WORLD HEALTH DAY TODAY

Improving Nutritional Status of Women

by M Kabir

IN the 1991 census Bangladesh had about 110 million people and about half of its population were women. There is now sufficient evidence of discrimination against girls in health care and nutrition. In Bangladesh, as in many other cultures, girls are seen as a net drain on family welfare. From birth onwards, girls receive less food, nurturing and health care than boys, with important effects on their growth, development and survival. Older girls experience conflicts over their use of time, instead of playing or attending school they are expected to work at home or on the family farm. At time their work causes energy conflicts, carrying water and babies may require so much of their energy that they have none left for growth or learning from their environment. While both boys and girls are usually assigned work, the long-term nutritional implications are worse for girls. If a girl's growth is stunted, her reproductive risks increase. Moreover, male school enrollment usually exceeds that of girls, which effectively increases the work load on girls and limits their human resource development.

As girls grow to maturity, their economic contribution to household increases, but cultural expectations for early marriage and childbearing take away them from both their economic and biological wellbeing. Once married, the number of conflicts in women's roles increase. Women of childbearing age are under the greater role stress.

Rapid gains achieved in food production in the country have been offset by high rates of population growth. For example, per capita food consumption declines from 886 gm in 1962-64 to 807 per persons per day in 1981-82. Average calorie intake according to the 1981-82 Nutrition Survey was 1943 KCal. It was 2094 KCal in 1975-76 survey and 2301 KCal in 1962-64 survey. This indicates that calorie intake has declined by seven per cent between 1981-82 and 1975-76 and by nine per cent between 1975-76 and 1961-64. Over the entire period there was a decline of 16 per cent. Current intake is 80 per cent of the requirement but 76 per cent of the households have inadequate calorie intake. The low intake of calorie affects mothers and children especially. Similarly per capita nutrient intakes also declined substantially between 1962-64 and 1981-82. Detailed analysis of the data implies that only 48 per cent of the households had adequate protein intake. Thus remaining 52 per cent suffered from various degrees of inadequacy. The situation is even worse for mothers and children who need relatively more protein.

Besides high infant and child mortality rates, Bangladesh has high maternal mortality rates. The number of pregnancy — related deaths in Bangladesh is estimated to be six per thousand live births. Malnutrition plays an important role in maternal mortality, just as in infant and child deaths. Breastfeeding and to a lesser extent and pregnancy are significant drains on a women's nutritional resources. Besides young children, pregnant and lactating women are the most vulnerable group. Very little is known about nutritional needs of pregnant and lactating mothers. Maternal malnutrition remains a major problem in Bangladesh, where a large majority of them are in a constant state of nutritional stress, beginning in childhood, then adolescence, and continuing through the childbearing period. This is coupled with a continuous cycle of pregnancy and lactation often resulting in premature death. Chronic protein energy malnutrition, irondeficiency anaemia, and deficiencies of iodine and vitamin A are among the common nutritional deficiencies that affect women and children in Bangladesh.

Since women in the households traditionally acquire, cook, serve, consume and store food, their own nutritional status is affected by these roles. Socio-economic and socio-cultural factors also affect both women's nutritional status and their nutrition-related roles.

Women's nutritional status, in the context of Bangladesh should be investigated by both absolute levels of nutrition among women, and their nutritional status relative to men — issues of discrimination between males and females in nutrition-related matters.

In Bangladesh, the Institute of Nutrition and Food Science (INFS) conducted three surveys since 1962 on household and individual food consumption and individual nutrition status. The survey information suggests that per capita calorie intake was consistently higher for males than females in all age groups. Overall males averaged 2277 calories per capita in comparison to 1849 calories for females. About 76 per cent households are deficient in calorie intake. It is evident from the information that none of the age groups of children, adolescent and mothers (pregnant, lactating or both) satisfy the calorie requirement. Among children and adolescents, a higher deficiency was associated with lower age groups. Pregnant and lactating mothers were deficient by 29 per cent. This implies that children and mothers are the most nutritionally vulnerable group of the population.

The effects of gender and poverty on nutritional status may be synergistic. Although discrimination by gender was the more statistically significant determinant of nutritional status, male-female differentials in nutritional status were large among the lower socio-economic group.

The data also suggest significant differences in the calorie adequacy between males and pregnant and lactating women. Pregnant and lactating women are more calorie inadequate than their non-pregnant and non-lactating counterparts. Sex differentials in food intake is also evident. Iron intake is also considerably lower for the adolescent girls than the adolescent boys. With the onset of menarche, young girls are highly susceptible to anaemia in the absence of adequate dietary iron. The prevalence of anaemia among women in Bangladesh is mainly attributed to low iron intake. In a poor country like Bangladesh, a vast majority of the pregnant women may be anaemic and as a result of that about half of the maternal deaths may be associated with anaemia. Deficiency in Vitamin A is also more among adolescent girls than the adolescent boys.

The effects of gender and poverty on nutritional status may be synergistic. Although discrimination by gender was the more statistically significant determinant of nutritional status, male-female differentials in nutritional status were large among the lower socio-economic group. Nutritional status among the higher socio-economic group was better on the whole, and the gender differential was also smaller. Although both high and low socio-economic groups discriminated against females in breastfeeding practices, girls in the better off households consumed as many calories and more protein, iron and supplementary food as boys because food resources were not scare among these households. Among the poor, however, discrimination against female children, coupled with inadequate purchasing power meant their younger girls had lower calorie intakes, consumed less supplementary food, and less solid food compared to boys. Gender differences in adult nutritional status also appear to be exacerbated by poverty.

A major consequence of girls' nutritional deprivation in early childhood and adolescence is their failure to achieve full growth potential. Girls who bear a child before the close of the adolescent growth spurt, may remain physically underdeveloped and hence are at greater risk of maternal death as well as of bearing low birth-weight infants. During pregnancy women's access to food is often restricted through the taboos and rituals observed in traditional society. High maternal mortality in Bangladesh, as in other developing countries, is also a reflection of women's malnutrition. Poor health status and poor access to or utilization of health services are some of the underlying factors. Several common causes of maternal deaths are related to malnutrition, particularly anaemia, while other serious causes, such as toxemia and septicemia, reflect the inadequate health care available to women in the ante-natal and post-natal periods.

In Bangladesh, low food intake during pregnancy is a major problem. Women consume little or no extra food during pregnancy. Food taboos often deprive women of protein and iron sources, as the survey data reveal major deferences in caloric intake between males and females. Pregnant and lactating women suffer a disproportionate burden of food deficit due to inappropriate distribution of food within households. In addition to suffering a calorie shortfall, women also work longer hours and spend more energy than men.

Other demographic influences on gender discrimination include a shorter period of breastfeeding for female children which may lead to shorter birth intervals with consequent risk of malnutrition and mortality. Low food intake during pregnancy is correlated with low-birth-weight infants, food taboos deprive women of protein and iron sources. Inadequate dietary intakes for female infants and children are precursors of the lower social status they enjoy throughout their life cycle. Early marriage means early childbearing which adversely affects not only women's nutritional status but also her education and employment opportunities.

Policy Implications

Women's nutritional status will not change substantially unless gender, employment and health care correlates also change. The critical role of female literacy in improving women's overall health and nutritional status should be well recognized. The coincidence of girls' adolescence and dropping out from school signals the need for education systems to focus on keeping girls in schools. This may be done through the provision of special incentives, public education and offering alternative forms of education. It is important to provide basic vocational skills, enhancing girls' employment, and delaying marriage until they are physically prepared for childbearing.

While these are long-term goals, in short-term efforts to specifically improve women's knowledge of health, nutrition and hygiene must be increased. The communication of basic nutrition information, based on a proper understanding of existing knowledge, attitudes and practices, and involving health workers, primary school teachers and other type of workers reinforced by appropriate use of mass media, can help empower women to successfully address malnutrition.

(The writer is Professor, Dept of Statistics, Jahangirnagar University)

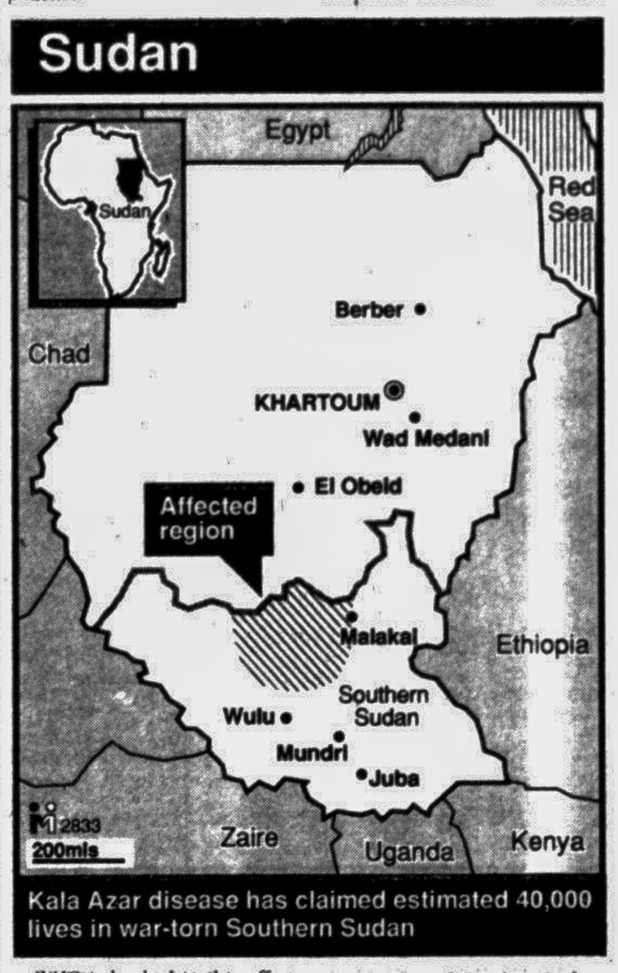
Deadly Disease Hits Southern Sudan

by Moyiga Nduru

AN international campaign is mounting to contain the spread of the deadly leishmaniasis epidemic which is claiming thousands of lives in war-torn southern Sudan.

Championing the campaign is the World Health Organisation (WHO), which has already appealed to the international community for funds, totalling $1 million, to contain the epidemic.

The funds would be used to purchase and transport the desperately needed drugs, disposable syringes and basic diagnostic equipment to identify and treat all existing patients.



Kala Azar disease has claimed estimated 40,000 lives in war-torn Southern Sudan

WHO is backed in this effort by the Non Governmental Organisation Medecins Sans Frontiers/Netherlands, which has established two centres for leishmaniasis victims in southern Sudan.

The group suggests that as many as 40,000 people may already have died, reducing the population of some villages by up to 40 per cent.

But the campaign has been opposed by the Sudan government, which describes as baseless the report that thousands have died because of the spread of the disease.

Dr Sadiq Mahjoub, director of the department of preventive medicine in Khartoum, issued a communique saying that "intensive studies carried out in connection with this showed there were no cases of a leishmaniasis in any part of the country."

This is likely to slow down international response to the WHO campaign, although government studies did not extend to the areas controlled by the rebels. Since 1983, the Christian dominated southern Sudan Peoples' Liberation Army (SPLA) has been fighting a secessionist guerilla war against the Muslim Khartoum government.

Fear is growing, especially among the overseas Sudanese community, about the stringent budgetary policy adopted by most donor nations. They say if the disease is not controlled, it could have far-reaching consequences.

Dr Lul Deng, a Sudanese doctor affiliated with the London-based Relief Association of Souther Sudan, warns: "If effective action is not taken, there is a risk of the disease spreading even further, with devastating consequences, into neighbouring Ethiopia and Kenya."

So far, the disease is confined to western Upper Nile province of Sudan, placing 400,000 people at risk.

Deng said: "The international community should put pressure on both the Sudan government and the SPLA to declare a ceasefire in the affected area to allow doctors to work in western Upper Nile."

Fighting between government troops and the SPLA has made it impossible to undertake effective treatment to control the spread of the disease.

In normal times, this disease affects only a limited and stable population. "But because of the war, displacements of population and famine, the situation has created the condition for an epidemic," Deng explained.

Leishmaniasis, also known as Kala Azar, is caused by a parasite transmitted by sandfly. The symptoms include prolonged fever, loss of weight, anaemia and enlargement of the spleen.

The treatment costs $100 per patient. "If untreated all patients with clinical symptoms will die," according to a recent WHO report.

Thousands of patients are still waiting for treatment in western Upper Nile, but MSF/Netherlands, which has so far treated 13,000 patients, does not have sufficient medication to deal with all victims.

In addition, there are security problems in the war zone. Prospects for a negotiated peaceful settlement between Khartoum and the SPLA appear remote. Efforts by Nigerian President Ibrahim Babangida to broker peace between the two failed last June in Abuja.

With the war intensifying, the situation does not bode well for the thousands of Kala Azar victims trapped in western Upper Nile. In the worst-hit areas, clinical cases represent only the "tip of the iceberg", according to WHO. In fact many more people are infected, developing severe forms of the disease, because they are malnourished.

Internationally, the disease is not widespread. But, it is suspected that during the 1991 Gulf War, a number of United States soldiers were infected, though few of them showed any immediate clinical manifestations.

The United States Walter Reed Army Institute of Research and the US National Institute of Health in Bethesda, Maryland are now looking at the magnitude of this infection among American soldiers.

Those who were present in the Gulf have meanwhile been barred from donating blood due to the potential risk of transmission. Blood in the US is not at present routinely screened for Kala Azar.

Another area badly affected by leishmaniasis is the Indian subcontinent, where approximately 400,000 new cases are estimated to occur each year. Mortality is reported to be between 5 and 7 per cent.

In southern Sudan, the first signs of the epidemic became apparent in mid-1988, although it was initially believed to be an epidemic of typhoid fever.

MSF/Netherlands, which had reported these first cases, determined later that year the disease was indeed Kala Azar and that it affected thousands of people in western Upper Nile and in the capital, Khartoum, where many had fled in search of security. A centre was set up at Gereif in Khartoum in 1988 where 2,500 patients have been treated so far.

Recalled Dr Samuel Kong of the London SPLA office: "That was the worst period for the Kala Azar victims." "The disease devastated Upper Nile, wiping out some families," he said. "As a result, many people fled Khartoum leaving behind their cattle." — Gemini News

Prejudice and Panic in China

by Mo Li

CHINESE researchers are warning that China, with a population of 1.1 billion could be a sitting target for the AIDS epidemic in Asia, as the country is plagued by increasing problems of prostitution and drug use. Officials have already admitted the virus "is showing a rather serious epidemic tendency".

China has 969 cases of HIV, according to recent official figures, but this is almost certainly an under-reporting. Nearly 80% of cases are drug-related and concentrated in Yunnan Province, which borders the heroin-rich "Golden Triangle" between Myanmar (formerly Burma), Laos and Thailand.

Although the figures appear to be insignificant in relation to the country's population, the risk of a major AIDS epidemic is hanging over the country, says researcher Qiu Renzong of the Academy of Social Sciences in Beijing, because of tremendous increases in sexually-transmitted diseases (STDs), injecting drug use and prostitution. Qiu warns in an article published in Hong Kong that sexual transmission among heterosexuals will become the dominant mode of HIV transmission in China in coming years.

Reported cases of STDs have increased at a frightening annual rate since 1982, according to Qiu. In 1982, there were 627 reported cases of STDs. The number grew to 85,430 in 1989. Between 1980 and June 1989, a cumulative total of 2,04,077 cases of STDs were reported nationwide. Qiu estimates that the actual number of STD cases could be as high as one million, and points to the fact that a large percentage of Chinese live in the countryside and have limited access to stahdard medical treatment.

The spread of STDs is linked with the increasing level of prostitution in Chinese cities, particularly in the prosperous southern provinces of Guangdong and Hainan. In Guangdong alone, the focus of China's efforts at economic reform, police raids last year broke up 300 prostitution rings, closed hundreds of brothels and dance clubs and arrested more than 7,000 prostitutes and their customers. According to a report in Nineties, a Hong Kong monthly, between 1982 and 1991, Chinese police identified about half a million prostitutes, a high percentage of whom were found to have STDs.

The report also quoted inside information from the Beijing Police Bureau suggesting that nearly 10,000 women are engaged in prostitution in Beijing government has built a large shelter-clinic on the outskirts of the city to offer moral education as well as medical treatment to women arrested as prostitutes. Both government officials and researchers fear that the current level of prostitution could become a major factor in the spread of AIDS in the country.

China reported its first domestically infected case of HIV/AIDS in 1988. Until then, all reported cases of HIV had been infected abroad, or through imported blood products. Most HIV-infected Chinese are injecting drug users, STD patients, prostitutes, and sexual contacts of HIV positive people, as well as people who contracted the disease abroad. Chinese researchers announced an "explosive" growth in HIV infection among Chinese returning from abroad at an international congress in November last year.

These are among the groups considered to be "at risk" and targeted by China's AIDS prevention programme for HIV testing, along with homosexuals, foreign residents, Chinese nationals who work with foreigners, residents of border areas and blood and organ donors.

By December 1992, about 2 million Chinese had reportedly been tested for HIV, according to the Beijing-based Workers' Daily — a doubtful figure since China is unlikely to be able to afford such large-scale HIV blood tests, which may cost several million US$.

The AIDS education campaign in China carries a strong moral message that the disease is a result of the "decadent western lifestyle", and that AIDS prevention means avoiding behaviour deemed contradictory to the Chinese social norm — such as sex outside marriage.

In 1989, when a Chinese man contracted HIV from homosexual contact with a foreigner, the Chinese for AIDS, Aisibing, was quickly corrupted into Aizibing — a pun meaning "the loving capitalist disease" [1]. Some media programmes on AIDS suggest that AIDS is a punishment for those who do not follow the moral principles of society.

Because of the moral stigma associated with AIDS, the general public reacts to any cases of AIDS or HIV infection with prejudice and panic. When a Southeast Asian student in Guangzhou City tested positive for HIV, all his female friends in the school were regarded as HIV positive and shunned by other students. The school itself was considered "AIDS-infected" by local residents.

Many medical professionals are reportedly reluctant to treat people with AIDS/HIV. Even prisons in Yunnan Province have refused to accept prisoners known to have AIDS or HIV, fearing the spread of HIV among inmates.

One ray of hope for the future of AIDS prevention is that Chinese people traditionally use condoms much more than Western. Although their use is not as widespread as in Japan, where up to 70% of men regularly use condoms, about 20% of Chinese men are regular users.

Rapid social changes in China are promoting the spread of AIDS. More open attitudes to sex, increased mobility for tens of millions and growing wealth which feeds the sex and drugs industries all present new opportunities for HIV transmission. To adapt to this new reality, the government must urgently promote AIDS education, argues Qiu. According to Wan Yanhai, head of a pioneering AIDS information telephone hotline in Beijing: "Current efforts to educate the public are far from adequate." — World AIDS


China's children: is it too late to avert an AIDS disaster?

There's Coca in Your Drink

THE case of Jeannette Vidangos, refused a job because she tested positive in a drug test yet guilty of no narcotic offence, has bigger repercussions than the loss of an employment opportunity.

It shows coca mate (tea) has no future in the United States, despite efforts by Bolivia — one of the world's biggest producers of coca leaf — to promote the product on the world market.

The Jeannette Vidangos issue, widely covered in the US press, brought coca into the limelight in the North American country.

Vidangos, who is of Colombian origin, flunked her test even though she is no drug user. Her only "sin" was drinking coca tea from Bolivia, the country her husband comes from.

Drug tests in the United States do not tell whether the alkaloids whose presence is diagnosed in a subject come from the inhaling cocaine or from drinking coca tea. The US Food and Drug Administration, the official agency charged with authorizing the entry and distribution of consumer goods in the United States, only allows coca leaf to be imported if the alkaloids are eliminated.

Even Bolivia's ambassador in Washington, Jorge Crespo Velasco, came out in defence of the leaf in an article in the press, pointing out the nutritional and medicinal properties of coca and drawing the line between it and its habit-forming derivative. "Coca is good,. cocaine is bad," he wrote.

Coca leaf is highly valued in South America's Andean region for its properties as a stimulant and food. But it is weighed down by the stigma of being the main raw material for cocaine, the most popular illicit drug in the United States.

Bolivia's efforts to uplift the image of what would be a major export product have included commissioning a World Health Organization (WHO) study on the properties of the leaf.

Research by US scientist William Carter in Bolivia shows

The cocaine-traumatised United States refuses to differentiate the drug from other coca products. Marco Antonio Sibaja of IPS reports.

the leaf is closely intertwined with all phases of the lives of the peoples of the Andes. It is used as a stimulant for workers, as an offering to the spirits, as a tonic to fight off the cold, as a medicinal drug to cure wounds and illnesses and as a commodity to cement social relationships and reward hardworking employees.

Its use dates back to 1,000 years ago, when coca was considered a divine plant. The Incas used it in religious ceremonies and its consumption was confined exclusively to the society's privileged classes.

After the Spaniards conquered the area, they distributed the leaf to the Amerindians to enable them to work long hours in the mines without feeling fatigue or hunger. Coca later made its way to Europe.

In the early days, the virtues of the leaf and its derivatives were tolerated in Western cultures. In the 19th century, there was an explosion of by-products of the leaf, which came in all forms: tablets, syrups, drops and ointments. The ailments they were used for ranged from indigestion and respiratory disorders to toothaches and sunburn.

All the uses benefited from the isolation of the leaf's active ingredient in 1860 by German scientist Theodor Aschenbrandt who had given cocaine to an exhausted soldier as part of an experiment. The man felt rejuvenated within minutes.

The use of the derivative spread among the European intelligentsia of that era, many of whom produced major works under its influence. English novelist Robert Louis Stevenson produced Dr Jekyll and Mr Hyde with the help of a few doses of the drug, which he used to cure his lung disorders.

But it was perhaps the father of psychoanalysis, Sigmund Freud, who was most instrumental in popularizing the drug. On learning of its properties, he experimented with it on his own body and produced a number of studies on its qualities, recommending it to all his friends and colleagues.

The drug quickly became a symbol of elitism and intellectuality during the 1890s, an era known for its hedonism and creativity.

One coca derivative went on to gain widespread and longlasting popularity. Developed in 1863 as a medicinal tonic under the name of 'Vin Mariani' (Mariani wine), the mixture of wine and coca extract was imitated and modified by many. These included John Styth Pemberton, who patented it in 1885 and gave it the name under which it has been known since: 'Coca Cola'.

Years later, scientists began to detect the negative side of cocaine — increasing addiction leading to paranoid delusions, insomnia and nasal ulcers. The drug then began to lose fans in the medical community, which proceeded to blacklist it. This led to its elimination as an ingredient of Coca Cola in 1903.

Around the same time, the first laws restricting its use were passed and when the United States issued its first anti-narcotics law, in 1914, cocaine was included, along with opium, morphine and heroin.

Yet the negative connotations attached to coca, whose mere mention galvanizes entire teams of security operatives at any US airport, stop short of Coca Cola, which has long become a cultural symbol of the United States.

The Coca Cola company never stopped using coca leaves to make its popular beverage, even though it replaced cocaine with another stimulant, caffeine. The United States imports huge quantities of coca leaves, mainly from Malaysia, and processes them in a laboratory in the north-eastern state of New Jersey for use in Coca Cola.