Vitamin B in the New Zealand Diet

(Written for "The Listener" by DR. MURIEL BELL, Nutritionist to the Department of Health)

A SERIES of articles recently published in these columns dealt with some of the different vitamin B factors. It is as well that we should be acquainted with what is known about the foods eaten by New Zealanders, and what they contribute towards our needs for these nutrients. A reference was made some months ago to certain studies that have been made on actual dietaries consumed by New Zealanders. In the most recent of these, the foods eaten by the families of 63 basic wage-earners were recorded and worked out in terms of the "average" person in the group studied. Of course, the "average" person is a theoretical consideration—but when we compare the "average" person here with the "average" person in another country, we do at least get some idea of certain trends. Now, here is a table which will give the "average" intake of various groups of foodstuffs per day as recorded in this study made in the autumn months of 1939, and what these furnish in the way of vitamin B factors. They are compared with the tentative standards of a first-class dietary as suggested in 1941 by the National Research Council of U.S.A. A word about these standards first: when we say that a good dietary should contain so many units or so many micrograms of vitamin, we should not think in terms of our own little selves and our particular requirements. Yours might not be so great as those of Mrs. Unfit, who appears to need a better dietary to keep her well. Again, when we adopt "standards" they are approximations just as are "averages" — they are some sort of yardstick by which to measure our tendencies and out shortcomings, but they must not be adopted too rigidly. Always remember that we are just beginning to learn about our food needs—we are far from being well-informed yet.

PRINCIPAL FOOD GROUPS — AVERAGE DAILY INTAKE — AND CONTRIBUTION OF VITAMIN B FACTORS

Foodstuff	Amount	Vitamin B1 micrograms.	Riboflavin micrograms.	Nicotinic Acid milligrams.
Bread, white	5.6 oz.	182	32	1.11
,, wholemeal	1.6 oz.	90	32	1.35
Flour, white	2.1 oz.	109	18	0.63
,, wholemeal	0.7 oz.	84	50	2.16
Meat (as purchased)	5.9 oz.	180	435	6.19
Milk	0.7 pt.	196	780	0.40
Cheese	0.1 oz.	1	15	—
Egg (½)	1.0 oz.	30	70	0.30
Fruit (as purchased)	9.8 oz.	44	81	1.10
Green Vegetables	4.8 oz.	112	114	0.37
Root Vegetables	2.2 oz.	33	15	0.19
Potatoes	6.0 oz.	125	54	1.94
		1186 to 1390*	1696	15.74
Standard for 3000 calories		1800	2700	18.00

*Depending on the natural variation in values.

Note how much is contributed by the foodstuffs — meat — milk — potatoes — bread. Note the deficits, and see what you could devise to improve the intake without adding too greatly to the cost. Keep this article so that we may turn our attention to these figures in the solution of the problem. Schools and Training Colleges which follow these articles may like to make ladder diagrams to illustrate them.

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Minister of Health, Hon. A. H. Nordmeyer, stated in a broadcast, that "the figures for diphtheria showed a downward trend," so why this wholesale inoculation?

Dr. Turbott further objects to our point that no guarantee can be given that treatment will cause a decline in the cases of diphtheria, and gives figures from Scotland, New York and Canadian cities. Again, we refer to figures given by the Minister of Health in the British House of Commons in September, 1942. In Scotland in 1941, over 1000 immunised children were officially admitted as having contracted diphtheria, and between January 1, 1940, and September 30, 1941, 2380 children who had received a course of immunisation developed diphtheria. The fact that there were 14 times fewer cases in the immunised does not affect the point, which is that thousands of immunised children have contracted diphtheria.

As for New York, the decline in diphtheria had been rapid, before immunisation was practised, even as far back as 1915 when there was the greatest drop, before immunisation was even thought of! Toronto and Hamilton's histories show that there had been a great decline in diphtheria before immunisation was widely practised. Yet, some Canadian cities that have practised immunisation have not experienced any remarkable fall in diphtheria, for Quebec City, which started immunising in 1930, had a very serious epidemic of diphtheria in 1936. An intensive campaign was then carried out, and in 1938 Quebec City had the highest death-rate of the cities of the world, according to statistics published by the Health Organisation of the League of Nations.

Also, as our advertisement pointed out, in wartime Germany and occupied countries, where inoculation has been made compulsory, there has been a severe epidemic, but in Sweden, where there is no immunisation, diphtheria is non-existent.

We claim that our statements are true and worthy of consideration by all fair-minded folk who wish to know both sides of the question.—L. I. OLDFIELD, Hon. Secretary, Auckland branch, British Union for the Abolition of Vivisection.—P.B.A.