



Nutritional Solutions
REGISTERED DIETITIANS

MODERN OBESITY MANAGEMENT

A practical toolkit for dietitians

Dr Monique Piderit

RD (SA) . PhD Dietetics . Nutritional Solutions, Johannesburg

Rediscover Dairy Evidence-Based Nutrition Forum . 2 October 2026

This information is intended for use by healthcare professionals only.



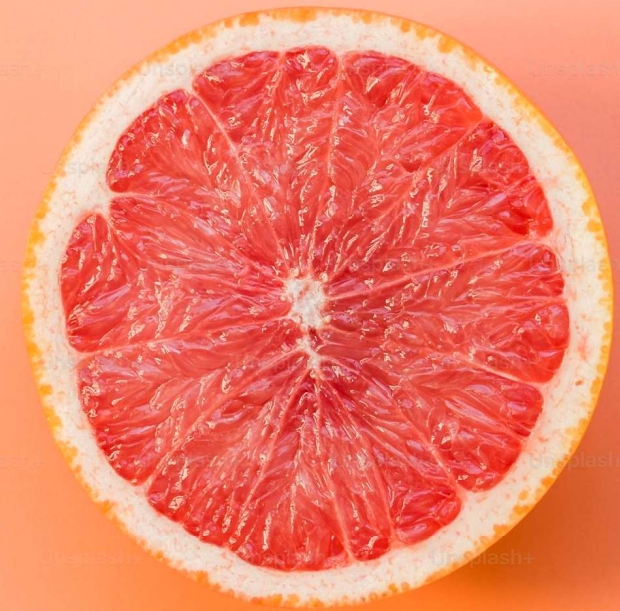
Disclaimer

The views, opinions and information presented in this presentation are those of the author/speaker and do not necessarily reflect the views or positions of Rediscover Dairy.

The content is provided for informational purposes only and should not be interpreted as an official Rediscover Dairy endorsement or statement.



Nutritional Solutions
REGISTERED DIETITIANS



What we will cover



1

How we used to think about weight

The old model, and why being incomplete is what fails patients.

2

Why obesity is more complex

Twelve drivers of weight, and why one prescription cannot serve everyone.

3

The modern obesity toolkit

Five tools, and how mature each one really is.

4

The dietitian's assessment toolkit

Eight domains, eight questions, and the two we skip most often.

5

From assessment to prescription

How what you find changes what you write down, in grams.

6

Where GLP-1s fit

What to do before, during and after, and when to refer.

SO WHAT? *Then: beyond the scale, a clinical case, and a one-page toolkit to take into your rooms on Monday.*

What should I do differently on Monday?

Not “why won’t this person lose weight?”

But “what is driving this person’s weight, and what do they need from me?”

You will leave with five tools. Do not write them down; they return assembled at the end.

1

**Driver
Wheel**

Twelve drivers, one patient

2

**Toolkit
Shelf**

Five tools, three not yet
ready

3

**8-Domain
Compass**

Eight domains, eight
questions

4

**Prescription
Ladder**

Driver to prescription in four
steps

5

**Health
Dashboard**

Six dials, one of them weight

SO WHAT? *Every slide from here answers one question: so what does this mean for me, in my rooms, tomorrow?*

01

HOW WE USED TO THINK ABOUT WEIGHT

What was the old model, and why is it incomplete?



This information is intended for use by healthcare professionals only.



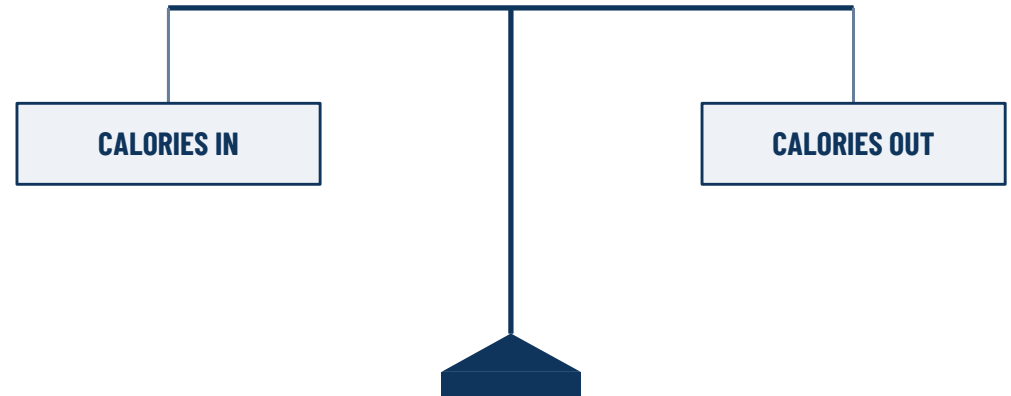
For forty years we treated weight as an arithmetic problem



CALORIES IN. CALORIES OUT.

Energy balance . willpower . adherence . the number on the scale

It is not wrong. It is incomplete, and incompleteness is what fails patients.



Theodorakis N, et al. Int J Mol Sci. 2024;25:13438.

This information is intended for use by healthcare professionals only.

Then the question changed



FROM

~~"Why won't this person lose weight?"~~

TO

"What is driving this person's weight, and what does this person need?"

The second question is answerable. The first one never was.

Rubino F, et al. Lancet Diabetes Endocrinol. 2025;13:221-62.

This information is intended for use by healthcare professionals only.

02

WHY OBESITY IS MORE COMPLEX

If not willpower, then what?

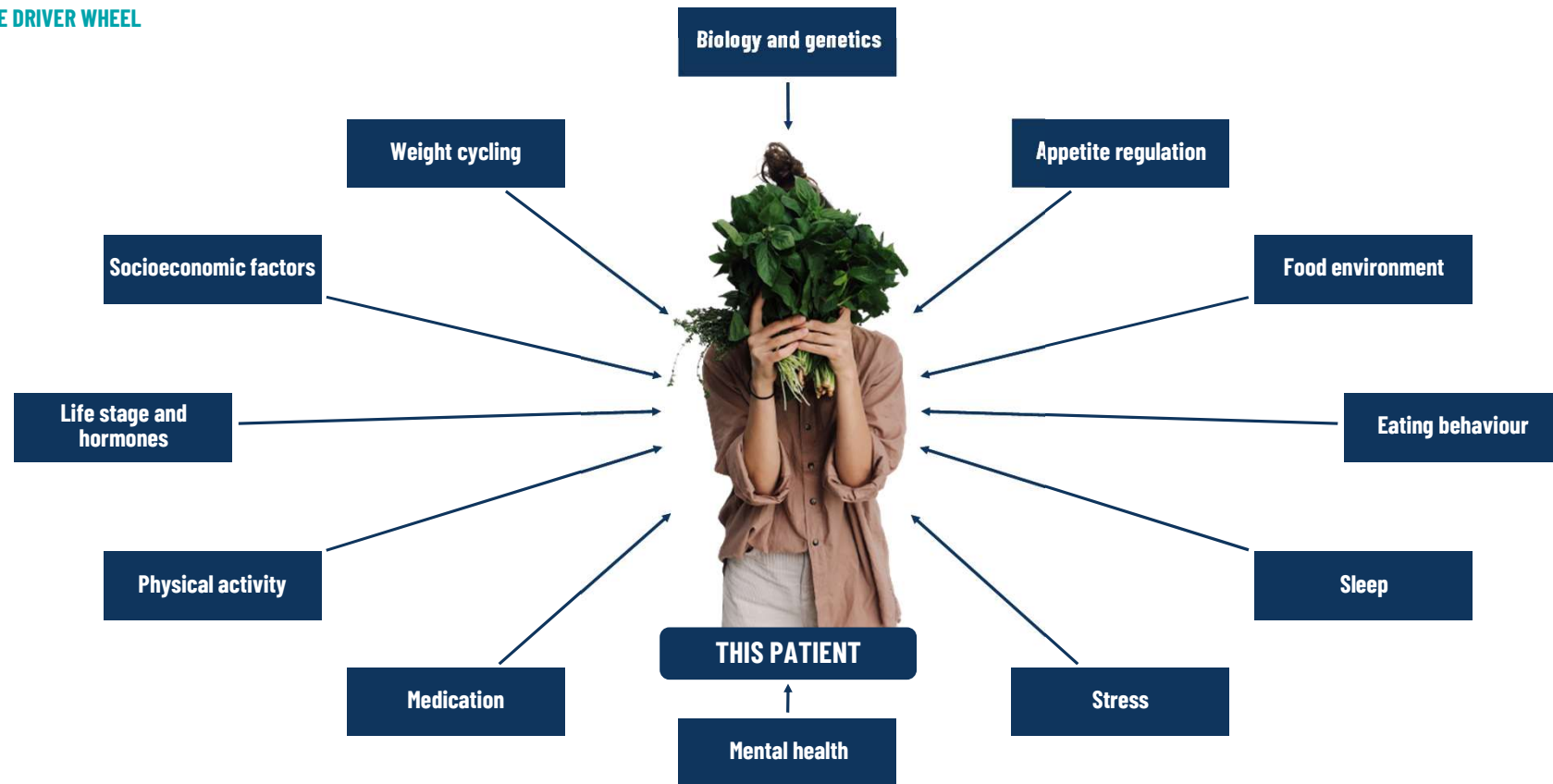


This information is intended for use by healthcare professionals only.



Twelve drivers. Every patient has a different dominant one.

FRAMEWORK 1. THE DRIVER WHEEL



SO WHAT? Same diagnosis, twelve different starting points. This is why one prescription cannot serve everyone.

Same BMI. Different disease.

Patient A		BMI 34 kg/m ²
WAIST	112 cm	
BLOOD PRESSURE	Treated, two agents	
HBA1C	6.3% (prediabetes)	
FUNCTION	Knee pain limits walking	
HISTORY	Three cycles of loss and regain	

Patient B		BMI 34 kg/m ²
WAIST	88 cm	
BLOOD PRESSURE	Normal, untreated	
HBA1C	5.2%	
FUNCTION	Runs twice a week	
HISTORY	Stable weight for eight years	

Meets criteria for CLINICAL obesity: adiposity plus organ and functional impairment.

Preclinical obesity: raised adiposity, no organ dysfunction.
Risk, not disease.

SO WHAT? Assess adiposity and organ function. A BMI category is a starting point, not a diagnosis.

Different drivers need different first moves



Appetite-driven

Satiety first: protein and fibre at every meal, and pharmacotherapy is genuinely on the table.



Environment-driven

Structure and access first: who shops, who cooks, what is in the house by Wednesday.



Sleep-driven

Fix sleep before you touch the meal plan. Six hours will undo a good prescription.

SO WHAT? *If you cannot name the dominant driver, you are guessing at the prescription.*

03

THE MODERN OBESITY TOOLKIT

What has actually changed, and how mature is each thing?



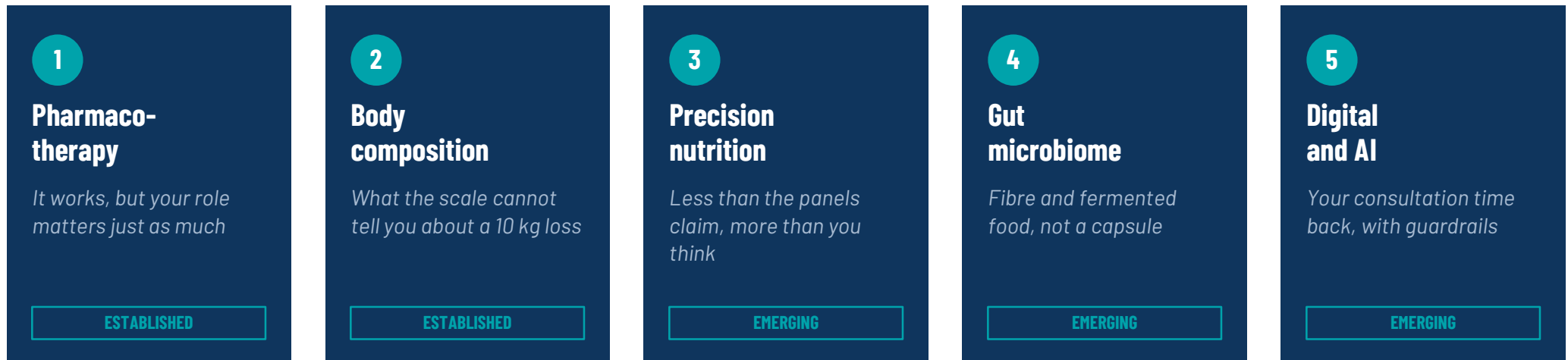
This information is intended for use by healthcare professionals only.



Modern obesity management is a toolkit, not a treatment



FRAMEWORK 2 . THE TOOLKIT SHELF



Two of the five tools are established: pharmacotherapy and body composition.

The other three are still emerging.

SO WHAT? *This is not a GLP-1 talk. Medication is part of the toolkit, but our roles still matter.*

Tool 1. The drugs work. That is the problem we now manage.

ESTABLISHED

Pharmaco-
therapy

Body
composition

Precision
nutrition

Gut
microbiome

Digital
and AI

BRAIN

Appetite falls, and so does
the food noise between meals



STOMACH

Gastric emptying slows,
so fullness arrives sooner



PANCREAS

Glucose-dependent
insulin release

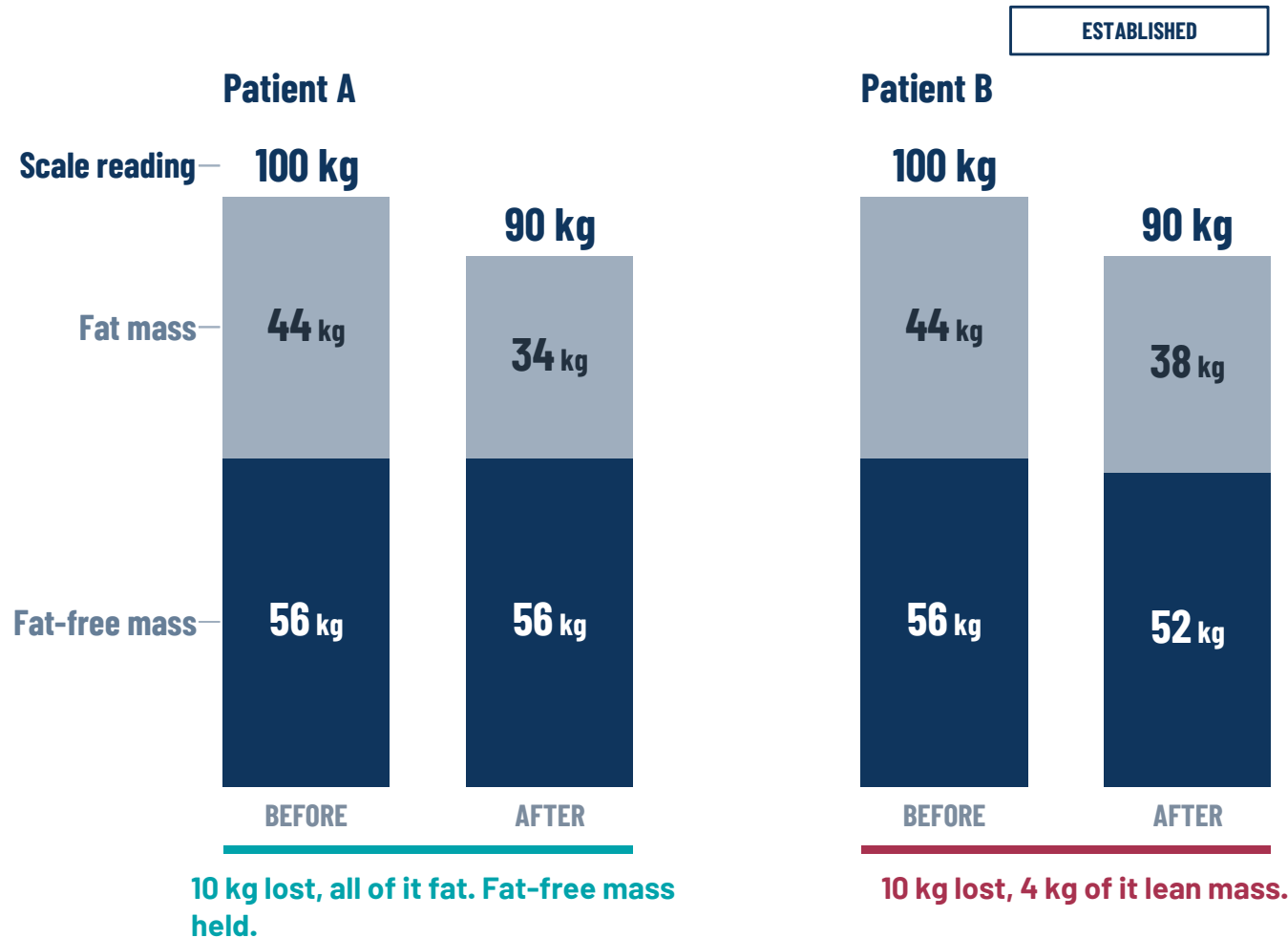


Energy intake falls, by roughly 20 to 30% in the trial populations.



Eating less is how these drugs work, and it is also where the nutritional risk comes from. The next four slides are about managing that.

Tool 2 . Weight loss is not the same as a good body-composition change



Pharmaco-therapy **Body composition** Precision nutrition Gut microbiome Digital and AI

Identical reading on the scale.

Both patients went from 100 kg to 90 kg.

Patient B lost 6 kg of fat and 4 kg of muscle, so she will feel **weaker**, her **resting energy expenditure** will be **lower**, and she is **more likely to regain**.

You cannot tell these two patients apart with a scale. You can with a tape measure, a BIA reading and a sit-to-stand test.

Tool 2 . What protects lean mass is not just protein

ESTABLISHED

Pharmaco-
therapy

Body
composition

Precision
nutrition

Gut
microbiome

Digital
and AI

RAW MATERIAL

1.2 to 1.6 g protein
per kg per day

+

SIGNAL

Resistance training
two to three times a week

=

RESULT

Lean mass preserved
through the loss

Leucine threshold roughly 2 to 3 g per meal is what switches muscle protein synthesis on.

LEUCINE-RICH, LOWER-VOLUME SOURCES



Milk

8 g / 250 ml



Amasi

8 g / 250 ml



Yoghurt

9-15 g / 175 g



Cottage cheese

14 g / 100 g



Eggs

13 g / 2 eggs



Tinned fish

22 g / 100 g

**Prescribing
protein
without
prescribing
training does not
preserve muscle.**

*SO: when you set a
protein target with
a patient, set a
resistance training
target alongside it.*

Mozaffarian D, et al. Obesity. 2025. Mesinovic J, et al. Rev Endocr Metab Disord. 2025. Di Vincenzo A, et al. Obes Facts. 2026;19:422-37(EASO).

This information is intended for use by healthcare professionals only.

Tool 3 . What we can personalise today, and what we cannot

EMERGING

Pharmaco-
therapy

Body
composition

Precision
nutrition

Gut
microbiome

Digital
and AI

ESTABLISHED

You can personalise this now

- The dominant driver, named
- Food preferences and what the household will actually eat
- Culture, religion and season
- Budget, and who does the shopping
- Shift patterns and meal timing
- Measured response over time, which is the only true personalisation

EMERGING

Promising, not yet practice

- Postprandial response profiling: PREDICT1 found large between-person variation in glycaemic, insulin and triglyceride responses to identical meals
- The gut microbiome predicted more of that variation than the macronutrient content
- No trial yet shows that profiling people this way produces better weight outcomes

NOT SUPPORTED

Not ready, whatever the brochure says

- Nutrigenomic panels to choose a dietary pattern. DIETFITS tested exactly this in 609 adults over 12 months and found no diet-genotype interaction
- Microbiome tests sold to direct a diet
- Lactase persistence is the best-established gene-nutrient interaction we have, and it tells you about tolerance, not about weight

SO WHAT? *You already personalise better than any panel on the market. Say that to the patient who brings you one.*

Tool 4 . The microbiome is real science and a marketing problem

EMERGING

Pharmaco-
therapy

Body
composition

Precision
nutrition

Gut
microbiome

Digital
and AI

ESTABLISHED

Do this on Monday

- 25 to 40 g fibre a day, built up over a month
- Thirty different plants a week, counted across the whole week
- A fermented food most days where it is affordable and liked: amasi, maas, plain yoghurt, kefir, sauerkraut

EMERGING

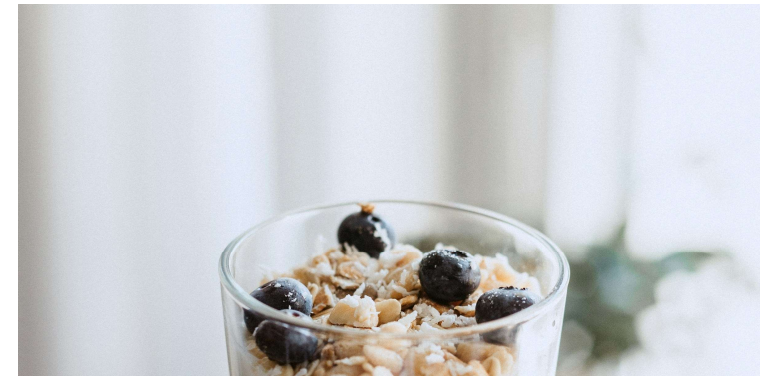
Watch this

- Probiotics and synbiotics: effects are small, strain-specific, and measured over 3 to 28 weeks
- No strain has a reproducible weight effect across populations

NOT SUPPORTED

Not ready

- Faecal microbiota transplantation for obesity
- Microbiome testing sold to direct a diet



THE HEAD-TO-HEAD WORTH SEEING:

Probiotic versus plain low-fat yoghurt, daily with main meals, in 89 women with overweight or obesity on an energy-restricted diet for 12 weeks: **no significant difference in weight loss.**

The probiotic arm did improve lipids and insulin sensitivity.

The yoghurt was doing more work than the strain.

SO WHAT? *The best-evidenced gut intervention is still fibre and food diversity, delivered as food. It is also the cheapest.*

Madjd A, et al. Am J Clin Nutr. 2016;103(2):323-9.. Van Hul M, Cani PD. Nat Rev Endocrinol. 2023;19:258-71.. Peckmezian T, et al. Diabetes Metab Syndr Obes. 2022;15:3777-98.. Rehman A, et al. Food Sci Nutr. 2026.

This information is intended for use by healthcare professionals only.

Tool 5 . The tools that give you your consultation back

EMERGING

Pharmaco-
therapy

Body
composition

Precision
nutrition

Gut
microbiome

Digital
and AI

Practice admin and records



Bookem . Kalix . Practice Better

Booking, notes and billing in one place. Lowest clinical risk, highest time return.

Consultation notes and ADIME



Heidi Health . Otter.ai . Wonder . Docy

Ambient scribing. You still read, edit and sign every note.

Photo-based dietary assessment



goFOOD 2.0 . NutrifyAI . Bitesnap

Useful for pattern and portion discussion. Treat the gram values as an estimate.

Draft plans and energy estimates



ChatGPT . Gemini . Copilot

A first draft you correct, never a plan you hand over.

Nudging between visits



Paola . eTRIP . GlucoGoalie

Conversational agents for adherence. Trials are short and small.

Remote monitoring



CGM . smartwatches . connected scales

Objective data between visits. Decide in advance what you will do with it.

SO WHAT? Administrative work takes about a quarter of your hours. Automate that first: high cost to you, low risk to the patient.

Tool 5 . The prompt is the clinical skill

EMERGING

Pharmaco-
therapy

Body
composition

Precision
nutrition

Gut
microbiome

Digital
and AI

PCCF, WORKED ON A REAL PATIENT

P . PERSONA

"You are a registered dietitian in South African private practice."

C . CONTEXT

"47-year-old woman, BMI 34, prediabetes, on semaglutide 1.0 mg, cooks for five."

C . CONSTRAINTS

"Budget R120 a day for the household. No dietary restriction. Protein 95 g a day. No identifiable detail."

F . FORMAT

"A seven-day framework as a table, with portion sizes in household measures."

THREE RULES THAT ARE NOT NEGOTIABLE

1

POPIA

No identifiable patient detail goes into a public platform. Ever.

2

HPCSA Booklet 20

Assistive only, within your competence. You stay liable, and you disclose it.

3

Algorithmic bias

Not trained on South African diets, budgets or portion norms.

THE STORY TO TELL

Ask a general model to prioritise a renal patient's diet and it may hand you tomatoes, confidently and in beautiful prose. It is not lying. It has no idea it is wrong.

SO WHAT? A slide-footer disclosure line, ready to copy: "Draft content generated with AI assistance and reviewed by a registered dietitian."

Two are ready. Three are promising. None replaces the consultation.



FRAMEWORK 2 RETURNS

1

Pharmaco-therapy

It works, but your role matters just as much

ESTABLISHED

2

Body composition

What the scale cannot tell you about a 10 kg loss

ESTABLISHED

3

Precision nutrition

Less than the panels claim, more than you think

EMERGING

4

Gut microbiome

Fibre and fermented food, not a capsule

EMERGING

5

Digital and AI

Your consultation time back, with guardrails

EMERGING

So the question is no longer which treatment. It is which tool does this patient need. That is an assessment question.

SO WHAT? Which is where the next twenty minutes go, because assessment is the part you control entirely.

Weight stigma: the barrier inside our own practice



Dietitians in a grounded-theory study expressed empathy for patients living with obesity, yet described refraining from weight-related care. The most common reason given was fear of causing offence.

Elliott A, et al. *Int J Obes.* 2025

So the conversation that would help most is the one least likely to happen. Two behaviours change that.

Ask permission

- “Would it be alright if we talked about weight today?”
- Four seconds. It converts an intrusion into an invitation, and it gives the patient a real no.
- If the answer is no, you have still learned something and you have kept the relationship.

Set the agenda together

- “What would you most like to get out of today?”
- The answer is often not weight. Sleep, energy, knees, a photoshoot coming up.
- Work on their goal first. The weight conversation gets easier once you have delivered something.

SO WHAT? *You cannot assess what you will not raise. Ask permission, then ask what they came for.*

04

THE DIETITIAN'S ASSESSMENT TOOLKIT

How do I assess my patient differently tomorrow? This is the heart of the session.



This information is intended for use by healthcare professionals only.



Assessment is the intervention that decides every other intervention



Five more minutes of assessment changes everything downstream. Five more minutes of education changes almost nothing.

A good assessment produces four things. A weight and a diet history produce one.

1

The dominant driver

What is actually pushing this patient's weight up, right now.

2

The rate-limiting barrier

The one thing that will stop any plan working until it is dealt with.

3

The risk

Micronutrient, musculoskeletal, psychological, and the risk of doing nothing.

4

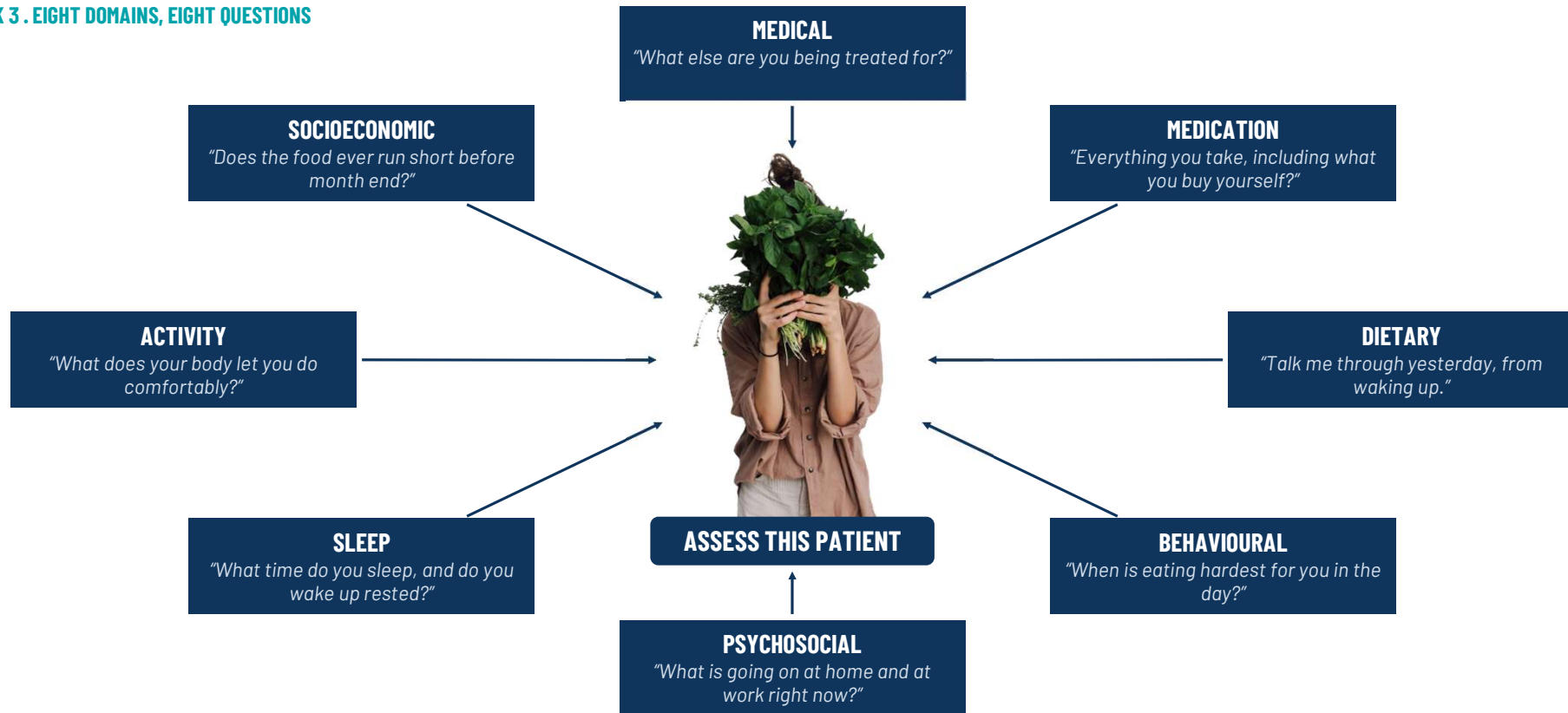
The patient's own priority

What they came for, in their words, which is often not weight.

SO WHAT? *If your assessment does not produce these four, it was a diet history with extra steps.*

The eight-domain compass

FRAMEWORK 3 . EIGHT DOMAINS, EIGHT QUESTIONS



SO WHAT? The two most often skipped are sleep and food security. Add both to your intake form this week.

What you are listening for

The compass being used, not described.



"I want the injection."



MEDICATION

An assessment finding, not a treatment plan. It tells you what she believes will work and what she has already tried. Ask what she has heard, and from whom.



"I'm fine until about four o'clock."



BEHAVIOURAL

A timing problem, not a knowledge problem. The intervention is a planned afternoon protein snack, not an education session.



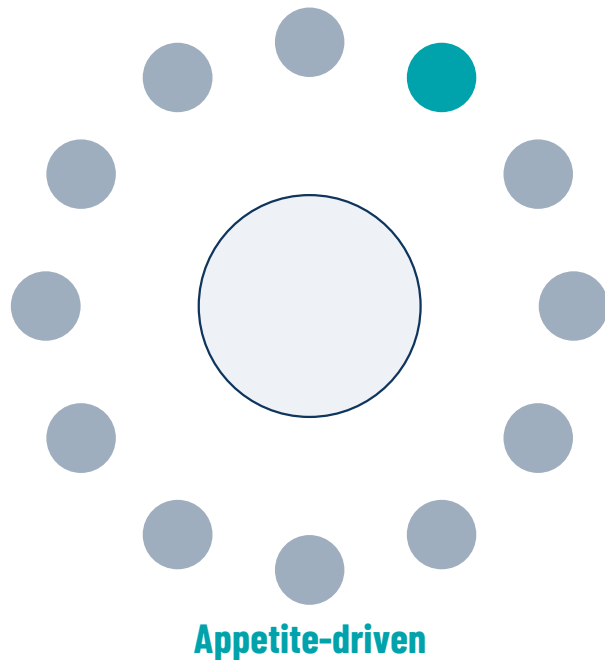
"Sometimes the food runs short near month end."



SOCIOECONOMIC

Everything you write must survive the last week of the month. Budget-realistic staples now become the plan, not a compromise.

SO WHAT? *Every one of these is a sentence the patient volunteers. The skill is hearing it as a finding.*



Obesity presents with multiple clinical phenotypes and varied treatment responses. That is established.

Formal subclassification systems are in development. None is yet validated for routine clinical practice, and none should be sold to your patient as one.

So phenotyping, in your rooms, means clinical pattern recognition: which of the twelve drivers dominates for this person, today. Not a commercial panel.

SO WHAT? *Pattern recognition is phenotyping you can do this week, for free, with a good history.*

05

FROM ASSESSMENT TO PRESCRIPTION

How does what I find change what I actually write down?



This information is intended for use by healthcare professionals only.



Assessment should change the prescription

FRAMEWORK 4 . THE PRESCRIPTION LADDER

DOMINANT DRIVER

Appetite and portion drift



TREATMENT PRIORITY

Satiety at every meal

CHANGE FIRST

Protein at breakfast, before anything else moves

WRITE DOWN

30 g protein at breakfast.
Review in three weeks.

DOMINANT DRIVER

Food environment at work



TREATMENT PRIORITY

Structure and access

CHANGE FIRST

A packed lunch on three named days

WRITE DOWN

Monday, Wednesday, Friday packed. Shopping list agreed.

DOMINANT DRIVER

Six hours of sleep, unrefreshed



TREATMENT PRIORITY

Sleep, before the meal plan

CHANGE FIRST

Screens out of the bedroom, and screen for apnoea

WRITE DOWN

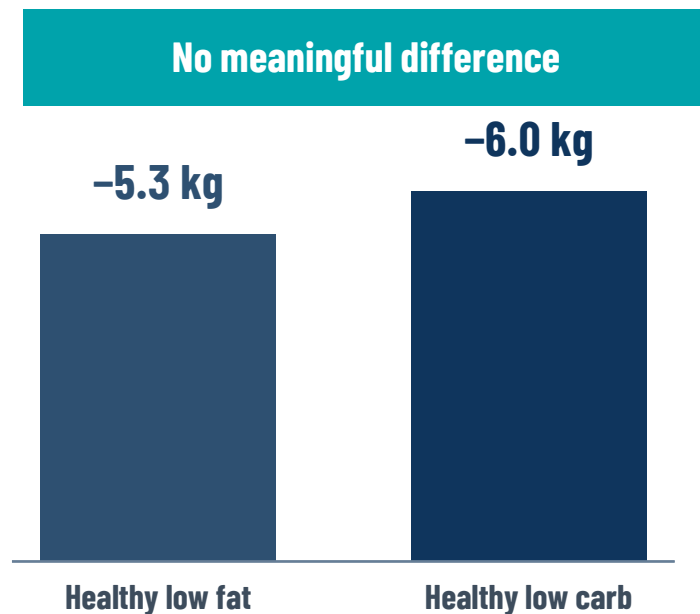
Sleep window 22:30 to 06:00.
Refer for a sleep screen.

SO WHAT? *If two patients with the same BMI leave with the same plan, the assessment changed nothing.*

There is no single best diet, and that is clinically useful

ESTABLISHED

DIETFITS . 609 ADULTS . 12 MONTHS



No diet-genotype interaction. No diet-insulin-secretion interaction. Both groups improved.

So stop defending a pattern. Pull these four levers instead.



Energy deficit the patient can hold

Modest and liveable beats optimal and abandoned.



Protein and fibre, in grams

The two levers that change satiety and body composition.



Meal timing and structure

Fewer decisions, at fixed times, in a predictable week.



Adherence, diagnosed

Find out why the last pattern stopped being followed. That is the real intervention.

SO WHAT? "Which diet?" is the wrong question. "Why did the last one stop?" is the right one.

The prescription, in grams

"More protein" is not a prescription. A number is.

ESTABLISHED

PROTEIN

1.2 to 1.6 g per kg per day

Which weight? Use adjusted or ideal body weight at higher BMI, not actual. In practice, 80 to 120 g a day across three meals.



Milk, 250 ml
8 g



Amasi, 250 ml
8 g



Yoghurt, 175 g
9-15 g



Cottage cheese, 100 g
14 g



Eggs, two
13 g



Tinned pilchards, 100 g
22 g



Biltong, 30 g
16 g



Lean mince, 90 g
22 g

FIBRE

25 to 40 g a day, built over a month

Add one high-fibre food a week, with fluid. Going from 15 g to 35 g in a weekend buys you bloating and a patient who stops.



Oats, 40 g dry
4 g



Wheat biscuits, two
4 g



Wheat bran, 15 g
6 g



Chickpeas, 150 g
9 g



Tinned beans, 150 g
8 g



Chia, 15 g
5 g



Popcorn, 30 g
4 g



Mixed seeds, 20 g
3 g

SO WHAT? Portion values are indicative. Check them against current South African labels before you quote them to a patient.

Dairy across the weight-management journey

ASSESSMENT	ACTIVE LOSS	ON PHARMACOTHERAPY	MAINTENANCE
Ask about it, do not assume it Intake, tolerance and affordability. Lactose intolerance and cost are both common reasons it is already out of the diet.	Protein and calcium on a smaller plate Complete, leucine-rich protein in a small volume. EASO: recommended calcium intake is generally achievable through daily dairy.	Where it is most clinically useful Cold, soft and bland tolerates well when appetite is low. Drinks made with milk or yoghurt, cottage cheese and soups.	Familiar, affordable, repeatable Amasi, maas and plain yoghurt are already in the household. A plan built on them survives month end.

ESTABLISHED	Established	A practical, affordable and culturally familiar way to deliver protein, calcium and satiety in a smaller volume. EASO states the recommended calcium intake is generally achievable through daily dairy, which matters more during rapid loss, not less.
EMERGING	Emerging	Pooled across roughly 150 randomised trials, milk protein supplementation raised lean body mass by 0.41 kg and fat-free mass by 0.67 kg, with fat mass down 0.66 kg and waist down 0.69 cm.
NOT SUPPORTED	Not supported	The same analysis found no effect on body weight or BMI. Dairy does not cause weight loss, and no one in this room should say that it does.

SO WHAT? Say the negative finding without hedging. It is what earns you the right to make the positive case.

Di Vincenzo A, et al. Obes Facts. 2026;19:422-37 (EASO).. Mohammadi S, et al. Nutrients. 2025;17:3877.. Mozaffarian D, et al. Obesity. 2025;33:1478-502.
This information is intended for use by healthcare professionals only.

The prescription has to survive a South African kitchen



SIX QUESTIONS BEFORE YOU WRITE ANYTHING

- Who does the shopping, and how often?
- Who cooks, and on which nights?
- How many people eat from the pot?
- What is the weekly food budget?
- Electricity or paraffin, and how much does cooking cost?
- Does the food run short before month end?

What actually works on the budget

Amasi and maas

High protein, familiar, shelf-stable before opening, and already in most households. The most under-used

Dried and tinned legumes

Protein and fibre in one. Cheapest protein per gram on the shelf.

Eggs

Complete protein, no cooking skill required, tolerated when appetite is low.

Oats and wheat bran

Fibre that costs almost nothing per portion.

Tinned pilchards

Protein plus omega-3 at a fraction of the price of fresh fish.

Seasonal vegetables

Buy what is cheap this month, not what is on the handout.

ESTABLISHED

Micronutrients to watch

RISK	WHY IT MATTERS HERE
Iron	Low intake plus reduced meat portions
Vitamin B12	Falls with lower animal-food intake and metformin
Calcium & vitamin D	Falls exactly when dairy intake drops
Folate	Low fresh-produce intake at month end

THE HONEST CAVEAT

Calcium and vitamin D supplementation during energy restriction shows small to negligible musculoskeletal benefit. This is a dietary adequacy argument, not a supplement one.

SO WHAT? A plan the household cannot cook or afford is not a plan. Ask who shops before you write it.

06

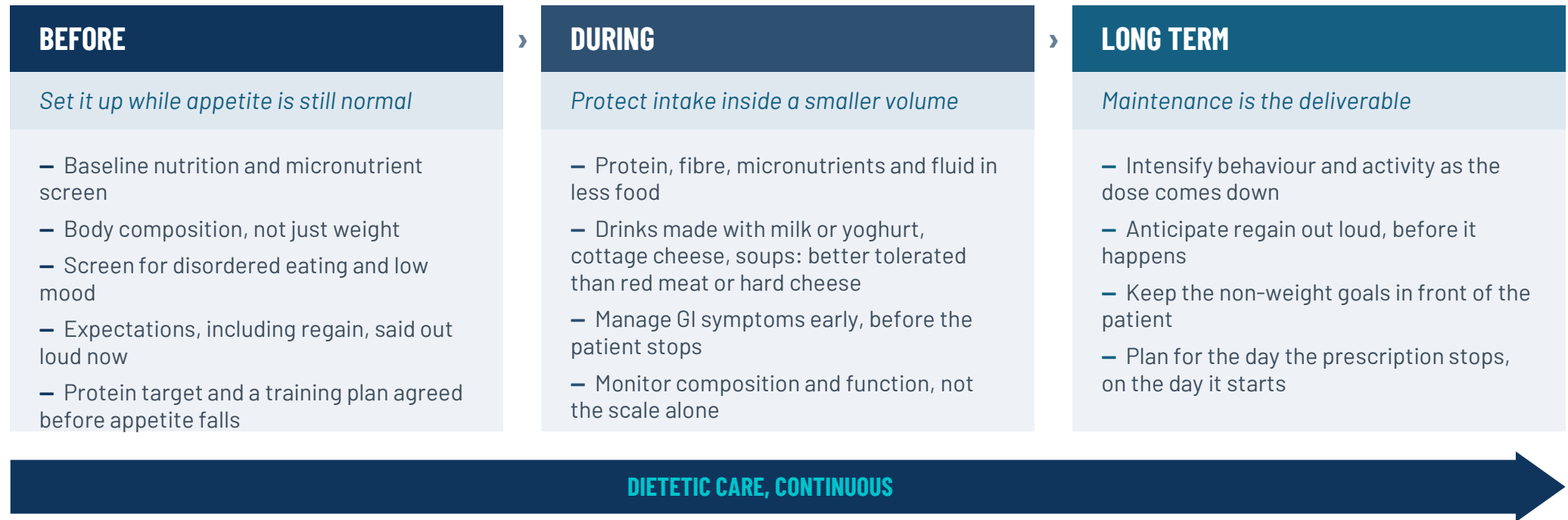
WHERE GLP-1S FIT

What do I actually do before, during and after?



Before . During . Long term

The drug is an episode. The dietetic care is not.



SO WHAT? *What you build in the first eight weeks is what the patient keeps when the prescription ends.*

The GI playbook: keeping patients comfortable and eating

ESTABLISHED

1 Titrate slowly



Dose escalation is negotiable. Ask the prescriber to hold a dose rather than lose the patient.

2 Five or six small meals



A smaller stomach volume needs more frequent, smaller loads.

3 Protein first, gentle foods at peak nausea



Eggs, yoghurt, maas, soup, samp, dry toast, ginger tea.

4 Sip 2 L, away from meals



Fluid with food fills the volume you need for protein.

5 One new high-fibre food a week



With fluid. Constipation is the symptom patients tolerate least.

6 Escalate the red flags



Know which symptoms are management and which are a same-day phone call.

OWN THIS CAVEAT BEFORE ANYONE RAISES IT

Yoghurt and maas are well tolerated at peak nausea: cold, soft, bland, and high protein in a small volume. **For GLP-1-associated diarrhoea, though, reducing dairy is a listed mitigation.**

SO WHAT? *GI symptoms are the most common reason patients stop. Most are manageable with food and timing.*

Red flags, and who to refer to

ESTABLISHED

SAME DAY

- Persistent vomiting or inability to keep fluids down
- Severe or radiating abdominal pain, or suspected pancreatitis
- Signs of dehydration
- Loss faster than the rate you agreed
- New or worsening low mood, or any mention of self-harm

PLAN AHEAD

- Any procedure or anaesthesia: the prescriber decides on withholding, not you
- Pregnancy, planned or possible
- Personal or family history of medullary thyroid carcinoma or MEN2
- Gallbladder symptoms
- A patient already taking something they bought without a prescription

REFER SIDEWAYS

- Psychology for disordered eating, binge eating or low mood
- Biokineticist for a resistance programme the patient will actually do
- Back to the prescriber for dose, tolerability and duration
- Physiotherapy where joint pain is the rate-limiting barrier

SO WHAT? *Recognising and routing these is what makes a dietitian a safe member of the team, not an optional one.*

Regain is biology, not failure



ESTABLISHED

+11.6%

Body weight regained in the year after stopping semaglutide, STEP-1 extension

14%

Regained after tirzepatide withdrawal, SURMOUNT-4

5.6%

Net loss still retained at week 120 in the STEP-1 extension

10-11%

The loss at which hypometabolism and hyperphagia typically appear

In both trials participants were still on an energy deficit and 150 minutes of activity a week. It was not enough.

"Your body will defend this weight. That is physiology, not willpower, and we plan for it from today."

Say this at visit one, not at the visit where it happens.

SO WHAT? *Physical activity remains the most consistent correlate of maintained loss. Prescribe it like a medicine.*

Reiss AB, et al. Biomolecules. 2025;15:408.. Wilding JPH, et al. Diabetes Obes Metab. 2022;24:1553-64.. Aronne LJ, et al. JAMA. 2024;331:38-48.. Paixão C, et al. Obes Rev. 2020;21:e13003.

This information is intended for use by healthcare professionals only.

The scale is one part of the dashboard, not the whole dashboard

FRAMEWORK 5 . THE HEALTH DASHBOARD



Pick four at visit one, one from each quadrant, and review them on the same schedule as weight.

SO WHAT? *A patient who has lost nothing but can climb the stairs and sleeps through the night is a success. Measure it, or you cannot claim it.*

What to measure, and how often



A schedule you can put on the wall of your rooms.

MEASURE	HOW OFTEN	WHY, AND WHAT TO WATCH FOR
Waist circumference	Every visit	Costs nothing, tracks visceral fat better than weight, and it moves before the scale does
Body composition	Every 8 weeks	Read BIA with hydration status and creatine use in mind. A trend matters; a single reading does not
HbA1c and lipids	3 to 6 monthly	The outcomes that justify the intervention to the patient and the funder
Micronutrient bloods	Baseline, then 6 monthly	Iron, B12, vitamin D, folate. More often if intake has been low for months
Grip strength or sit-to-stand	Every 8 to 12 weeks	A functional read on whether you are protecting muscle. Free, and it takes 30 seconds
The patient's own goal	Every visit	The one they told you at assessment. It is the measure they will judge you on

On access. DXA is not available to most South African patients, and BIA is not in every practice. A tape measure and a sit-to-stand test are a defensible minimum, and they beat weight alone in every respect.

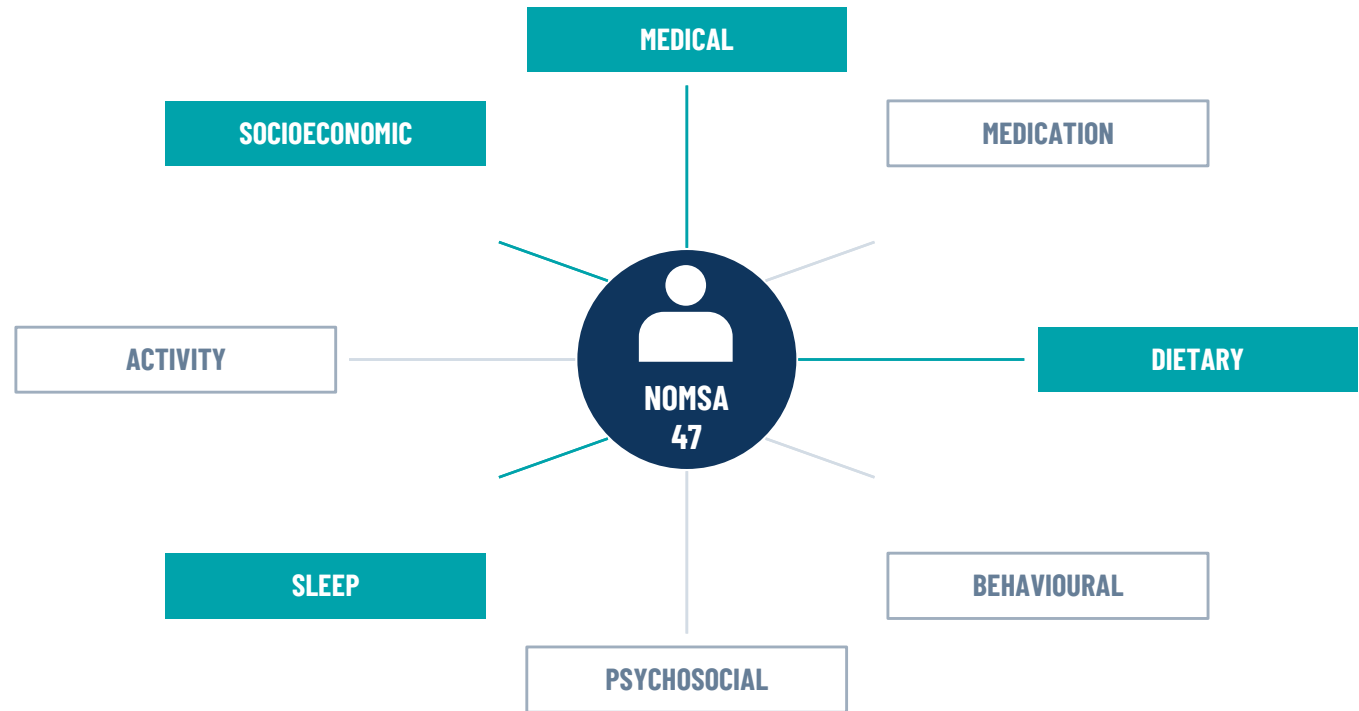
SO WHAT? *Waist circumference and a sit-to-stand test cost nothing. There is no excuse for weight alone.*

Meet Nomsa

A de-identified composite. Nobody in this story is a real patient.

47 . TEACHER . JOHANNESBURG

- Weight climbing since her second pregnancy
- Waist raised. Blood pressure treated on two agents
- HbA1c 6.3%, in the prediabetes range
- Knee pain limits how far she can walk
- Six hours of sleep, wakes unrefreshed
- Cooks for five on a fixed budget
- Three commercial programmes. Lost and regained each time
- Arrives asking for “the injection”



ASK THE ROOM

Which two would you fill in first, and what one question would you ask in each?

Four domains filled from the referral. Four still blank.

From her answers to her prescription

FRAMEWORKS 1 AND 4 RETURN, POPULATED



Dominant driver: sleep

Six hours, unrefreshed, and she snores. Everything else she has tried was built on top of that.

DOMINANT DRIVER

Short, poor-quality sleep. Appetite and portions follow it.

TREATMENT PRIORITY

Sleep first, then satiety, then activity she can tolerate.

CHANGE FIRST

Refer for a sleep screen. Protein at breakfast, 30 g.

WRITE DOWN

Amasi or yoghurt with oats at breakfast. seated resistance twice a week. walk the dog

MONTHS 2 TO 4

- Started semaglutide with her GP at month 2
- Nausea and constipation by week 3
- Protein intake fell to about half target
- GI playbook applied: dose held, smaller meals, maas at peak nausea, fibre rebuilt slowly

MONTH 6

11% loss. Waist down 9 cm. HbA1c normalised.

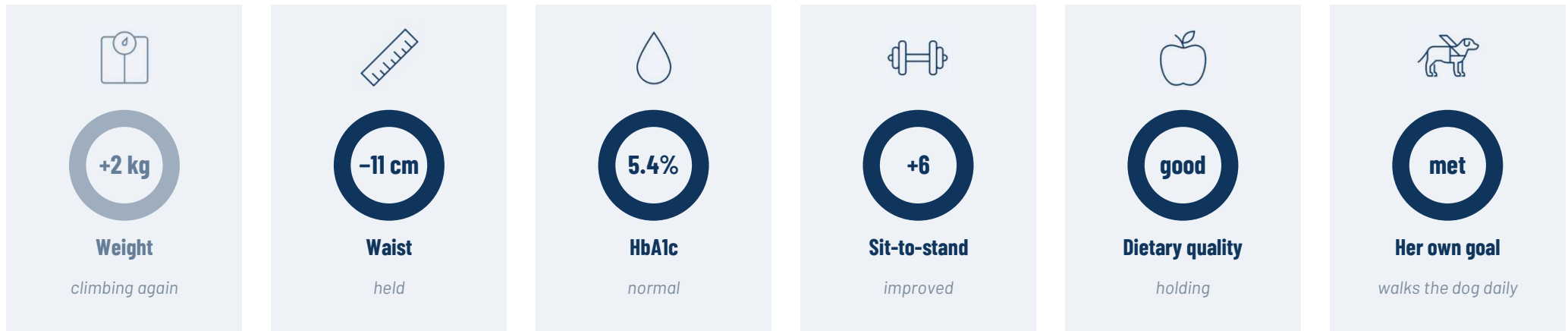
But BIA shows a disproportionate fall in fat-free mass, and she has quietly stopped training.

ASK THE ROOM What is your single next move?

Month 12: the medicine stops

Stopped on cost, which is the most common reason for discontinuation in South African practice.

FRAMEWORK 5 RETURNS, WITH HER NUMBERS



Five of six dials are still improved. Only one has moved back, and it is the one she is watching.

ASK THE ROOM She has regained 2 kg in three weeks. What do you say in the first thirty seconds?

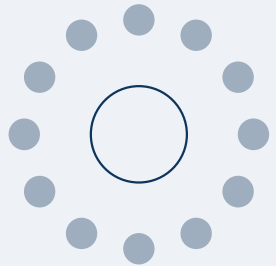
"Your body is defending this weight. We planned for this. Here is what we do now."

The Modern Obesity Toolkit, on one page



ALL FIVE FRAMEWORKS

1 The Driver Wheel



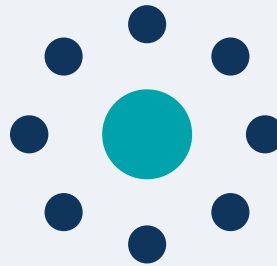
Name the dominant driver

2 The Toolkit Shelf



Two ready, three not yet

3 The 8-Domain Compass



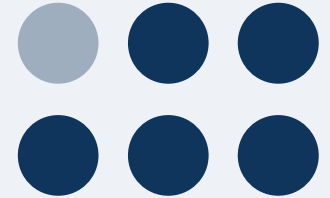
Eight questions, verbatim

4 The Prescription Ladder



Driver to written plan

5 The Health Dashboard



Six dials, one is weight

Six things to do on Monday

1 Ask permission before you raise weight

2 Add sleep and food security to intake

3 Protein in grams, training in sessions

4 Waist and sit-to-stand, every patient

5 Say the regain sentence at visit one

6 Automate one admin task this week

FIVE THINGS TO TAKE AWAY

- 1** Obesity is chronic, relapsing and heterogeneous, so the care has to be long-term.
- 2** Assessment decides every other intervention. Five more minutes there is worth more than any handout.
- 3** Protein and training together, delivered through food people will actually eat and afford.
- 4** Medication is one tool of five, and it is the one you do not prescribe.
- 5** Measure more than kilograms, or you will miss the patient who is getting better.

Thank you

Dr Monique Piderit, RD(SA). [Nutritional Solutions . monique@nutritionalsolutions.co.za](mailto:monique@nutritionalsolutions.co.za)

This information is intended for use by healthcare professionals only.



References



- 1 Rubino F, Cummings DE, Eckel RH, Cohen RV, Wilding JPH, Brown WA, et al. Definition and diagnostic criteria of clinical obesity. *Lancet Diabetes Endocrinol*. 2025;13(3):221-62. doi:10.1016/S2213-8587(24)00316-4
- 2 Conradie-Smit M, May W. Transforming obesity care: evidence-based guideline for South Africa. *S Afr Med J*. 2025;115(9b):e4377. doi:10.7196/SAMJ.2025.v115i9b.4377
- 3 Theodorakis N, Kreouzi M, Pappas A, Nikolaou M. Beyond calories: individual metabolic and hormonal adaptations driving variability in weight management. *Int J Mol Sci*. 2024;25(24):13438. doi:10.3390/ijms252413438
- 4 Reiss AB, Gulkarov S, Lau R, Klek SP, Srivastava A, Renna HA, et al. Weight reduction with GLP-1 agonists and paths for discontinuation while maintaining weight loss. *Biomolecules*. 2025;15(3):408. doi:10.3390/biom15030408
- 5 Dandgey S, Patten E. Psychological considerations for the holistic management of obesity. *Clin Med (Lond)*. 2023;23(4):318-22.
- 6 Elliott A, Bauer J, McDonald C, Gibson S. Exploring dietitians' experiences caring for patients living with obesity in acute care: a qualitative study. *Int J Obes*. 2025;49:698-705. doi:10.1038/s41366-024-01697-y
- 7 Mozaffarian D, et al. Nutritional priorities to support GLP-1 therapy for obesity: a joint advisory. *Obesity (Silver Spring)*. 2025;33(8):1478-502. doi:10.1002/oby.24336
- 8 Di Vincenzo A, et al. European Association for the Study of Obesity position statement on the management of obesity in older adults. *Obes Facts*. 2026;19(4):422-37. doi:10.1159/000549751
- 9 Mesinovic J, et al. Exercise and dietary recommendations for preserving musculoskeletal health during weight loss. *Rev Endocr Metab Disord*. 2025;26:785-803.

References (continued)



- 10 Mechanick JI, Butsch WS, Christensen SM, Hamdy O, Li Z, Prado CM, et al. Strategies for minimizing muscle loss during use of incretin-mimetic drugs for treatment of obesity. *Obes Rev*. 2025;26:e13841. doi:10.1111/obr.13841
- 11 Gardner CD, Trepanowski JF, Del Gobbo LC, Hauser ME, Rigdon J, Ioannidis JPA, et al. Effect of low-fat vs low-carbohydrate diet on 12-month weight loss in overweight adults and the association with genotype pattern or insulin secretion: the DIETFITS randomized clinical trial. *JAMA*. 2018;319(7):667-79. doi:10.1001/jama.2018.0245
- 12 Mohammadi S, Ashtary-Larky D, Alaghemand N, et al. Effects of supplementation with milk proteins on body composition and anthropometric parameters: a systematic review and dose-response meta-analysis. *Nutrients*. 2025;17(24):3877. doi:10.3390/nu17243877
- 13 Madjd A, Taylor MA, Mousavi N, Delavari A, Malekzadeh R, Macdonald IA, et al. Comparison of the effect of daily consumption of probiotic compared with low-fat conventional yogurt on weight loss in healthy obese women following an energy-restricted diet: a randomized controlled trial. *Am J Clin Nutr*. 2016;103(2):323-9. doi:10.3945/ajcn.115.120170
- 14 Van Hul M, Cani PD. The gut microbiota in obesity and weight management: microbes as friends or foe? *Nat Rev Endocrinol*. 2023;19(5):258-71.
- 15 Peckmezian T, et al. Microbiome-targeted therapies as an adjunct to traditional weight loss interventions: a systematic review and meta-analysis. *Diabetes Metab Syndr Obes*. 2022;15:3777-98. doi:10.2147/DMSO.S378396
- 16 Rehman A, et al. Role of the gut microbiome in obesity and weight management. *Food Sci Nutr*. 2026;14(4). doi:10.1002/fsn3.71801
- 17 Piderit MC. The role of artificial intelligence in dietetic practice: a narrative review of current evidence and practical applications. *S Afr J Clin Nutr*. 2026;39(2):67-73. doi:10.1080/16070658.2026.2679826
- 18 Kim H, et al. Evaluation of an artificial intelligence-generated personalised diet plan in a weight management clinic. *Front Nutr*. 2024;11:1374834. doi:10.3389/fnut.2024.1374834

References (continued)



- 19 Health Professions Council of South Africa. Ethical guidelines on the use of artificial intelligence: Booklet 20. Pretoria: HPCSA; 2025.
- 20 Barrea L, et al. A multidisciplinary perspective on semaglutide treatment and medical nutrition therapy. *Curr Obes Rep*. 2025;14:73.
- 21 Jalleh RJ, Plummer MP, Marathe CS, Umapathysivam MM, Quast DR, Rayner CK, et al. Clinical consequences of delayed gastric emptying with GLP-1 receptor agonists and tirzepatide. *J Clin Endocrinol Metab*. 2025;110(1):1-15. doi:10.1210/clinem/dgae719
- 22 Kindel TL, Wang AY, Wadhwa A, Schulman AR, Sharaiha RZ, Kroh M, et al. Multisociety clinical practice guidance for the safe use of glucagon-like peptide-1 receptor agonists in the perioperative period. *Surg Obes Relat Dis*. 2024;20(12):1183-6. doi:10.1016/j.soard.2024.08.033
- 23 Wilding JPH, Batterham RL, Davies M, Van Gaal LF, Kandler K, Konakli K, et al. Weight regain and cardiometabolic effects after withdrawal of semaglutide: the STEP 1 trial extension. *Diabetes Obes Metab*. 2022;24(8):1553-64. doi:10.1111/dom.14725
- 24 Aronne LJ, Sattar N, Horn DB, Bays HE, Wharton S, Lin WY, et al. Continued treatment with tirzepatide for maintenance of weight reduction in adults with obesity: the SURMOUNT-4 randomized clinical trial. *JAMA*. 2024;331(1):38-48. doi:10.1001/jama.2023.24945
- 25 Paixão C, Dias CM, Jorge R, Carraça EV, Yannakoulia M, de Zwaan M, et al. Successful weight loss maintenance: a systematic review of weight control registries. *Obes Rev*. 2020;21(5):e13003. doi:10.1111/obr.13003