant to future obesity-service planning in Qatar.

LIMITATIONS OF THIS REVIEW

This narrative review has several limitations. It was designed as a focused, practice-oriented synthesis and did not use a formal systematic-review protocol, exhaustive database search, duplicate study selection, or quantitative meta-analysis. The available literature is heterogeneous in intervention intensity, populations, outcomes, and healthcare settings, which limits direct comparison across studies. Evidence specific to Qatar remains less extensive than the international obesity literature, and some service-level information is derived from policy documents and institutional sources rather than comparative trials. Rapid changes in obesity pharmacotherapy also mean that recommendations and availability may evolve after publication. Accordingly, the review should be interpreted as a synthesis of current guidance and recent evidence rather than as a definitive comparative effectiveness analysis.

CONCLUSION

Obesity management in primary care is most effective when it is organized as long-term chronic-disease care rather than a sequence of isolated counselling encounters. Comprehensive lifestyle treatment remains the therapeutic foundation and should combine individualized dietary change, progressive physical activity, behavioural strategies, goal setting, self-monitoring, and repeated follow-up. Brief physician counselling is valuable, but patients with greater clinical risk or insufficient response require timely escalation to multidisciplinary programmes and, when appropriate, pharmacotherapy or bariatric assessment.

Qatar has important structural assets for this model, including PHCC primary-care services, Healthy Lifestyle clinics, Wellness Centres, health-coaching capacity, national clinical guidelines, and a national strategy focused on obesity and cardiometabolic risk [7-10]. The next phase of improvement should emphasize

consistent referral pathways, stronger behavioural support, integration of modern anti-obesity medications, coordinated follow-up across services, and routine measurement of treatment access and outcomes. These changes can help convert obesity screening and counselling into a sustained, evidence-based treatment pathway capable of reducing long-term cardiometabolic burden.

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