

ers. (They are, we should note, recruited from several countries).

We can now turn to the particular issue of the place of origin of any given paper submitted to the Journal. With regard to reviewing, we note that authors are to some degree protected from bias about the source and place of origin of a paper by our review process, in which the reviewers are blind to authorship. With regard to editing, we note that although the Journal is the scientific organ of the American Public Health Association, editorial judgments and actions about content are independent and never impeded by the Association. That specific policy has its source in beliefs and values about science and about public health.¹ These reach far beyond the particularity of locality and nationality.

Outside mundane circumstance, scientific knowledge has no location, no bounds, and no topography other than in the minds of those who would wish to advance it, know about it, learn it, or use it. Public health is of necessity committed to science. It is also committed to the health of populations. Although that commitment has arguably had and may still have bounds, health is a broad and inclusive modern value. It is humane, and humanitarian, and embraces a search for equity.² For utilitarian as well as philosophical reasons, it is a value that recognizes and rests on the interconnectedness of human populations.

These ideas may seem more highfalutin than the occasion warrants, but they are in truth the foundation for the simple everyday criteria that inform our judgments and guide our actions about all manuscripts, and no less about those that come to us from abroad. Our policy is to treat equally all international and US papers in the following respects: they must have general scientific significance, beyond the borders of the local source; or describe a situation or phenomenon that

can be seen as providing significant comparative data or results; or report a unique phenomenon, local as it may be.

In one respect—namely where a paper has significance for the United States but not necessarily elsewhere—the Journal, being American, might accept it when we would not accept one that was analogous for another country. However, the balance goes the other way in respect of literary quality. We discriminate in favor of a submission from abroad that meets one of the above criteria but is deficient in syntax and idiom and even in methods that might be remediable.

In seemingly worthwhile instances, editors aim to be more tolerant of deficiencies in idiomatic English and to do a good deal more copyediting than for papers from English speakers. In a promising case that presents substantial difficulties, we may, at the risk of seeming presumptuous, advise authors to proceed by enlisting the aid of an editor competent in English. We also tend to stretch further (some authors may think too far) in recommending methodological changes consonant with Journal requirements.

At the same time, we cannot deny the appearance of discrimination in the fact, as one analysis of submissions from 1989 shows, that international papers that had an author from a developed country fared better.³ The explanation is not far to seek. In addition to the problem of language and idiom, less developed countries are sorely lacking in well-trained public health researchers as in much else. In other aspects, moreover, the analysis found no evidence of discrimination and a distinct improvement in the number of submissions and the proportion of acceptances for the years examined. From 1983 to 1989, the number of annual submissions rose from 778 to 1043; those from countries other than the United States and Canada rose disproportionately, from 41 to 111. The acceptance rate for

international papers also rose disproportionately: for the United States and Canada the rise was small, from 22% to 25%; for other countries the acceptance rate more than doubled, from 5% to 11%.

It is certainly possible that we can better the present proportion of papers from abroad, and from the less developed world especially. A recent report in *Scientific American*⁴ describes the plight of researchers in less developed countries who feel themselves trapped in a vicious circle by barriers to publication. One suggestion made in that report could have merit for this Journal as well as others. The idea is to recruit—from among our reviewers and from other readers qualified to review—mentors willing to help authors from less developed countries to shape their work into a form suitable for publication. Any reader who might wish to volunteer should send a curriculum vitae to the Journal with a note expressing willingness and specifying fields of interest. We shall proceed depending on the response.

This explication aims as best we can to lay to rest any suspicion that international submissions are less welcome than others. We offer the Journal as the appropriate forum for a worldwide readership. Our constant effort is also to sustain a Journal that is the vehicle for all the best work in public health both abroad and at home. □

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Editor

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Editorial: Determining the Nutritional Status of the Elderly in Post-Cold War Russia

The collapse of the Soviet Union in late 1991 signaled the end of the Cold War and set in motion profound social and economic changes in the newly independent states, including the Russian Federation. The sudden imposition of market reforms, the collapse of free trade

among the former Soviet republics, declining productivity, and unstable currencies have led to commodity shortages, spiraling inflation, and burgeoning government deficits. High prices for basic items such as food and medicines, as well as increasing difficulties in maintaining an adequate

social welfare system, have raised fears that large numbers of economically vul-

Editor's Note. See related articles by Rush and Welch (p 361) and Popkin et al. (p 355) in this issue.

nerable citizens, including elderly pensioners, will fall through the social safety net.^{1,2}

In this issue of the *Journal*, two papers arrive at different conclusions on the nutritional situation among the elderly in the republics of the Former Soviet Union since the end of the Cold War. While Rush and Welch present data from four republics,³ we focus our discussion on the results of studies in Russia for the purpose of comparison. Rush and Welch conclude that from January to September 1992, acute weight loss was highly prevalent among the elderly in Russia and that it was associated with elevated mortality rates.³ On the other hand, Popkin et al. present compelling evidence that the weight status of the elderly in Russia has been stable since late 1992 and suggest that this demographic group is not currently among the most vulnerable.⁴

What then can we conclude about the nutritional status of the Russian elderly from these two papers? Both studies offer convincing evidence of diminished purchasing power among the elderly, especially during the first 9 months of 1992 and, again, in late 1994. Popkin et al. describe both the consumer price index and the income level that defines "poverty" increasing rapidly through late 1994.⁴ However, their household income data suggest that elderly pensioners living in extended family situations have fared worse than those in households composed exclusively of elderly pensioners, perhaps because the former group has had to share their income with other, possibly underemployed, family members.

The two papers differ mainly in their findings on nutritional outcomes. On the one hand, Rush and Welch describe self-reported weight loss of at least 5 kg during a 6-month period in 1992 among approximately 50% of urban Russian pensioners over 70 years old.³ This acute weight loss was associated with self-reported declines in purchasing power. In contrast, by assessing anthropometric measurements Popkin et al. found that during a 12-month period between 1992 and 1993, the mean weight of elderly Russian pensioners, including those over 70 years of age, actually increased.⁴ Although no directly comparable studies of the US elderly are available, one American study showed that among persons aged 65 to 74 years, the mean change in body mass index units (weight/[height²]) over a 10-year period was -1.1 kg/m^2 for men and -1.7 kg/m^2 for women.⁵

The studies reported by Rush and Welch took place in urban centers during

1992, which was a time of great political upheaval and uncertainty. Anxiety over the collapse of a system that had promised security in old age might have significantly influenced the responses by elderly Russians to subjective questions on weight loss. In any case, changes in weight in an elderly population could be due to illness or psychosocial stress as well as nutritional deprivation. The body mass indexes documented in their study, although not based on actual anthropometric measurements, are not low relative to Western populations. For example, the mean body mass indexes reported in October 1992 for elderly men and women in Moscow of 24.7 kg/m^2 and 25.9 kg/m^2 , respectively, are only slightly lower than those found in the US population (26.9 kg/m^2 for men and 27.2 kg/m^2 for women aged 60 to 74 years).⁶

There are at least two ways to explain the different findings of these studies. First, the studies may represent the true evolution of nutritional changes among the elderly in Russia following the break-up of the Soviet Union: a high rate of acute weight loss from January through September 1992, followed by a period (late 1992 through late 1994) during which further weight loss was relatively uncommon. In support of this theory, the mean body mass indexes among Russians aged 70 or more years (24.4 kg/m^2 in men; 26.4 kg/m^2 in women) reported by Popkin et al. in September 1992 are similar to the mean values reported by Rush and Welch for the same age group in Moscow in October 1992 (24.7 kg/m^2 and 25.9 kg/m^2 , respectively).^{3,4}

Alternatively, methodologic differences between the two studies might explain the different findings. Rush and Welch rely on self-reported weight, height, and weight loss to characterize nutritional change.³ US adults—especially those who are overweight—tend to underreport their weight⁷; however, the direction of self-reporting bias is unknown for Russians. On the other hand, the studies reported by Popkin et al. rely on more accurate anthropometric measurements.⁴ Rush and Welch studied only pensioners aged 70 years or more whereas the study populations described by Popkin et al. comprised all adults over 60 years, including many who were still employed.^{3,4} Nevertheless, for this editorial, we have compared the findings for pensioners over 70 years old only.

Differences in study design and sampling were significant. The serial cross-sectional studies reported by Rush and

Welch were conducted on equal probability samples drawn from government lists of pensioners³; however, they covered only five urban areas in Russia. In contrast, the studies reported by Popkin et al. had the advantage of a national sampling frame that included rural and urban households, larger sample sizes, and longitudinal design during the first phase.⁴ The exclusion of rural households in Rush and Welch's study may have influenced their findings. A 1993 national study of household food security in Armenia showed that urban households had considerably less access to food than rural households.⁸

Whatever the validity of the two studies' respective findings on weight loss, it is not clear whether the association suggested by Rush and Welch between a high prevalence of self-reported weight loss and the recent increase in mortality among the elderly in Russia is causal in nature. Some studies have demonstrated a strong association between acute undernutrition and mortality in young children,⁹ but this association has not been clearly demonstrated for otherwise healthy adults. One US study showed an association between long-term weight variability and mortality risk¹⁰; however, these results do not necessarily indicate a causal association between acute weight loss and subsequent mortality.

The 15% increase in mortality cited by Rush and Welch among Russian adults aged 60 years and over between 1990 and 1993 took place in the context of a gradual decline in life expectancy in Russia since the mid-1960s.³ Although there was some improvement following restrictions on the purchase of alcohol introduced in 1985, the negative trend in life expectancy resumed in 1988.¹¹ Increases in Russian mortality rates are most likely due to a number of factors. First, there may have been important changes in the way in which mortality data are collected. Second, increases in mortality related to both cardiovascular diseases and alcohol-related causes have been well documented.¹¹ Third, the increase in mortality may be associated with deterioration in the quality of medical services in Russia.¹² Indeed, for their study population, Rush and Welch report a close relationship between weight loss, dietary intake, and having an illness requiring medication.³ As they correctly point out, the relative importance of acute weight loss leading to terminal illness, on the one hand, and severe illness causing weight loss, on the

other, cannot be clarified with the limited data available.

In the light of these studies, perhaps the most important issue to examine is the relevance and use of food and nutrition data in managing public health programs. The studies reported by Rush and Welch were relatively low cost, quick to perform, and provided timely data on both economic and health outcome variables. On the other hand, the studies reported by Popkin et al., while employing more reliable measurement methods, provided information some time after the events had occurred and were costly. Moreover, from the information presented, it is not known whether the data generated by either of these studies affected decisions on public health management by relevant Russian agencies or by international humanitarian assistance organizations.

Monitoring nutritional risk in a previously overweight, elderly population with a high rate of underlying illness is a tremendous challenge. The prevalence of low weight or low body mass index is a late and nonspecific indicator; therefore, early and more specific indicators of nutritional deprivation need to be developed. In addition, the studies of Rush and Welch and of Popkin et al. focused on outcomes related to protein-energy nutrition;^{3,4} they did not address other aspects of nutrition, such as iron or vitamin deficiencies. Historically, micronutrient deficiency diseases, including goiter and rickets, have been significant problems in Russia and may reemerge as public health threats.¹³ Because of the current transient economy, Russians must adapt their diets to shrinking incomes, and Russian food fortification programs may deteriorate; therefore, micronutrient deficiency disease rates also should be monitored.

Developing a Russian health surveillance system that provides reliable data on the current needs of elderly Russians—and, perhaps, all Russians—may be feasible. For example, in adjacent Armenia, a country severely affected by an economic

blockade, an emergency public health information system has successfully integrated facility-based anthropometric surveillance, small sample surveys of pensioners, morbidity and mortality reporting, market price surveys, and periodic national surveys on household food security to provide timely public health and nutrition data that are published in a regular bulletin.¹⁴

Both papers conclude that recent economic trends make it difficult for Russians dependent on state pensions, including elderly pensioners, to maintain adequate incomes. However, as Popkin et al. point out, other groups, such as large families and the unemployed, may also be at high risk of failing to meet their basic needs.⁴

There is a clear need to establish routine systems of monitoring trends in food security that include economic indicators as well as dietary intake and anthropometric data. If a nationally representative reporting system is not feasible, then efforts should focus on sentinel reporting in areas of the country and among demographic groups perceived to be at high risk. In characterizing a useful system, a recent Institute of Medicine report stressed the need to generate timely information on emerging nutritional problems, identify population groups most at risk, and define the causal factors that can be addressed by interventions.¹³ □

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Editorial: The Psychosocial Work Environment and Heart Disease

Over the past half century, we have greatly deepened our understanding of the roles of hypertension, high cholesterol, and other factors in coronary artery disease. In parallel but less dramatically, we have added to our knowledge about

the role of psychosocial factors. In this issue of the Journal, Johnson and colleagues in Sweden further expand our understanding of the possible causal contribution to cardiovascular disease, and especially coronary artery disease, of

occupational and nonoccupational psychological demands, control of the work

Editor's Note. See related articles by Johnson et al. (p 324), North et al. (p 332), and Nordentoft (p 347) in this issue.