Anatomy & Physiology: Current Research

Chapa, Anat Physiol 2016, 6:5
DOI: 10.4172/2161-0940.1000240

Short Communication Open Access

Exporting Disease

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Received date: July 22, 2016; **Accepted date:** August 24, 2016; **Published date:** August 31, 2016

Keywords: Gestational diabetes; Guatemala

Exporting Disease

I spent my childhood summers in a small town ninety kilometers south of Texas. Back then, the road wasn't paved. A drive to the border would take two hours. This is assuming there wasn't a dead cow or horse or a flock of sheep or goats blocking the bus. The weather was typically forty degrees Celsius. A passenger would happily accept a window versus an aisle seat. I say accept because after the ride, the window facing passenger would be covered with traces of the road. This included the smell of manure the danger of the driver hitting a vehicle or something hitting the face. If nothing else, a window passenger would get to the border with a film of itchy dirt on the face and neck and possibly an arm. I had the task of going with my non-English speaking aunts to translate when they went shopping. This included groceries.

In my hometown, Anahuac, Nuevo Leon, our sugar, rice and wheat were brown. My aunts complained, when I made limeade from the key limes in the back yard, if the limeade had a brown tint. They said American rice puffed up in whole pieces whereas our rice looked like it was the ugly rice no one wanted. The town had a corn tortilla factory where I was sent to buy our lunch tortillas – steaming hot. Still, people had a predilection for sliced white American bread. This was especially evident when there was company – you offered them a sandwich. The belief was that if it was American, it was better. The fact that you had American things meant you could afford them. It was a proxy for income and social status.

In 1995, before the peace accord was signed in Guatemala, I started taking college students from Connecticut. I was responsible for teaching cultural epidemiology. I explained how some social norms were protective. Drinking and smoking weren't appropriate behaviors for women. I told my students infectious disease was more of an issue than chronic disease. But it wasn't just me talking, many times it was someone from the community. I was the official translator. This sounds like it would be useful, but there are over thirty indigenous languages spoken in Guatemala. I needed someone who spoke the local dialect and Spanish, which I could translate into English. I did these trips until 2004.

It seems logical to think that in that almost decade period, health indicators would have improved. To the contrary, with the advent of American junk food, health status decreased. This was especially apparent in pregnant women.

Every year, we visited the midwife in San Juan de los Lagos on Lake Atitlan. She was tiny, wore a gray-hair braid and beautiful handmade traditional clothing. She didn't speak Spanish but was very animated in her answers to my student's questions. She used her hands to explain how she would massage a woman's abdomen if the baby was breech. She proudly told my students how she reported her statistics to the health department. This sounded very impressive but I was curious about how she did this given the fact that she couldn't write.

Her reports to the health department consisted of taking two glass jars the same day every month. For every baby delivered, she placed a black bean in one jar. She used nuggets of corn to report prenatal visits. I wanted to ask her how she reported maternal or infant death -- but I didn't. I worried that these things might be underreported. While visiting a clinic, I asked a physician about maternal and infant death. He said women with complications were taken to the local hospital. Many died. As a result, women didn't want to go to the hospital. The physician assured me maternal death was a rare event. The epidemiologist in me wanted more information – data points. But if the data collection consisted of reporting black beans or corn nuggets, I couldn't expect more detail. The well-intended but perhaps inconsistent data collection is reflected in reports which are hard to trust.

Years later, a local physician told me there were an increasing number of women with gestational diabetes. The World Health Organization (WHO) published gestational diabetes guidelines in 1999 and revised these in 2013 [1]. They also reached consensus on defining adverse outcomes and in rating these. The most critical outcome is perinatal mortality. In developed countries, gestational diabetes is less likely to cause infant death. We have technology not available in countries like Guatemala, especially not in the rural highlands [2]. Far more basic than a neonatal intensive care unit to treat low gestational age babies, common when gestational diabetes is present, is screening. In 2016, According to the United Nations, the only available form of screening for diabetes in Guatemala is what we in the United States call a glucometer reading [3]. For gestational diabetes, the standard is in an oral glucose tolerance [4].

My last visit to Guatemala, just over a decade ago, I asked the physician why they didn't screen for gestational diabetes. He said they couldn't do anything about it. Indeed, The Who 2016 Guatemala country profile reports the availability of glucose lowering drugs and insulin but fails to report the availability of electricity, as insulin needs to be refrigerated [5]. The World Bank reports that in 1990, 72% of the Guatemalan population had electricity. In 2012, twenty-two years later, less than 80% of all households had access to electricity. Moreover, the WHO country profile does not have a definition for "availability".

The doctor answering my first world question wasn't bothered by my ignorance. I felt embarrassed, humbled by his explanation, and ashamed. Western junk food had crossed not only the border but the placenta. I wanted to help the doctor but couldn't. I felt like I did as a child watching out the bus. I felt dirty and helpless.

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