

The variation in anemic parameters in the ethnic groups of Pakistan

ABSTRACT

Aims: To observe any diversity of pattern in the anemic parameters in the ethnic groups of Pakistan. It is to probe into any genetic inborn structure or any cultural norms of a certain ethnic group that would stand out as a specific culprit leading to anemia. **Study design:** Observational, crosssectional. **Place and Duration of Study:** Sample: Department of Medicine, Creek general Hospital, Korangi, Karachi, Pakistan from October 2017 to March 2018. **Methodology:** We included 1200 adults above 18 years. Pregnant females, age less than 18 years and any severe organ insufficiency, stroke, neurodegenerative disease, known blood dyscrasias or terminal illness at baseline evaluation were excluded. The ethnic background was grouped into Urdu speaking, Punjabi, Baluchi, Sindhi, Pashtun, Bengali, and Gilgit according to place of origin, mother tongue or parents' place of origin. The complete blood picture was performed to identify anemia, grade the severity, classify the red cell indices and exclude any blood dyscrasias. **Results:** Out of 1200 adults, 626(52%) were anemic. In decreasing order, the most anemic were Bengalis (57.6%), Sindhis (55%), Urdu speaking (54%), Pashtuns (54%), Baluchis (52%), Gilgits(49%) and Punjabis(45%). In males, Sindhis (60%), Pashtuns (57%), Bengalis (56%), and Urdu speaking (51%) were most anemic. In females, Baluchis (71%), Bengalis (64%), Urdu speaking (55%) were most anemic. Regarding age groups, Urdu speaking, Pashtun and Sindhis had most anemias in the younger group while the rest had most in the middle age group. In males, anemia was highest in the young age group of Urdu Speaking, Sindhis, and Pashtuns while in females in all the ethnic groups the middle age group was most anemic and had least anemia in elderly females except in Bengalis where the least was in young females. Mild anemia was most common overall and in both genders. Regarding red cell indices, Punjabis and Bengalis were normocytic while in the rest the most were microcytic. In the males, Urdu speakers, Punjabis and Bengalis were significantly more normocytic anemic, while Sindhis were more microcytic. In females, in all the ethnic groups' microcytic anemia was prevalent. Anemia was three times more in the Sindhi group of smokers compared to the Sindhi nonsmokers while in the rest of the ethnic groups there was no specific correlation. **Conclusion:** This survey specifies that in Pakistan the key measures of health status are albeit dependent on the financial status, literacy rate, sanitation, access to primary care facilities, effective role of health providers but the genetic composition and cultural norms also play their part.

Keywords: *Anemia, Ethnicity, Hemoglobin, Red cell Indices*

1. INTRODUCTION (ARIAL, BOLD, 11 FONT, LEFT ALIGNED, CAPS)

Anemia persists to be a primary universal health concern with a global prevalence of 33% as stated in 2010[1]. the world health organization (who) estimated approximately 1.62 billion people of the world to be anemic [2]. Pakistan is foremost in this concern as more than half of its population is anemic leading to a deterioration of mental and physical growth, subsequently affecting its economic progress. Its identification, correction and prevention being an urgent priority should be the key focus in the domain of health of this country. [3]

Anemia is a multidimensional disease with both nutritional and non-nutritional etiologies being responsible such as iron, folate or cobalamin deficiencies, chronic or acute blood loss, inherited genetic defects, chronic diseases and/or inflammatory disorder, parasitic infestations, etc. [4]

Genomics is linked to public health science as population genetics and the epidemiology of a disease is found to be associated under a certain pattern which then affects the clinical practice of that population [5] [6] this health inequality between ethnic groups are seen due to a number of reasons

like reluctance in accessing healthcare, language and cultural barriers, certain myths and religious views, gender discrimination, poverty or underprivileged sectors. [7] understanding the health physiognomies of each group can enable us to prioritize screening programs, education and resource allocation according to their need.

Pakistan has several ethnic communities personalized by their culture and language according to their place of origin [8]. This Karachi based study is to observe any difference in the pattern of anemia and its extended parameters with respect to the ethnic groups in adults. It is to probe whether any genetic inborn structure or any cultural norms of a certain ethnic group would stand out as a specific culprit leading to anemia. An insight into these health inequalities with respect to ethnicity is needed for effective healthcare to be delivered appropriately.

2. MATERIAL AND METHODS / EXPERIMENTAL DETAILS / METHODOLOGY (ARIAL, BOLD, 11 FONT, LEFT ALIGNED, CAPS)

The study was a cross sectional, observational one conducted in the outpatient clinic of a tertiary care hospital, Creek General Hospital, Korangi, Karachi from October 2017 to March 2018. The hospital is located in a multi ethnic area where strata from different ethnic backgrounds present to the clinics. It was done on 1200 adults (age 18 years and above) selected by convenient sampling. Pregnant females, age less than 18 years and any severe organ insufficiency, stroke, neurodegenerative disease, known blood dyscrasias or terminal illness at baseline evaluation were excluded. The ethnic background was noted and grouped into Urdu speaking, Punjabi, Baluchi, Sindhi, Pashtun, Bengali, and Gilgit according to place of origin, mother tongue or parents' place of origin. Other relevant information was obtained. The complete blood picture (CBC) was performed by ABX Micros 60 Hematology Analyzer to identify anemia, grade the severity, classify the red cell indices by Mean Corpuscular Volume (MCV) and exclude any blood dyscrasias or acute hemolytic conditions. The data was analyzed on SPSS version 22.

Objective Definitions;

Anemia (WHO Criteria) [9]

Hemoglobin levels; Males :< 13 g/dl Females: <12 g/dl

Severity of anemia

	Mild	Moderate	Severe
Females	10-11.9 g/dl	8 – 9.9 g/dl	8.0 g/dl
Males	10-12.9 g/dl	8 – 9.9 g/dl	8.0 g/dl
MCV Classification of anemia: Normocytic; 84-96 Microcytic ;< 84 Macrocytic >96			

3. RESULTS AND DISCUSSION

Among the 1200 adults that presented 631(52.6%) were Urdu Speaking, 250(20.8%) were Punjabis, 92(7.7%) were Sindhis, 80(6.7%) were Pashtuns, 71(6%) were Gilgits, 52(4.3%) were Bengalis, and 24(2%) were Balochis. Out of them 626(52%) were anemic. The frequency of anemia in each ethnic group and the gender distribution of anemia in each group are demonstrated in table 1. The mean hemoglobin (with std deviation and range) of each ethnic group is shown in table 2. the percentage of anemia in the ethnic groups according to age groups is displayed in figure 1. the severity of anemia in the various ethnic groups is presented in figure 2. The frequency of anemia with respect to age groups in males is displayed in figure 3. In females, the anemia percentage was highest in the middle age group in all the ethnic groups and least in the elderly group of all ethnicities except the Bengalis where the young females had least anemia ($P= 0.12$). Mild anemia was more common in male gender of all groups ($P=.743$) and in the female gender ($P=.090$) when severity was checked separately in each gender. The red cell indices in the different ethnic groups are tabularized in table 3. When analyzed gender wise; in the males - Urdu speakers, Punjabis and Bengalis were significantly more normocytic anemic, while Sindhis were more microcytic. The Balochis, Pashtuns, and Gilgits were equally more normocytic and microcytic than macrocytic. ($P= .884$) in females, in all the ethnic groups' microcytic anemia was more prevalent. There is no specific correlation or pattern of variation of anemia with the number of children in the females in any of the ethnic groups. Anemia was three times more in the Sindhi group of smokers compared to the Sindhi nonsmokers while in the rest of the ethnic groups there was no specific correlation on linear regression. There was no specific ethnic group in which diabetics had significantly more anemia compared to non-diabetics of that group.

Table I: Anemia in different ethnic groups and with respect to gender in that ethnic group
($P=0.282$)

Ethnicity group	Total presented	The no. of Anemic/ % anemic in that group	The no. of males of that group	The no. and % of anemic males in that group	The no. of females of that group	The no. and % of anemic females in that group
Bengali	52	30(57.6%)	27	14(56%)	25	16(64%)
Sindhi	92	51(55%)	40	24(60%)	52	27(52%)
Urdu speaking	631	341(54%)	252	130(51%)	379	211(55%)
Pashtun	80	43(54 %)	35	19(54%)	45	24(53%)
Baluchis	24	12(52%)	10	2(22%)	14	10(71%)
Gilgits	71	35(49%)	26	12(46%)	45	23(51%)

Punjabis	250	114(45%)	104	37(35%)	146	77(53%)
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Table 2: Mean hemoglobin found in all the groups

ethnicity	Mean	Std. Deviation	Range
Urdu Speaking	11.93	3.84	89.00
Punjabi	12.59	6.47	104.50
Sindhi	11.62	2.09	10.30
Bengali	12.04	2.16	11.00
Gilgit	12.02	1.87	9.20
Balouchi	11.86	2.45	8.80
Pashtun	12.22	2.42	14.60
Total	12.07	4.21	107.00

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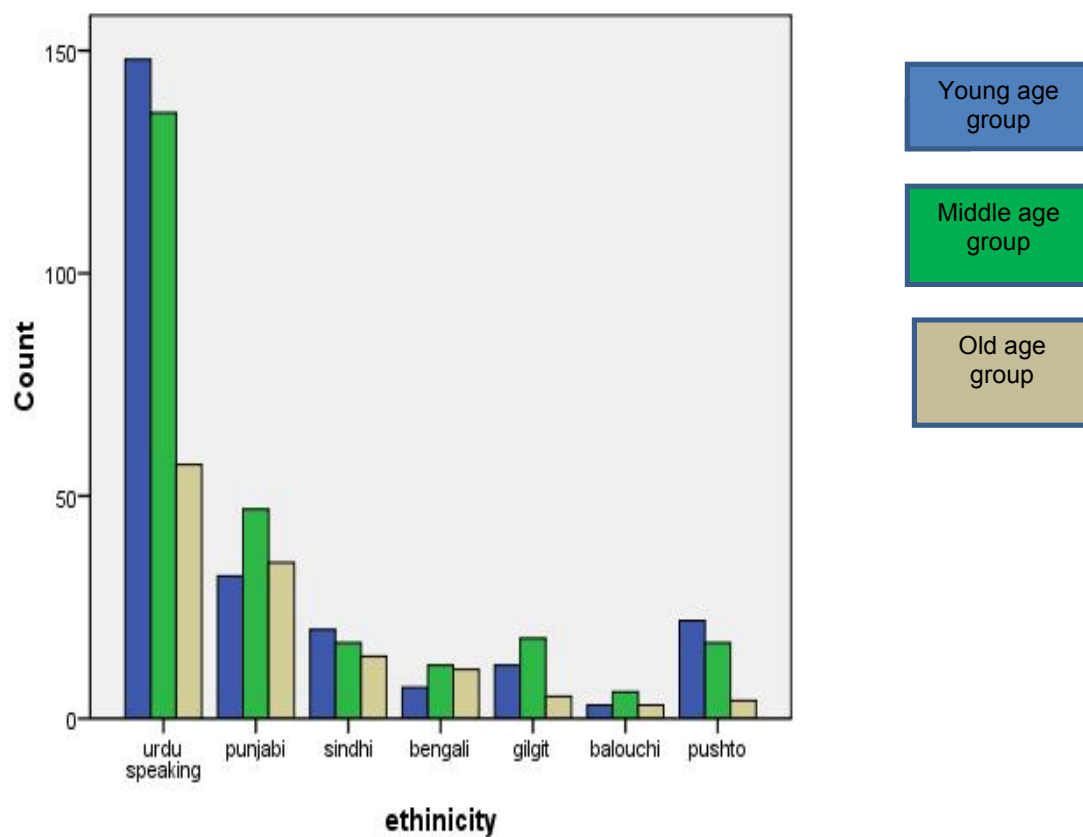
Table 3: The frequency of red cell indices in ethnic groups(P= .197)

Ethnicity	MCV group			Total anemic in that group
	Normocytic (% of total anemic of that group)	microcytic<84(% of total anemic of that group)	macrocytic>96(% of total anemic of that group)	
Urdu Speaking	140(41)	182(53)	19(5)	341
Punjabi	55(48)	53(46)	6(5)	114
Sindhi	17(33)	31(60)	3(5)	51

Bengali	16(53)	13(43)	1(3)	30
Gilgit	14(46)	17(48.5)	4(11)	35
Balouchi	2(16)	10(83)	0	12
Pushto	12(27)	29(67)	2(4)	43
Total	256	335	35	626

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93 Figure 1 The anemic distribution in the ethnic groups according to age group



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Figure 2 The severity of anemia in different ethnic groups ($P= .856$)

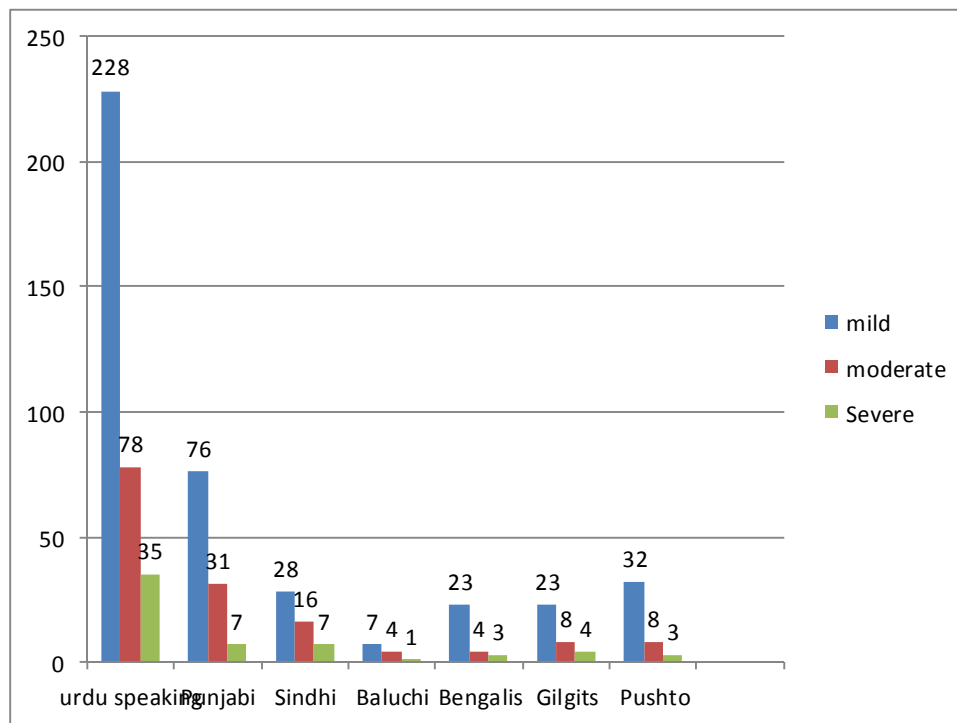
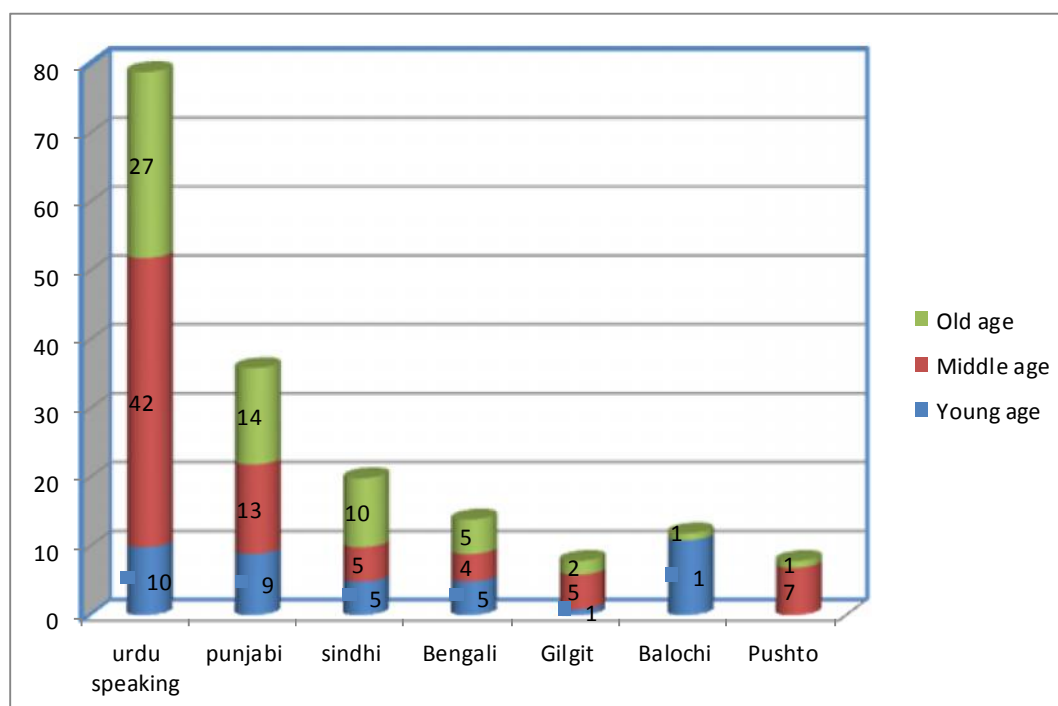


Figure 3 The pattern of anemia frequency according to age groups in the males of the different ethnic groups (P= .164)



DISCUSSION

Ethnicity influences the parameters of a disease by factors such as differences in service availability, geographical origin, communication and language obstacles, cultural attitudes/beliefs, socio-economic status, and genetic differences in disease prevalence. We analyzed the anemic parameters of each ethnic group residing in Karachi and then compared the statistics with the adults of that group living at their place of origin. The severity of anemia was by large mild in all groups and genders giving a hope that the risk factors if effectively attended to would minimize the prevalence of anemia in Pakistan.

Bengalis had the highest frequency of anemia in this cohort and the equal prevalence in both genders points to certain common factors that is contributing to anemia in the whole population. The Bengalis of Karachi are mainly involved in the fishing industry living near the coastal areas in unhygienic and poor conditions. [10] Their diet mainly consists of rice, lentils and fish which lack iron and other micronutrients. This lack of red meat in their diet was also stressed upon by Faruk in his Bangladeshi study [11]. Males had mostly normocytic anemia probably because of the mixed nutritional deficiencies (of iron and cobalamin) and prevalence of chronic diseases. The females are microcytic understandably due to their hormonal cycles, multiple pregnancies and malnutrition with inadequate iron intake compared to the loss which is why the middle age group was worst affected. Bharti [12] studied anemia in West Bengal and noted that it was prevalent in all socioeconomic group of females and Merrill insisted that females are subject to gender biasness in diet availability [13]. Factors, present in Bengalis of Karachi, common to both genders are parasitic infestation, daily diet lacking foliate and iron, unhygienic conditions, poverty and food contamination by sea pollutants which was seen more in the middle and elderly age group.

A conspicuous result in Sindhis which was an eye opener was the higher frequency of anemia in males compared to females with both the genders being microcytic. A probable conclusion is that dietary iron deficiency, hookworm manifestation, acid peptic disease and smoking are the main anemic culprits here (after we exclude blood dyscrasias). The addiction profile was very high in Sindhi

males and anemia being three times more in smokers than nonsmokers' glares at the consequences of gutka and tobacco and explains why the young males are more anemic than other age groups of Sindhis. The growing use of gutka and other forms of tobacco results in severe malnutrition as these noxious products suppress appetite and prevent absorption of micronutrients in the body. This low hemoglobin is present despite the secondary physiological erythropoietin response caused by tobacco. The statistics of Sindhi women health has also worsened. The results of the NNS 2011 for anemia showed that the prevalence of anemia in non-pregnant females had risen from 28% in 2001 to 50% in 2011 [14, 15]. Cultural myths, lack of approach to healthcare, ineffective counseling by health care providers, multiple pregnancies and addiction to 'beeri'(raw tobacco) is causing a serious setback in decreasing the rising ratio of women with malnutrition which takes its toll in the middle age group females. Laghari [16] studied anemia in students of Sindh University, Jamshoro and his studies showed females to be more anemic compared to males which is unlike our ratio of the Sindhis presiding in Karachi.

The Urdu speaking community is preliminary an urban population and their exposure and tendency towards Fad diets and unhealthy junk food which then causes acid peptic disease as a sequel is comparatively more compared to other communities. Their high percentage of addiction to gutka and betel nut has led to high prevalence of anemia in young males. Bharati [12] has already emphasized that there is a high anemic frequency in India with factors more or less common to both sides of the country boundary. The females suffer more due to the gender discrimination, unequal food sharing and child bearing leading to the middle age group being most anemic and the elderly females having attained menopause are the least anemic.

The Pashtuns of Karachi are physically strong and involved in strenuous physical occupational work yet more than half of them were found to be anemic. One of the prevailing offenders of the high anemic prevalence in young males is the rampant Niswar addiction. There is also suspicion of high frequency of constipation leading to hemorrhoids in Pashtuns (but studies are needed to confirm this) which could be the cause of microcytic anemia in them. Shahab's study [17] conducted in Peshawar agreed to our results which shows that there are common correctable propensities in both genders of the community.

The Balochis that presented here were mostly those living in the coastal areas and are fisherman by profession. They catch trade and eat fish. This then leads to another important factor of sea pollution which is the toxic effect of the minerals consumed by the fish which eventually is transferred to the fish consumers. This sea pollution is taking a heavy toll on human health. There is also a high addiction rate of 'tiryak' (finer opioid). The women were triple times more anemic than men and when we compared this to the Balochis living in Baluchistan the statistics were similar for women. In Baluchistan, poverty and unemployment coupled with worsening law and order situation have deepened woes and severely affected the nutritional status of women [18]. However, a common factor in most Balochi women, whether urban or rural, was the issue of multiple pregnancies, low adult literacy rate and conservative restricted living. [19] According to National Nutrition Survey (NNS) conducted in 2011, the anemic statistics of Baluchistan jumped from 26.9 to 49 per cent in 2011 with higher prevalence of anemia in females and the knowledge of micronutrients being least in Balochis.[14].

Half of the Gilgits of Karachi were anemic which is a higher rate compared to the natives living in the Gilgit Baltistan. One obvious reason of the natives to be less anemic is the high altitude in the Northern region of Baltistan which causes secondary polycythemia masking anemia if it is internally present. Karachi is a low lying area which would alienate the erythropoietin effect. Uzma [20] stressed in her study on anemia in Gilgit that the anemia frequency is lower because of higher literacy rate in the region due to a well-established system of basic education. Inference can be drawn from this fact that educational status of women has a major impact in solving this problem. Khalil [21] showed that there is a high prevalence of intestinal infestations especially *Ascaris Lumbricoides* among Gilgits which can then be a factor causing anemia even if they migrated to Karachi. The highest percentage of macrocytic anemia was in Gilgit group showing cobalamin/folic acid deficiency to be a contributing factor which is assured by Tanweer in his Karachi based study on macrocytic anemia. [22] This needs to be explored in further studies to rule out any genetic intrinsic factor anomalies.

Punjabis residing in Karachi had the lowest percentage of anemia in this study cohort showing them to be nutritionally balanced. Females were considerably more anemic, and a microcytic one, due to

their physiological processes along with being in a male privileged society. According to the NNS 2011 report the knowledge of micronutrients was the highest in Punjab area [14] which again emphasizes the deep impact education has in the development of healthcare. Middle age group of males are the working class and the revenue generator and they being normocytic anemic means that we need to reinforce awareness of diet and health checkups in them.

4. CONCLUSION

This survey specifies that in Pakistan the key measures of health status are albeit dependent on the financial status, literacy rate, sanitation, access to primary care facilities, effective role of health providers but the genetic composition and cultural norms also play their part. It is important to try to understand where and how ethnic differences impacts on healthcare delivery if health inequalities are to be reduced across the whole population. Evidence suggests that the poorer socio-economic position of some ethnic groups is the main driver and aggravator of ethnic health inequalities.

Pakistan needs a more comprehensive strategy to prevent losing 'working years' from anemia by focusing on practically implemented, home based interventions that includes diet counseling, micronutrient supplementation, food fortification to attend to nutritional anemia while concomitantly responding to other etiologies of anemia. Hygiene and sanitation, deworming. Malaria prevention is other areas of necessary interposition. Health policies are required to tackle health inequalities keeping the ethnic variations in mind. Callen's review [23] on healthcare facility of Punjab points to a necessity for improvement in the role and availability of healthcare officers at Basic Health unit level in the whole country who can then tackle issues at a local ground level. Specific health messages through electronic media can promote the importance of a healthy, prestigious woman in the family. Woman employment and family planning programs should be stressed [26] to relieve the misery of poverty.

CONSENT (WHERE EVER APPLICABLE)

"All authors declare that 'written informed consent was obtained from the patient. A copy of the written consent is available for review by the Editorial office/Chief Editor/Editorial Board members of this journal."

ETHICAL APPROVAL (WHERE EVER APPLICABLE)

"All authors hereby declare that all experiments have been examined and approved by the appropriate ethics committee and have therefore been performed in accordance with the ethical standards laid down in the 1964 Declaration of Helsinki."

Limitations of Study;

It was a hospital based study and a larger scale research should be done in the community. There could have been an overestimation of the frequency of anemia since it was a hospital samplig. There was also an inability to know for certain whether patients had underlying occult hemoglobinopathy or X-linked G6PDH disorder which is known causes for anemia here.

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