EDITORIAL

Contextual factors for prevention and management of obesity in India

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When the Prime Minister recently described obesity as a 'silent crisis' for India, it elevated the issue from a clinical concern to a matter of national policy priority (1). Obesity is now widely recognized as a formidable public health challenge in India, with prevalence rising rapidly in both urban and rural settings. As of 2025, India is preparing its first national obesity guideline**,** aiming to shift the focus beyond global standards to a home-grown framework that accounts for prevention, early diagnosis, and culturally appropriate interventions (2).

A recurring theme in this discourse is whether lower BMI thresholds—such as ≥23 kg/m² for overweight and ≥25 kg/m² for obesity—should be formally adopted in place of the WHO's international cut-offs (≥25 and ≥30, respectively).

The cut-off debate: While several expert consensus statements and smaller studies support the use of lower thresholds for Asian Indians, the evidence remains fragmented. Some cross-sectional studies suggest that cardiometabolic risk factors, including diabetes and hypertension, cluster at BMI levels well below 30 kg/m² (3). Yet, large-scale cohort data directly linking these lower cut-offs with incident cardiovascular events and mortality in Indian populations are still limited. As such, the question of optimal thresholds remains open and could be a focus of systematic research rather than a settled matter.

Broader contextual factors: The cut-off issue is only one dimension of contextualisation. India's unique "thin–fat" phenotype, characterised by higher body fat percentage and visceral adiposity at lower BMI, points to the need for greater emphasis on waist circumference and waist-to-height ratio as markers of risk. Equally, cultural dietary patterns—from carbohydrate-heavy staples to fasting traditions—shape both the epidemiology of obesity and the feasibility of interventions.

Physical activity recommendations must also be contextualised. While international guidelines emphasise structured exercise, the Indian reality is often one of limited public space, gender barriers, and reliance on informal physical activity. Indigenous practices like yoga offer a promising, culturally acceptable avenue, but require more rigorous evaluation for long-term weight and metabolic outcomes.

Health Systems readiness and feasibility: 'Evidence to decision' factors such as values and preferences of Indian patients, feasibility within our health system, cultural acceptability, equity, and resource use are critical to ensure that recommendations are not only evidence-based but also implementable. Even the most scientifically sound guidelines must consider health system capacity and equity. Pharmacotherapy and bariatric surgery, central features of many international guidelines, remain inaccessible for most Indians due to cost,

availability, and limited specialist infrastructure. In contrast, scalable strategies—such as community-based counselling, school interventions, and integration with the NP-NCD framework—may offer more sustainable impact, but remain under-researched.

Lessons from International Guidelines: Guidelines such as NICE (UK), CMAJ (Canada) and the American Gastroenterological Association (AGA)(4-9) provide recommendations on behavioural therapy, diet, physical activity, pharmacotherapy, and bariatric surgery, some of which can be adopted and adapted to the Indian context (Table 1). However, they often assume resource availability, health insurance coverage, and multidisciplinary teams—conditions not always feasible in India. Cost, feasibility, and cultural acceptability receive limited attention. Importantly, international guidelines do not address the "thin–fat" phenotype or proposed South Asian anthropometric cut-offs.

Moving Forward: In short, while global guidelines provide a foundation, their direct transplantation to India risks missing key contextual factors. The cut-off debate, highlighted by recent policy discussions and media coverage, is emblematic of the broader need to generate high-quality Indian evidence—from prospective cohort studies to implementation research.

Developing obesity guidelines for India should therefore be seen not as a one-time exercise of adopting international guidelines, but as an ongoing process of adapting global evidence, testing assumptions, and incorporating local realities. Only then can India arrive at definitions and recommendations that are both scientifically credible and practically feasible.

Table 1: Coverage of specific contexts in international guidelines on obesity

Guideline (Year)	Anthropometry (BMI/WC/WHtR)	Metabolic risk & comorbidities	Thin–Fat / central obesity	Resource constraints	Pharmacotherapy / surgery
NICE NG246 (UK, 2025)	BMI + WC + WHtR; ethnic risk noted	Strong focus on DM, HTN, CVD, NAFLD, OSA	Acknowledges South Asian risk	Community cost-effectiveness; not LMIC-specific	Full pathway for meds + surgery
AGA Pharmacotherapy (USA, 2022)	BMI ≥30 or ≥27 + comorbidities	Comorbidities guide drug use	Not covered	Mentions cost but not LMIC	Pharmacotherapy focus
CMAJ Adults (Canada, 2020)	BMI + WC + Edmonton staging	Detailed labs + comorbidity screening	Recognises adiposity at lower BMI	Acknowledges variation in resources	Recommends meds + surgery
CMAJ Children (Canada, 2022)	BMI z-scores + WC	Screening BP, HbA1c, lipids, ALT	Normal BMI + adiposity flagged	Considers family/cost barriers	Meds limited; surgery in select adolescents

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