



Childhood Overweight and Obesity in Sub-Saharan Africa : Current Definition, Prevalence and Risk Factors

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Abstract

Childhood overweight and obesity are one of the most serious public health challenges in the 21st century, with its consequences gradually felt in middle and low-income countries. In this article we discuss the definition, prevalence and risk factors of childhood overweight and obesity in sub-Saharan Africa in a bid to draw up possible preventive strategies to curb the incidence, as well as the morbidity of childhood overweight and obesity in this part of the African continent.

Keywords: Obesity; Overweight; Childhood; Sub-Saharan Africa

Introduction

Childhood overweight and obesity are one of the main global public health challenges of the 21st century, especially in sub-Saharan Africa due to the rising urbanisation and westernised lifestyles (SSA) [1,2]. It is a major risk factor for childhood non-communicable diseases (NCD), in particular, cardiovascular diseases [1]. Several preventive interventions to reduce its incidence over the last three decades have been unsuccessful [3,4]. The prevalence of childhood overweight and obesity increased by 47.1% over the last three decades [3], and it has been estimated that by 2020, an increase of 9.1% will be recorded [5]. In 2010, about 6.7% or 43 million (35 million in developing countries) of children under five were either overweight or obese [5]. Furthermore, the prevalence of childhood overweight and obesity in developing countries increased from 8.1 to 12.9% in boys and from 8.4 to 13.4% in girls over the last three decades [3], demonstrating the time trend of this rapidly growing epidemic.

Childhood overweight and obesity are worrisome because of its potential long-lasting sequelae in adulthood [6]. If not well-managed in childhood, it could lead to obesity, metabolic, cardiovascular, psychological, malignant complications, and premature death in adulthood [11-14].

In addition, there is a positive correlation between childhood overweight and obesity and the various risk factors for CVD, including atherogenic dyslipidaemia, early and accelerated atherosclerosis, metabolic syndrome, hypertension, type 2 diabetes mellitus and obstructive sleep apnea [11-15]. Determining risk factors for overweight and obesity among children is crucial because childhood is a critical period for the development of obesity in adulthood [16]. These risk factors however, have not been fully examined in overweight and obese children in SSA. In this article therefore, we reviewed the current definition, prevalence, risk factors for childhood overweight and obesity, and possible forms of management in SSA. The overall aim being to draw recommendations to curb the burden of childhood overweight and obesity in SSA.

Definition of childhood overweight and obesity

Childhood overweight and obesity has been a subject of on-going debate in SSA due to the absence of a standard definition [17]. The assessment of childhood overweight and obesity using body mass index (BMI) may be subject to several drawbacks: BMI does not differentiate between lean and fat mass, and it varies a lot with respect to gender, growth, and racial background [18,19]. The BMI also has a low sensitivity to detect adiposity [20]. As a result, international limits using percentiles and standard deviations from a median reference point are worldwide preferred to traditional BMI cut-off values of $\geq 30\text{kg/m}^2$ and $\geq 25\text{kg/m}^2$ for obesity and overweight respectively [21–24]. These international cut-offs were put forth by the WHO, the Centre for Disease Control and Prevention (CDC), and the International Obesity Task Force. For children and adolescents of age between 5 and 19 years, limits of $\geq 1\text{SD}$ and $\geq 2\text{SD}$ defines overweight and obesity respectively, based on the WHO criteria [21]. The CDC defines overweight based on cut-off values between the 85th to the 94th percentiles and $> 95\text{th}$ percentiles for obesity [21]. The Centre for Disease Control defines overweight based on cut-off values 85th – 94th percentiles and $> 95\text{th}$ percentiles for obesity [23]. Childhood overweight and obesity are defined by the International Obesity Task Force as percentile curve passing through body mass index (BMI) of 25kg/m^2 at age 18 years for overweight and percentile curve passing through BMI of 30kg/m^2 at age 18 for obesity [24].

Prevalence of childhood overweight and obesity in SSA

Data from the Demographic and Health Surveys (DHSs) conducted between 2010 and 2014 from 26 SSA countries suggest that 10.7 million children under five (6.8%) are overweight or obese [25]. There is a high heterogeneity in studies reporting the prevalence rates of overweight and obesity in under-fives in SSA due to the rapidity of the epidemiologic transition and the large sociocultural differences [17]. In 2013, studies conducted in several SSA countries found that the prevalence of overweight and obesity in children between 5 and 17 years old was 10.6% and 2.5% respectively [17].

Risk factors associated with childhood overweight and obesity in SSA

To begin, the gender distribution of overweight and obesity in SSA has a predilection for the female gender. Averagely 7.6%

of boys and 15.4% of girls between 5 and 17 years old are either overweight or obese in SSA [17]. Higher trends of overweight or obesity in girls from SSA may be explained by the different roles played by each gender; while boys involve themselves in more strenuous physical activities, [26] the girl child in less strenuous activity, there is a cultural attachment whereby being overweight or obese is an admired trait for girls in SSA [27].

Secondly, childhood overweight and obesity is very linked to increased physical inactivity of children as a result of indoor activities such as computer games, television viewing and internet [28,29]. Many factors contribute to physical inactivity of overweight and obese children in SSA such as urbanisation of cities with resultant lack of open playgrounds in schools and communities, and the persistent emphasis on academic excellence at the expense of physical activity of children [30].

Thirdly, children in SSA are at increased risk of overweight and obesity considering the rightward shift in consumption of traditional healthy foods to high-calorie westernized foods [31]. This diet is rich in saturated fats, refined carbohydrates, and sweetened carbonated beverages, with low levels of polyunsaturated fatty acids and fibres. These predispose them to obesity, metabolic syndrome, type 2 diabetes and coronary artery disease. Furthermore, children of high socioeconomic level are more prone to overweight and obesity compared to those low socioeconomic level in SSA [17,32], probably due to increased sedentary lifestyles and increased accessibility to high-calorie diets which are more affordable to children of high socioeconomic levels.

Still more, some maternal factors seem to play a role in the development of childhood overweight and obesity in SSA. Overweight or obese mothers have a 1.5 to 2 times increased odds of having an overweight/obese child [25,33,34], while children whose mothers have primary education or no formal education have a 1.23 and 1.10 times increased odds of being overweight or obese [25]. This may probably be explained by the fact that less educated mothers may have poor knowledge on high-caloric diets.

Lastly, the birth weights $\geq 4000\text{g}$ have been shown in a systematic review [25] and two cross-sectional studies [33,34] to predispose children to either overweight or obesity in SSA.

Conclusion

The above elucidates the definition, prevalence and risk factors of childhood overweight and obesity in SSA. Interventions to curb the burden of childhood overweight and obesity in SSA should focus on the aforementioned modifiable risk factors: physical inactivity, consumption of high-caloric diets and maternal education. These interventions entail health promotion activities through health education of parents or guardians and children on the ill-health of childhood overweight and obesity. Furthermore, there is the need to incorporate a compulsory module on physical activity and healthy diets in schools in SSA. Finally, ministries of education in SSA should work in collaboration with ministries of health to ensure adequate implementation of these public health interventions through the assessment of a reduction in overweight and obesity in children. These policies will go a long way to build sustainable health and educational systems that could help reduce the burden associated with this condition in SSA.

Competing Interests

The authors declare that they have no competing interests.

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