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EDITORIAL

A Human rights approach to clinical nutrition: addressing the challenges of disease-related malnutrition in resource limited settings

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Abstract

A human rights-based approach can be the cornerstone in the field of clinical nutrition. By endorsing the five principles of the Vienna Declaration, the global clinical nutrition network is developing initiatives and strategies for implementing programmes for improving awareness, advocacy, education, research and collaboration. The prevalence of disease-related malnutrition in hospitalized patients is higher in Asian resource limited countries than in Europe with unacceptably high nutrition risks in cancer, tuberculosis and intestinal failure in Indonesia. The international human rights working group has recommended practical steps involving evaluation of the applicability of the current international guidelines, and development of new resource-stratified guidelines followed by promotion and implementation.

Introduction

In 2016, the United Nations General Assembly proclaimed the Decade of Action on Nutrition 2016–2025 (Nutrition Decade).[1] This was an opportunity to establish an international human rights working group (IHRWG) to globally promote a human rights-based approach (HRBA) to clinical nutrition (CN) by developing strategies to fight disease-related malnutrition (DRM). This initiative culminated in 2022, with the main international clinical nutrition societies (ASPEN, ESPEN, FELANPE, PENSA) in conjunction with >75 national societies/associations from across the globe who signed The Vienna Declaration (VD) advocating recognition of nutrition care as a human right.[2] The declaration was also endorsed by patient groups and representatives from the European Commission and World Health Organization (WHO). The VD, and other publications from the IHRWG[3,4] are designed to provide an international framework for programmes that aim to promote access to nutrition care for all patients who are at risk of DRM, based on a HRBA.

Following the landmark VD, the major signatories have responded to the calls for international action with plans for appealing to other scientific medical societies, public authorities, international governmental and non-governmental organizations (NGO) on the importance of the human right to optimal, nutrition care for all patients. For example, the parenteral and enteral nutrition society of Asia (PENSA)[5] recognizes that CN is a human right, and member countries advocate for policies and guidelines that support the provision of CN to patients, specifically endorsing the 5 principles of the VD:

- Awareness: by raising awareness about CN as a human right through public campaigns, social media, and other communication channels. PENSA works to inform the public about the importance of CN and the impact it has on patient health and well-being.
- Advocacy: by advocating for recognition of CN as a human right in national and regional policies and guidelines, PENSA is working

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closely with governments and other stakeholders to raise awareness and to ensure that patients have access to high-quality nutrition support.

- Education and Training: PENSA provides training programmes and educational workshops for healthcare professionals to improve their CN knowledge and skills.
- Research: CN researchers are encouraged by PENSA to develop evidence-based practices and guidelines for improving the provision of nutrition care to patients in Asia.
- Collaboration: PENSA collaborates with WHO and other professional societies to develop guidelines and policies that support the provision of CN to patients in need.

To further assist these initiatives, the IHRWG recently published guidance specifically designed for countries in resource-limited settings (RLS). This latest consensus paper and recommendations[6] for the basis for this editorial, with an added specific focus on Asia and Indonesia, in particular the urgent need to address DRM in the diseases of tuberculosis and intestinal failure.

It is now well documented, from clinical data generated primarily from Europe and the USA, that nutritional care for at-risk hospitalized medical and surgical inpatients improves clinical outcomes, including survival.[7,8] In contrast, DRM increases health care costs with prolonged hospital stays, comorbidities and delayed rehabilitation. However, data on the prevalence of DRM in RLS at both the national and international level[9,10] particularly in low-income countries (LIC) are scarce. Proposals for tackling DRM in RLS form the basis of the latest initiative of the IHRWG.[6]

Results of the IHRWG survey (in which PENSA members; Afghanistan, India and Sri Lanka participated) confirms that the prevalence of nutrition risk in hospitalized patients is higher in those Asian countries than in Europe (40% vs 30%).[11] Diseases most associated with DRM include cancer, non-communicable and gastrointestinal diseases, intestinal failure (IF), intensive care patients, tuberculosis (TB)and other infectious diseases. Indonesia did not participate in the original survey, but the members of the Indonesian Nutrition Society (INA) will be invited to answer a similar questionnaire during 2025. Meanwhile official government statistics confirm that, for example Cancer (1.2/million), obesity (23%) diabetes (11.7%) and wasting/ underweight (7.8%) are leading causes of DRM.[12]

More specifically the country recorded over 800,000 cases of TB in 2023, making Indonesia one of the countries with the highest TB burden in the world. According to WHO, malnutrition is the leading risk factor for TB infection.[13] Malnourished patients are twice as likely to die from TB compared with non-malnourished patients. Moreover, for every 25-30 cases of lung TB there is one case of enteroperitoneal (ETB) a life-threatening abdominal catastrophe with mortality up to 26%, that if diagnosed and treated properly can be successfully treated with a combination of nutrition support (NS) and multidrug therapies.[14] It is therefore important that policy and decision-makers should require nutritional screening and assessment at diagnosis and every 4 weeks during TB treatment. Guidelines for prevention and malnutrition management plans should focus on nutrition support with optimum protein, energy and micronutrient intake, key components of TB treatment.[15]

Intestinal failure (IF) has been a relatively under recognized organ failure that has a major contribution to DRM in hospitals. According to Jeppesen[16] the number of IF patients should not be less than 10% of the number of patients receiving dialysis for renal failure and patients should have the same rights regarding access to treatment and

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care as patients with other organ failures. Data on the prevalence of IF in Indonesia and other LIC is scarce, whereas in the EU, Denmark with a population of 6 million has approx 600 IF patients receiving Home Parenteral Support (100 per million), the highest prevalence in the world. It is therefore important to increase awareness that the cost of IF treatment is lower than cost of other organ failure treatments such as dialysis, survival of IF is better than other organ failures, and, with correct nutritional management, the quality of life of IF patients is better.

To tackle the lack of awareness of the important benefit of addressing DRM in the most common diseases, the IHRWG organized an expert panel from the 4 global societies to analyse and address the identified barriers to nutritional care access in RLS. The list of expert recommendations with mostly 100% consensus agreement[6], included:

- Malnourished patients should aspire to receive the best nutritional care possible, despite any economic barriers.
- To improve nutritional care in RLS it is recommended to establish a local nutritional care organization/CN society with guidelines, education and training of HPs and research to help strengthen the health care system
- CN societies, NGOs and International organizations must recognize that the delivery of safe, equitable and high-quality nutritional care in RLS is a priority and should provide potential solutions when resources are constrained.
- CN practice in RLS can benefit from literature generated by developed countries but guidelines should reflect local healthcare needs and available resources.
- Until local research generates RLS clinical guidelines, adaptation of existing guidelines is essential for safe, feasible and effective bedside practices
- Health care professionals from non-RLS have a duty to promote nutritional care for patients in RLS and help to adapt recommendations for the management of DRM.

Detailed analysis of RLS responses to the survey enabled the IHRWG to identify gaps in the following fields:

- *Epidemiological data and evidence for best practices*: Health professionals in RLS and LMIC can initially rely on best practice literature from high income countries (HIC) but these guidelines must be adapted to the specific local characteristics of the RLS before implementation.
- *Education and Capacity Building*: Training health care professionals must strike a balance between "best-known" standards of care and the "best available" standards in RLS.
- *Strengthening Health Systems*: strategies to tackle DRM in RLS should ensure availability of basic hospital resources witha reliable supply chain of essential equipment for optimum nutritional care, and a plan for human resource development.

Recommendations

The IHRWG, on behalf of the international nutrition societies, has recommended a three-step strategy for tackling DRM and promoting nutritional care access in RLS.[5]

1. Evaluation of the applicability of the current guidelines in RLS
2. Development of resource-stratified guidelines (RSG).
3. Promotion and implementation of RSG.

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Conclusions

Adopting a human-rights based approach to clinical nutrition in resource-limited settings is difficult, due to the higher-than-average prevalence of disease-related malnutrition, associated with diseases like tuberculosis and intestinal failure in Indonesia and other low-income Asian countries. Food security, and socioeconomic factors that contribute to the higher prevalence of nutritional risk, poor availability of medical nutrition therapy in hospitals with limited referrals and resources for nutritional screening/assessment are factors that the INA in Indonesia and other professional societies in Asia are working hard to address. Current guidelines may not be fully applicable due to various barriers to the provision of appropriate nutritional care which are gradually being addressed by national professional societies. The three-step strategy, recommended by the international working group, for consideration by national societies and governments, is designed to increase awareness, promote the development of resource-stratified guidelines to optimize access to nutrition care for all patients.

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