obesity in women in developing countries might impact negatively on existing maternal health services in low-resource settings. Women with obesity have greater risk of pre-eclampsia, gestational diabetes, premature delivery, macrosomia, dystocia, post-partum haemorrhage, and miscarriage, and their babies are at a 62% increased risk of dying within 48 hours after birth compared with newborn babies of mothers without obesity. Caesarean section rates are higher in women with obesity, with three times more emergency caesarean sections, often associated with intra-operative and postoperative complications.

Additional equipment required includes larger cuffs for measuring blood pressure or theatre tables stable enough to tolerate additional weight. Skilled personnel are required for registering fetal heart beats, finding veins, or positioning in some women with obesity. Caesarean sections can be more difficult and additional help is often required to retract abdominal tissues. For spinal and epidural anaesthesia, failures and repeated pricking have been reported, but longer spinal needles for such cases are often not available in low-resource settings. Post-partum and breastfeeding problems because of mechanical and endocrinological issues in women with obesity require attentive nursing support. Based on these observations, targeted actions are required, as the problem of obesity in developing countries will rapidly increase in the coming years and services have to be prepared to avoid obesity-related maternal morbidity and mortality.

We declare no competing interests.

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The recent Obesity Series published in The Lancet considered the bigger picture of environmental factors. The authors of The Series emphasised and proposed important obesity prevention measures, including changing the environment, stimulating the expression of healthy food preferences, and establishing smart food policies. Some individual factors play an essential part in the development of obesity and therefore should also be a target for obesity prevention. For example, it is well established that alterations in fetal growth increase the risk for developing obesity and its metabolic consequences later in life. We and other groups have shown that fetal growth restriction modifies food preferences and feeding behaviour, increasing spontaneous intake of highly palatable foods in individuals over the life-course. As acknowledged by Corinna Hawkes and colleagues, although food preferences can be modified over time, they are often resistant to change. To us, the small picture—a healthy fetal life, optimised through adequate prenatal care—is essential to avoid the long-term consequences of fetal programming on childhood and adult health, including obesity.

It is important to avoid the idea that fetal growth restriction is simply the result of an inappropriate caloric intake during pregnancy. Many maternal factors affect fetal growth, such as hypertension, diabetes, smoking, and obesity. Most of these conditions are treatable with good and frequent prenatal care. Despite being acknowledged in large campaigns such as the 1000 Days Initiative real prenatal care improvements are still very timid. In Brazil, for example, less than 62% of livebirths were preceded by at least 7 prenatal visits. Besides health promotion and surveillance, prenatal care should be a time for parental orientation and teaching about breastfeeding, ideal weaning time and healthy weaning foods, which in the long term will also affect obesity risk. To provide such support, professional training is necessary, but not always available—this is another point where intervention or policy could have an enormous effect.

We declare no competing interests.

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The Lancet Series on obesity missed an important opportunity to more fully address non-Western food and the implications for policy and consumer engagement. While citing a few low-income and middle-income country examples, and noting the need for sociocultural dimensions...
in policy, the Series seemed more oriented to the Americas, in particular the USA, and other western perspectives, than to the experiences and needs of the great majority of the world’s population. Now that diet has been shown to be a more important factor associated with disease burden than physical inactivity or high body-mass index, a culturally-grounded, comprehensive approach to the global challenge of poor diet would seem called for.

With the population of Asia estimated around 4.427 billion and the population of Africa estimated at 1.069 billion, this combined non-western population of 5.496 billion people represents 76% of the worldwide population.

According to WHO, almost three quarters of all non-communicable disease deaths occur in low-income and middle-income countries. A related trend is the increasing westernisation of diets—the so-called nutrition transition—in Asia and Africa, with energy-dense, nutrient-poor foods such as animal products, plant oils, and sugar gaining preference over traditional vegetables, grains, and pulses. This has been matched by a narrowing in global crop diversity, favouring major crop plants in the energy-rich food categories over traditional food crops.

In Asia, the food industry continues to promote fast foods. Meanwhile, the media increasingly reports on the Mediterranean diet as a healthy option to the fast food trend and rising rates of non-communicable diseases. However, the Mediterranean diet, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, diet, can be seen as a western diet, studied by westerners on westerners, diet, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners, can be seen as a western diet, studied by westerners on westerners,

Evidence exists for the value of the Japanese diet, Chinese dietary traditions, and some ingredients of south and southeast Asian diets. Yet there is a lack of coordinated national or regional research aimed at identifying and promoting Asia’s deeply rooted food traditions.

Both China and India, which have an extensive cultural legacy on food traditions throughout Southeast Asia, have articulated personalised and seasonally-based frameworks for food and nutrition—all enriched with medicinal herbal ingredients with well documented pharmacological properties. Such an approach has the potential to restore traditional food varieties to agriculture and local markets, to create low cost and low input crops that have high nutritional benefit, and culturally familiar food that is supported by evidence to combat non-communicable diseases. It could even result in evidence-based, health-promoting diets coming on offer to Western countries.

We declare no competing interests.

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