Extremes of malnutrition in low- & middle-income countries

Star Health Desk

A new approach is needed to help reduce undernutrition and obesity at the same time, as the issues become increasingly connected due to rapid changes in countries' food systems. The new approach is especially important in low- and middle-income countries, according to a new four-paper report published in The Lancet.

More than a third of such countries had overlapping forms of malnutrition (45 of 123 countries in the 1990s, and 48 of 126 countries in the 2010s), particularly in sub-Saharan Africa, South Asia, and East Asia and the Pacific.

Undernutrition and obesity can lead to effects across generations as both maternal undernutrition and obesity are associated with poor health in offspring. However, because of the speed of change in food systems, more people are being exposed to both forms of malnutrition at different points in their lifetimes. This phenomenon further increases harmful health effects.

Globally, estimates suggest that almost 2.3 billion children and adults are overweight, and more than 150 million children are stunted. However, in low- and middle-income countries, these emerging issues overlap in individuals, families, communities and nations. The new report explores the trends behind this intersection – known as the double burden of malnutrition – as well as the societal and food system changes that may be causing it, its biological explanation

and effects, and policy measures that may help address malnutrition in all its forms.

High-quality diets reduce the risk of malnutrition in all its forms by promoting healthy growth, development, and immunity, and preventing obesity and non-communicable diseases (NCDs) throughout life. The components of healthy diets are: optimal breastfeeding practices in the first two years; a diversity and abundance of fruits and vegetables, whole grains, fibre, nuts, and seeds; modest amounts of animal source foods; minimal amounts of processed meats, and minimum amounts of foods and beverages high in energy and added amounts of sugar, saturated fat, trans fat, and salt.

Exposure to undernutrition early in life followed by becoming overweight from childhood onwards increases the risk of a range of non-communicable diseases – making the double burden of malnutrition a key factor driving the emerging global epidemics of type 2 diabetes, high blood pressure, stroke, and cardiovascular disease. Adverse effects can also pass across generations – for example, the impact of maternal obesity on the likelihood of the child having obesity may be exacerbated if the mother was undernourished in early life.

Despite physiological links, actions to address all forms of malnutrition have historically not taken account of these or other key factors, including early-life nutrition, diet quality, socioeconomic factors, and food environments. In addition, there is some evidence that programmes addressing undernutrition have unintentionally increased risks for obesity and diet-related NCDs in low-income and middle-income countries where food environments are changing rapidly.

While it is critical to maintaining these programmes for undernutrition, they need to be redesigned to do no harm. Existing undernutrition programmes delivered through health services, social safety nets, educational settings, and agriculture and food systems present opportunities to address obesity and diet-related NCDs.

The report identifies a set of 'double-duty actions' that simultaneously prevent or reduce the risk of nutritional deficiencies leading to underweight, wasting, stunting or micronutrient deficiencies, and obesity or NCDs, with the same intervention, programme, or policy. These range from improved antenatal care and breastfeeding practices, to social welfare, and new agricultural and food system policies with healthy diets as their primary goal.

To create the systemic changes needed to end malnutrition in all its forms, the authors call on governments, the UN, civil society, academics, the media, donors, the private sector and economic platforms to address the double burden of malnutrition and bring in new actors, such as grass-roots organisations, farmers and their unions, faith-based leaders, advocates for planetary health, innovators and investors who are financing fair and green companies, city mayors and consumer associations.

CLIMATE CHANGE

Climate risks to health are growing along with lack of prioritised funding

Safeguarding human health from climate change impacts is more urgent than ever, yet most countries are not acting fully on their plans to achieve this, according to the first global snapshot of progress on climate change and health. The new report drew on data from 101 countries surveyed by the World Health Organisation (WHO) and reported in 2018 WHO Health and Climate Change Survey Report.

Countries are increasingly prioritising climate change and health, with half of the countries surveyed have developed a national health and climate change strategy or plan. Worryingly, only about 38% have finances in place to even partially implement their national strategy of policy, and fewer than 10% channelling resources to implement it completely.

The survey found that countries have difficulties in accessing international climate finance to protect the health of their people. Over 75% reported a lack of information on opportunities to access climate finance, over 60% a lack of connection of health actors to the climate finance processes, and over 50% a lack of capacity to prepare proposals.

HEALTH *bulletin*

Lower BMI means lower diabetes risk

Lower body mass index (BMI) is consistently associated with reduced type II diabetes risk, among people with varied family history, genetic risk factors and weight, according to a new study published this week in PLOS Medicine by Manuel Rivas of Stanford University, and colleagues.

Weight-loss interventions have shown demonstratable benefit for reducing the risk of type II diabetes in high-risk and pre-diabetic individuals but have not been well-studied in people at lower risk of diabetes. In the new study, researchers studied the association between BMI, diabetes, family history and genetic risk factors affecting type II diabetes or BMI.

Nearly 5% of the participants had a diagnosis of type II diabetes, and diabetes prevalence was confirmed to be associated with higher BMI, a family history of type II disease and genetic risk factors. Moreover, a 1 kg/m^2 BMI reduction was associated with a 1.37 fold reduction in type II diabetes among non-overweight individuals with a BMI of less than 25 and no family history of diabetes, similar to the effect of BMI reduction in obese individuals with a family history.

"These findings suggest that all individuals can substantially reduce their type II diabetes risk through weight loss," the authors say.

Keeping the promise to the women who will deliver UHC

Star Health Desk

Women have always played a vital leadership role in their communities as traditional healers, keepers of medicinal recipes, carers of the sick and birth attendants. In many traditional societies, they still do. But when medicine formalised, women had to fight their way, and that partly explains why, although women are 70% of health and social care workers, they are clustered into lower status, low paid roles today.

This year's Universal Health Coverage (UHC) Day was the first since the landmark September 2019 United Nations High-Level Meeting on UHC when Heads of State and Government made strong commitments to deliver UHC. And one of the most important promises made was to address the gender inequities in the health and social workforce that disadvantage women and limit their advance into leadership. Heads of State and Government agreed unanimously that this has to change. And it has to change for three critical reasons:

First, we have a moral duty to look after the people who look after us when we are at our most vulnerable. It is a reasonable social contract that, in return for what they do for us, female health workers should have decent working conditions where they can focus on their work without fear of violence and harassment. And it is their right to receive equal pay and indeed, to be paid for the work they do. Health systems cannot be healthy resting on the fragile and inequitable foundation of unpaid work by women and girls. Recognising and paying women fairly for all the work they do in health and social care will result in stronger health systems for us all.

Second, 18 million new health and social care jobs, primarily in low- and middle-income countries, must be created to deliver UHC. And that is in the context of a wider predicted demand of 40 million health workers by 2030. It would be a tragedy to have got the commitment to UHC at the highest political level and to fail to realise it because we do not have health workers to deliver care. Women are studying medicine and entering health occupations in more significant numbers than ever before in most countries, and that trend seems set to continue. Women will fill the majority of health worker jobs and deliver UHC if we enable them to do so.

Finally, Delivered by Women, Led by Men reality, must change to achieve UHC. With men holding 75% of senior roles in global health, health systems are not drawing from the total talent pool. Our health outcomes are poorer because we are losing the perspectives of the women who run health systems, from both design and delivery. If UHC is to keep the promise of reaching everyone, we need diverse perspectives and the diverse leadership to reflect the populations we serve. We need women to lead health systems and have an equal voice in shaping them.

Source: World Health Organisation

Attenuated psychosis syndrome, validated

The Diagnostic and Statistical Manual of Mental Disorders (DSM)-5 has listed attenuated psychosis syndrome (APS) as a "condition for future study." APS can involve mild delusions, hallucinations, and disorganised speech, with relatively intact reality testing in the absence of an apparent psychotic disorder, and has been thought to be a risk state for later schizophrenia spectrum disorders. To examine the clinical utility of this diagnosis, researchers performed a systematic review of 56 articles and meta-analysis of 23 prospective studies that used different APS definitions.

The prevalence of APS was 0.3% in the general population and 3.5% in college students. The most common attenuated psychotic symptoms included derealisation, overvalued beliefs, and simple auditory hallucinations, such as hearing one's name called. The risk for progression to a clear psychotic disorder (usually schizophrenia) was 23% at 36 months.

While many schizophrenia patients retrospectively report prodromal symptoms of APS, at least 30% do not experience these. Similarly, most people with apparent APS do not rapidly become psychotic. For a large number of patients, however, odd experiences and ideas and an altered sense of reality do predict later obvious illness, and early treatment could prevent such progression.

Many people with APS do not seek help because they do not think they are sick. The challenge to clinicians is to identify high-risk patients — especially in families of psychotic patients — and engage them in a therapeutic relationship that at least facilitates regular monitoring.