Abstract Globally, dietary factors are responsible for about one in five deaths. In many low- and middle-income countries different forms of malnutrition (including obesity and undernutrition) can co-exist within the same population. This double burden of malnutrition is placing a disproportional strain on health systems, slowing progress towards universal health coverage (UHC). Poor nutrition also impedes the growth of local economies, ultimately affecting the global economy. In this article, we argue that comprehensive primary health care should be used as a platform to address the double burden of malnutrition. We use a conceptual framework based on human rights and the Astana Declaration on primary health care to examine existing recommendations and propose guidance on how policy-makers and providers of community-oriented primary health care can strengthen the role of nutrition within the UHC agenda. Specifically, we propose four thematic areas for action: (i) bridging narratives and strengthening links between the primary health care and the nutrition agenda with nutrition as a human rights issue; (ii) encouraging primary health-care providers to support local multisectoral action on nutrition; (iii) empowering communities and patients to address unhealthy diets; and (iv) ensuring the delivery of high-quality promotive, preventive, curative and rehabilitative nutrition interventions. For each theme we summarize the available strategies, policies and interventions that can be used by primary health-care providers and policy-makers to strengthen nutrition in primary health care and thus the UHC agenda.

Introduction

About one in five deaths globally are attributable to poor diets, making dietary factors responsible for 11 million deaths annually, more than any other risk factors covered by the Global Burden of Disease study. More than two billion adults are overweight or obese; both are known risk factors for numerous noncommunicable diseases, notably cardiovascular disease and type 2 diabetes. Almost two-thirds of infants between 6 months and 2 years old do not receive an adequate diet, putting them at-risk of the short- and long-term health effects of poor nutrition.

In many low- and middle-income countries different forms of malnutrition, including undernutrition and obesity, can co-exist within the same population. More than half of deaths in children younger than 5 years are due to diet-related risk factors, particularly undernutrition, while 41 million children in the same age group are obese. This evidence of a double burden of malnutrition prompted a series of papers in 2019 calling for double-duty action to address malnutrition in all its forms. The distribution of the burden of these diet-related risk factors and diseases is highly unequal, both within and between countries. Malnutrition drives disease and stunts economic growth, costing the global economy approximately 3.5 trillion United States dollars (US$) per year. As the prevalence of malnutrition and diet-related noncommunicable diseases grow, these economic impacts increase. An even stronger economic case exists when considering the impact of the inefficiencies and environmental impacts of the food systems that produce such unhealthy diets, in addition to the direct health-related costs themselves. A conservative estimate of the potential economic benefits to society from addressing the current hidden costs of food systems sums to US$ 5.7 trillion annually by 2030, increasing to US$ 10.5 trillion annually by 2050.

We argue that tackling this double burden of malnutrition is an urgent global health and development challenge. We provide an overview of similarities and links across the nutrition, primary health care and universal health coverage (UHC) agendas, presenting past and present debates on this issue. We use a conceptual framework based on human rights and the Astana Declaration of 2018 on revitalizing primary health care to examine existing recommendations and propose guidance for policy-makers on how community-oriented primary health care can strengthen the role of nutrition within the UHC agenda.

Nutrition and sustainable development

The challenge of malnutrition is intrinsically linked to the United Nations 2030 agenda for sustainable development. Several of the sustainable development goals (SDGs) are directly related to nutrition: zero hunger (SDG 2), good health and well-being (SDG 3) and responsible consumption and production (SDG 12). Nutrition can be considered an outcome of the global food system, the complex network of food-related activities including the production, processing, transport, marketing and consumption of food. The global food system is among the largest drivers of global environmental change, including climate change, biodiversity and habitat loss, and land degradation. Thus, from a planetary health perspective, nutrition is also closely linked to other SDGs: access to

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water and sanitation for all (SDG 6), climate action (SDG 13) and life on land (SDG 15). A fundamental target for SDG 3 is UHC, defined as ensuring that all people have access to needed health services, including prevention, promotion, treatment, rehabilitation and palliation, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship.

Nutrition and UHC are linked in several ways. First, progress towards UHC is threatened by the growing burden of malnutrition and noncommunicable diseases, which are placing a disproportional strain on health systems and are threatening to reverse progress towards UHC. Second, UHC can serve as a framework for programmatic action for improved nutrition in the population. The World Health Organization (WHO) has described primary health care as the programmatic engine of UHC. Primary health care is defined as an overall approach, which encompasses multisectoral policy and action to address the broader determinants of health; empowering individuals, families and communities; and meeting people’s essential health needs throughout their lives. In this context primary care is a subset of primary health care and refers to essential, first-contact care provided in a community setting. Comprehensive primary health care is well-positioned to serve as a link between the nutrition and UHC agendas. First, the nutrition and primary health care agendas are similar in concept. Both require a human-rights based framework, multisectoral action, community involvement and a life-course based delivery of evidence-based preventive and curative health care integrated with public health services. Second, the primary health-care sector is the place where primary and secondary prevention can be scaled up, disadvantaged population groups reached and treatments for diet and nutrition-related diseases delivered most cost-efficiently. Finally, primary health-care providers witness on a daily basis the burden of poor nutrition and unhealthy diets, such as malnutrition-related child mortality or the adverse outcomes of obesity. Primary health-care providers’ role at the frontline of the health-care system makes them natural advocates for improvements in the production, processing, transport, marketing and consumption of food. Two examples are the minimum unit pricing policy for alcohol in Scotland that was advocated by primary health-care providers and advocacy for climate-responsible health-care systems by Health Care Without Harm, an international nongovernmental organization.

The contribution of primary health care to improved nutrition was explicitly outlined in the Alma-Ata Declaration of 1978. In a speech in 1982, Halfdan Mahler, the then Director-General of the WHO and a key architect of the Declaration, argued that primary health care improves nutrition when countries have: (i) explicit nutritional objectives; (ii) sustained and adequate levels of nutritional care components; (iii) integrated monitoring and evaluation mechanisms for nutrition-related outcomes; and (iv) community involvement. Furthermore, he emphasized intersectoral action for nutrition and health and the role of health professionals in promoting intersectoral policy-making. More recently, the relationship between UHC and nutrition was highlighted by WHO in a policy brief on nutrition in UHC, which made the point that UHC cannot be achieved without ensuring equitable access to quality nutrition services. The document highlighted the role of primary health care, in combination with secondary and tertiary care, as a platform for addressing the determinants of unhealthy diets both within and beyond the health system.

Framework for action on nutrition

Four interconnected thematic areas, based on human rights and the Astana Declaration on primary health care, can be used as a framework for action on nutrition. In this article we summarize the available strategies, policies and interventions for each area. The first thematic area explains how primary health care can bridge the gap between systems- and individual-level thinking in nutrition. Discussing nutrition in the context of primary health care strengthens the notion of nutrition as a human right of immediate, tangible relevance in people’s lives. The second thematic area originates in the view that primary health-care providers are in a unique position to identify and contribute to multisectoral solutions on the local level. We examine how primary health-care providers can make a difference by improving governance mechanisms, working towards public awareness and empowerment and making local food production healthier, and by influencing and shaping local policy and regulations. The third thematic area focuses on community empowerment to identify reasonable ways to involve the community in addressing dietary patterns and their local determinants. Such activities include increased nutrition literacy, community classes and adequate sensitization and training of health professionals. In the fourth thematic area we outline some of the most important promotive, preventive, curative and rehabilitative nutrition interventions, and how to provide them in an equitable and non-stigmatizing way.

Nutrition as a human right

Both diet and nutrition need to become a central part of the medical and scientific discourse in primary health-care institutions and local health administrations. This approach has the potential to foster community-led advocacy to improve existing food systems and to contribute to more community-oriented ways in which knowledge is gathered, understandings are reached and priorities are set. Making clear that nutrition is an inseparable part of comprehensive primary health care brings nutrition within the human rights-based foundation of the Alma-Ata and Astana Declarations and strengthens equity considerations, and the right to safe and nutritious food. The power of using a human-rights-centred approach in addressing complex global health issues is reflected in the global response to the epidemic of human immunodeficiency virus infection. In 2019, scientists and health policy-makers and providers called for the development of international guidelines on human rights, healthy diets and sustainable food systems. Sustainable change needs a compelling narrative. The focus of discourse about action on nutrition in global health has shifted to social, political and commercial determinants of nutritional health, and how to change the global food system to modify these determinants. This shift contrasts with the traditional biomedical model that emphasizes individual responsibility and the need for medical interventions. However, neither of these two viewpoints alone represents the experi-
enches and possibilities of individuals and communities. The emphasis on social, political and commercial determinants of health is far removed from the individual. Conversely, the biomedical model risks placing too much responsibility and blame on the individual, who is often deprived of the choice or possibility to act. Community-oriented primary health care can bridge this gap between systems-level and individual-level thinking. The links between both models become clearer when looked at from a comprehensive primary health-care perspective. This perspective recognizes the principles of multisectoral action, community involvement and integrated delivery of preventive, promotive, curative and rehabilitative services. To alter the narrative to integrate both macrolevel and individual determinants, the nutrition agenda needs to be considered in the global, national and local policy planning processes, where health systems and health-related development policies are discussed. Global fora, for example the World Health Assembly, United Nations General Assembly and initiatives such as the Global Nutrition Summit (scheduled in Japan in 2020) can be platforms to work towards concrete financial and political commitments intended to strengthen the role of nutrition in primary health care.24

Local actions for better nutrition

A unique strength of primary health-care providers is their ability to identify and contribute to multisectoral solutions on the local level that are adapted to community needs.20 The advantage of local knowledge is well-demonstrated by primary health-care providers’ use of social prescribing to link patients to a range of local, non-clinical services across multiple sectors in a community (for example, cookery classes, volunteering and exercise groups).21 In the context of nutrition, primary health-care providers, by being embedded at the local level, can act to shape food environments. Food environments can be defined as the physical, economic, political and sociocultural context by which consumers engage with the food system to make their decisions about acquiring, preparing and consuming food.22

There are several of existing frameworks and examples of action on public health nutrition. In 2009, the Brazilian government published the Matrix for Food and Nutrition Actions in Primary Health Care. The matrix is a framework for teams of health professionals from diverse areas of knowledge to systematize and organize the food and nutrition actions and nutritional care components in primary health care.23 In 2019, the EAT-Lancet Commission on Food in the Anthropocene suggested some crucial strategies to change food systems.24 Specifically, the report called for complex systemic interactions that take place across food systems to be addressed at both a global scale and at scales adapted to local realities and needs.25 The United Nations Environmental Programme outlined four action steps in a collaborative framework for food systems transformation: (i) identifying a group of food systems champions; (ii) conducting a holistic system assessment; (iii) initiating a multistakeholder process for dialogue and action; and (iv) strengthening institutional capacity for long-term food systems governance.26 Actions (i) to (iii) of this approach are close to the multisectoral nature of comprehensive primary health care and can be directly supported by primary health-care providers at the local level (Box 1). For action (iv), primary health care can play an important role by holding policy-makers and politicians accountable based on their immediate experience of policy impact, high public trust and roles as patient advocates.

Altering the macrolevel determinants of people’s diets is also needed, through mechanisms such as improved trade, agricultural and taxation policies, as well as better regulation of the powerful private-sector forces, such as multinational corporations active in the global food system.26 Advocacy by primary health-care providers, including nutritionists, nurses and doctors, and fostered in primary health-care institutions, can be an important driver for commitment to macro-level policy change. Such an approach has been demonstrated by the climate and health movement.27

Empowering communities and people

Primary health-care providers are usually well placed to understand the local dietary context and identify reasonable ways to involve the community in addressing dietary patterns and their local determinants of health. Healthy diets are about much more than the science of nutritional components and how to optimize production and consumption of the right nutrients. After all, it is generally dietary patterns rather than individual food products that affect people’s health. Socioeconomic factors such as culture, religion, gender, geographical location and employment status are important determinants of human diets. In many cultures, eating is a communal activity with social interaction that means much more than just providing fuel for the human body. Policies and interventions that recognize factors that are embedded within the local context are likely to be sustainable and effective. An example is the Brazilian government’s dietary guidelines which “are designed to be sustainable personally, culturally, socially, economically and environmentally.”28

Considering the relevant local factors could also help to address power imbalances between health systems and the people they serve. Health systems can be made more person-centred and equity-oriented, such as by prioritizing those with greater need by allocating greater resources to the vulnerable. This approach is also relevant to the delivery of health and nutrition literacy and education programmes in an equitable manner that ideally takes into account the individual agency required of each community member for sustainable change.

Empowerment of communities and individuals to address unhealthy diets through primary health-care structures involves the provision of information, and the strengthening of nutrition literacy, the ability to obtain, read, understand and use nutrition information. Effective distribution channels include primary health-care providers in health-care facilities, public institutions, such as schools, and public awareness campaigns in the mass media. One example is community-based nutrition education, including cooking skills, which is a worthwhile approach in many settings, for instance as a part of community health schemes that also provide training to caterers and food providers in public service facilities.29 These approaches can be supported by coordination across different sectors and by the employment of health outreach teams in schools, at social events or public food markets. To do this, primary health-care providers should ensure that clinics employ appropriately trained professionals to offer classes and consultations. By
Horizonte city, Brazil. New York’s People’s Restaurants initiative in Belo city, United States of America, or the comprehensive food policy in New York follow suit. Positive examples are the use of food, such as municipal canteens, to providers can advocate for large procurers of food options, primary health-care providers can play a key role in delivering promotive, preventive, curative and rehabilitative nutritional interventions as part of comprehensive care. Health professionals in primary care are well-placed to assess patients’ diets, screen for dietary risk factors, to diagnose obesity and other diet-related diseases early, and to take appropriate action. Comprehensive primary health-care services are also in a good position to ensure health equity by reaching all groups of people, including those who are marginalized, especially when health care is free at the point of care. A greater degree of individual agency is often required for an individual-level intervention to be effective. Interventions are therefore more likely to preferentially benefit people of higher socioeconomic status compared with those with more limited social and economic resources. Accordingly, interventions focused only on education and behaviour change could reinforce existing inequities. Primary health-care services can rebalance this equity consideration by prioritizing resources and attention on the most vulnerable individuals.

A major limitation in many primary health-care systems is the lack of training of health professionals for dietary assessments, dietary counselling and the prevention and treatment of malnutrition.
Box 2. Role of primary health care in promotive, preventive, curative and rehabilitative interventions for better nutrition

- Provide advice on healthy diets and appropriate nutrition, as well as other lifestyle factors (e.g. physical activity, sedentary behaviour, alcohol and tobacco use).
- Conduct early identification of obesity in children, particularly children.
- Counsel patients with obesity on weight loss or refer to specialist care, consistent with evidence-based national clinical guidelines and the local context.
- Provide pre-conception, antenatal and postpartum nutrition guidance and support for healthy pregnancy, including iron and folic acid supplements.
- Promote, protect and support breastfeeding; ensure all health-care settings adopt best-practice breastfeeding policies and practices.
- Ensure patients with comorbidities (e.g. tuberculosis and human immunodeficiency virus infection) receive appropriate nutritional advice.
- Identify elderly people with or at risk of malnutrition and provide appropriate preventive and curative care in line with national clinical guidelines.
- Integrate dietary assessments and counselling in the educational curricula for primary health-care professionals.

Sources: World Health Organization (WHO), 2019;54 United Nations Children’s Fund (UNICEF), 2005.51 WHO, 2017;52 WHO, 2018;53 WHO, 2018;54 Moore et al., 2000.55 UNICEF, 2019.56 Wadden et al., 2018.57 Brown et al., 2019.60

Conclusion

We have focused on four thematic areas for action in primary health care to strengthen the role of nutrition within the UHC agenda: (i) bridging narratives and strengthening links between the primary health care and nutrition agendas, with nutrition as a human rights issue; (ii) encouraging primary health-care providers to support local multisectoral action on nutrition; (iii) empowering communities and patients to address unhealthy diets; and (iv) ensuring the delivery of high-quality promotive, preventive, curative and rehabilitative nutrition interventions. We believe this framework of available strategies, policies and interventions can serve to address the human suffering caused by the growing burden of malnutrition and noncommunicable diseases, and to pre-empt the disproportional strain on health systems that threatens to jeopardize progress towards UHC.

Competing interests: None declared.
Primary health care, nutrition and UHC

Christian Kraef et al.

Abridged version

Nutrition and primary health care

In an article by Christian Kraef et al. (Bull World Health Organ. 2020;98:886–893; doi: http://dx.doi.org/10.2471/BLT.20.251413) the authors discuss the importance of linking nutrition with primary health care. They propose four areas of action: (i) aligning discourses and strengthening the links between primary health care and nutrition, with nutrition being viewed as a human rights issue; (ii) encouraging primary health care providers to support local multi-sectoral actions on nutrition; (iii) empowering communities and patients to address unhealthy diets; and (iv) ensuring the implementation of high-quality promotion, preventive, curative and rehabilitative nutrition interventions. For each area, the authors summarize strategies, policies and interventions that can be used by primary health care providers and decision-makers to strengthen the role of nutrition in primary health care and the universal health coverage (UHC) agenda.
Resumen

Atención primaria de salud y nutrición

Los factores alimentarios son responsables de aproximadamente una de cada cinco muertes en todo el mundo. Diferentes tipos de malnutrición (incluyendo la obesidad y la desnutrición) pueden coexistir en la misma población de muchos países de ingresos bajos y medios. Esta doble carga de la malnutrición está ejerciendo una presión desproporcionada sobre los sistemas sanitarios, lo que ralentiza los progresos hacia la cobertura sanitaria universal (CSU). Además, la mala nutrición dificulta el crecimiento de las economías locales, lo que en última instancia afecta a la economía global. En este artículo, se argumenta que la atención primaria de salud integral se debería utilizar como plataforma para abordar la doble carga de la malnutrición. Se utiliza un marco conceptual basado en los derechos humanos y en la Declaración de Astaná sobre la atención primaria de salud para analizar las recomendaciones existentes y proponer directrices sobre cómo los responsables de formular las políticas y los proveedores de atención primaria de salud orientada a la comunidad pueden fortalecer la función de la nutrición dentro del programa de la CSU. En concreto, se proponen cuatro áreas temáticas de acción: (i) narrativas de vinculación y fortalecimiento de los vínculos entre la atención primaria de salud y el programa de nutrición en donde la nutrición sea una cuestión de derechos humanos; (ii) alentar a los proveedores de atención primaria de salud a que apoyen la medida multisectorial local sobre la nutrición; (iii) potenciar a las comunidades y a los pacientes para tratar las dietas poco saludables; y (iv) garantizar la realización de intervenciones de nutrición de alta calidad de tipo promocional, preventivo, curativo y de rehabilitación. Para cada tema se resumen las estrategias, políticas e intervenciones disponibles que los proveedores de atención primaria de salud y los responsables de formular las políticas pueden utilizar para fortalecer la nutrición en la atención primaria de salud y, por consiguiente, el programa de la CSU.

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