

Gender barriers to TB control in Bangladesh

Globally, the estimated male-to-female ratio of notified tuberculosis (TB) cases based on passive case finding is 2:1. Yet, the progression from infection to disease is almost 130 percent higher among women patients compared to men. Why are fewer women than men diagnosed with TB? In what ways are the help seeking, diagnosis, treatment, and compliance different for men and women?



Over the last couple of years, interest in identifying and addressing gender issues in TB control programme has increasingly been growing. In June 1999, the Joint Coordinating Board of the Special Programme for Research and Training in Tropical Diseases (TDR) endorsed the expansion of its disease portfolio to include TB. This opened up the way for WHO

and TDR's Task Force on Gender Sensitive Interventions (GSI) to work together and develop approaches to identify and address gender issues in TB control. Following several meetings on this critical issue, TDR funded a cross-country research programme covering Bangladesh, Colombia, India and Malawi for exploring different facets and natures of gender barriers to TB

interactions at labs, observations of patient-provider interactions during treatment initiation at community and key informant interviews with health providers.

TB is branded as a disease of poverty (WHO, 2002). The women patients were more likely to come more from poorer economic conditions than men patients. Gender differences in the perceived causes of the disease is frequently found. Women patients explain that everyday they are to eat last and least after serving all other family members. Consequently, the women patients strongly believe that such unfair practice damage their health making them more susceptible to TB than men. The men patients, on the other hand, argue that they are more susceptible to TB as they have to do hard work for earning family income but could not afford to eat as required. The common theme that emerge from these perceived vulnerability responses to TB among both men and women is poverty that compel them to remain underfed leading to malnutrition. Malnutrition in turn weakens the immune system making them more vulnerable to TB. However, for women, the burden is more severe as unequal intra-household food allocation seriously affects them. Therefore to redress gender inequalities any disease control interventions should focus on the particular societal disadvantages faced by women.

Women were more likely than

men to be victims of different stigmas attached to TB. These stigmas pose grave consequences for women. For instance, due to social stigma of TB, they often had to hide the disease and sought professional help only at very late stage. In many instances, having TB might make it difficult for women to find a husband or might result in divorce. Women TB patients' vulnerability is pervasive -- husbands frequently torture their wives mentally and physically and forced them to move to their parental homes.

Gender differences are also evident in terms of health seeking behaviour. Women patients are more likely than men to rely on self-medication for respiratory illnesses. As women's mobility is restricted (needed males' permission and someone to escort on movement), their travel to health service sources needed more time and cost.

Somatic distress out of TB is more acute for women than men. Among these coughing brought unbearable sufferings to them. They reported that while coughing, tears and urine came out that put them in an extremely vulnerable condition. Indeed, coughing and sputum have some culture-sensitive gender implications in our society. Men can freely cough up with a sound and spit sputum anywhere. In contrast the same act by women is viewed badly. Many women patients are also afraid of coughing, as they often thought that as a result of cough-

ing their neighbours might come to know leading to loss of face and image of her family in the community. Thus the women have to often suppress coughing and delay in appropriate help seeking. However, in spite of physical weakness caused by TB, women have to continue daily household chores without having rest. Unlike the men they often are unable to avoid it.

Men are more concerned about the economic distress caused by TB. Not unexpectedly given that men are considered as the main breadwinners of a typical Bangladeshi family, women are more concerned about men's TB than their own. They give more priority to the treatment of men's TB than their own. However, men often do not give much importance to the need of treatment of women's TB. The women patients do not receive social support to the extent they need either from the in-laws or from the parental side during the disease.

During interactions at laboratory and DOTS (Directly Observed Treatment Strategy) initiation, the service providers, especially men sometimes give more importance to men TB patients than women. Even some women providers do the same in their interactions during DOTS initiation. This implies that unequal gender relations that exist in our society are institutionalised in various settings that adversely affect the women.

Women patients are less likely to report their symptoms and get

sputum examined. This implies that the TB services are less accessible to the women. Even the women, who undergo sputum examination, are less likely to be smear positive. Perhaps many women do not receive proper instructions on how to produce effective sputum for test. The cultural construction of the act of coughing as we noted earlier is probably a barrier here. But no gender difference is evident in treatment outcome of TB. The health issues, particularly of the elderly women in TB control programme are neglected. Delays at different stages of help seeking and diagnosis appear to be unacceptably long, especially for women patients.

The overall findings revealed considerable gender inequalities and barriers in many aspects of TB control programme in Bangladesh that have many forms and faces and mostly embedded in our socio-economic, cultural and political milieu. This warrants more gender-sensitive interventions for TB control in Bangladesh, especially given our national commitment to attaining the Millennium Development Goal of reducing the incidence of diseases like TB.

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This article is based on a research work of a BRAC team. The team members were Fazlul Karim, Md. Akramul Islam, Insana Begum, AMR Chowdhury, Faruque Ahmed, Aminul Alam and Imran Matin.

Filariasis in Bangladesh

Eighteen million people in 12 districts are considered to be at risk of filariasis. A revised strategy for the elimination of filariasis is being pilot tested in one district. This strategy involves administering a single dose of ivermectin with albendazole yearly for a period of three years to the total population in the district.

Source: <http://w3.whosea.org>



Sustained weight loss is possible

Every dieter has heard the depressing prediction: You can take weight off, but eventually you will gain it all back.

Now, a new study refutes that thinking. It finds that many participants in an organised weight-loss programme maintained much of their weight loss two, and even five, years later.

"In fact, there is hope for long-term weight loss," said Dr. James Rippe, a cardiologist and Associate Professor of Medicine at Tufts University School of Medicine.

He noticed that almost all the weight is regained. In the new study, Michael R. Lowe, a Psychologist at Drexel University, and his colleagues evaluated the weight status of 246 participants in the Weight Watchers Programme two years after their initial loss. They also studied 135 participants five years after they had reached their weight goal.

Those who had attained their weight goal two years before had lost an average of 24 pounds. And "an average of 6.7 pounds was regained," Lowe said. The five-year participants had lost an average of 19.6 pounds, "and 9.9 pounds was regained five years later," he said.

The participants were asked about their weight status during telephone interviews, Lowe said. Then,

to account for any "under-reporting" of weight, Lowe surveyed a comparable sample of participants who were asked to give their weight over the telephone, and then asked to come to a facility to be weighed. About 230 participants came in to be weighed. Their data provided an "adjustment factor" to compensate for under-reporting of weight, he said.

The Weight Watchers programme -- and others like it -- focuses on a healthy approach to eating in which portions are controlled. It also encourages participants to engage in physical activity and to seek out group support through weekly meetings, Lowe said. Taken together, these components "helped these people keep off weight long-term," he added.

Other research has also found that monitoring food intake, exercising regularly, and seeking group support can produce long-term weight loss.

The study was funded by Weight Watchers International, which hired an independent research firm to conduct the surveys. Rippe and Weight Watchers will launch a collaborative project to further study weight maintenance.

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Source: <http://health.yahoo.com>

The anti-hunger hormone!

English researchers found that people who were injected with an experimental hormone ate one-third less food while visiting a buffet than people who had not gotten the injection. The substance nickname the "third-helping hormone" is secreted by cells in the intestine when you

eat. "The injections fooled people's brains into thinking they would already eaten," says Steve Bloom, the study author. A weight-loss drug containing the hormone is in development.

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Source: Health, February 2004

Why is hand washing so important?

A delicious mud pie, a good-luck rock, or a friendly frog are just a few of the presents children love to bring to their parents. But did you know that behind these adorable gifts - and countless others - millions of germs could be lurking?

Your children may not always listen when you tell them to wash their hands before dinner, but it is a message worth repeating. Hand washing is by far the best way to prevent germs from spreading and to keep your kids from getting sick.

The first line of defense against germs

Germs such as bacteria and viruses can be transmitted several different ways:

- Through contaminated water and food
- Through droplets released

during a cough or a sneeze

- Through dirty hands
- Through contaminated surfaces
- Through a sick person's body fluids

If your child picks up germs from one of these sources, he can unknowingly become infected simply by touching his eyes, nose, or mouth. And once he is infected, it's usually just a matter of time before the whole family comes down with the same illness.

Good hand washing is your first line of defense against the spread of many illnesses and not just the common cold. More serious illnesses such as meningitis, bronchiolitis, influenza, hepatitis A, and most types of infectious diarrhea can be stopped with the simple act of washing your hands.

How to wash your hands correctly

Here are some simple steps for scrubbing those germs away. Demonstrate this routine to your child or better yet, wash your hands together with your child several times a day so he learns how important this good habit is.

1. Wash your hands in warm water, which kills germs better than cold water. Make sure the water is not too hot for little hands.

2. Use soap and lather up for about 10 to 15 seconds (antibacterial soap is not so necessary - any soap will do). Make sure that you get "in-between" places like between the fingers and under the nails (where uninvited germs like to hang out). Do not forget the wrists!

3. Rinse and dry well with a clean towel.

To minimise the germs passed around your family, make frequent hand washing a rule for everyone, especially:

- Before eating and cooking
- After using the bathroom
- After cleaning around the house
- After touching animals, including house pets
- After visiting or taking care of any sick friends or relatives
- After blowing one's nose, coughing, or sneezing
- After being outside (playing, gardening, walking the dog, etc.)

Do not underestimate the power of hand washing! The few seconds you spend at the sink with your child could very well save you trips to the doctor's office.

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Source: <http://health.yahoo.com>



Preeclampsia: Searching for the cause

Three to five percent of pregnancies are complicated by preeclampsia, a multisystem disorder characterised by hypertension and proteinuria (protein in urine) that occurs after 20 weeks of pregnancy.

Preeclampsia is associated with substantial risks. For the fetus, these include intrauterine growth restriction, death and pre-maturity with attendant complications, whereas the mother is at risk for seizures (eclampsia), renal failure, pulmonary edema (fluid accumulation in the lungs), stroke, and death. Despite considerable research, the cause or causes of preeclampsia remain unclear and there are no clinically useful screening tests to identify women in whom it will develop. Anti-hypertensive therapy lowers maternal blood pressure but does not improve fetal outcomes; the only 'cure' is the delivery of the infant.

Preeclampsia has been dubbed the "disease of theories" because of the multiple hypotheses proposed to explain its occurrence. It is recognised that abnormal placentation and placental vascular insufficiency

are core features of preeclampsia, but why these and associated systemic abnormalities occur remains uncertain. Among the many proposed causes are immunologic derangements (a maternal immune reaction to paternal antigen in the placenta), genetic factors, increased insulin resistance (and associated elevation in the levels of insulin, free fatty acids and triglycerides), dietary calcium deficiency, increased oxidative stress and prostaglandin imbalance (an increased ratio of thromboxane levels to prostacyclin levels).

Preeclampsia is likely to be multifactorial in origin, and characteristics of the mother and the placenta may interact to lead to its development.

Recent research has focused on endothelial dysfunction as a central abnormality in preeclampsia. Abnormal pressor responsiveness in this disorder was recognised decades ago, when it was observed that women in whom preeclampsia was later diagnosed first lost the refractoriness to infused angiotensin-II that is characteristic of normal preg-

nancy. More recent studies in preeclamptic women have demonstrated increased levels of factors associated with abnormal endothelial function, such as cytokines (e.g. tumor necrosis factor) and endothelin-1.

Clinical research interventions that may cause preeclampsia has been complicated by the misclassification of study subjects, since not all hypertension in pregnancy is due to preeclampsia. Gestational hypertension -- elevated blood pressure without proteinuria or other systemic manifestations -- is frequently confused with preeclampsia but usually has a benign course. Other women who are labeled as having preeclampsia have unrecognized chronic hypertension. It is also unclear whether many abnormalities observed in women with preeclampsia are primary (causal) or are secondary to the disease process. At the same time, the lack of an animal model of preeclampsia has hampered laboratory research into this condition.

Given the uncertainty regarding the cause of preeclampsia, it is not surprising that effective

interventions are lacking to prevent its occurrence. Despite encouraging preliminary observations, large studies of interventions based on hypothesised causes of preeclampsia have yielded inconsistent and often disappointing results.

Currently, women who are at increased risk for preeclampsia are identified on the basis of epidemiologic factors. A first pregnancy, diabetes mellitus, preexisting hypertension or previous preeclampsia, multiple gestation, and higher body-mass index are among the recognised risk factors for the disorder, but they lack sensitivity and specificity. Although several markers have been proposed for the prediction of disease (including, for example, low urinary calcium levels, a hyperinsulinemia), the substantial overlap with regard to these measures between women in whom preeclampsia later develops and women in whom it does not, as well as the low positive predictive values of these measures for disease, makes them of little use in practice.

The results of a nested case-control study demonstrating the

presence of increased levels of soluble frms-like tyrosine kinase 1 (sFlt-1) and reduced levels of placental growth factor (PlGF) in women in whom preeclampsia develops. These changes were detected not only once disease was clinically apparent, but also several weeks earlier. The hypothesis is that high levels of sFlt-1 lead to placental vascular insufficiency and other systemic manifestations of preeclampsia by antagonising the angiogenic and vasodilatory effects of vascular endothelial growth factor and PlGF. Some other reports demonstrated that the infusion of sFlt-1 into pregnant rats resulted in findings consistent with preeclampsia (including hypertension, proteinuria, and glomerular endotheliosis -- a characteristic renal lesion in preeclampsia). The current findings, coupled with the research in rats, suggest that these factors may have a role in the pathogenesis of preeclampsia.

These data are intriguing, but questions remain. In the current study, preeclampsia did not develop in all women with high sFlt-1 levels and low PlGF lev-

els, and it did develop in some women with low sFlt-1 levels and high PlGF levels. This suggests that other maternal and placental factors are also likely to affect the occurrence and expression of disease. Prior experience with markers that ultimately turned out to lack sufficient predictive value, however, suggests the need for caution. Whether strategies for reducing the level of sFlt-1 or blocking its effects will have a therapeutic role is currently unknown.

The complications of preeclampsia have been recognised for centuries. Clinical and laboratory investigations over the years have better defined its pathophysiology but have failed to identify its "cause". Although more work is needed, the current report brings us one step closer.

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The article was first published in 'The New England Journal of Medicine' February 12, 2004.

Antidepressant relieves premenstrual syndrome

For women with severe premenstrual syndrome, the antidepressant drug sertraline brings relief -- and it makes no difference if they take the drug continuously or just before their periods.

Dr. Ellen W. Freeman, of the University of Pennsylvania School of Medicine, Philadelphia, and colleagues assigned 167 women with premenstrual mood problems to receive continuous sertraline (also known as Zoloft), intermittent sertraline, or an inactive placebo.

The study, published in the American Journal of Psychiatry, showed that women's premenstrual symptom scores were significantly more improved in both sertraline groups than in the placebo group. Mood and physical symptoms were significantly more improved in the sertraline groups.

The investigators report

that improvement with sertraline occurred swiftly in the first month of treatment.

Improvement with placebo also occurred, but gradually. However, it was similar to improvement with sertraline in the third month.

Improvements in family relationships, social activities, and sexual functioning were more often reported by patients who received sertraline compared with placebo-treated patients.

"The conclusion from these data is that the decision between full-cycle and premenstrual dosing for women with severe PMS ... can be based on patient/physician preference and individual experience of side effects," the authors write.

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Source: American Journal of Psychiatry February 2004.