STUDY ON NUTRITIONAL STATUS OF 6 MONTHS TO 59 MONTHS CHILDREN IN

GUREI SUBURB OF NYARKENYI PAYAM, JUBA COUNTY, SOUTH SUDAN AND FACTORS ASSOCIATED WITH IT

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# **DECLARATION**

I hereby declare that this research paper is my original work and has not been presented for a diploma in any other university or institution of higher learning

Signed………………………….. Date…………………………………….

Kenyi Sam

This proposal is submitted with our approval as institute supervisors

Signed………………………….. Date……………………………………

Name: Ratemo Fredrick

Signed………………………….. Date……………………………………

Name: ………………………….

# **DEDICATION**

This thesis is dedicated to my lovely son Alvin Kenyi, my wives; Bonsuk Safina Kenyi, Asio Jane Kenyi, for their support, continuous love and encouragement, to my parents Mr. Abigo Henry, Mrs. Modong Joseline and Mrs. Juan Mary for their support throughout the study process.

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**ABSTRACT**

Despite substantial presence of humanitarian and other aid agencies, malnutrition remains a serious obstacle to child survival, growth and development in South Sudan. The current prevalence of acute malnutrition among under five children in South Sudan is unprecedented. Global acute malnutrition (GAM) rates now exceed emergency thresholds of 15% in all states except Central Equatoria. An estimated 5.1 million people are classified as severely food and nutritionally insecure in the country. Protein-energy malnutrition (PEM) and micronutrient deficiency are most common types of malnutrition. In South Sudan, 17.6 percent of children are wasted. Children whose weight-for-age is below minus two standard deviations from the median of the reference population are considered underweight. The measure reflects the effects of both acute and chronic under nutrition. 30% of children under five years of age are underweight and 8 percent are severely underweight. South Sudan suffers from extensive malnutrition, ranking in the top 15 countries with the highest prevalence of stunting (less than -2 SD scores). It was against this backdrop that this study was designed.

The purpose of the study is to find out the magnitude and distribution of malnutrition. To analyze the causes of malnutrition and the factors that are directly or indirectly associated with the nutritional status. Therefore, this study is designed to assess the prevalence of malnutrition and associated factors among children aged 6-59 months which can be used as a reference in priority setting and designing effective nutritional programs at Gurei Suburb of Nyarkenyi Payam, Juba County.

These findings will serve as helpful guide to plan suitable nutritional and health programs for this community based on the facts and figures discovered from this study. The study will further provide information to government and voluntary institution like NGOs about nutritional status as well as different demographic factors as well as encourage government and other stake holders for the development of programs and policies related to nutrition.

A community based cross-sectional survey will be conducted to assess the nutritional status and associated factors among children aged 6-59 months. The study will be conducted at Gurei Suburb of Nyarkenyi Payam, of Juba County, Central Equatoria State, South Sudan located about 15Km west from Juba town.

Cluster sampling technique followed by simple random sampling will be used to select children from households. The basic criterion for the selection of household sample is that the household containing at least one child of 6-59 months of age will be included in the sample. The sample size is determined by using a single proportional formula assuming the prevalence rate of malnutrition to be 50% in the survey area, 95% confidence interval (CI), 8% margin of error (d) and 10% non-response rate is added to the total calculated sample size.

The data collection instruments will be validated at Africa Institute of Project Management Studies department of Nutrition and Dietetics. Data will be collected using structured questionnaire and anthropometric measurement. Interview will be conducted with parents/care takers of the children to fill the questionnaire. The data will be checked for completeness and consistency. Then it will be coded and entered in the computer using statistical software. Likewise, qualitative data will be transcribed and coded by assigning labels to various categories.

# **1. CHAPTER ONE; INTRODUCTION**

**1.0 Overview**

This chapter presents background to the study, followed by statement problem as well as the objectives of the study. Research questions follow as well as the purpose of the study. The chapter is crowed by justification of the study and the scope of the study.

# **1.1 Background to the study**

Adequate Nutrition is the fundamental right of every human being. Poor nutrition is cited as the major factor in more than half of all child deaths in South Sudan - a significantly higher proportion than those claimed by other infectious diseases. Malnutrition is not just a stark manifestation of poverty, it is also the non-income face of poverty and it helps perpetuate poverty (World Bank Report, 2017). Nutritional status is defined as the condition of the body resulting from the intake, absorption and utilization of food. It is determined by a complex interaction between internal/constitutional factors and external environmental factors: Internal or constitutional factors like: age, sex, nutrition, behavior, physical activity and diseases. External environmental factors like: food safety, cultural, social and economic circumstances (Joshi et al, 2011).

South Sudan is one of the least developed nations in Africa, which was ranked 163 among 189 countries in the Human Development Index (UNDP 2018). According to World Bank, 2017, the total population of South Sudan is 12.58 million. More than 79% of population resides in rural area. The infant and under five mortality rates are 39.3 and 99.2 per 1000 live births respectively. The population growth rate in 2011 is 1.41% (WHO, 2014 - 2019).

Gurei Suburb of Nyarkenyi Payam, Juba County lies in Juba County and is located about 15Km west of Juba city. This village consists of people of different ethnic group and different economic status. Mostly Bari, Mundari, Pojulu resides here along with Muru, Zande etc. The major occupation of the place is agriculture. But nowadays most of the people are dependent on remittance and also large number of population work as labor in agriculture and construction. There are 550 households, 9,600 total population and 1,728 children below five year of age. (Gurei Boma office)

# **1.2 Problem of Statement**

Malnutrition refers to a pathological state resulting from a relative or absolute deficiency or excess of one or more essential nutrients. It is a state of nutrition where the weight for age, height for age and weight for height indices are below -2 Z-score of the NHCS reference.

Malnutrition continues to be a major public health problem in developing countries. It is the most important risk factor for the burden of disease causing about 300, 000 deaths per year directly and indirectly responsible for more than half of all deaths among children. Health and physical consequences of prolonged states of malnourishment among children are: delay in their physical growth and motor development; lower intellectual quotient (IQ), greater behavioral problems and deficient social skills; susceptibility to contracting diseases. Major types of nutritional problems in developing countries are undernutrition and nutritional disorders which are resulting from inadequate food intake both in quality and quantity, particularly of calories, proteins, vitamins and minerals; and parasitic infection and disease.

Malnutrition remains a serious obstacle to child survival, growth and development in South Sudan. The current prevalence of acute malnutrition among under five children in South Sudan is unprecedented. Global acute malnutrition (GAM) rates now exceed emergency thresholds of 15% in all states except Central Equatoria (South Sudan Ministry of Health Nutrition report, 2018). An estimated 5.1 million people are classified as severely food and nutritionally insecure in the country (WFP health survey report, 2010). Protein-energy malnutrition (PEM) and micronutrient deficiency are most common types of malnutrition. In South Sudan, 17.6 percent of children are wasted (World Bank report, 2017). Children whose weight-for-age is below minus two standard deviations from the median of the reference population are considered underweight. The measure reflects the effects of both acute and chronic under nutrition. 30% of children under five years of age are underweight and 8 percent are severely underweight (2018 South Sudan Nutrition country profile). South Sudan suffers from extensive malnutrition, ranking in the top 15 countries with the highest prevalence of stunting (less than -2 SD scores) (Global Nutrition Report, 2018). This study is to identify the nutritional status of 6 months to 59 months children in Gurei Suburb of Nyarkenyi Payam in Juba County of South Sudan and the factors associated with it.

# **1.3 Objectives of the study**

# **1.3.1 General Objective**

The main objective of this research work is to assess the nutritional status of children between 6 – 60 months’ age, also to assess and analyze the factors that are directly and indirectly associated with nutritional status and suggest appropriate measure against the problem assessed in that area.

# **1.3.2 Specific Objectives**

1. To determine the nutritional status of children aged 6-59 months at Gurei Suburb of Nyarkenyi Payam, Juba County.
2. To identify associated factors of malnutrition among children aged 6-59 months at Gurei Suburb of Nyarkenyi Payam, Juba County.

# **1.4 Research Questions**

a) What are the underlying factors that are associated with malnutrition on the children of particular age group residing in these living areas and what parameters are responsible to induce low food availability in household level to cause malnutrition in child.

# **Purpose of the study**

The purpose of the study is to find out the magnitude and distribution of malnutrition. To analyze the causes of malnutrition and the factors that are directly or indirectly associated with the nutritional status. To suggest corrective measures so that which could be intervened in order to uplift current nutritional status. To create ideas that will contribute to improve poor nutritional status of children in accordance to their socio-economic status, religion, culture, livelihood etc. To provide necessary information for the policy makers in the field of food and nutrition. To provide information regarding the nutritional situation of children below 5 year of age, to the governmental as well as non-governmental organizations to initiate steps to eradicate the problem. To act as helpful guide for planning appropriate nutritional program in that particular place.

# **1.6 Significance of the study**

The findings of the study will be helpful to encourage local people to improve current nutritional status by improving feeding pattern and habit of children, pregnant and lactating women. It will also serve as helpful guide to plan suitable nutritional and health programs for this community based on the facts and figures discovered from this study. The study will further provide information to government and voluntary institution like NNGOs and INGOs about nutritional status as well as different demographic factors as well as encourage government and other stake holders for the development of programs and policies related to nutrition. It is also envisaged to discover the problems related to nutrition, care practices and feeding behavior of this community and act as a tool to reflect sanitary condition, socio-economic variables, degree and types of malnutrition and condition of 6 to 60 months’ age group child. Last but not least, it will identify individuals or group of people who are at risk of being malnourished and who need special care and attention. It will also help researchers in this field as a source of literature review.

# **1.7 Justification of the study**

The prevalence of malnutrition imposes significant costs on the South Sudanese economy as well as society. The high mortality due to malnutrition leads to the loss of the economic potential of the child. It affects children in many ways, predisposing them to different infectious diseases, psychosocial mal-development, and cognitive deficiencies.

Therefore, this study is designed to assess the prevalence of malnutrition and associated factors among children aged 6-59 months which can be used as a reference in priority setting and designing effective nutritional programs at Gurei Suburb of Nyarkenyi Payam, Juba County.

# **1.8 Scope of the study**

Gurei is located in the west part of Juba town about 15km – accessible through some of the most recent neighborhoods of Juba city, where new residents and returnees settled from 2005 onwards. Gudele 1 and 2 grew between 2005-2011, the year where South Sudan’s independence was declared. After Gudele 2, you reach Kobri Haboba (“Grandma’s Bridge” in Arabic), an area which was largely inhabited prior to 2011. According to Juba elders, it was named after the first woman who settled there. Right across Kobri Haboba, you’ve arrived in Gurei. “Gurei” is the name of a grey bird in Bari.

Like other neighborhoods, Gurei has been plagued by unemployment, poverty and the lack of food. At the Gurei Primary Health Care centre, the Ministry of Health together with humanitarian organizations treat mothers and children for malnutrition.

The scope of the study done will be supporting and informing policy dialogue, strengthen knowledge and support policy development to implement intervention programs for the improvement of nutritional status of said age group children. This study will be able to categorize the severity of different forms of malnutrition that had habitat in children. The study of nutritional status in society give the real image of condition of household occurrence of malnutrition at national level and help to introduce intervention to uplift their status as healthy living. It is the study which generate the level of education on health, hygiene, sanitation, occupation, living standard, pattern care of children feeding, knowledge in food habit food consumption situation in particular moment. Nutritional status related survey is one of the best methods to interact directly with people and most applicable method to bring out change in the faulty living practices.

# **Limitations of the study**

1. Instrumental and personal errors may arise while measuring and recording anthropometric data. In order to reduce the gross errors in measurement, different correction factors will be applied and in the extreme condition, instruments shall be recalibrated carefully. Random error may be reduced by taking the average of a large number of readings.
2. Difficulties may be encountered in assessing socio-economic information like family income, family property, expenditure on food and non-food items, food consumption pattern etc. as they are considered to be related with the family prestige. Following the National Council for Applied Economic Research criteria for household income, households will be randomly selected for the study, in Gurei suburb of Nyarkenyi Payam, Juba (South Sudan). This area is considered as poor on the basis of the income level of the residents. Data will be collected using both quantitative (structured interview schedule) and qualitative (in-depth interview and key informant interview) tools. Ethical approval was obtained for the study from the Health Ministry of the Government of South Sudan. Informed consent will be obtained from the respondents prior to data collection. Responses will be anonymized to ensure confidentiality of the participants. The structured interview schedule will focus on; a) usual food acquisition in the household, b) household decision-making on food purchases, c) the usual food purchaser, d) location of where food purchases are made, e) household budget for food, and f) percentage of household income spent on food. In-depth interviews (IDIs) will explore these issues in greater detail including intra-household food distribution pattern. The interview schedule will be administered to those, who are responsible for the food preparation and distribution in the households. IDIs will be carried out with the ‘perceived’ head of household. Key informants (food vendors) will be interviewed using a predetermined interview guideline to explore food purchasing behaviour of the households, and will be selected purposively from the study areas.
3. Correct age or birth date of child may not be obtained in some illiterate families and some tribal groups. Independent variables such as mother's age at the time of child birth (15-19, 20-29, 30+ yr), sex of the child (female/male), birth order (1, 2-3, 4+), birth interval (≤ 24 months, > 24 months); mother's education (illiterate, literate); mother's work status (not working, working at home, working away from home); wealth (poor/rich); full antenatal care (ANC) (No/Yes); safe delivery (No/Yes); region (North, Central, East, Northeast, West, South); sanitation facility (unsafe/safe); cooking fuel (unsafe/safe); drinking water (unsafe/safe) will be used during data collection.
4. Uneven floor surface for weight and height measurement and other circumstances for measuring weight and height might cause error. To measure height accurately at home to calculate BMI-for-age, the following procedures will be followed by research assistants:
5. Remove the child or teen’s shoes, bulky clothing, and hair ornaments, and unbraid hair that interferes with the measurement.
6. Take the height measurement on flooring that is not carpeted and against a flat surface such as a wall with no molding.
7. Have the child or teen stand with feet flat, together, and against the wall. Make sure legs are straight, arms are at sides, and shoulders are level.
8. Make sure the child or teen is looking straight ahead and that the line of sight is parallel with the floor.
9. Take the measurement while the child or teen stands with head, shoulders, buttocks, and heels touching the flat surface (wall). Depending on the overall body shape of the child or teen, all points may not touch the wall.
10. Use a flat headpiece to form a right angle with the wall and lower the headpiece until it firmly touches the crown of the head.
11. Make sure the measurer’s eyes are at the same level as the headpiece.
12. Lightly mark where the bottom of the headpiece meets the wall. Then, use a metal tape to measure from the base on the floor to the marked measurement on the wall to get the height measurement.
13. Accurately record the height to the nearest 1/8th inch or 0.1 centimeter.

The following procedures shall be adhered to during measure of weight accurately at home to calculate BMI-for-age:

1. Use a digital scale. Avoid using bathroom scales that are spring-loaded. Place the scale on firm flooring (such as tile or wood) rather than carpet.
2. Have the child or teen remove shoes and heavy clothing, such as sweaters.
3. Have the child or teen stand with both feet in the center of the scale.
4. Record the weight to the nearest decimal fraction (for example, 55.5 pounds or 25.1 kilograms).
5. Problem may arise in measuring mid upper arm circumference. It is possible to use mid-upper-arm-circumference as a measurement for malnutrition in children, discriminating between severe and moderate malnutrition and providing the basis for the decision on whether to admit a child to a nutritional rehabilitation unit or not. During this study, data collectors shall be intensely trained to measure the circumference, a pre-test exercise will be conducted among randomly selected volunteers living around the training vicinity to measure the circumference of 9 different arms (between 9 and 13 cm) using their own fingers and hands. The training will be short and consisted of an introduction of 5 min, a first training phase of 10-15 min, a test, the critical discussion of the results, a second training phase of 5 min and a final test. A subsequent discussion with the participants will be on the influence of procurement, maintenance and pricing of MUAC measurement tool. This method shall be considered as a future training in the villages to detect the trend towards malnutrition early enough.

# **1.10 Assumptions**

It is assumed that majority of children under five year of age in Gurei Suburb of Nyarkenyi Payam, Juba County are malnourished. The causes of malnutrition are assumed to be low economic status of family, low education of parents, unhygienic care practices, infectious diseases, improper feeding practices, discontinued breast feeding.

## **2. CHAPTER TWO; LITERATURE REVIEW**

## **2.1. Nutritional Status**

Nutrition has been defined as the food at work in the body. Nutrition includes everything that happens to food from the time it is eaten until it is used for various functions in the body (Srilakshmi 2002). Nutrition is a core pillar of human development and concrete large-scale programming not only can reduce the burden of under nutrition and deprivation but also advances the progress of nations (Medical Gazzette, 2012) Nutritional status is the state of our body as a result of the foods consumed and their use by the body. Nutritional status can be good, fair or poor (Mudambi et al, 2012)

Currently, the infant mortality rate in South Sudan is 99.2 deaths per 1,000 live births. Under-five mortality is 96.4 deaths per 1,000 live births. Mortality rates are much higher in rural than urban areas. According to the 2017 NHDS, 26% of South Sudanese children age 12–23 months have received all recommended vaccines—one dose each of BCG and measles and three doses each of DPT and polio. Almost half (48%) of South Sudanese children age 6-59 months are suspected with pneumonia were taken to health provider. 39% percent of children under five years with diarrhea received oral rehydration salts. 46% of children under five sleep under insecticide-treated mosquito nets. 66% of households are owning at least one insecticide-treated nets (ITNs (South Sudan National Health Demographic Survey key findings, 2017)

According to the UNICEF report on Children in South Sudan, in July 2011, 30.3% of children under the age of 5 were underweight (low weight for age), 25% were stunted (low height for age), and approximately 22.7% were wasted (low weight for height)

## **2.1.1.1. Factors affecting nutritional status**

The factors affecting nutritional status are mother ‘s food security, breast feeding practices, types of food given to young children, feeding frequency, status of women and child nutrition and last but not the least who feeds the child and how the child eats (Wageningen Academic Publisher, 2006).

There are many other factors that influence the nutritional status, some of which are food availability and its distribution system, consumption of food, income source and purchasing power, family size, illiteracy, sociocultural and religious belief, environmental sanitation and health facility.

## **2.1.1.2. Food Availability and Nutritional Status**

Food is not just something to eat; it is an integral part of culture of a community, region, or nation. Food is a relative concept. Good health depends on an adequate food supply and this in turn depends on sound agricultural policy and a good system of food distribution (Adel P.den Hartog et al, 2006)

For the achievement of nutrition adequacy, increased production of food groups making the national diet balanced is one of the most important measures. Adverse consequences are manifested themselves if the national diets are deficient in nutrients. Vitamin A deficiency followed by iron deficiency, blindness among children, PEM and so on which could be overcome by supplying or consuming diets rich in these nutrients (Gyawali, Rajiv 2002)

## **2.2. Nutritional Requirements**

Nutritional Requirements refers to the amount of food, energy and nutrient needed on an average per day by specific group and sex categories to meet the needs of healthy individuals for normal functioning of the body for work and growth (Burk, 1984). The energy supplies seem to occur important in those developing countries where the staple commodities are either very low in protein content or the protein is of very low quality. Most of the people of developing countries depend upon starchy food and derived their 80% of total calories from them. The people of those countries are able to obtain about 87% of calorie intake and 79% of gross protein intake and they receive only 6.4% of their calories and 8.9% of their protein from the consumption of meat, egg, milk and milk fats combined (Yadav DK,1994).

The recommended daily allowance (RDA) of nutrients for preschool children (1-5 years is shown in table below:

|  |  |  |
| --- | --- | --- |
| NUTRIENTS | YEARS | |
| 1-3 | 4-6 |
| Calories (Kcal)  Protein (g)  Fat (g)  Calcium (mg)  Iron (mg)  Vitamin A (ug)  Thiamine (mg)  Riboflavin (mg)  Nicotinic acid (mg)  Pyridoxine (mg)  Ascorbic acid (mg)  Folic acid (ug)  Vitamin B12 (ug) | 1240  22  25  400  12  400  0.6  0.7  8  0.9  40  30  0.2-2 | 1690  30  25  400  18  400  0.9  1.0  11  0.9  40  40  0.2-1 |

Fig: - Table no.1 RDA of preschoolers. (Srilakhsmi B, 2011)

## **2.3. Nutrition, Health Promotion and Human Development**

Nutrition and health education has been defined as educational measures for including desirable behavioural changes for the ultimate improvement in the nutritional and health status of individual. This is one of the most commonly implemented measures, not only of the health sector, but of other sector concerned with development of human resources. Growth is influenced by nutrition. Frequent attacks of infectious diseases affect their growth and increase the requirements of various nutrients. (Srilakhsmi B 2011)

As we know, nutritional status of individual has direct impact upon one’s development and as a whole on the productivity too. It is hampered because of under nutrition and good nutrition is not possible with low productivity as it results in low living standard. Thus, the developing and under developed countries generally have a vicious cycle of poverty resulting in malnutrition (Dahal P 2002)

Fig: 1.1The vicious cycle of poverty

(Source: Sited in [www.eschooltoday.com/poverty-in-the-world/the-vicious-cycle-of-poverty.html](http://www.eschooltoday.com/poverty-in-the-world/the-vicious-cycle-of-poverty.html)). Retrieved at 3.30 PM on July 26th 2019.

## **2.4. Malnutrition**

South Sudan suffers from extensive malnutrition, ranking in the top 15 countries with the highest prevalence of stunting (less than -2 SD scores) and the top 20 countries by number of stunted children less than five years of age worldwide (Action Against Hunger, 2017).

When the person is not getting enough food or not getting the right sort of food, malnutrition is just around the corner. Even if people get enough to eat, they will become malnourished if the food they eat does not provide the proper amount of micronutrient vitamins and minerals-to meet the daily nutritional requirement (UN‘s WFP).

Disease and malnutrition are closely linked. Sometime disease is the result of malnutrition; sometime it is the contributing cause. In fact, malnutrition is the single largest contributor to disease in the world, according to United Nations Standing Committee on Nutrition (SCN).

According to WHO report (2017), 46% of children under the age of five years suffer from under nutrition. Malnutrition is the direct or indirect cause for 50% of the total deaths among children (Srilakshmi 2014). Malnutrition has been defined as ―a pathological state resulting from a relative or absolute deficiencies or excess of one or more essentials nutrients (Park 2011).

## **2.4.1. Malnutrition and Infection**

It is generally recognized that frequent occurrence of infectious diseases such as diarrhea, dysentery or malaria affects adversely the health of individuals. In developing countries, infection and infestation are important factors involved in the causation of severe malnutrition among preschool children consuming inadequate and ill balanced diets. (Swaminathan M, 2008) Some of the ill effects of infection and infestation are:

1. Decreased food intake due to poor appetite
2. Decreased absorption of nutrients due to diarrhea, vomiting or long continued micro hemorrhage
3. Increased needs of nutrients for human host due to increase in basal metabolism and catabolism of tissue proteins.

## **2.4.2. Malnutrition and Mental development**

The result of studies performed by Dobbing and Coworkers (1968) have shown permanent deficits in the physical structure of the brain could be produced by under nutrition at the most vulnerable period. Malnutrition can significantly affect the intelligence and learning capacity of children. Similarly, Cravioto et al. (1966) reported that children who have recovered from severe malnutrition proved much inferior to normal well-nourished of the same age group with respect to their mental development and learning capacity (Swaminathan M, 2008)

## **2.4.3. Forms of Malnutrition**

**a) Undernutrition**

The pathological state resulting from the consumption of an inadequate quantity of food over an extended period of time (Jelliffee D.B 1966)

**b) Over Nutrition**

It is the pathological state resulting from the consumption of an excessive quantity of food, and hence a calorie excess, over an extended period of time. (Jelliffee, 1966)

**c) Specific Deficiency**

It is the pathological state resulting from relative or absolute lack of an individual nutrient.

**d) Imbalance**

This state results from a disproportionate consumption of essential nutrients with or without the absolute deficiency of any nutrients as determined by the requirements of a balanced diet.

## **2.5. Protein Energy Malnutrition**

Protein energy malnutrition, also known as starvation, is defined as a diet with insufficient amounts of all the major macronutrients: proteins, carbohydrates and fats. A starving person becomes skeletally thin and weak and is in danger of death. Protein energy malnutrition usually is seen during famines in Third-World countries and in eating disorders in Western societies (WFP 2011).

PEM is a range of pathological condition arising out of coincident lack of protein and energy in varying proportion, most frequently seen in infants and young children and usually associated with infections (WHO).

Classification of PEM

* Kwashiorkor: It is derived from African word meaning ―first child – second child. It refers to the observation that the first child develops PEM when the second child is born and replaces the first child at the breast. Symptoms include oedema, diarrhea, apathy, dermatosis, old man face, failure to thrive, fatty liver etc. There is predominant deficiency of calorie than protein.
* Marasmus: It occurs due to the deficiency of protein. It is most predominant form of PEM in developing countries.
* Marasmic Kwashiorkor: Children suffering from this type PEM exhibit a mixture of some of the features of both marasmus and Kwashiorkor.
* Nutritional Dwarfing: Retardation of growth is observed in the children who are deprived of food for prolonged period of time. Weight and height are both reduced resembling children a year and more younger.
* Underweight Child: These children ate growing up smaller than their genetic potential and of greater importance as they are at risk of gastroenteritis, respiratory and other infections, which can precipitate frank malnutrition. (Srilakhsmi, 2011)

## **2.6. Breast feeding practice and weaning process in South Sudan**

Breastfeeding in the first years of life protects children from infection, provides an ideal source of nutrients, and is economical and safe. However, many mothers stop breastfeeding too soon and there are often pressures to switch to infant formula, which can contribute to growth faltering and micronutrient malnutrition and is unsafe if clean water is not readily available. WHO/UNICEF report provide the following feeding recommendations (UNICEF & WHO 2017).

1. Exclusive breastfeeding for first six months of life
2. Continued breastfeeding for two years or more
3. Safe, appropriate and adequate complementary foods beginning at six months of age
4. Frequency of complementary feeding: two times per day for 6–8- month-olds; three times per day for 9–11-month-olds

It is also recommended that breastfeeding be initiated within one hour of birth. Breast-feeding is nearly universal among South Sudanese mothers, but its duration and frequency are not always optional. In most communities, a mother begins feeding their infants almost immediately, but in some parts of the country, (UNICEF 1987) feeding doesn’t begin for two days or after the colostrum has been discarded. Such practice means some new infants are deprived of the immunological qualities of colostrum (Swaminathan 1988). Breast feeding is usually continued together with the provision of cereal weaning until child is 2-3 years old or until the mother is pregnant again. In certain communities, children receive only breast milk until they begin to eat adult food. Mother will generally feed their infants on demand but workloads interfere with the frequency of feeding.

According to UNICEF global statistics (July 2018), 44.5 percent of children under age 6 months are exclusively breastfed, and 37.7 percent of children 6-8 months (breastfed and non-breastfed) are introduced to complementary foods at an appropriate time. 93 percent of all children are still breastfeeding at age 1, and 96.3 percent are still breastfeeding at age 2. 93.2 percent of South Sudanese children ages 0-23 months are breastfed appropriately for their age. This includes exclusive breastfeeding for children age 0-5 months and continued breastfeeding along with complementary foods for children age 6-23 months. Four-fifths of children under 6 months are predominantly breastfed. This percentage includes children who are exclusively breastfed and those who receive breast milk and only plain water or non-milk liquids such as juice. Finally, 5.6 percent of children under age 2 are bottle fed.

Reasons for breast milk feeding are: -

1. Any milk other than breast milk has no anti-infective properties to protect the infant in the early months.
2. Bottle feeds are often too difficult. The mother makes the expensive milk lost as long as possible and often is unable to follow written instructions on the can or container (Cameron and, Hofvander 1983).

## **2.7. Population growth in South Sudan**

Although South Sudan birth and death rate are both relatively high, the population is growing at a fairly rapid rate. More than two fifths of the population are younger than 15 years of age. However, the population growth rate in 2011 is 1.41 % (SSNDHS 2011).

## **2.8. Infant mortality rate, Life Expectancy, and Birth-weight**

Infant mortality, life expectancy and birth-weight are commonly used indicators to reflect malnutrition. According to South Sudan Demographic Health Survey (2011), Infant and under-five mortality rates in the past five years (2006-2007 to 2011-2012) are 94.6 deaths per 1,000 live births, respectively. At these mortality levels, one in every 12 South Sudanese children dies before reaching age 1, and one in every 9 does not survive to his or her fifth birthday. Eighty-five percent of deaths among children under five occur during the first year of life: infant mortality is 99.2 deaths per 1,000 live births. During infancy, the risk of neonatal deaths and post neonatal deaths is 33% and 13 deaths per 1,000 live births, respectively. Childhood mortality is relatively higher in the rural areas than in the urban. The neonatal mortality rate in the past five years is 39.6 deaths per 1,000 live births, which is two and a half times the post neonatal rate. The maternal mortality ratio is 789 per 100,000 live births. The average life expectance of South Sudanese men and women is around 56.81 respectively (SSNDHS 2017, World Bank 2017).

## **2.9. Assessment of Nutritional status**

Assessment of nutritional status of community is one of the first steps in the formulation of any public health strategy to combat malnutrition. The principle aim of such an assessment is to determine the type, magnitude and distribution of malnutrition in different geographic areas to identify at risk groups and to determine the contributory factors. In addition, fractural evidence of the exact magnitude of malnutrition is essential to sensitize administrators and politicians to obtain allocation of materials and human resources and to plan appropriately (Srilakshmi, 2002).

The nutritional assessment may require encompassing nations, communities, vulnerable segments of communities or individuals. It may be done as a part of an exercise to document current status as compared with post status or as specific attempt to evaluate the impact of an intervention program. (Ramchandran, 1987).

## **2.10 Conceptual Framework**

Conceptual Framework showing causes of malnutrition in South Sudan context given below

Inadequate dietary intake Disease

Conflict/Displacement

Family Income/Economic Structure/Potential Resources

Mother’s Education

Breastfeeding Status

Weaning Procedure

Birth Intervals

Culture

Water & Sanitation

Family Size

Rural/Urban Location

Political and ideological superstructure

Fig 2: A conceptual Framework for Causes of Malnutrition developed by Kenyi Sam

## **2.11 Research gap**

Very few studies were found in nutritional interventions that explore which factors and attributes have the strongest positive effects and what can be done to improve nutritional statuses of children between the age of 5 – 59 months, pregnant and lactating mothers. Reports do not provide enough evidence.

There are a lot of assessment reports on the nutritional needs of children between the age 5 – 59 months, pregnant and lactating mothers but little has been written about the effects of malnutrition on children under five years.

Thus, this explanatory study is designed as an extension to the existing body of knowledge found in Gurei Suberb of Nyarkenyi Payam, Juba (South Sudan)

### **3. CHAPTER THREE; METHODOLOGY**

### **3.1 Research Design**

Research design is defined as a framework of methods and techniques chosen by a researcher to combine various components of research in a reasonably logical manner so that the research problem is efficiently handled. It provides insights about “how” to conduct research using a particular methodology. (De Vaus, D. A., 2001)

The sketch of how this research will be conducted was prepared using research design. Hence, this study will be carried out on the basis of research design detailed below taking into consideration the elements of neutrality, reliability, validity and generalization:

A community based cross-sectional survey will be conducted to assess the nutritional status and associated factors among children aged 6-59 months which includes

a) Anthropometric measurement of 6-59 months children at household level.

b) General household survey by the application of questionnaire to the parents of children under study to find out the situation of household.

### **3.2 Study Area**

The study will be conducted at Gurei Suburb of Nyarkenyi Payam, of Juba County, Central Equatoria State, South Sudan. Gurei is one of the least developed suburbs in Juba City of South Sudan, which was ranked 3rd among 49 suburbs in the Population Distribution Plan of Juba City (Juba City Council, 2015). According to World Bank report, 2017, the total population of Gurei is 9,600. More than 90% of population survives with below one US dollar a day. The infant and under five mortality rates are 97 per 1000 respectively. It is against this background that Gurei suburb is chosen for this study.

Gurei is located about 15Km west from Juba town. This village is divided into 4 sub-bomas with 9,600 total populations, 550 households and 1,728 under five-year children. (Source: Gurei Boma office, 15th August 2015) year when this information was published)

### **3.3 Target Population**

Source population or universe of the study will be all 6-59 months children living in the

Target village and the study population will be children of 6-59 months age randomly selected and included in the study.

Inclusion and exclusion criteria

Inclusion criteria: - Children aged 6-59 months who live in Gurei Suburb of Nyarkenyi Payam, Juba County will be included in the study.

Exclusion criteria: - The study participants who are seriously ill or who are not available at household during the time of survey will not be included in the study.

### **3.4 Sampling Techniques**

Cluster sampling technique followed by simple random sampling will be used to select children from households. From 4 sub-bomas of the village, 2 sub-bomas will be selected by simple random sampling (lottery method). The basic criterion for the selection of household sample is that the household containing at least one child of 6-59 months of age will be included in the sample.

Study Variables

Dependent variable: - Malnutrition indicated by stunting and wasting.

Independent variable: -

* Socio-economic and demographic variables; head of household, ethnicity, family size, income, occupation, education
* Child characteristics; Age, sex, breastfeeding status and morbidity status
* Child care practices; Feeding, hygiene
* Maternal characteristics; age, no. of children born
* Environmental health condition; water supply, sanitation and housing condition.

### **3.5 Sample Size**

The sample size is determined by using a single proportional formula assuming the prevalence rate of malnutrition to be 50% in the survey area, 95% confidence interval (CI), 8% margin of error (d) and 10% non-response rate is added to the total calculated sample size.

Calculation of sample size for infinite population: -

Sample size (n0) = Z2 ×p (1-p)/d2

Where z= confidence interval at 95% (standard value of 1.96)

P= estimated prevalence of malnutrition (50%)

d= margin of error (8%)

Now

N0=1.962×0.5× (1-0.5)/ (0.08)2

= 150.06

≈ 150

Calculation of sample size for finite population: -

From personal communication of this village we found that the total no. of children of 6 - 60 months are 959.Thus we apply finite population sample formula to obtain new sample size to conduct survey in this particular village.

Therefore,

New SS = n0 / [1+ {(n0-1) / POP}]

Where,

New SS = New sample size for finite population

N0 = Sample size in infinite population

POP = Total number of population (in this case total number of population is number of 6-59 months age children in this village)

New sample size obtains as

= n0 / [1+ {(n0-1) / POP}]

= 150 / [1+ {(150-1) / 959}]

= 129.8

i.e., 130

Thus, calculated sample size is adjusted for non-response. Considering non-response rate as 10%, the adjusted sample size is calculated to be 143.

### **3.6 Research Instruments**

Instruments and equipment necessary for the conduct of the survey are:

1. Weighing Machine: - Weighing machine with the capacity of 100kg and having the least count of 0.1Kg. (1piece)
2. Height measuring scale (stadiometer): - 1 Piece
3. MUAC Tape: - For measuring mid-upper arm circumference. (1piece)
4. Questionnaire: - A well designed and pretested set of questionnaires to collect household information.

### **3.7 Pre-Testing**

The prepared sets of questionnaire and anthropometric instruments will be pre-tested among few parents/caretakers of 6-59 months children and 6-59 months children respectively who are under sampling plan. Pre-testing should be conducted in order to maintain accuracy and clarity of questionnaire, to check the consistency in interpretation of questions by respondents and to identify ambiguous item. After pre- testing all the ambiguous, misleading and wrongly interpreted questions will be omitted and questionnaire will be revised in accordance with the findings of pre-testing.

### **3.8 Validity and Reliability**

To ascertain the degree to which the data collection instruments will measure what they purposed to measure, the instruments will be validated at Africa Institute of Project Management Studies department of Nutrition and Dietetics. The expected tests in the questionnaire would also be drawn according to the available literature in nutrition education for young children. The questionnaire would also be pre-tested prior to data collection to ascertain content and face validity.

Reliability refers to quality control measure of data collected. Before data collection, detailed study will be based on the objectives of the study and on data collection techniques. Questionnaire will be checked daily for completeness, consistency and clarity as mentioned earlier. In addition, the thesis supervisors may also visit the research site periodically to monitor the process of data collection.

### **3.9 Data Collection Techniques**

Data will be collected using structured questionnaire and anthropometric measurement. Interview will be conducted with parents/care takers of the children to fill the questionnaire. In households with more than one child of age between 6-59 months, one child will be collected by lottery method.

### **3.10 Data Analysis**

First the data will be checked for completeness and consistency. Then it will be coded and entered in the computer using statistical software. Likewise, qualitative data will be transcribed and coded by assigning labels to various categories. Verified test parameters will be used to establish the relationships between the variables and nutritional status of children.

### **3.11 Logistic and Ethical Considerations**

Ethical clearance will be obtained from Africa Institute of Project Management Studies, Department of Nutrition and Dietetics and office of the Payam Administration of Gurei Suburb of Nyarkenyi Payam, Juba County. Verbal consent from parents/care taker of study subjects will be obtained and the objective of the study was explained to them. Privacy and confidentiality of collected information will be ensured at all level.

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# **APPENDICES**

Hello, my name is Kenyi Sam. I am a student studying ‘Human Nutrition’ at Africa Institute for Project Management Studies (AIPMS) looking to learn more about the nutritional status of 6 months to 59 months children in Gurei suburb of Narkenyi Payam, Juba County and the factors associated with it. I'd love to hear from you about these questions. This will help me learn what improvements need to be prioritized.

I will really appreciate your time and responses. Thank you!

# **Questionnaires:**

**General Descriptions**

1. Area of survey:
2. Name of family head:
3. Child identification number:
4. Family size:

Male Female

1. Number of Children:

Male: Female: Below Five Year:

1. Child death Yes: No:

If yes how many?

Cause of death: Known: Unknown:

1. Main occupation of the family:

Business: Agriculture: Service: Labor:

1. Your educational level:

Primary: Secondary: College:

1. Total annual income sufficient for family living:

Yes: No:

1. What is your staple food?
2. House occupied by the family?

Own: Rental:

1. House type?

Temporary: Permanent:

**Nutrition**

1. Do you have kitchen garden?

Yes: No:

1. What food items do you feed to your children/baby?

Milk/ Rice/ Chapati/ Vegetable/ Fruits/ Pulses/ Litto/ Fish and Meat/ All

1. Do you know about weaning and supplementary food?

Yes: No:

1. At which age should weaning food be started?

4 months: 5 months: 6 months: 7 months:

1. What do you do after extracting starch while cooking food?

Mix in curry: Mix in animal feeds: Do not extract:

1. What are the foods given when you are pregnant?

Milk/ Meat/ Pulses/ Green leafy vegetables/ All

1. Is there any person who does not see properly in presence of light in the night?

Yes: No:

If yes, how many?

1. Do you know what malnutrition is?

Yes: No:

1. Are any of your children suffering from malnutrition?

Yes: No:

1. Do you feed colostrum to your baby?

Yes: No:

1. Did you breast-feed the baby the same day of the birth?

Yes: No:

When do you stop breast-feeding?

**Immunization**

1. Is your child being immunized?

Yes: No:

1. Are you being vaccinated during pregnancy?

Yes: No:

1. If yes, wht vaccine have you taken? Or would you take?

DPT/ BCG/ Polio/ T.T

**Environmental Sanitation**

1. How do you do the garbage disposal?
2. Toilet facility?

Yes: No:

1. How do you use the water?

By Filtration/ by Boiling/ Without any treatment

**Mother and Child Health (MCH)**

1. Have you ever been to Health Post to take information for any pregnant woman in your family?

1. How do you manage to feed the food when anybody in your family is pregnant?
2. Give more food than usual
3. Less than usual
4. In the same ratio as usual
5. Do you feed colostrum to your baby?

Yes: No:

1. Is it necessary for pregnant women to take rest?

Yes: No:

1. Do you know the method of preparing oral rehydration solution (ORS)?

Yes: No: