Women Respond Better to GLP-1 Drugs. Most Still Cannot Get Them.

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> Women already carry a higher global burden of obesity than men, and they respond to GLP-1 receptor agonists with greater weight loss on average. A Series paper published in The Lancet Obstetrics, Gynaecology & Women's Health argues that neither fact has translated into evidence or access built around women's actual needs.1

KEY TAKEAWAYS

- The Pivot: Women carry a higher global obesity burden and respond to GLP-1 drugs with greater weight loss, yet the evidence base and access pathways for these drugs remain built around men by default.
- The Data: Nearly 80% of clinically eligible adults live in low- and middle-income countries where GLP-1 drugs can cost over $90 a month, against a manufacturing estimate under $5.
- The Action: Push for mandatory sex- and ethnicity-stratified reporting in GLP-1 trials, and treat cost as the central, addressable barrier to equitable access rather than a fixed constraint.

The Global Burden of Disease group estimated overweight or obesity affected 46.7% of women and 43.4% of men worldwide in 2021, projected to reach 60.3% and 57.4% by 2050.1 The gap is widest in low- and middle-income countries, particularly sub-Saharan Africa and south Asia, while some high-income countries see higher male prevalence, a pattern the authors trace to socioeconomic inequality rather than biology alone.

Against that backdrop, GLP-1 receptor agonists have become the default pharmacological response to obesity, and women are already their predominant users. The paper, led by Paul Franks and Claire Meek, sets out where the evidence and the access supporting that use both fall short.1

Why Women Respond Differently

Weight loss with GLP-1 drugs runs higher in women than men, while glycaemic improvements stay comparable between the sexes.1 The paper points to higher systemic drug exposure in women that persists even after adjusting for body mass, alongside evidence that women experience stronger suppression of food-motivated behaviour and greater inhibition of palatable food intake on these drugs. Preclinical work has also flagged a possible interaction between GLP-1 signalling and oestrogen, though the mechanism is not established in humans.

Side-effect reporting tells a more complicated story. Real-world data show women reporting headache, vomiting and dizziness at higher rates than men, while placebo-controlled trials show similar rates across sexes, a gap the authors

attribute to reporting behaviour as much as biology and flag as needing dedicated study rather than assumption.

Weight regain after stopping a GLP-1 drug is well documented, and the paper raises a specific concern for women: regained weight tends to be fat without a matching gain in muscle, a pattern with implications for long-term physical function that has not been adequately studied by sex.

The Access Gap

Manufacturing cost estimates put oral semaglutide under $1 per month and injectable formulations around $5, yet retail prices across 99 countries analysed exceed $90 per month in many settings.1 Nearly 80% of adults who meet clinical eligibility criteria live in low- and middle-income countries, where access remains minimal for women relying on public systems or paying out of pocket.

The paper names a specific, underserved population directly: women with type 2 diabetes in low- and middle-income countries are frequently lean by Western standards, and the BMI threshold at which the disease develops runs lower than in populations of European ancestry, meaning significant weight loss could carry a more pronounced clinical impact in exactly the group least likely to access treatment.

The authors also raise what they term polyendocrine metabolic ovarian syndrome, describing it as an updated name for the condition long known as polycystic ovary syndrome, affecting an estimated 12% of women worldwide with the highest rates in the eastern Mediterranean and southeast Asia. Despite documented benefits from weight loss in this population, GLP-1 drugs are not generally available or centrally funded for this indication in most health systems.

> **CLINICAL IMPLICATIONS**
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> The finding that women lose more weight on these drugs while facing worse access to them is not a paradox, it is the entirely predictable result of a drug class developed and priced without women's specific circumstances built into the process from the start. A hundred-fold gap between manufacturing cost and retail price is not a biological fact about GLP-1 drugs, it is a policy choice, and the paper is right to frame it as the central lever available to close the access gap rather than treating cost as background noise.
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> For companies and health systems, the call for mandatory sex-stratified and ethnicity-stratified trial reporting is not a bureaucratic add-on. Given documented differences in drug exposure and response between women and men, a trial that does not report results by sex is withholding information clinicians need to prescribe accurately, not just failing an equity standard.
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> The polyendocrine metabolic ovarian syndrome funding gap deserves specific attention from payers: a condition affecting roughly one in eight women worldwide, with clear evidence that weight loss improves it, sitting outside GLP-1 funding criteria in most systems is a policy gap that outlived the evidence justifying it some time ago.
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> None of this argues against GLP-1 therapy for women, it argues for building the evidence and the access model

> to match how these drugs actually behave in women rather than assuming the male-weighted evidence base generalises cleanly. The paper's own framing is the right one: this is a genuine opportunity to improve women's health globally, contingent on treating equitable access as a design requirement rather than an afterthought.

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REFERENCES

1. 1. Franks P, Meek CE, et al. GLP-1 receptor agonists and women's health: evidence gaps and equitable access. Presented at: European Association for the Study of Diabetes (EASD) Annual Meeting; September 28-October 2, 2026; Milan, Italy. Forthcoming in The Lancet Obstetrics, Gynaecology & Women's Health. Available from: https://www.thelancet.com/journals/lanogw/article/PIIS3050-5038(26)00228-1/fulltext

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