

Composite index of anthropometric failure (CIAF) classification: is it more useful?

Editor – The paper published by Nandy et al. in the *Bulletin* on the composite index of anthropometric failure (CIAF) is welcome in view of the paucity of recent attempts to classify undernourished children satisfactorily.¹ However, the usefulness of the CIAF classification has to be considered vis-à-vis Waterlow's widely used stunting-wasting classification.²

In addition to height for age (HA) and weight for height (WH), the CIAF classification uses weight for age (WA) — a measure that does not differentiate acute, chronic, and past (recent or remote) undernutrition. The CIAF classification introduces two new groups of children (group B and group C). Group B (2.6%) has normal HA and WA but low WH, an improbable anthropometric combination; group C (6.1%), with higher HA but low WH and WA, is of little immediate concern and can be considered “healthy”, presumably growing up to become thin tall adults.³ Other groups, A, D, E, F and Y in the CIAF classification are covered by the Waterlow classification.⁴

The CIAF classification does not address the limitations of the Waterlow classification.² Firstly, it does not satisfy the long-felt need for a combined clinical and anthropometric classification that would be useful for clinical as well as community health work. The classification proposed by the Wellcome Trust Working Party in 1970⁵ and the one used in a WHO monograph in 1999⁶ are inadequate because their coverage of syndromes is incomplete and predetermined, and inappropriate anthropometric criteria are assigned to the syndromes. Personally, I prefer to

use a composite classification in which a syndrome is first diagnosed clinically and the anthropometric status (criteria not predetermined) of stunting-wasting is then applied to it.^{7,8}

Secondly, although children with Z-scores of less than -3 are considered to be severely undernourished, the lower limit of severity remains undefined. I have observed children aged 3–5 years suffering from prolonged or repeated nutritional assaults with extremely low Z-scores (HA: -6 to -7; WA: -5 to -6; and WH -3 to -4) and identified a very severe type, the *nutritionally battered child*.⁷⁻⁹ Possibly such cases are flagged as improbable in National Family Health Surveys (NFHS) and hence excluded.¹ The severe cases of stunting-wasting in the absence of kwashiorkor or marasmus reported by Indian workers may resemble these.⁸

Lastly, although in the Waterlow classification² wasting means low WH, as a clinical sign it means visible loss of subcutaneous fat and skeletal muscles. Low WH is observed with clinical wasting in cases of acute undernutrition and in chronic undernutrition of marasmic but not mild-to-moderate or severe (florid kwashiorkor) types where fat masks muscle wasting, if present. Hence, low WH may or may not be associated with clinical wasting, and wasting in the Waterlow classification² should be differentiated as anthropometric wasting. In their paper, Nandy et al. do not seem to have appreciated this difference and have incorrectly stated that “wasting is an indicator of acute undernutrition”.¹

NFHS data are not always reliable,¹ and the reliability of the CIAF model needs to be tested using carefully collected data. However, the associations exhibited between the types of anthropometric failure and morbidities are interesting. ■

Competing interests: none declared.

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1. Nandy S, Irving M, Gordon D, Subramanian SV, Smith GD. Poverty, child undernutrition and morbidity: new evidence from India. *Bull World Health Organ* 2005;83:210-6.
2. Waterlow JC. Some aspects of childhood malnutrition as a public health problem. *Br Med J* 1974;5936: 88-90.
3. *Physical status: the use and interpretation of anthropometry*. Geneva: World Health Organization; 1995. Report of a WHO Expert Committee. Technical Report Series, No. 854.
4. Waterlow JC, Buzina R, Keller W, Lane JM, Nichaman MZ. The presentation and use of height and weight data for comparing the nutritional status of groups of children under the age of 10 years. *Bull World Health Organ* 1977;55:489-95.
5. Wellcome Trust Working Party. Classification of infantile malnutrition. *Lancet* 1970;2:302-3.
6. *Management of severe malnutrition: a manual for physicians and other senior health workers*. Geneva: World Health Organization; 1999.
7. Bhattacharyya AK. Protein-energy malnutrition (kwashiorkor-marasmus syndrome): terminology, classification and evolution. *World Rev Nutr Diet* 1986;47:80-133.
8. Bhattacharyya AK. Assessment of growth and nutritional status in Indian population. *J Indian Anthropol Soc* 2000;49:69-102.
9. Bhattacharyya AK. Child abuse in India and nutritionally battered child. *Child Abuse and Neglect: the International Journal* 1979; 3:607-14.

Call for Papers — Public Health Reviews

The *Bulletin* welcomes submissions for the Public Health Reviews section. We are seeking evidence-based review articles that focus on an important aspect of a particular disease or condition or public health policy and which are likely to be of general interest to our readership. Papers should have no more than 3000 words and have a non-structured abstract. No more than 50 references should be cited. Papers received will be subject to the *Bulletin's* usual peer review process.

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Clinical trial registry initiative

Editor – The news item in the January 2006 issue of the *Bulletin* announcing a new WHO clinical trial initiative,¹ inappropriately and inaccurately refers to Merck, a company that has always been committed to the highest standards of scientific integrity and patient safety. Merck promptly and appropriately disclosed the results of Vioxx clinical trials — positive and negative — including VIGOR and APPROVe. Merck's behaviour over Vioxx is not that of a company “withholding negative research findings,” as your article inaccurately suggests.

We also wish to clarify the timing of certain events. The editorial by the International Committee of Medical Journal Editors (ICMJE) calling for registration of clinical trials as a condition of publication, which you cite in your news item, appeared online at www.nejm.org on 8 September 2004, and on 16 September 2004 in the print version of the *New England Journal of Medicine*, as well as in other ICMJE journals. This was several weeks **prior** to Merck's voluntary withdrawal of Vioxx on 30 September 2004,² i.e. not in response to the withdrawal as the *Bulletin* news item implies. Additional information can be found on our Vioxx information page at: http://www.merck.com/newsroom/vioxx_withdrawal/.

Merck has been an active participant in the WHO International Clinical Trials Registry Platform, taking part in meetings when invited, and commenting on proposals. Merck's commitment to registering all Phase II, Phase III, and post-marketing controlled clinical trials that we conduct anywhere in the world goes well beyond both the current US law that mandates registration of clinical trials designed to test the efficacy of products for life-threatening or otherwise serious illnesses and the industry commitment to register all “confirmatory” trials. Our policy on the registration and publication of clinical trials is posted at: http://www.merck.com/mrl/swf/Merck_Position_on_Clinical_Trials_Registries.swf.

We look forward to continued dialogue with WHO and other stake-

holders to promote transparency and allow patients and their health-care providers access to clinical trial information, while preserving protection of intellectual property. ■

Competing interests: none declared.

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1. WHO clinical trials initiative to protect the public. *Bull World Health Organ* 2006;84:10-1.
2. Clinical trial registration: a statement from the International Committee of Medical Journal Editors. *N Engl J Med* 2004;352:1250-1.

Dual job holding by public-sector health professionals may be beneficial to patients

Editor – The paper recently published in the *Bulletin* by Jan et al. on dual job holding (in the public and private sectors) by health professionals in developing countries makes an important contribution to the debate on human resources for health.¹ Dual job holding can provide continuity of care to those patients who can move between the two sectors. For example, patients attending a private facility would have the opportunity of obtaining services they cannot afford to pay for but which might be available in the public sector.

Jan et al. appear to be suggesting that the flow of patients from the public to the private sector is a bad thing *per se*. In the case of Malawi, however, the flow of patients from the predominantly free public health sector to the private sector may even be desirable as it reduces pressures on the public sector. Also, patients who demand services that are not available within the public sector, but which are available in the private sector, can be offered them against payment by dually employed physicians.

Dual job holding can also increase health professionals' status, as patients can witness that those working in state facilities are equally competent to work in private facilities, whose infrastructure may support first-world medicine.

Dual job holding also increases the productivity of health professionals as they can be employed after “normal working hours”. Such health professionals may be able to inject new ideas from the private into the public sector, where in some cases the quality of care may be better than that in the public health system. Clearly, it would be unethical for health professionals to treat private patients during the time they are employed by the public sector and to use its resources for individual income generation. But if health professionals bear this in mind, and refrain from abusing public resources, there should be no problem.

The migration of health professionals from Africa to developed countries is bad enough² and all attempts to retain them in developing countries should be investigated. But doing it in an ethical way that does not jeopardize patients' wellbeing is a difficult challenge. Finally, although the phenomenon of public health sector professionals who also hold jobs in the private sector has been described,³ there is a need to study their private-sector counterparts who also work in the public sector. ■

Competing interests: none declared

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1. Jan S, Bian Y, Jumpa M, Meng Q, Nyazema N, Prakongsai P, et al. Dual job holding by public sector health professionals in highly resource-constrained settings: problem or solution? *Bull World Health Organ* 2005;83:7716.
2. Muula AS. Is there a solution to the “brain drain” of health professionals and knowledge from Africa? *Croat Med J* 2005;46:219.
3. Ferrinho P, Van Lerbege W, Fronteira I, Hipolito F, Biscaia A. *Hum Resour Health* 2004;2:14.

Corrigendum

In Vol. 84, issue number 3, 2006, page 181, the correct affiliations for the sixth author of this paper, Yohannes Kinfu, should be “Australian National University, Canberra, Australia, and ACDIS, Africa Centre, University of KwaZulu-Natal, Durban, South Africa”. The name of the eleventh author was incorrectly spelled; it should read “Kubaje Adazu”.

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