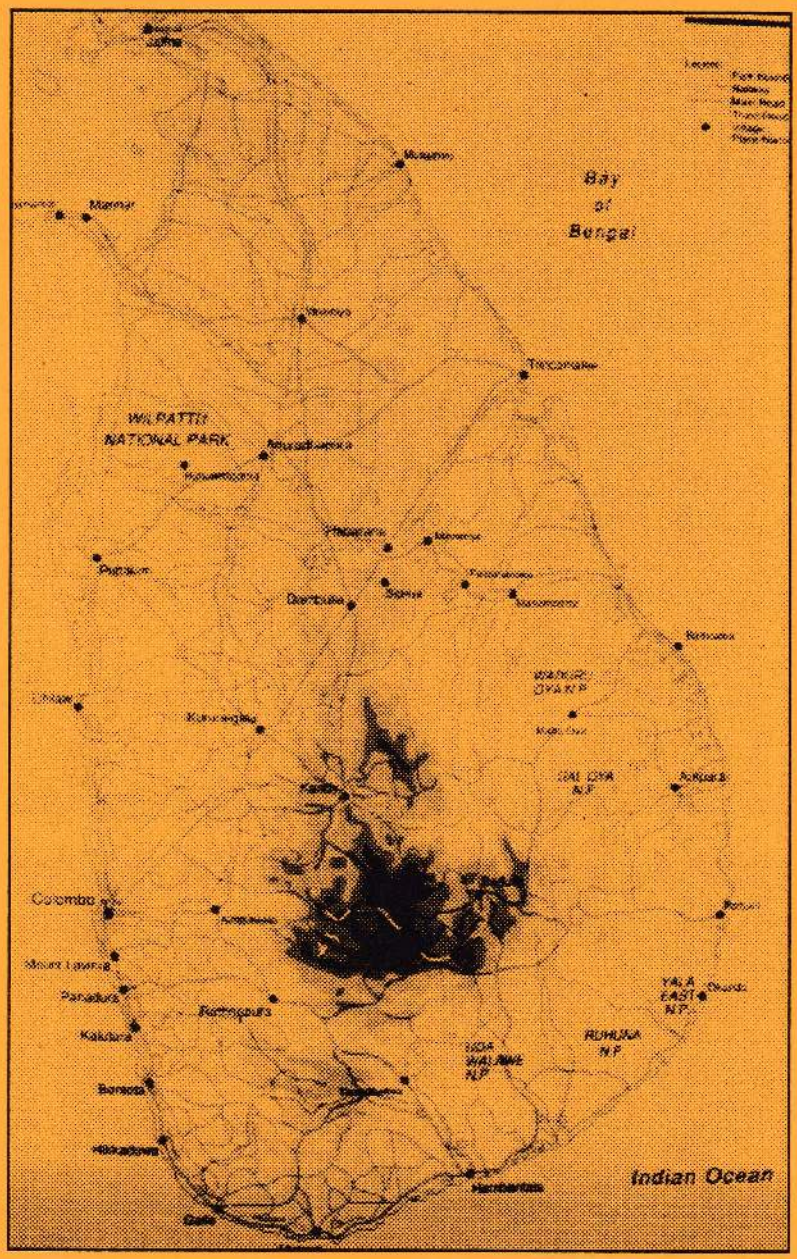
MIOT
YOUTH FORUM

SCIENTIFIC AND CULTURAL SEMINAR ON HEALTH PROBLEMS IN IMMIGRANTS

30TH SEPTEMBER 1995


Bay
of
Bengal
WILPATTU
NATIONAL PARK
Trincomalee
Colombo
YALA
EAST
N.P.
RUHUNA
N.P.
Indian Ocean

Proceedings 30th September

MIOT Youth Conference

Scientific and Cultural Seminar

9.30am	Registration and coffee
10.00am	Welcome Speech by Chairman Professor R. Swaminathan
10.15am	Cardiovascular Disease with special emphasis on immigrants in the UK Professor R. Swaminathan
11.00am	Discussion
11.15am	Coffee
11.30am	Cultural background of Tamils to health problems Mr V. Rajayogeswaran
12.15pm	Discussion
12.30pm	Lunch
1.45pm	Migration and Mental Health Dr S. Thiriloganathan, Consultant Psychogeriatrician
2.15pm	Discussion
2.30pm	Diabetes Mellitus - Screening and prevention Dr R. Namasivayam
3.00pm	Discussion
3.15pm	Care of the Asian Elderly - 21st Century Dr M. Visvaratnam
3.45pm	Discussion
4.00pm	Tea
5.00pm	Conference ends

Message from the MIOT President

The dispersal of the Tamil people across the globe in recent years, often against their wishes, has created special problems that need to be addressed. The scale of the migration is unprecedented in the long history of our people. As communities settle down in their host countries special social, medical and psychological problems emerge. This seminar was an attempt to study this need.

The new generation of Tamils need to be aware of their heritage and their own identity to be meaningful citizens in the countries of adoption. The MIOT, as a medical organisation, has attempted to cater for the young Tamils in medical and allied fields. The Scientific and Cultural Seminar was well received by the participants.

Dr P Arulanantham

President MIOT

Professor R. Swaminathan

Editor

Publication date - 19.4.96

CARDIOVASCULAR DISEASE IN IMMIGRANT ASIANS

Professor R Swaminathan, PhD, FRCPath, FRCPA
Head of Department of Chemical Pathology, Guy's and St Thomas' Hospital

Health problems in developing and developed countries differ. In developing countries, parasitic and bacterial infections are responsible for 41% of deaths and diseases of the circulation such as cardiovascular disease and cerebrovascular accidents account for 15% of deaths. In contrast, in developed countries, diseases of the circulation account for 32% of the mortality and infections only account for 11%. Another major difference is the mortality due to cancer which is 4% in developing countries and 15% in developed countries. Major health problems in the immigrant population include vascular disease (coronary artery disease and cerebrovascular disease), diabetes mellitus, psychological and psychiatric problems. South Asians (Bangladesh, India, Pakistan, Sri Lanka) constitute more than 20% of the world population and 11 - 15 million of this population live outside South Asia, in developed countries. For instance, there are more than a million Indians living in the United States.

Prevalence of ischaemic heart disease varies between different countries. It is highest in Scotland and Finland and lowest in countries such as Japan and Hong Kong. Accurate statistics are not available from South Asian countries such as Bangladesh, Pakistan, Sri Lanka and India. What little information available suggests that prevalance of coronary heart disease (CHD) in India and Sri Lanka is relatively low compared to Western countries. For example, a study from Sri Lanka by Mendis[1] showed that the overall prevalance of CHD in middle-aged men in Sri Lanka is nearly two times lower than that of a comparable group in Britain. A study conducted in Kerala showed similar results[2]. However, physicians practising in these countries tell us that ischaemic heart disease is rising, especially in younger age groups. Studies from Singapore, Uganda, South Africa, Fiji, Trinidad, Mauritius, United Kingdom and United States show that the prevalence of CHD in South Asian immigrants is higher than the indigenous population[3]. Mortality rate from CHD in Asian immigrants varies from 1.5 to 4.0 times that of the indigenous population *(Table 1)*.

Table 1

Coronary Artery Disease Mortality among Overseas Indians
Compared with the Indigenous Population

Country	Period of Survey	Standardised Mortality
Singapore	1954 - 57	400
Singapore	1957 - 78	300
South Africa	1968 - 71	145
Fiji	1971 - 80	300
Trinidad	1977 - 84	260
England & Wales	1979 - 83	313
*Standard mortality in the reference population is 100		

A recent study by Balarajan conducted in England and Wales shows that mortality from CHD and cerebrovascular disease was highest in men and women born in the Indian sub-continent[4]. Young men (age group 20 -29) born in India suffered the greatest excess. Balarajan also showed that mortality from ischaemic heart disease in men born in the UK declined by 5% between 1970 -72 to 1979-83. A similar decline in mortality from CHD has been shown in other developed countries including the U.S.A. In contrast, immigrants from South Asia showed an increase in mortality from CHD - 6% in men and 13% in women[4]. These studies show that CHD has become a major health problem among the immigrants from South Asia. and that the disease is severe, extensive and runs a malignant course.

The exact aetiology of atherosclerosis which leads to CHD, is not fully understood. Several longitudinal epidemiological studies such as the Framinglam, Whitehall and Bedford studies have identified several risk factors for CHD. The major risk factors are smoking, hypertension and hyperlipidaemia and others include diabetes, obesity, lack of exercise and alcohol. Mortality rate from CHD increases progressively with smoking and, in heavy smokers, the risk of heart disease is increased ten fold. Similarly, in hypertensives, mortality from heart disease in nearly 4 or 5 times that in normotensives. The presence of diabetes increases the risk by 2-fold. For alcohol, the mortality curve is a U-shape curve suggesting that a moderate intake of alcohol may be beneficial. Subjects with high cholesterol concentration has an increased risk of developing CHD and this risk increases progressively with increasing total cholesterol concentration. At a serum cholesterol concentration of 7.5mmol/l or greater, the risk of CHD is increased by a factor of 4.

Cholesterol is carried in several sub-fractions in the serum and of this, the high density lipoprotein cholesterol (HDL) is responsible for moving cholesterol from tissues to the liver. It has been shown that the incidence of CHD is inversely related to HDL cholesterol, hence HDL is termed the 'good' cholesterol. Epidemiological studies from America, Europe and other countries have clearly demonstrated that an elevated level of HDL protects against CHD. This is true, even when the total cholesterol is not high. In one study, it was shown that myocardial infarction was 3.2 times more common in subjects with reduced HDL but normal total cholesterol. These risk factors described so far applies to CHD in developed countries. The prevalence of these risk factors among the immigrant population has only been recently studied. Smoking is less frequent among the immigrant Asian population and it is unusual among Indian women. Compared to the white population, blood pressure and total cholesterol in immigrant Asians are either the same or lower. Diabetes mellitus and a low HDL cholesterol are known risk factors for CHD and these are more prevalent among immigrant Asians[5]. A study of physicians of Indian origin in the United States showed that the prevalence of angiographically-proven CHD was three times higher in Asians compared to the white population[5]. The prevalence of diabetes mellitus and serum concentration of triglyceride was higher and HDL cholesterol was lower in this group. The prevalence of cigarette smoking and hypertension were lower. Several other studies have confirmed a low HDL cholesterol concentration in immigrant Asians. In a recent study of young males (age 19 - 25 years), it was found that the cholesterol concentration among Asians living in the UK was higher than that of the white population[6]. In this study it was also shown that young Sri Lankans living in Colombo had high cholesterol and low HDL cholesterol (Table 2). The higher total cholesterol and a lower HDL cholesterol in young Sri Lankans is a highly worrying scenario.

Table 2

Lipid Profile among young Asians (19-25 years) in the UK and in Asia compared to Europeans

	I	II	III	IV
Body Mass Index	23.9±3.23	23.3±3.67	20.3±3.00	19.8±3.18
Total Cholesterol (mmol/l)	3.97±0.68	4.38±0.86*	5.41±0.73*	3.67±0.57
Serum Triglycerides (mmol/l)	1.20±0.56	1.51±1.12	1.41±0.70	0.82±0.40
HDL Cholesterol	1.18±0.27	1.16±0.26	1.09±0.25*	1.04±0.22
Apo A1 (mg/dl)	1.48±0.34	1.46±0.28	1.27±0.20*	1.06±0.16
ApoB (mg/dl)	0.85±0.32	0.97±0.39	1.02±0.17*	0.74±0.14
Lp(a) (mg/dl)	20 (5-92)	24 (5-132)	36 (114-71)*	15 (5-74)

I Europeans in London
II Asians in London
III Sri Lankans in Colombo
IV Indians in Gujarat

Results are Mean±SD except for Lp(a) which is given a median and range * Significantly different from Group I

Detailed studies of serum lipids have shown that proteins associated with the carriage of lipids are also different in those who develop atherosclerosis. For instance, apolipoprotein B and lipoprotein (a) (Lp(a)) are higher and apolipoprotein A1 is lower in those who develop CHD. In the study of young Asians shown in Table 2, Lp (a) and apo B concentrations was highest among the Sri Lankans. This suggests that Sri Lanka may be at greater risk of developing CHD than other groups.

Diabetes mellitus and insulin resistance are two other independent risk factors for CHD. Asians in general and immigrants, in particular, have a higher prevalence of non-insulin dependent diabetes mellitus (NIDDM)[7] and this is associated with a high waist/hip ratio (truncal obesity). The association of glucose intolerance, insulin resistance, high triglyceride concentrations, low HDL cholesterol and high waist hip ratio is sometimes called 'Syndrome X'. Features of this syndrome are more commonly found among South Asian immigrants.

The next question is whether the high prevalence of CHD and the associated risk factors, is acquired or inherited. In a recent study, risk factors for CHD of Punjabi immigrants settled in the UK was compared with a group of their siblings living in India and a European population. It was shown that Asians living in this country, as well as their siblings, had high Lp (a) and lower insulin sensitivity compared to the European population. These observations suggest that Asians are probably genetically pre-disposed to CHD. The fact that, after migration, the cholesterol concentration increases, suggests that westernisation further aggravates this.

In summary, available evidence suggests that excess cardiovascular mortality among immigrant Asians is associated with insulin resistance, low HDL cholesterol and high Lp (a). These factors are related to a combination of genetic and environmental factors. Environmental factors include lack of exercise and westernisation of diet.

Several measures can be taken to reduce the risk of CHD. These include :-

(i) Cessation of Smoking.

(ii) Identification and early treatment of hypertension.

(iii) Regular exercise which will cause reduction in body weight and increase insulin sensitivity.

(iv) Diet - reduce intake of fat, especially saturated fat.

References

1 Mendis S, Ekanayake EMTKB. Int. J Cardiol 1994 46:135-42.

2 Kutty VR, Balakrishnan KG, Jayasre AK, Thomas J. Int. J. Cardiol. 1993 39: 59-70.

3 Enas EA. Yusuf S, Mehta JL. Ann.J Cardiol. 1992 70:945-9.

4 Balarajan R. Br. Med. Journal 1991. 302 : 506-4.

5 Mckeigue PM, Shah B, Marnot MG. Lancet 1991 337 : 382-6.

6 Mehta H, Sivagnam F, Andrews V, Balarajan R, Swaminathan R. Clin. Sci 1996; 90: 14P.

7 Bhatnagar D, Anand IS, Durrington PN, et al. Lancet 1995 345: 405-9.

CULTURAL BACKGROUND IN RELATION TO THE HEALTH PROBLEMS OF IMMIGRANT TAMILS IN THE UK WITH SPECIAL EMPHASIS ON ORAL HEALTH

Mr V Rajayogeswaran BDS (Ceylon) MSc. DDPH. FDSRCS (Eng)
Senior Clinical Lecturer, Guy's Hospital

"Study the past if you would divine the future" Confucius 551B.C.

Medicine cannot be isolated from one's culture. The term culture is defined as a way of life including ideas, beliefs, language, institutions and structure of power. It is accepted that the immigrant populations tend to retain their cultural and religious identity. An understanding of these basic facts are essential to understand the health problems of immigrants.

The first civilisation emerged between 3500 BC and 5000 BC. During this period, Asia's first civilisations became well established east of Egypt in the fertile crescent near river Sind. Tamil are part of the Dravidian race from the Indus valley civilisation. The two cities of this civilisation are Mohanja - Daro and Harrapa which were about 400 miles apart. Harrapan language was akin to the Dravidian languages which is now spoken in Southern India. There are 63 Dravidian dialects of which the four major ones are Tamil, Kannada, Telugu and Malayalam.

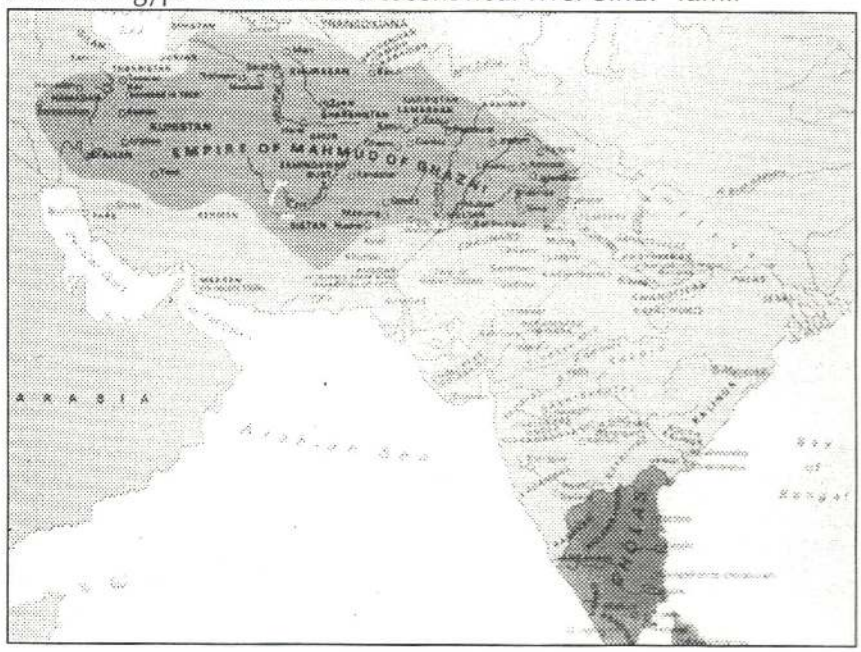


Fig (1) India/Ceylon.

The Indus valley civilisation fell around 1750 BC and around 1500 BC Indo Aryan's arrived in India. Between 2000 - 1500 BC, Dravidians moved to the East and South of India and southern India became the lands of Pandya, Chola and Chera around 500 BC.

Today, there are 65 million Tamils in the world - 60 million in Southern India, 3 million in Sri Lanka and the rest dotted around the world.
Tamils have a long history of sea travel and Trade. Trading with ancient Greeks, Romans and Arabs was developed. Great temples, irrigation tanks, dams and roads were built and the culture and religion of Tamils spread as far as Indonesia and Phillippines to the East.

The earliest surviving Sanskrit literature is that of the RegVeda. Pali, the only Indian language in which the earliest Buddhist scriptures have been preserved, dates back to 250BC. Tamil inscriptions, however, have been found on stone, dating back to 3000 BC. Tamil literature

proper began around 1st century AD. Earlier works of poetry on religion or epics were written on leaves. Printed material dates from the late 17th century to 18th century AD. Tholkapiam was before the three Sanka periods.

The Sanka period, between the 4th to the 6th century AD saw notable literary works. These works include the five famous epics: Sinthamani, Chilappatikaram, Manimekalai, Valiapathy and Kundalakesi. A beautiful collection of 1330 moral aphorism in Tamil verse is the Tirukkural. Tirukkural is composed of verses of two lines that spell out great truth and this distinguishes Tirukkural from other works. These sacred couplets attributed to Tiruvalluvar date back to the 4th - 5th century AD and the morals described in Tirukkural still hold good in the present society. Below are two examples of stanzas translated into English:

1 "The greatest duty of a parent towards a child is to provide every opportunity for education and welfare to enable the child to procure a prominent place in the society".

2 "The biggest gift a child can give to a parent, is to earn the public acclaim and make them wonder, how much good deeds the parents must have performed to deserve a child like this"

Thirrukural has been translated into many modern languages. Between the 6th - 9th century Bhakti, the poetry and religious hymns of personal devotion were created by 63 Nayanars, and Alvars in honour of Shiva, Vishnu and other gods. From the12th - 16th century, many philosophical treatises and anthologies of religious legends; including the classic writings of the poet Kampan, were composed.

Let us now look at the history of Ceylon (Sri Lanka). Ceylon, a country of beauty, was the centre of a great civilisation. This is evident from the immense sprawling ruins of its ancient cities, unparalleled anywhere else in South Asia. Today, the island is inhabited by a mixture of people who had migrated to the island at intervals since ancient times. These include Sinhalese, Tamils, Arab Muslims, Burghers, Malays, Chinese and Europeans.

The island of Ceylon has a continuous record of settled and civilised life for over 2000 years. Both Ceylon and India developed similar social institutions and ideologies. The island's first human settlers were probably the pre-Dravidian hill tribes of Southern India. Descendants of the tribe can be found in central Ceylon and they are known as veddhas. Around 300 BC, immigrants from North East India (Bengal) - the Indo Aryans, came to the island and they developed into the Sinhala race. The Mahavamsa and the Culavamisa

Figure 2

records the arrival of Prince Vijaya from India; the establishment and development of the Sinhala race and the arrival of Buddhism to the island (Fig 2). The Tamils of Ceylon originated from the Dravidians of Southern India.

There had been repeated invasions of Ceylon from South India by Pandyas and Cholas displacing the Sinhala kings from Anuradhapura and Polonnaruva, driving them to the South and the South West of the island as far as Kotte and Ruhuna.

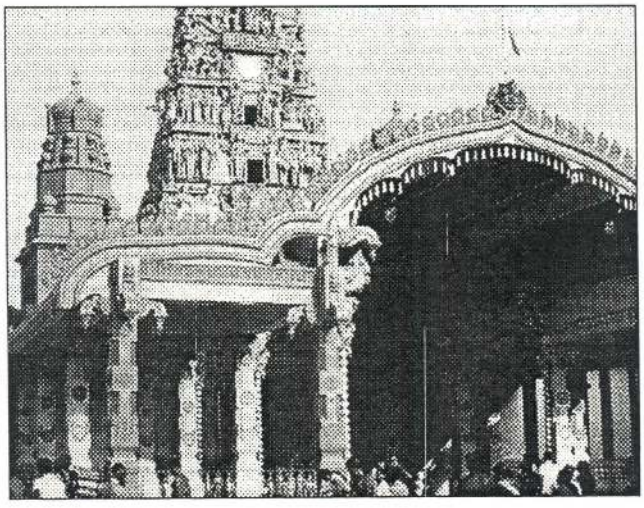


Figure 3

In the early part of the 12th century, Aryachakarawathi, a South Indian dynasty seized power from the Sinhalese and founded a Tamil kingdom with its capital at Nallur. Jaffna patnam soon expanded southwards to Chilaw on the west and to Amparai to the east (Fig 3).

The first westerners, the Portugese, arrived in the island by accident, in 1505. The Portugese fleet commanded by Lourenco de Almeida was blown into Ceylon by adverse winds. By 1597, the Portugese took formal possession of the Sinhala kingdom and Jaffna was annexed in 1619. The period of Portugese rule was marked by intense Roman Catholic missionary activity. The Dutch, who arrived in 1602 were Calvinist and they spread the reformed faith. Dutch law is still in use in Sinhala areas but Thesavalamai or laws and customs of the Tamils of Jaffna remain in force, even today. The Dutch surrendered to the British in 1769 and in 1802 Ceylon was made a crown colony. The Kandyan kingdom was annexed in 1815. A unitary administrative and judicial system was fully established in 1833 with the Colesbrook constitution. Early 19th century saw the rise of the Ceylonese nationalist movement along with revivalist movements in Buddhism and Hinduism against Western establishments. Constitutional changes were introduced in 1920-21 to satisfy nationalist demands. In 1931, Ceylonese leaders were given political power in the form of a State Council and universal franchise was granted. The first State Council speaker was Sir Vaithilingam Durisamy, a Tamil. In 1945, on further demand for a full and responsible government, a Dominion status was granted on the recommendation of the Soulbury commission. Independence was finally granted in February 1948. We should not forget our great leaders of this century like Sir Ponnampalam Ramanathan and Sir Ponnampalam Arunachalam.

Customs and Beliefs

The Tamil people are the proud inheritors of a rich cultural heritage. It was a Tamil poet of the 4th century who left these words of wisdom, the like of which cannot be found in any other literature. The poet said:

"All world is my abode, all mankind my kin,
The evil and good one doth experience come not from external source."

It is an impossible task to elaborate in detail every custom and belief that have been in practice or that are practised today. Practices and beliefs vary between different villages. Some of them are based on superstition and many others have scientific explanations. For

example, when there is an infection like chickenpox, measles, mumps or whooping cough in the house, Margusa leaves or Turmeric bark are kept in the patient's room; Margusa seed or oil is burnt and a paste made out of Margusa leaves and Turmeric is applied over the skin lesion. There is scientific evidence that Margusa and Turmeric have disinfectant properties. Another example is the practice of not eating from one communal vessel or plate and not serving food by hand or a used spoon. These customs prevent contamination of food with one's saliva and, hence, may explain the lower incidence of Hepatitis B and C among Tamils compared to other communities such as the Chinese and the Arabs. One obvious area of daily life that has a profound effect on our people is a healthy nutritional dietary pattern, mainly derived from vegetables. A variety of vegetables which provide nourishment are chosen at each meal time. Many herbs and spices are incorporated for their medicinal properties as much as for their taste. Today, many people in Western society favour a vegetarian diet and it is true that there is much to recommend vegetarianism from a nutritional point of view. Vegetarian diets typically contain little saturated fat, ample anti-oxidants and dietary fibre.

The Earliest Medicine

"The life so short, the craft so long to learn" Hippocrates 460 B.C.

For thousands of years, humanity practiced primitive preventative medicine, pleasing the gods through ritual and sacrifice. Folk remedies provided a rich heritage of practical experience. As civilisation gathered pace, so did medicine. The first tentative attempts to treat medicine as a science developed at more or less the same time in Greece, India and China. The Indian system of medicine is called Ayurveda which means "knowledge of life" (Ayur - knowledge, Veda - life) and is based on ancient wisdom of the holy wise men (Rishi's). It is a science of life as it incorporates medical, psychological, cultural, religious and philosophical concepts. It is also called the "Mother of all healing". The Samhita or encyclopaedia of medicine was written about 2000 years ago and it describes both medicine and surgery. Charak Samhita is a treatise on eight major branches of human care and Sushrita Samhita is a treatise on surgery. Ayurvedic physicians believed that disturbances in the level of various bioforces (doshas) were responsible for disease. The bioforces (doshas) are the wind (vata), bile (pitta), phlegm (kapha) and blood (Rakta). The idea of the four humours is also found in Greek medicine. Indians excelled in surgery and one of the most remarkable operation is the repair of the nose and the ear lobes. At that time, 121 different steel instruments were used. A leading expert on the History of Medicine concluded that Western medicine originated in ancient Greece and the Greeks learned much from the Indians. It is believed that Hippocrates, who has been called the father of Western medicine, took his whole system directly from India.

Figure 4

The medical practitioners, in ancient times, were thought of as gods in the Middle Ages and were accused of engaging in black magic. By the 15th century, a new air of enquiry into medicine began with the Renaissance. The 17th and 18th centuries saw scientific and technological progress in medicine. The 19th century saw more research into technology, producing equipments for use in medicine. The turn of this century saw advances in general scientific understanding and many discoveries. The second half of the 20th century produced many life-saving methods in medicine, investigative equipments and many drugs. Science still awaits a breakthough in the treatment of cancer and AIDS. Forecasting the future has a fascination all of its own. Future developments need to be based on existing knowledge and techniques. Is the future full of hope or gloom? - only time will tell. (Fig 4)

Oral Health

The perception by the Dental profession is that the immigrant population gives a low priority to oral health. Whether this is due to fear or ignorance is not known. The majority of immigrants do not attend dental clinics for regular check-ups and only seek help when they are in some discomfort. This may be too late to save the tooth in many circumstances. Others do not attend dental clinics for fear of cross-infections such as Hepatitis B and HIV (AIDS).

All tissues in the mouth are vulnerable to disease. The most common oral diseases are dental decay (caries) and gum disease (periodontal disease). Both of these are caused by poor oral hygiene or neglect of good dental health. The early signs of dental decay are hypersensitivity to hot cold and followed by spontaneous excruciating pain lasting 2-3 days. This is due to death of vital pulp tissue leading to the formation of an abscess. Gum disease starts with bleeding during brushing, with redness and swelling of the gum margins. If this is neglected, it may lead to a chronic nagging type of pain, spontaneous bleeding from the gum, bad breath, bone loss and very loose teeth. Asians are more prone to gum disease than dental decay. Studies on Tea Estate Workers in Sri Lanka showed that one third of the study population, by the age of 40, had lost all their teeth. Similar studies on other Tamil populations are not available. Traditionally, Tamils used to clean their teeth with Margusa, Banyan twigs or Charcoal and they massaged their gums with gingelly oil (sesame oil). The Margusa twig has antiseptic properties and Charcoal removes bad breath. Gingelly oil hardens the gums and gives a healthier look. Tamils also have the habit of swishing their mouth with water before and after a meal. They chew firm fibrous foods to make their teeth stronger. We also have many other healthier oral regimes, and dietary habits. Today, the use of fluoridated toothpaste, flossing, antiseptic mouth washes and regular visits to a dental surgeon could reduce dental diseases and enable the detection of early signs of oral malignancy.

The most common oral malignancy is squamous cell carcinoma. A very high incidence of oral cancer has been noted among Sri Lankan people and this is associated with the use of "betel quid" which contains betel leaf, dried crude tobacco, slices of arecanut and slaked lime. Over 23% of the population are affected by oral carcinoma and the male to female ratio is 5:1. Alcohol consumption and smoking is higher in males. Heavy smokers who smoke about 30

cigarettes, 20 cigars or 40 beedi per day constitute about 6% of the population. Age range at which cancer presents is between 45 - 70 years and cancer is most often seen in the rural population and is less common among the educated. Common sites of cancer are tongue, mandible, buccal sulcus, cheek, floor of the mouth, palate and lip. In patients who present very late, the lesion has already broken through the skin of the face. In the UK, the incidence of oral malignancy is about 2% of all new malignancies - that is about 450,000 new cases per year. It is common in the fifth and sixth decades of life and the incidence among the young is rising due to high consumption of alcohol and cigarettes. Oral cancer predominantly presents as leukoplakia and/or squamous cell carcinoma in the mouth. Despite the general public's awareness of cancer, and the ready accessibility of the mouth for examination, many patients with oral cancer present late and thus the prognosis has not really improved over the last few decades.

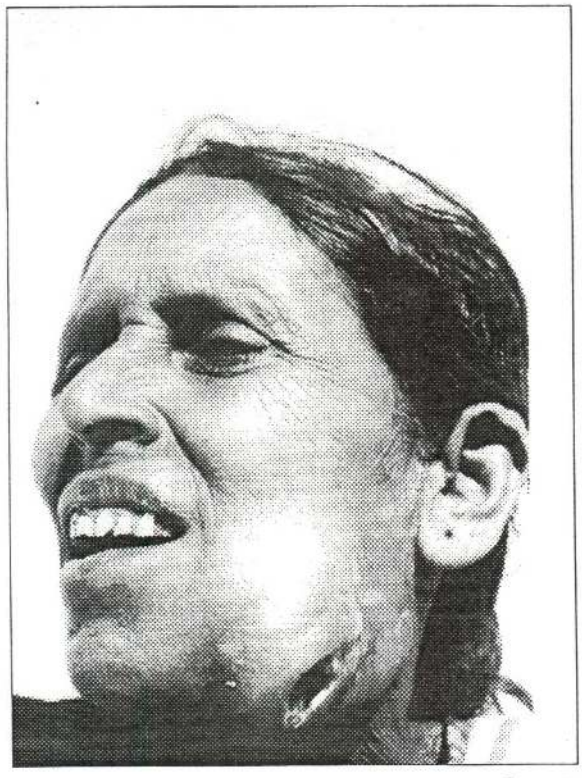


Figure 5

Less common malignancies in the mouth are salivary gland tumours, antral carcinoma, bone neoplasia and secondaries.

All diseases have social, ethical and political dimensions. There is a long tradition of connecting disease with moral issues. "Sickness" and "Sin" are terms which have long been linked, and often interchangeably, especially during periods of heightened social anxiety. AIDS have been culturally interpreted and given strong moral meaning. The first case report of AIDS appeared in 1981 and by 1994, 16 million people of all ages worldwide had become infected with HIV. Many have no sign or symptoms and are unaware that they are infected. Infection is life long and once acquired, can be transmitted to others. Clinical symptoms appear as the virus destroys the immune system and opportunistic infections and neoplasms develop leading to the full blown picture of AIDS. The symptoms which may suggest AIDS are profound fatigue, which lasts for several weeks with no obvious cause, shortness of breath and dry cough leading to pneumonia and blotches like skin lesions. Despite progress in almost all aspects of HIV and AIDS research, understanding of the disease is still inadequate.

Orofacial manifestations of HIV infection: - Most patients with AIDS have head and neck manifestations at some stage, and oral lesions are often early signs of HIV infection. Oral Candiasis presents as white or creamy plaques (thrush) usually on the soft palate and tongue or as erythematous candiasis on the palate. Hairy leukoplakia may be characteristic of late stages of HIV disease. It presents as white non-removable lesions on the lateral or ventral aspects of the tongue. Other oral lesions may be large shallow ulcers resembling aphthous ulcers. Kaposi's sarcoma usually presenting as a red, blue or purple macule, papule or nodule, especially on the palate and gums.

MIGRATION AND MENTAL HEALTH

Dr S Thiriloganathan MBBS (Ceylon) MRCPsych (UK),
Consultant Psycho-Geriatrician, Halifax, West Yorkshire

Migration from one country to another is often determined by a combination of 'push' and 'pull' factors. 'Push' factors from the home country include fear, frustration and feelings of hopelessness. Fear is a basic emotion linked to self-preservation and survival. It gives rise to the behaviour of flight or fight. Frustration and feelings of hopelessness, when persistent and prolonged, leads to actions for survival. 'Pull' factors from the host country include better prospects for education, standard of living, opportunities to explore and enticement of those already settled here. Elective migration is very much influenced by 'pull' factors and refugees seeking asylum is largely because of 'push' factors.

Mental health is not merely an absence of mental illness but it is the presence of positive mental well being. Mental illness on the other hand, is usually multifactorial, complex and elusive to identifiable aetiology and pathology in the brain. The ways in which mental ill health manifests are through altered thinking, changes of feelings and changes in behaviour. These usually interact and treatment strategies are usually directed primarily towards one or the other, in clinical practice. These methods of treatment include cognitive therapy, chemotherapy, behaviour therapy and so on.

Mental Health of Immigrants

The question that has been raised is that immigrants have a higher rate of mental illness. This is being addressed by Psychiatrists and social scientists. Research studies have produced equivocal results. Differences observed between host population and immigrants could be due to several reasons:

a) The differences seen may reflect mental health patterns in the home country.
b) During the incipient phase of mental illness, when interpersonal relationships get strained, migration may result.
c) Immigrants tend to live in inner-city areas, where the prevalence of mental illness is high for various other reasons.
d) The increased prevalence may reflect stress associated with migration.
e) Diagnostic errors by host country health professionals, unfamiliar with the cultural beliefs and behaviours of immigrants.

Since the factors thought to be associated with mental health problems are often complex and interactive, it is useful to have a framework under broad heading such as:

i) Predisposing factors (eg. genetic, personality)
ii) Precipitating factors (eg. bereavement, loss of job, loss of self esteem)
iii) Perpetuating factors (eg.family strife, alcohol abuse)
iv) Protective factors (support network from family, friends)

The most frequently found mental disorders in immigrants are depression, anxiety states and paranoid reactions. Depression can be an illness due to chemical changes in the brain. Depression can present in various ways such as loss of interest in normal, pleasurable activities, tendency to withdraw from social contact, disturbed sleep, lack of energy, feeling worthless and hopelessness. When depression sets in, it alters one's habitual way of thinking; cognitive errors creep in and include:

1 Arbitrary inference (drawing 'rash' conclusions without a factual basis)
2 Selective abstraction (drawing information that is only negative)
3 Maximisation (making a mountain out of a molehill)
4 Minimisation (diminishing one's potential and capabilities)
5 Personalisation (everything bad is only happening to that person)
6 Generalisation (from one bad experience, everything in life is considered to be wrong or bad for them)

The lower incidence of psychiatric morbidity in Asian immigrant children compared to British children, found in studies by Rutter, Cochrane et al. is attributed to factors such as:

a) Affectionate but strong and protective nature of Asian family
b) Effective discipline in upbringing
c) Relative economic success. The psychological well-being of migrants is also explained in terms of the protective role of "cultural buffering" through organised social functions and by "ethnic density effect" of families living near to one another.

"Allegiance to religious and cultural norms can be seen as health promoting" - Levin 1994.
A person at any one time, is:
what the person was
what the person is
and what the person wants to be.

Competence and coping often require adjustment and adaptation to new and changing circumstances. Satisfying perceived deficiencies avoids mental ill health. Satisfying one's growth needs to produce positive mental health. If positive experiences outnumber negative ones, we enjoy positive mental health.

The road to success is always under construction.

DIABETES MELLITUS SCREENING AND PREVENTION

Dr R K Namasivayam, MBBS (Mysore)
General Practitioner, Croydon, Surrey, England

Diabetes mellitus is a common disease and it can be classified into:

i) Type I or insulin dependent diabetes mellitus (IDDM).
ii) Type II or non-insulin dependent diabetes mellitus (NIDDM) and
iii) Gestational diabetes - which results from glucose intolerance during pregnancy, usually diagnosed during the 2nd or 3rd trimester. It occurs in approximately 3% of pregnancies and disappears after delivery.

IDDM is known to be an autoimmune disorder with a genetic basis.

In NIDDM, genetic and environmental factors play an important role in causation. Highest prevalence rates yet recorded for NIDDM in adults of 25 years and over are in Pima Indians of Arizona (42%) and Micronesian Nauruans in the Pacific Islands (40%). Mauritius, a multi-ethnic island nation has one of the worlds highest diabetes mortality rates. Prevalence of NIDDM amongst Asians is in the region of 13% and it is increasing.

In developed countries, NIDDM and its complications presents a public health problem greater than that of any infectious disease. It is specifically a public health problem because about half the patients who develop complications do so before their diabetes is diagnosed. The prevalence of diabetes mellitus in a given practice is determined by the age and sex distribution and the ethnic mix of the population - particularly the proportion of residents of Asian and Afro-Caribbean origin. At least 4-5% of total health care expenditure (about £1 billion) is being devoted to the care of people with diabetes in the U.K.

Diabetes Mellitus in Asians

There is very little difference between the rates of IDDM in U.K. Asians and the white population whereas NIDDM is 3-4 times more prevalent in Asians and presents usually in middle age. Thus Asians should be considered as a high risk group. Asians are no more obese than their white counterparts but the impact of central obesity, and therefore of insulin resistance, is greater. A therapeutic approach is broadly the same as for any other patient group; but one must understand the cultural differences that influences the lifestyle; so that care can be restructured to reflect the different needs of the Asian patient. Asian diet in the U.K. is generally high in fat and refined carbohydrates. This diet is known to be a poor diet, especially for diabetics. Some types of food items used by Asians have good value. For instance, bitter gourd (pavakai or karela) is known to have antidiabetic properties. Prevalence of illiteracy and poor knowledge of English can be high and in any district several languages may be spoken. In Croydon, we have Gujeratees, Punjabis from Northern India, Malayalees and Tamils from the South and Sri Lanka respectively.
A structured Asian diabetic education programme with specific materials and skilled staff

should be accessible in all areas with high Asian population. Health education should be provided not only in Primary Care Centres and Hospitals but through other channels, such as community centres, temples and Asian media.

Screening and Prevention

Professional alertness remains the most efficient approach to diagnose those with unsuspected diabetes mellitus. It is not cost effective to screen the entire population. Therefore screening for diabetes mellitus should be directed towards high risk populations. High risk groups include:

1 Specific ethnic groups, Asians, Afro-Caribbeans, Africans.
2 Pertinent medical history -
    a)Multiple risk factors for vascular disease
    b)Women with a history of gestational diabetes or delivery of big babies (7lb)
3 Pregnant women
4 Symptoms suggestive of diabetes.
5 Family history of diabetes mellitus

PREVENTION

Primary

Primary prevention is the prevention of the development of disease and this can be achieved by:-

a) Dietary advice
b) Lifestyle changes - regular exercise, etc.

Secondary

Diabetes mellitus is a chronic disease with long term macrovascular and microvascular complications, including diabetic renal disease, neuropathy and retinopathy. It is a leading cause of death, disability and blindness - secondary prevention aims to prevent the development of complications.

The three initial priority areas identified by the St Vincent Declaration which is a joint BDA/Department of Health St Vincent Task Force, are:

1 Reduction of diabetic blindness
2 Reduction of amputation
3 Reduction of diabetic kidney failure

These can be achieved by:

1 Education/Training
2 Good control of diabetes. Concensus based on the diabetic control and complication trial (DCCT) is that intervention improves the outcome.

United Kingdom Prospective Diabetes Study (UK PDS) currently in progress is examining the effects of different treatment regimes in patients with NIDDM. Study is expected to finish in 1998.

CARE OF THE ASIAN ELDERLY IN THE UK

Dr M Visuvaratnam MBBS, FRCP (Lond), FRCP (Edin)

This paper discusses:

1 The demographic changes that are expected to occur over the next 50-60 years.
2 The care of an increasing elderly population
3 The special problems for the Asian elderly

Demography

This century has been called 'the century of old age' because there has been a 26 year gain in life expectancy since 1900 which compares with an increase of only 29 years in the preceding 5000 years ie. from about 3000 BC to 1900. The diseases that caused death at the turn of the century were infections, but now heart disease, stroke and cancer are the main causes of death in developed countries. Life expectancy at birth in a developed country at present is around 71 for males and 78 for females. It is about 6 or 7 years less in Sri Lanka mainly due to the high infant mortality and possibly due to infections in early life. At the age of 65, life expectancy here is about 15 years for males and 19 years for females and the figure is not much different in Sri Lanka - in fact, it is a little more.

Future increase in life expectancy is not expected to be as dramatic and over the next 60 years, the projected increase in life expectancy at birth is about 4-5 years and at 65, it is 2.5 years for males and 4.5 years for females. Health education with advice on smoking, exercise, diet and high blood pressure have postponed the onset of cardiovascular diseases by 15 - 20 years but even in the latter part of the next century, life expectancy is unlikely to increase to more that 80 to 90 years and very few people will live past the age of 100 years.

Another change which has happened this century and that is equally relevant is the fall in the fertility rate. This will result in the rate of increase in the elderly population to be much more than the rate of increase in the total population. Over the next 50 years, the elderly population in the world is expected to double whereas the total population will increase by only 35%. In 1901, 5% of the population in this country were over the age of 65 years. .It is now 16% and is expected to reach 20% by the year 2020 (the figures for India are 4% and 10% respectively). At present, 3.6% of the population in this country is over the age of 80 years and this is expected to increase to 6% by the year 2020. In the USA at present, there are 3 million people over the age of 85 years and the estimates for the number in 50 years vary from 13 to 40 million. The age distribution of ethnic minorities in this country at present is different from that of the local population. For instance, 32% of ethnic minorities are under the age of 15 years whereas only 15% of whites are under this age. In 1981, only 4% from the New Commonwealth were over the age of 65 whereas about 14% of whites were over this age. This is, however, expected to change over the next few years and the age distribution of ethnic minorities will become similar to that of the host population.

Caring for the Elderly

What problems will an ageing population create? As people get older, they are not only more likely to get diseases that cause their death, but they are also more likely to get chronic diseases that are non-lethal but disabling and make them dependent. The main diseases that cause disability but are not life threatening are dementia or other neurological diseases such as Parkinsonism that affect the nervous system, arthritis or osteoporosis which affect the bones or joints and impaired vision and possibly hearing. The diseases that cause death can also cause a period of disability prior to death. When people become disabled, they can initially be maintained in their own homes with support and this will on average be for about 1.5 years for men and 3.5 years for women. In the USA at present, there are about 3 million people with dementia and this is expected to increase to 8-10 million in the year 2050 and many of these people will need nursing homes. Even now, there are more nursing homes than hospitals in the USA with 2 million nursing home beds and 1 million hospital beds. The figures for the UK in 1993 were 282,000 residential and nursing home beds and 231,000 hospital beds. The prediction is that in 50 years time, about 5 million nursing home beds will be required in the USA and it is estimated that the likelihood of a 65 year old ending life in a nursing home is 1:2 for women and 1:3 for men. The majority - 95% of the elderly, however, continue to live in the community and not in residential homes. Some of those living alone at home are 100 years old.

Caring for the elderly in nursing and residential homes costs about £1 billion a year in this country at present. With the increase in the numbers of the elderly, this cost will escalate. At the present time, Social Services will pay the cost if it is within their limits (about £290 per week for residential homes and £370 for nursing homes) and if the person does not have over £8,000 in savings. If the person owns a house but has no other assets, Social Services will pay the nursing home charges but will recover this after the person's death by the sale of the house.

Can we reduce the duration of disability prior to death so that people can be independent until shortly before death - what has been termed the 'compression of morbidity?'. Unfortunately, at present, except possibly for osteoporosis, none of the conditions mentioned earlier that cause morbidity rather than death can be prevented. So unless there is some dramatic medical advance, costs will continue to escalate and decisions have to be made as to how the care of the elderly is going to be funded. Funding can be from taxation or by getting people to contribute towards their care in later life.

The Asian Elderly

It is difficult to define culture but it is a set of beliefs, behaviours and values of a particular group. It is handed down from generation to generation. It helps the group to deal with crucial events in life such as birth, development, illness and death. Solutions to life's problems are those that earlier members have found by trial and error to work. Traditionally, Asians

have had extended families and the grandparents have lived with their children and grandchildren. Every member had a defined status. There was a hierarchial system with older people having authority over younger people and men over women. The elderly were reveried and received physical and emotional support. They had a good deal of power. Income and property belonged to the whole family. Adult members felt responsible for their brothers, sisters and cousins and looked after them. Each member considered himself or herself to be a part of the family rather than as an independent individual. They had a positive role in the house and were actively involved in day to day activities. Though this limited privacy and at times, did not meet the social and emotional needs of people, it worked fairly well in the East. This state no longer exists, even in Sri Lanka, at least among the affluent and westernised sections of society. Naturally, one does not expect it to exist amongst the immigrant community here. On the other hand, it is difficult, if not impossible, for an immigrant to totally adopt the culture of the host country. First generation Asians would have the greatest difficulty, the second generation would tend to stand between the two cultures and the third generation could possibly becom closely integrated.

Elderly Asians in this country at present are mostly the parents of those who immigrated recently and are looked after by them. Quite a few of them emigrated following racial persecution and have got their parents down for the same reason. They feel that they are responsible for the care of their parents and that admission to a residential home is a rejection of this responsibility. The next generation, however, may not have similar views and it is quite likely that some Asians will need residential accomodation in the future. However, Jews who migrated here in the latter part of the 19th century and in the 1930's have not totally integrated with the host community and probably the same would apply to the majority of Asians. Even the elderly of the host population suffer from various forms of discrimination, mainly because of considerations of cost-services are provided on the basis of a one-track assessment and there is no flexibility. To provide appropriate help for people with different priorities and needs, those providing the service should be much more flexible and capable of appreciating the different lifestyles. The Asian elderly may find special day care centres more attractive. They are now able to go to temples, cultural events and social gatherings but this is because their children take them. But will this continue? There may also be a place for sheltered accomodation and residential care homes for Asians, similar to what the Jews and other ethnic minorities who immigrated here earlier have, at present. In Coventry, an area of high Asian population, sheltered housing together with a day care centre and residential home was established for Asians. The problem is that the Asian community is not a homogenous group and except in areas where there is a large population belonging to one particular group, it would be difficult to cater to their needs.

It is obviously difficult to predict how the Asian immigrants will cope with the elderly in the future. It is possible that they may integrate with the host community and be content with the services that are available to them. It is also possible that some will live with their children and others may want special day care centres, sheltered housing and residential care homes. It is likely that there will be a combination of these possibilities as has happened to the earlier immigrants with distinct cultures such as the Jews, Polish or Italians. It is not difficult to imagine that some may even want to go to the warmer land of their parents or grandparents! Or that the first generation British children may want to live in an extended family environment with their parents and grandparents!!

MIOT Youth Forum

Seminar on the Health of Immigrants

This was a great opportunity for young Tamils brought up in the UK to understand the health needs of their people living in this country, especially for those intending to take up a medical career whether to become a Doctor or other professional in the allied fields of medicine and even for those already in the medical field.

As a student at St George's where there is a large Tamil community living in the catchment area, many of them recently arrived due to the conflict, this seminar was very valuable. There were many health issues that were raised, that are in actual fact reality for students and medics at hospitals situated in areas where there are large immigrant populations: language, culture, diet are obvious problems but issues such as higher incidences of CVS disease, diabetes and psychiatric problems were also discussed. Studying in an area such as Tooting I have already unfortunately encountered problems such as chronic alcoholism, language problems in Tamil patients, and sadly whilst doing paediatrics a case of NAI in a young Tamil boy recently arrived without parents. There are unfortunately no provisions within our community to help assist these or others at present. Since we will be the next generation working in the UK, being aware of health and social problems within our own community can help in providing care for those in need either within the NHS or independently as community service.

The discussions not only informed us of problems within immigrant communities but also highlighted problems relating to Tamils specifically and how Tamils immigration due to fleeing the war has affected Tamils. Also positive and negative aspects of the Tamil culture, diet and habits which affect disease processes were also presented.

The most enjoyable aspect of this seminar for myself, was learning about the cultural background of the Tamils, and many of us brought up in this country have unfortunately, for a number of reasons lost out on that aspect of our education. The guided tour of the origins of Tamils and our culture and language was very well presented by Dr Rajayogeswaran.

A lively debate on male chauvinism in Sri Lankan society took place. Maybe it should be noted that mothers should not indulge in pampering their sons as this is likely to result in young men having high expectations of their future wives! In an age of equal opportunities and when women are working full-time but are still expected to carry out the housework, cooking and caring for the children, young Tamil men should be educated by their mothers on how to cook and clean as well as sew, so they can take an equal responsibility in a partnership for life! (Does such an ideal new man exist amongst young Tamils? If so contact..... only joking!)

Miss S. Suntharalingham BSc Hons
Final year Medical Student and Youth Forum Co-ordinator

Sponsored by MIOT South Thames Regional Branch

Printed by Photography, Printing and Design, UMDS