

A Paradigm Shift in Social Vulnerability to Nutritional Diseases. A Perspective

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ABSTRACT

Vulnerability to nutritional diseases has for a long time been associated with social factors like poverty; gender more particularly women, and ignorance. Malnutrition was viewed to be more prevalent in rural areas than in urban areas. However, today there is a shift in vulnerability based on these social determinants. Overnutrition is becoming more prevalent than under nutrition, and the diseases associated with over nutrition poses great health, social and economic burdens. The purpose of this paper was to analyze the shift in social vulnerability to malnutrition. Kenya Demographic & Health Survey (2008-09) though I didn't capture on obesity only <5yr malnutrition reported a higher prevalence of obesity in the urban areas (39%) compared to rural areas (20%) and those with higher education and wealth quintiles being the most affected. Women are a vulnerable group due to their physiological needs. Currently, because violence against men is prevalent, it may be necessary to view this group as vulnerable. Men who are battered by their wives may be denied food leading to reduced food intake; moreover the psychological stress they go through may affect their appetite and further exacerbate the condition. KDHS-2014 spousal violence for men- 24% There has been a lot of focus on the girl child owing to the fact that culture had made her vulnerable. This focus has been over emphasized creating a shift of vulnerability. This has been quite evident in the education sector where in some parts of Kenya the enrollment of boys is lower. Boys drop out of school and turn out to be alcoholics, this makes the boy child economically unproductive and therefore not able to afford food, this and the alcoholic state reduces food intake, food utilization and predisposes them to other non-communicable diseases. This review concludes that a paradigm shift exists in vulnerability to malnutrition which should be noted by policy and other stake holders. This should be considered during allocation of resources for research and intervention so that ultimately a gap is not created.

Keywords: social vulnerability, nutrition, gender, poverty, education

INTRODUCTION

Vulnerability to nutritional diseases has been for a long time associated with social factors like poverty; gender more particularly women, and ignorance. Malnutrition was viewed to be more prevalent in rural areas than in urban areas. However, today there is a shift in vulnerability based on these social determinants. Malnutrition, which is often associated with the poor and rural population, is a malaise that has not spared even the well-to-do urban elites living in towns and cities(1).

United Nation Children's Fund (UNICEF) defines malnutrition as a broad term commonly used as an alternative to under-nutrition but technically it also refers to over-nutrition and the medical dictionary defines it as the condition that develops when the body doesn't get the

right amount of vitamins, minerals and other nutrients it needs to maintain healthy tissues and other organs. These definitions therefore comprehensively inform that malnutrition is a major concern to all groups.

Urban Malnutrition

Given the lifestyle changes in both rural and urban population, poor nutrition has become a common problem with insufficient, excessive or imbalanced consumption of nutrients, among both the poor and rich. The world is rapidly urbanizing – and it is giving rise to the challenge of urban malnutrition. The UN predicts that over 60% of the world population will live in urban areas and that 90% of this growth will take place in low and middle-income countries. Global, national and local governments have to start anticipating how they will cater for 5

billion people living in cities in 2030 and how they will have access nutritious foods in a sustainable manner (2)

In Kenya, the Kenya Demographic & Health Survey (2008-09) reported a higher prevalence of obesity in the urban areas (39%) compared to rural areas (20%) (3).

In India, the National Institute of Nutrition (NIN) has shown that urban kids from higher socio-economic strata suffer from obesity due to inadequate nutrition in their diet.

Dr K Baruah, a cardiologist in India attributed poor diet to at least 50 % of the cases for ailments among the urban population including cardiac problems, stroke, diabetes, hypertension, obesity. Over dependence on rice and oily and deep fried and junk food, high salt containing food such as pickle along with rice and poor intake of fruits and salads are the dietary pattern of Indians in urban areas (1). This situation is a replica in other urban areas globally. Economic pressure resulting in many people shifting their work hours late into the night, and not giving keen attention to their diet, has led to eating disorders. People have improper timings for food, take a quick bite of junk food at their workplace and they don't get adequate nutrition with compromised intakes of vitamins and minerals. These ultimately result in undesired weight gain and nutritional diseases associated with the gastrointestinal tract. They eventually put on weight, suffer from acidity and gastric problems, for good health it is advisable to eat balanced nutritious diet, maintain proper timings of food intake, abstain from high protein, carbohydrate and fatty foods during late night and give preference to green and dark leafy vegetables, fruits and drink adequate water. Apart from eating healthy daily exercises such as jogging, cycling is recommended to keep a healthy lifestyle.

Urban food deserts have been an increasingly important concern in high income countries such as the United States where supermarkets have retreated from low-income areas, closing downtown stores and opening mega-stores on the urban periphery. With diminishing numbers of local supermarkets, access to fresh, healthy and affordable food has made access to healthy and affordable foods more difficult (2).

In Africa food deserts take on a different form. Food deserts in Africa would be characterised as urban neighborhoods with high food insecurity with a mix of formal supermarkets and informal

food markets existing side by side but nutritious food still remains limited. These urban food deserts may have previously been ignored because food security and under nutrition has often been seen as a rural issue rather than an urban one in the development agenda (2).

Prevalence of hypertension in Kenya is increasing due to risk factors, like obesity, stress, decreased physical activity, poor diets, and tobacco use. Prevalence of hypertension in both men and women in Kenya ranges from 7.4% to 21.4% in rural areas, and from 12.3% to 22.8% in urban areas indicating higher rates in urban areas (4)

Psychosocial Factors and Malnutrition

Psychosocial factors that contribute to decreased food intake and consequently malnutrition include depression, social isolation, and loneliness. Depression is a prevalent condition in the older population; approximately 7% have major depressive disorders and up to 17% have clinically significant depressive symptoms (5). Risk factors for depression include female gender, lower educational status, loss of a partner, cognitive decline and chronic health conditions (6).

In Kenya the Kenya Demographic & Health Survey (2008-09) reported a higher prevalence of malnutrition among the highly educated and wealthy people (3).

In India, the problem of poor nutrition is prevalent across all sections of the social class, the urban middle class always tries to compromise on nutritious diet in order to save money to purchase luxury items (1). An interview with mothers of some mal-nourished children in a city in India revealed that most of them have been saving to buy expensive household items by curtailing expenses on food and feeding children rice, pickle or curd rice and buttermilk daily. Such diet finally leads to health problems (1). Social isolation and loneliness are common among rural dwelling adults who live alone, the older ones' have functional impairments, lack transportation, low morale, and have limited social networks (7). Social isolation and loneliness are correlates of chronic health conditions, cognitive impairment, poor self-reported health, and sleep disorders (8). Older adults who experience these psychosocial determinants are more likely to eat alone and often have chronically marginal nutrient intake, putting them at a greater risk for malnutrition (9). This is especially common

among widowed or single older men since they tend to have fewer close relationships outside of their spouse. They also lack cooking skills, and or are unable to prepare food (10).

Gender and Malnutrition

Women are a vulnerable group due to their physiological needs. Currently, because violence against men is prevalent, it may be necessary to view this group as vulnerable.

In many African traditions men beat their wives to show their superiority. In some customs, women are equated to children and men discipline their wives just as they would their children. The Kenya Demographic survey of 2014 indicates that 39 percent of women surveyed have been abused by their partners. A survey by the Federation of Women Lawyers - Kenya (FIDA Kenya) indicates that almost 75 percent of surveyed women have experienced spousal violence.

But 'modern' domestic violence is not just about men disciplining women. While reported rates of violence of men against women are much higher than those of women against men, experts are worried over the rising number of cases. Use KDHS 2014 data (5)

In the 2014 Kenya Health Demographic Survey (KDHS) – 44% of Kenyan men (15-49 years) have suffered violence since the age of 15 years from either their parents, teachers and others. Men who are battered by their wives may be denied food leading to reduced food intake; moreover the psychological stress they go through may affect their appetite and further exacerbate the condition. A Kenyan local daily reported that men living in Nairobi and other big towns are more likely to be battered than their rural counterparts. Men have suffered physical injuries including burns, cuts etc. these are public health problems in society today.

Local dailies in Kenya have reported that in Central Kenya men drink illicit brew from early morning to late evening.. The brew is cheap and most men do not work. While their wives look for causal jobs, the men indulge in drinking and force-control the hard-earned income of their wives. This led to the presidential directive of a national crackdown on illicit brew. Drinking is a risk factor of non -communicable diseases; moreover, most of those who drink from morning to evening do that without eating food, which becomes a risk factor of under nutrition among the alcoholics. Because most men who drink do not engage in any economic activity,

there is reduced labor and consequently reduced food production- a challenge to food security.

There has been a lot of focus on the girl child owing to the fact that culture had made her vulnerable. This focus has been over emphasized creating a shift of vulnerability. This has been quite evident in the education sector where in some parts of Kenya the enrollment of boys is lower. Boys drop out of school and turn out to be alcoholics, this makes the boy child economically unproductive and therefore not able to afford food, this and the alcoholic state reduces food intake, food utilization and predisposes them to other non-communicable diseases.

CONCLUSION AND RECOMMENDATION

The shift in vulnerability, therefore predisposes previously assumed "well-population" groups to risks of malnutrition and call for policy –makers to target sustainable interventions to specific cohorts.

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