

Anemia

A Public Health Problem

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Anaemia

- is a condition in which the number of **RBCs** or the **Hb** concentration within them is lower than normal.
- ❖ Hb is needed to carry oxygen and
- ❖ if **too few** or abnormal RBCs , or not enough **Hb**, there will be a
- ❖ **decreased of oxygen** carried to the body's tissues via blood
- The optimal Hb concentration needed to meet physiologic needs **varies** by **age, sex**, elevation of residence, **smoking**, & pregnancy
- **Anemia** is a global public health problem affecting both developing and developed countries
- with major consequences for human **health** as well as **social** and **economic** development.
- ❖ It occurs at all stages of the life cycle, but is
- ❖ **more prevalent** in pregnant women and young children

- ❑ Anemia is the result of a wide variety of causes that can be isolated
- Indeed these factors are multiple and complex
- ❑ The most common causes of anemia include nutritional deficiencies particularly iron deficiency
- ❑ Globally, the most significant contributor to the onset of
- ❖ anemia is iron deficiency (IDA)
- ❖ so that IDA and anemia are often used synonymously and
- ❖ prevalence of anemia has often been used as a proxy for IDA.
- ❑ It is generally assumed that 50% of the cases of anemia are
- ❑ due to iron deficiency but the proportion may vary among population groups and in different areas according to the local conditions

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In 2002, iron deficiency anemia (IDA) was considered to be among the **most important contributing factors** to the global burden of disease

- though deficiencies in folate, vitamins B12 and A are also
- important causes; haemoglobinopathies; and infectious diseases, such as malaria, tuberculosis, HIV and parasitic infections

❑ The primary objective of the WHO Globally is to fight against anemia.

❑ This needs collection of information on anemia prevalence

Types of dietary iron

There are two distinct types of dietary

1- iron-haem and 2- non-haem iron.

❑ Haem iron:

is a constituent of haemoglobin and myoglobin and therefore is present in meat, fish and poultry, as well as in blood products.

❑ non-haem iron:

❖ is the second type of dietary iron, it is more important source;

❖ it is found to varying degrees in **all foods of plant origin**.

❖ **non-haem** iron is absorbed in a fundamentally different way from haem iron.

❖ **Haem iron** Its **bioavailability** is little affected by the nature and composition of a given meal.

❖ meat, and fish are **enhancers** the of **iron absorption** of the non-haem contained in the rest of the meal



In contrast, the absorption of **non-haem iron** is **highly variable** and

- ❖ **depends on what other** foods are eaten with the meal,
- especially on the balance between foods that **promote** and those that **inhibit** iron availability.

- **Besides** the iron derived from food, the diet may also contain

- **exogenous iron** originating from

- ❖ the soil, dust, water or cooking vessels.

- ❖ such **contamination iron** in a meal may be several times greater than the amount of food iron.

- ❖ **Another form of exogenous iron** is that **present in foods** such as

- ❖ **flour, sugar and salt** which are **deliberately fortified** with iron or iron salts.

- **How much iron** is effectively **absorbed** by the body varies considerably depending on a number of factors

Absorption of dietary iron

The absorption of dietary iron is **influenced** by the

- **amount** and **chemical form of the iron**,
- **the consumption during the same meal of factors enhancing and/or inhibiting** iron absorption, and
- the **health and iron status** of the individual

□ MAJOR DETERMINANTS OF IRON ABSORPTION

❖ **DIETARY FACTORS:**

(1) **factors that enhance non-haem iron absorption:**

- - ascorbic acid (vitamin C)
- - meat, poultry, fish and other seafood
- - low pH (e.g., lactic acid)

(2) **factors that inhibit non-haem iron absorption:**

- - Phytates whole grains, seeds, legumes, البقوليات, some nuts
- - polyphenols, including tannins

HOST FACTORS:



❖ **HOST FACTORS:**

(1) iron status

(2) health status (infections, malabsorption)

When the anemia is due to iron deficiency, increasing the person's intake of absorbable iron will raise the Hb concentration

However, many individuals with **seemingly normal Hb levels** likewise **respond to iron** administration with a rise in haemoglobin, which implies that they **were actually deficient in iron**

.Assessing the frequency of iron deficiency anemia in a population by means of haemoglobin

S&S

Anaemia can cause a range of symptoms including fatigue, weakness, dizziness and drowsiness.

The main risk factors for IDA include

- A. Low intake of iron**
- B. Poor absorption** of iron from diets high in phytate or phenolic compounds,
- C. Period of life** when iron requirements are especially high (i.e.growth and pregnancy).
- D. Heavy blood loss** as a result of menstruation, or parasite infections such as hookworms, ascaris, and schistosomiasis **can lower blood Hb concentrations.**
- E. Acute and chronic infections**, including malaria, cancer, TB, and HIV can also lower blood Hb concentrations.

Infections interfere with food intake and the absorption, storage and use of many nutrients, iron among them. Repeated episodes of infection may result in the development of anaemia, particularly in young children whose morbidity burden is much higher than that of adults. This explains in part the high prevalence of anaemia among infants and preschool children.

- F. The presence of other micronutrient deficiencies**, including vitamins A and B12, folate, riboflavin, and copper can increase the risk of anemia.



G. Furthermore, the impact of haemoglobinopathies on anemia prevalence needs to be considered within some populations.

Congenital haemolytic diseases such as sickle-cell anaemia and thalassaemia are also found in certain populations, particularly in Africa, Asia, and some Pacific islands, although they rarely constitute a significant public health problem. In some Asian countries, Thailand and Viet Nam, the high prevalence of thalassaemia should be taken into account when iron supplementation programmes are envisaged.

Health consequences

Anemia is an indicator of both poor nutrition and poor health.

❑ The most dramatic **health effects** of anemia, i.e. **increased risk of maternal** and **child mortality** due to severe anemia, have been well documented

❑ In addition the negative consequences of IDA on
❖ **cognitive** and **physical development** of children, and
❖ on **physical performance**— particularly work productivity in **adults** – are of major concern

❑ **The consequences of iron deficiency, and especially iron deficiency anemia, are many. They include the following:**



They include the following:

❑ *In infants and children*

- ❖ impaired **motor** development and coordination
- ❖ impaired **language** development and **scholastic** achievement
- ❖ **Psychological and behavioural effects** (inattention, fatigue, insecurity, etc)
- ❖ decreased **physical** activity

❑ *In adults of both*

- ✓ decreased **physical** activity :
- ✓ decreased **physical work** and **earning capacity**;
- ✓ decreased **resistance** to fatigue.

❑ *In pregnant women;*

- increased **maternal morbidity** and **mortality**
- increased **fetal morbidity** and **mortality**
- increased risk of **low birth** weight.

There is a growing body of evidence, based on animal studies, that iron deficiency as such, even before the stage of frank anaemia is reached, **adversely affects the immune system.**

Assessing anaemia

- ❑ Hb concentration is the **most reliable indicator** of anaemia at the population level,
- ❖ Measuring Hb concentration is relatively easy and inexpensive, and this measurement is frequently used as a proxy indicator of iron deficiency.
- ❑ However, anaemia can be caused **by factors other than iron deficiency**.

the causes of anaemia **need to be identified** considering that they may vary according to the population

Anemia may be diagnosed with confidence when the Hb concentration is **lower than the level considered normal** for the person's age/sex group.



Table 5.2: Stages of anemia. Source (48) and values used in demographic and health surveys.

	Anemia measured by hemoglobin (g/dL)			
	Anemia	Mild	Moderate	Severe
Children 6–59 months	<11.0	10–10.9	7.0–9.9	<7.0
Children 5–11 years	<11.5	10–11.4	7.0–9.9	<7.0
Children 12–14 years	<12.0	10–11.9	7.0–9.9	<7.0
Non-pregnant women above 15 years	<12.0	10–11.9	7.0–9.9	<7.0
Pregnant women	<11.0	10–10.9	7.0–9.9	<7.0
Men (above 15 years)	<13.0	12–12.9	9.0–11.9	<9.0

Note: Hemoglobin values change with altitude and formulas are available to adjust hemoglobin values at different altitudes to define anemia.

Magnitude of the problem

Table 2.3 *Classification of anaemia as a problem of public health significance*

Prevalence of anaemia (%)	Category of public health significance
≤4.9	No public health problem
5.0–19.9	Mild public health problem
20.0–39.9	Moderate public health problem
≥40.0	Severe public health problem

Source: adapted from reference (2)

Prevalence

- ❑ Globally, anemia affects **1.62 billion people**
- ❖ which corresponds to **24.8%** of the population
- ❑ The **highest** prevalence is in **preschool-age children (47.4%)**, and
- ❑ the **lowest** prevalence is in **men (12.7%)**,

Anaemia is a serious global public health problem that particularly affects young children and pregnant women.

❑ **Worldwide, WHO estimates that anemia.**

- ❖ **42% of children** less than 5 years of age and
- ❖ **40% of pregnant women**
- ❖ **non-pregnant women 35%, and**
- ❖ **adult males 18%**

- ❑ The prevalence of anemia remains high globally, **particularly**
 - ❑ **in low-income settings**, where a significant proportion of **young children and women of childbearing** age can be assumed to be anemic.
- ❑ Iron deficiency anaemia is considerably more prevalent in **the developing (36%-versus 8%-) than** in the industrialized world,
- ❑ Africa and South Asia have the highest overall regional prevalence rates estimated prevalence of anemia in all groups is more **than 40% in both regions** and is as high **as 65% in pregnant** women in South Asia.

Prevalence of Anemia in Jordan

prevalence of anaemia to be

4.9% in males,
19.3% in non-pregnant females, and
27.4% in pregnant females.

Anaemia was predominantly mild
males: 81%,
non-pregnant females: 57%, and
pregnant females: 65.2%.

Iron deficiency anaemia (IDA) accounted for
68% of an anemic females and
38% of an anemic male

Control of anaemia

- Given the multifactorial nature of this disease,
- ❖ correcting anemia often **requires an integrated approach**.
- In order to effectively combat it, the **contributing factors must** be identified and addressed.

1-In **settings where iron deficiency** is the most frequent cause, **additional iron** intake is **usually provided through**

- ❖ **iron supplements to vulnerable** groups; in particular pregnant women and young children.
- ❖ Food based approaches to increase iron intake **through**
- ❖ **food fortification** and **dietary diversification** are important
- **sustainable strategies** for preventing IDA in the general population.



Cont.... Control of anaemia

2-In settings where **iron deficiency is not the only cause** of anaemia, approaches that **combine iron interventions with other measures are needed.**

taking into account the specific etiology and prevalence of anemia in a given setting and population group

Prevention of iron Deficiency anaemia

The **four basic approaches** to the prevention of iron deficiency anemia are

- 1. Supplementation with medicinal iron,**
- 2. Education and associated measures to increase dietary iron intake,**
- 3. Control of infection, and**
- 4. Fortification of a staple food with iron.**

I Supplementation with medicinal iron

- ❖ Supplementation with medicinal iron has the advantage of
- ❖ **producing rapid improvements** in iron status.
- ❖ it can **be targeted at the population at greatest risk** of becoming iron-deficient. such as **pregnant women, infants and preschool children,**

The **effectiveness** of iron supplementation is **constrained by two important factors:**

- a. the gastrointestinal side-effects of oral iron and
 - b. the difficulty of sustaining motivation for two to three months **in "patients"** who do not perceive themselves to be ill.
- ❖ Both factors result in **poor compliance** with treatment,

II Dietary modification

Dietary iron intake can be increased in poor communities in two ways.

A. First is to ensure that people consume larger amounts of their habitual foods so that their energy needs are fully met

Since no qualitative changes in the diet are needed, this approach may appear to be simple but it involves increasing the purchasing power of households-which is beyond the capabilities of the health sector alone.

B. Second basic approach is dietary manipulation

Enhancing the bioavailability of the iron ingested, rather than its total amount either on;

Promoting the intake of iron absorption enhancers, including haem iron, or on

reducing the ingestion of absorption inhibitors such as tannin and phytic acid



III Control of viral, bacterial and parasitic infections

- ❖ Effective, timely curative care could diminish the adverse nutritional consequences of viral and bacterial disease.
- preschool children, in particular, would benefit from such improvements in health care.
- It is vital to educate the family about proper feeding practices during and after periods of infective illness
- Breast-feeding should not be interrupted.
- Immunization

IV Food Fortification

- ❑ Iron fortification of foods is a preventive measure that aims at
- ❖ improving and sustaining iron nutrition on a permanent basis
- ❑ It can be targeted to
 - a. groups at risk of iron deficiency or
 - b. to whole populations,

❑ Fortification of foods

- a. can include only iron (**single fortification**), or it can
 - b. be extended to encompass two or more nutrients (**multiple fortification**).
- It can use a variety of iron compounds and vehicles

❑ For fortification of any kind to be effective,

Three essential factors are necessary:

- (1) an effective and affordable iron compound must be available and acceptable;
- (2) a food vehicle must also be available and accessible; and
- (3) detailed production instructions and monitoring procedures must be in place and enforced by law.

□ A variety of foods have been used for iron fortification.

- Ideally, the food selected is; **consumed** regularly in sufficient, stable quantities by the target populations and is **centrally processed**,
- **Easy** to fortify,
- **Stable** in storage,
- **inelastic** to price,
- **minimally altered** by the addition of the fortificant, **and**
- **amenable** to proper regulation and monitoring.

The food that is **used** also needs to be **priced** so that an increment in cost of the fortified product, including packaging, can be absorbed by the population, the government, the producer, or the retailer, or in some combination of these groups

Thank You

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