

RESEARCH PAPER

OBESITY AND HOLISTIC WELLNESS

*An Integrative Perspective on Body Weight,
Comorbidity Risk, Global Statistics and Responsible
Lifestyle Support*

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Page

ABSTRACT

Obesity is a chronic, complex, relapsing disease and one of the fastest-growing public health challenges worldwide. In 2022, an estimated 1 in 8 people globally were living with obesity, including 890 million adults and 160 million children and adolescents, with worldwide adult obesity more than doubling since 1990 and adolescent obesity quadrupling over the same period (WHO, 2025).

This paper examines obesity from a holistic wellness perspective while maintaining the primacy of evidence-based diagnosis and appropriate medical care. It reviews global prevalence statistics, BMI classification, the multi-organ-system health consequences of obesity, diagnostic evaluation, red-flag presentations and modern management. The paper proposes the SR VAIDYA Integrative Framework for Obesity Wellness Education, built on early screening, verified diagnosis, individualised lifestyle support and responsible Ayurvedic integration. Ayurvedic and Panchakarma approaches are discussed within clear safety boundaries as complementary wellness measures

that must never replace or delay evidence-based diagnosis or treatment, including pharmacotherapy or bariatric surgery where clinically indicated.

Keywords: Obesity, Overweight, Body Mass Index, Weight Management, Metabolic Health, Holistic Wellness, Ayurveda, Panchakarma, Lifestyle Medicine, Integrative Health.

1. INTRODUCTION

Obesity has been formally recognised as a chronic, complex disease rather than simply a risk factor or lifestyle choice, reflecting growing scientific understanding of its biological, genetic, hormonal and environmental determinants. The World Health Organization defines obesity as abnormal or excessive fat accumulation that presents a risk to health, distinct from the everyday, non-clinical use of the term (WHO, 2025).

The rise in global obesity prevalence has been described as a modern pandemic: worldwide adult obesity has more than doubled since 1990, and obesity among children and adolescents has quadrupled over the same period, with the trend now firmly established in low- and middle-income countries as well as high-income settings (WHO, 2025).

2. GLOBAL STATISTICS

Reliable prevalence data are essential to appropriately scale awareness, clinical services and research investment. The scale of the global obesity burden has grown substantially over recent decades.

Figure 1. Global Obesity Burden in Numbers (WHO, 2025)

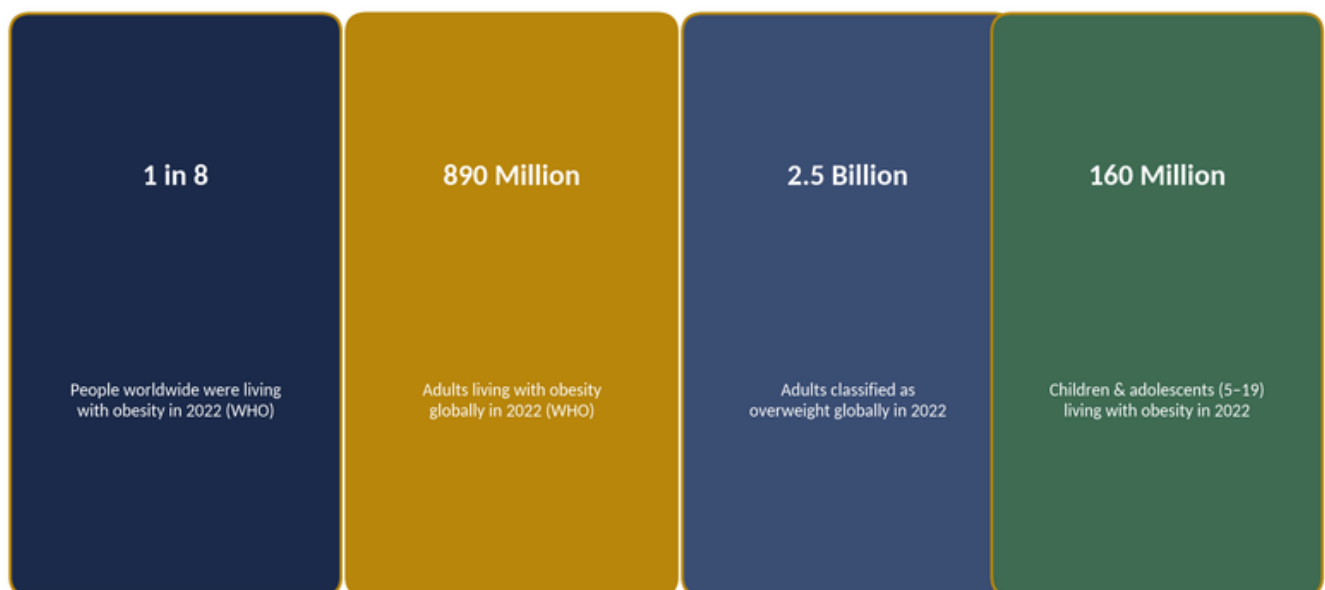


Figure 1. Global Obesity Burden in Numbers (WHO, 2025)

In 2022, 43% of adults aged 18 and over were classified as overweight and 16% as living with

obesity, an increase from 25% overweight prevalence in 1990 (WHO, 2025). Prevalence of overweight varies substantially by region, from 31% in the WHO South-East Asia and African Regions to 67% in the Region of the Americas. A comprehensive Lancet analysis covering over 220 million people across more than 190 countries projects that, without intervention, the number of adults with overweight or obesity worldwide could reach 3.8 billion by 2050 — over half of the projected global adult population (NCD-RisC, 2024).

3. BODY MASS INDEX CLASSIFICATION

Body Mass Index (BMI), calculated as weight in kilograms divided by height in metres squared, remains the most widely used population-level screening tool for classifying weight status, though it has recognised limitations at the individual level.

Figure 2. WHO Body Mass Index (BMI) Classification Scale

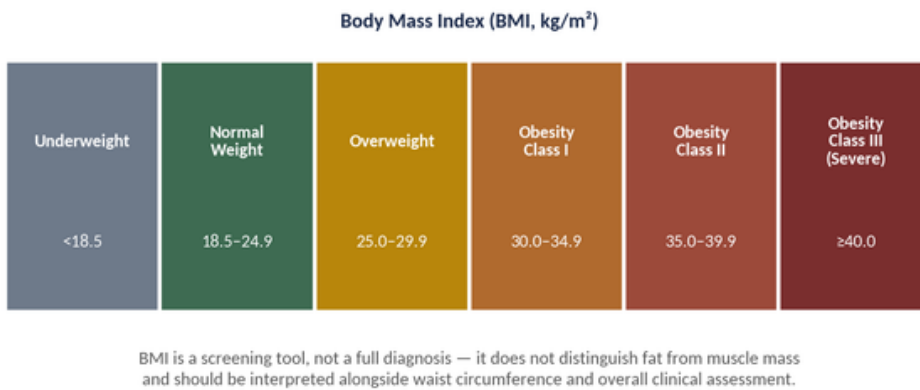


Figure 2. WHO Body Mass Index (BMI) Classification Scale

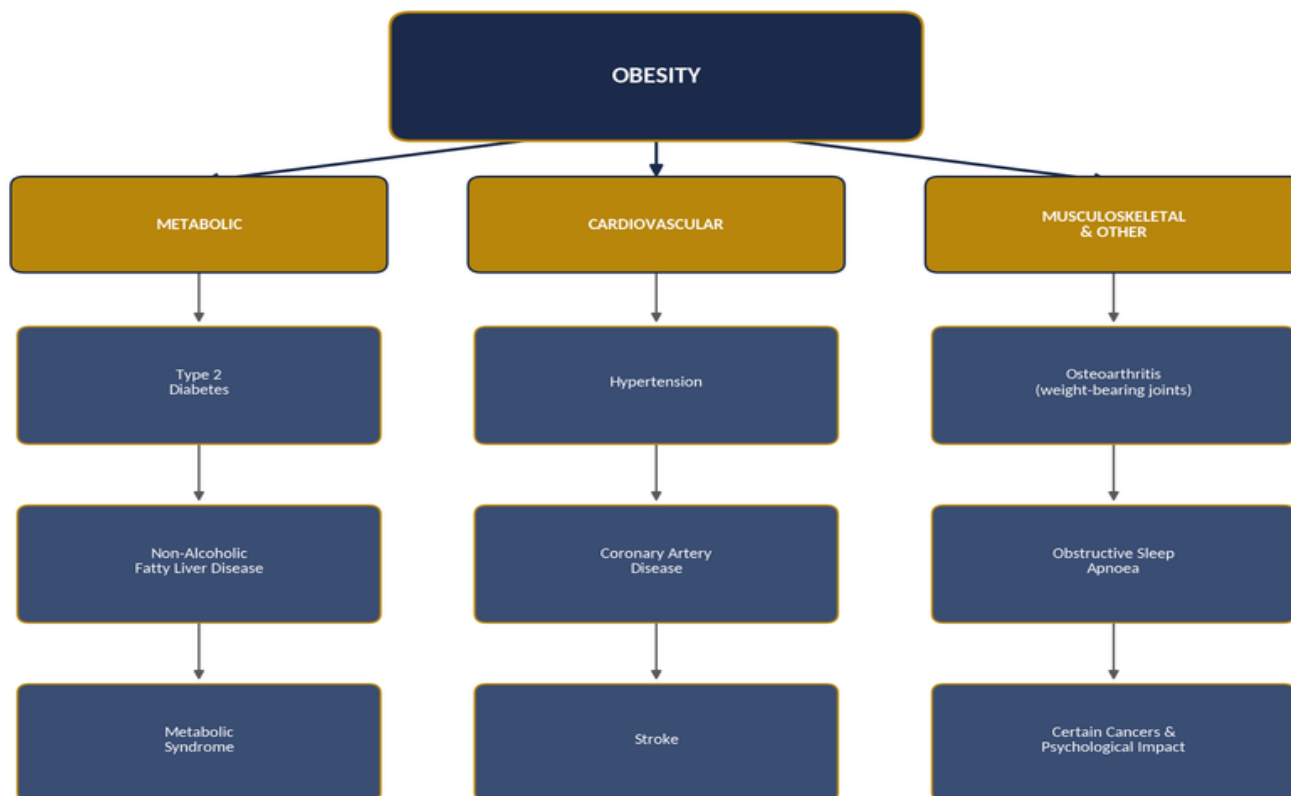
BMI does not distinguish between fat mass and muscle mass, and does not capture fat distribution — an important limitation, since central (abdominal) obesity carries independently elevated metabolic risk compared with peripheral fat distribution at the same BMI. Waist circumference, waist-to-hip ratio and, where available, body composition assessment provide valuable complementary information to BMI-based classification.

4. HEALTH CONSEQUENCES OF OBESITY

Obesity is a major contributor to noncommunicable disease burden globally, affecting nearly every organ system through both mechanical and

metabolic pathways.

Figure 3. Obesity-Related Health Complications Across Organ Systems



Obesity-attributable risk is graded, not binary — risk of most comorbidities rises progressively with BMI class and, independently, with central (abdominal) fat distribution.

Figure 3. Obesity-Related Health Complications Across Organ Systems

Beyond physical health, obesity is also associated with significant psychological burden, including depression, anxiety, body image distress and weight-related stigma, which can in turn create barriers to seeking care — underscoring the

importance of a compassionate, non-judgemental clinical approach throughout assessment and management.

5. DIAGNOSTIC EVALUATION

A responsible approach to obesity assessment goes beyond a single weight or BMI measurement to characterise overall metabolic risk and identify contributing factors.

Assessment	Purpose
Body Mass Index (BMI)	Population-level screening classification of weight status
Waist Circumference	Assesses central adiposity and associated metabolic risk
Blood Pressure & Fasting Lipid Panel	Screens for cardiovascular risk factors
Fasting Glucose / HbA1c	Screens for insulin resistance and type 2 diabetes
Thyroid Function Tests	Excludes hypothyroidism as a contributing endocrine factor
Sleep & Psychological Screening	Identifies obstructive sleep apnoea, mood and eating-pattern factors

No single measurement should be interpreted in isolation. A comprehensive assessment characterises overall metabolic and cardiovascular

risk rather than focusing on body weight as an isolated number.

6. RED FLAG PRESENTATIONS REQUIRING URGENT ASSESSMENT

- Rapid, unintentional weight change (gain or loss) without a clear explanation — warrants evaluation for underlying endocrine, medication-related or other medical causes.
- Severe obesity (BMI ≥ 40) with evidence of complications such as uncontrolled diabetes, severe sleep apnoea or heart failure — requires prompt specialist assessment.
- Signs and symptoms suggestive of obstructive sleep apnoea (loud snoring, witnessed breathing pauses, severe daytime sleepiness) — warrants sleep-study referral.
- Significant depression, disordered eating patterns, or body image distress — requires prompt mental health support alongside medical evaluation.
- Signs of an endocrine cause (e.g., features suggestive of Cushing's syndrome or hypothyroidism) accompanying weight gain — warrants endocrine work-up.

7. MODERN MANAGEMENT OF OBESITY

Management is individualised according to BMI class, presence of comorbidities, prior treatment history and patient preference, following a stepped-care approach.

- Lifestyle Intervention: Structured dietary modification, increased physical activity and behavioural support form the foundation of care at every BMI class.
- Pharmacotherapy: GLP-1 receptor agonists and other approved weight-management medications for selected patients as an adjunct to lifestyle intervention.
- Bariatric (Metabolic) Surgery: Considered for selected patients with severe obesity or moderate obesity with significant comorbidities, following comprehensive assessment.
- Psychological & Behavioural Support: Addressing disordered eating patterns, weight stigma and the psychological dimensions of weight management.
- Ongoing Monitoring: Regular reassessment of weight trajectory, metabolic parameters and comorbidity status to guide treatment adjustment.

8. THE PSYCHOLOGICAL AND

ENVIRONMENTAL CONNECTION

Weight regulation is influenced substantially by factors beyond individual willpower, including genetic predisposition, hormonal appetite regulation, sleep quality, chronic stress and the broader food environment. Modern “obesogenic” environments — characterised by easy access to energy-dense, convenient foods and reduced opportunities for physical activity — are widely recognised as major structural contributors to rising obesity prevalence.

A holistic assessment may therefore include attention to sleep quality, stress levels, food environment and psychological relationship with eating, alongside standard metabolic assessment.

9. AYURVEDIC AND HOLISTIC WELLNESS PERSPECTIVE

Ayurvedic literature describes obesity under Sthaulya or Medoroga, traditionally attributed to impaired digestive fire (Agni) and excess Kapha and Meda Dhatu accumulation, with emphasis on Ahara

(diet), Vihara (lifestyle), Vyayama (exercise) and correction of underlying metabolic imbalance rather than weight alone.

Responsible holistic integration means that Ayurvedic dietary science, meal-timing discipline, appropriate physical activity guidance and stress management may complement conventional obesity care by supporting general metabolic and psychological wellbeing — but must never be presented as a substitute for verified diagnosis, pharmacotherapy, or bariatric surgical evaluation where clinically indicated.

10. PANCHAKARMA: THE NEED FOR RESPONSIBLE INTEGRATION

Panchakarma represents an important therapeutic system within Ayurveda, with several procedures historically directed at weight and metabolic concerns. Its use in individuals with obesity requires careful assessment of cardiovascular stability, glycaemic control, presence of sleep apnoea, and general health, given the physiological demands

some procedures place on the body.

Within appropriately supervised settings and stable health status, general categories such as structured Ahara-based dietary correction, Udvartana (herbal powder massage, traditionally associated with fat mobilisation) and mild, individualised Basti protocols have been discussed in traditional literature as supportive measures for metabolic wellbeing. Any such intervention requires practitioner-level clinical judgement, is contraindicated in unstable cardiovascular disease, uncontrolled diabetes or severe untreated sleep apnoea, and must be sequenced around — never in place of — medical or surgical management.

Panchakarma should not be promoted as a rapid weight-loss treatment, a substitute for approved pharmacotherapy, or an alternative to bariatric surgery in patients meeting established surgical criteria.

11. THE SR VAIDYA HOLISTIC WELLNESS FRAMEWORK

The following integrative framework is proposed for

responsible holistic wellness education in obesity care, structured around the Institute's name to support ease of recall among practitioners and patients alike.

Figure 4. The SR VAIDYA Integrative Framework for Obesity Wellness Education (S-R-V-A-I-D-Y-A)



12. ROOT-FACTOR ANALYSIS: A SCIENTIFICALLY RESPONSIBLE APPROACH

Obesity does not arise from a single root cause. A more scientifically defensible concept is Root-Factor Analysis, which identifies multiple genetic, hormonal, dietary, activity-related, sleep-related, psychological, environmental and medical factors contributing to an individual's overall weight status and treatment response.

Figure 5. Root-Factor Analysis Wheel for Obesity
(Multidimensional Contributing Domains)



Figure 5. Root-Factor Analysis Wheel for Obesity (Multidimensional Contributing Domains)

13. EVIDENCE GRADING OF KEY CLAIMS

In keeping with the Institute's evidence-grading standard, the principal claims discussed in this paper are graded below as Strong, Moderate or Weak, reflecting the current weight of peer-

reviewed evidence.

Claim	Evidence Grade	Basis
Approximately 1 in 8 people globally were living with obesity in 2022, including 890 million adults	Strong	WHO fact sheet, 2025, based on NCD-RisC data
Obesity is an independent risk factor for type 2 diabetes, cardiovascular disease and certain cancers	Strong	Extensive epidemiological and mechanistic evidence
GLP-1 receptor agonists produce clinically significant weight loss as adjunctive therapy	Strong	Multiple large randomised controlled trials
Bariatric surgery produces sustained weight loss and comorbidity improvement in eligible patients	Strong	Extensive surgical outcomes literature
Structured behavioural and dietary counselling improves weight-loss maintenance	Moderate	Consistent evidence; effect sizes vary by programme intensity
Specific Ayurvedic herbal formulations produce weight loss comparable to pharmacotherapy	Weak	Limited, heterogeneous trials; insufficient for treatment substitution
Panchakarma alone produces sustained, clinically significant weight loss	Weak / Unsupported	No robust controlled evidence; not a substitute for established therapy

14. DISCUSSION

The future of obesity care increasingly requires integration without exaggeration. Conventional medicine provides diagnostic precision, pharmacotherapy, surgical treatment and structured behavioural programmes. Holistic

wellness can contribute through dietary education, physical activity promotion, sleep improvement, stress management and compassionate patient support.

A successful integrative model should therefore be evidence-aware, patient-centred, safety-oriented, referral-conscious, lifestyle-focused, weight-stigma-free and individualised — consistent with the approach adopted throughout this paper.

15. PROPOSED CONFERENCE RECOMMENDATIONS

- Recommendation 1: Encourage comprehensive assessment (waist circumference, metabolic panel) alongside BMI rather than weight or BMI in isolation.
- Recommendation 2: Train wellness practitioners to recognise red-flag presentations requiring urgent medical or endocrine referral.
- Recommendation 3: Focus lifestyle interventions on sustainable behaviour change rather than claiming rapid or guaranteed weight-loss outcomes.

- Recommendation 4: Adopt a weight-stigma-free, compassionate communication approach across all wellness and clinical settings.
- Recommendation 5: Individualise Ayurvedic and Panchakarma interventions and never delay pharmacotherapy or bariatric surgical evaluation where indicated.
- Recommendation 6: Conduct ethically designed observational and controlled studies of integrative wellness approaches in obesity management.
- Recommendation 7: Study quality of life, psychological wellbeing and metabolic outcomes without unsupported rapid-weight-loss claims.

16. FUTURE RESEARCH PROPOSAL FOR SR VAIDYA HOLISTIC WELLNESS RESEARCH INSTITUTE

Proposed Title: “Effect of a Structured Holistic Lifestyle and Behavioural Support Programme on Weight Maintenance and Quality of Life in Adults Receiving Standard Medical Care for Obesity.”

Study Type: Prospective observational study or pilot randomised controlled study.

Participants: Adults with BMI ≥ 30 kg/m² under

active medical management, target sample size 120–150 participants across two sites.

Standard Care: Participants continue prescribed medical management, including pharmacotherapy where applicable, throughout the study.

Holistic Components: Structured dietary counselling, physical activity guidance, sleep hygiene, stress-management practices and appropriate yoga-based wellness practices delivered within professional scope over a 12-week intervention period.

Primary Endpoint: Change in body weight and waist circumference at 12 weeks. **Secondary Endpoints:** quality-of-life score, psychological wellbeing measures and metabolic parameters.

Important Principle: The study should investigate whether a structured holistic programme improves weight-related outcomes and quality of life as an adjunct to standard medical care, rather than claiming rapid or guaranteed weight loss.

17. CONCLUSION

Obesity is a major, rapidly growing global health concern, now affecting more than one in eight people worldwide. The relationship between genetic

predisposition, hormonal regulation, environment, psychological wellbeing and lifestyle requires both precise medical management and sustained, compassionate lifestyle support.

SCREEN → VERIFY → REFER → SUPPORT → FOLLOW UP

Holistic wellness has an important role in promoting healthy lifestyle behaviours, metabolic health, stress management and patient awareness. However, responsible integration requires clear boundaries.

MEDICAL DIAGNOSIS PROVIDES CLARITY. LIFESTYLE PROVIDES FOUNDATION. HOLISTIC WELLNESS PROVIDES SUPPORT. RESPONSIBLE REFERRAL PROVIDES SAFETY.

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