

See discussions, stats, and author profiles for this publication at: <https://www.researchgate.net/publication/314807157>

Comparison of Protein–Energy Malnutrition and *P. falciparum* Malaria levels in AMPATH and Non- AMPATH COBES centres in Western Kenya

Article · June 2012

DOI: 10.15373/22778160/February2014/52

CITATIONS

0

READS

86

5 authors, including:



Joyce Baliddawa
Moi University

36 PUBLICATIONS 683 CITATIONS

[SEE PROFILE](#)



Kyla Taylor
Clark Atlanta University

11 PUBLICATIONS 18 CITATIONS

[SEE PROFILE](#)



Simeon Mining
Moi University

20 PUBLICATIONS 85 CITATIONS

[SEE PROFILE](#)

Some of the authors of this publication are also working on these related projects:



Breast cancer subtyping in Kenya [View project](#)



Effects of Nematode Infection on Immune Responses to Killed Vaccine and Live Mycoplasma Capricolum Capripneumoniae antigenus in Goats [View project](#)



Comparison of Protein-Energy Malnutrition and *P. falciparum* Malaria levels in AMPATH and Non- AMPATH COBES centres in Western Kenya

* A.M. Kwena

Department of Medical Biochemistry, School of Medicine, College of Health Sciences, Moi University, P.O. Box 4606- 30100, Eldoret, Kenya. * correspondent author

J.B. Baliddawa

Department of Behavioural Sciences , School of Medicine, College of Health Sciences, Moi University, P.O. Box 4606- 30100, Eldoret, Kenya.

K. Taylor

Department of Immunology, School of Medicine, College of Health Sciences, Moi University, P.O. Box 4606- 30100, Eldoret, Kenya.

Mary Ann McDowell

Notre/Dame University, USA.

S. Mining

Department of Immunology, School of Medicine, College of Health Sciences, Moi University, P.O. Box 4606- 30100, Eldoret, Kenya.

ABSTRACT

Objective:

The Broad objective of the study was to determine the nutritional status and levels of P. falciparum malaria in children in COBES AMPATH and non-AMPATH centres.

Specific objective was to ascertain if the presence of AMPATH has been beneficial in reduction of malnutrition and malaria in the centres.

Materials and Methods:

Nutritional status: Cross-sectional studies were carried out between March and May 2008 to February and March 2011 and April to May, 2013, in 16 COBES centres in Western Kenya. Cluster sampling technique was used with each health centre as the sampling unit. Anthropometric measurements were performed on all children aged 5-59 months within the households sampled. The sample size depended on the number of cases seen in the households within the period of study. The parameters considered included Age (in months), Weight (Kgs) and the mid upper arm circumference (cms). The nutritional status of the children was determined using the WHO recommended Z- score values as well as the Kenya Government Ministry of health recommended charts based on anthropometric measurements . Analysis of nutritional data was carried out using Epi-info 2000 computer program to determine the Z- score values from anthropometric data.

Malaria: Health centres records were assessed for the prevalence of malaria during the period of study and prevalence compared in AMPATH and NON-AMPATH centres.

Results:

A total of approximately 700 children were measured for anthropometry in the seven Health Centers: (Stunting- HAZ<-2, Wasting-WHZ <-2, underweight -WAZ<-2 and MUAC, < 12.5mm). Preliminary published results indicated that Meteitei (non-AMPATH) had the highest malnutrition prevalence (53% HAZ, 15% WHZ, 27% WAZ and 18.1 MUAC) whereas Chulaimbo (AMPATH) showed the lowest prevalence (7% HAZ, 3% WAZ). The other centres showed mixed prevalence. Malaria was the leading cause of mortality and morbidity in all the COBES centres except for only two.

Conclusion:

AMPATH centres showed improved nutrition status compared to other COBES centres whereas presence of AMPATH had no effect on prevalence of malaria.

KEYWORDS : Nutritional status, Malnutrition, Malaria, COBES, AMPATH

INTRODUCTION

Malnutrition is an imbalance - a deficiency or an excess - in a person's intake of nutrients and other dietary elements needed for healthy living. Malnutrition can manifest itself as hunger (or under nutrition), deficiency in vitamins or minerals, or overfeeding. The World Health Organization [1, 2] estimates that fully half of the human family, some 3 billion people, suffer from malnutrition of one kind or another. One out of five people in the developing world suffers from the worst of the variants of malnutrition - hunger [3, 4, 5]. The problem is accelerated by a number of factors among them poverty. Protein Energy Malnutrition (PEM) affects a large proportion of children under the age of 5 years in the developing world [6]. The prevalence of PEM varies greatly from region to the other. World Health Organization (WHO) has estimated that 32.5% of all pre-school children under 5 years of age are malnourished. Globally, Kenya was ranked 47 out of 144 countries as far as PEM stands based on Height for Age (Stunting) by the year 2003. In sub-Saharan Africa the prevalence stands at (55.2 %) [6]. In Kenya the prevalence stands at 30% stunting [7], while in Western Kenya it also stands at 30% stunting[8].

Malaria is, and has been, the most important parasitic disease of man in terms of mortality, morbidity worldwide. (Bradley,1992) It is caused by a parasite called Plasmodium, which is transmitted via the bites of infected mosquitoes. In the human body, the parasites multiply in the liver, and then infect red blood cells (WHO, 2000).

Community Based Education and Service (COBES) is the training of health professionals at the Moi University, School of Medicine in the community. It is a school-wide activity, not a department. All of School members (Staff and students) are involved [9,10,11]. It incorporates theory, Clinical and Field activities. In Second year of study, COBES incorporates community diagnosis where a number of Health problems in the community are diagnosed including nutrition status of children under five years of age. A total of 21 Health centres were identified, namely: Amukura, Bokoli, Bukura, Burnt Forest, Chwele, Chulaimbo, Kabartonjo, Kabuchai, Kaptumo, Kilibwoni, Mautuma, Makunga, Matayos, Nambale, Mbale, Miteitei, Mosoriot, Nyahera, Sirisia, Turbo and Naitiri. AMPATH initially stood for Academic model for Prevention and Treatment of HIV-Aids but this was recently changed to Academic Model Providing Access

to Healthcare. Some of the COBES Health centres double up as AMPATH centres namely Amukura, Chulaimbo, Mosoriot, Turbo and more recently Nambale and Naitiri. Due to logistic reasons, not all of them were visited for year of data collection.

It is with this in mind that the nutrition status was determined in COBES centres in Western part of Kenya from March to May, 2008. In this study we further report the comparison of malnutrition in centres where AMPATH activities are carried out against non- AMPATH ones.

Objectives

The broad objective of the study was to determine the nutritional status and prevalence of *P. falciparum* malaria in children in selected representative Health Centres where Moi University students go for COBES placement during their second year of study for community diagnosis fieldwork. The specific objectives were to compare the nutritional status and malaria prevalence in AMPATH and non- AMPATH COBES centres.

MATERIALS AND METHODS

Study area and population

The studies were carried out in selected COBES Centres namely Kabuchai in Bungoma County, Makunga in Kakamega County, Matayos in Busia County, Meteitei in Nandi County, Mosoriot in Nandi County, Chulaimbo in Kisumu County and Mbale in Vihiga County, all in the larger Western part of Kenya, for the period March to May, 2008, 2010, 2011 and April to May, 2013 respectively. Two of the Centres are also used as AMPATH centres, namely: Chulaimbo and Mosoriot for the first survey. Subsequent surveys looked at more AMPATH centres namely Turbo, Amukura, Burnt Forest and Nambale. A total of approximately 700 children were sampled during the study from the seven areas.

Kabuchai:

This is in Bungoma county in Western province. It is one of the six rural areas of Bungoma District. There is high incidence of malnutrition, poverty and a lack of HIV/AIDS awareness. There is lack of knowledge on the benefits of nutrition in the treatment in the HIV infection. There is also lack of knowledge on the on the potential of food crops in the reduction of malnutrition and food poverty levels. The main income is from small scale farming in cash crops such as sugarcane and maize.

Makunga:

is in Butere/Mumias District and also in Kakamega County. The major cash crop in the area is sugarcane that is milled by the nearby Mumias Sugar Company. Most of the inhabitants in the area have turned their farms into small plantations of sugarcane with an average size of plot holding of 4 acres. This type of farming has left many families with very small pieces of land that are used for food crops resulting in increased malnutrition in the area. Especially among children hence increased family expenditure on health [12], there is good climate with rainfall occurring twice a year. Apart from sugarcane, maize, millet, cassava and sweet potatoes are also grown. There is very little livestock farming in the area. No grass is readily available due to overdependence on sugarcane.

Matayos:

Found in Busia county. Has a population of about 56,186 [12]. The main economic activity is trade with the neighbouring Uganda with Busia town. The area is heavily reliant on fishing and agriculture with cassava, millet, sweet potatoes beans and maize being principal cash crops. Malnutrition levels are not well documented in the area.

Meteitei:

Found in Nandi county in Tinderet Division. It lies on the outskirts of the famous Tinderet forest well known for tea growing. It lies at an altitude of 9,000 feet above sea level in Rift valley area of Western Kenya. It also borders Lake Victoria as well as Kakamega and Kisumu Counties [12]. The topography is dominated by the Nandi Hills. Population of Tinderet is 58,925 [12]. Malnutrition has also not well documented in the area.

Chulaimbo:

Found in Kisumu county, Nyanza, Western Kenya. Situated near Maseno on the Equator and about 20 kilometers from Kisumu City. The area is surrounded by the Bunyore Hills. HIV prevalence is high leading to establishment of an (Academic Model for the prevention and Treatment of HIV-Aids) AMPATH Centre in the area. Academic Model for the Pre-

vention and Treatment of HIV-Aids (AMPATH) is jointly run by collaboration by Moi University and Indiana University in USA. Malnutrition linked to HIV-AIDS was reported in the area by AMPATH but the levels have since then come down.

Mosoriot:

Situated in Nandi county and close to Eldoret. It is also an AMPATH Centre like Chulaimbo. Malnutrition levels have been reported to be low [12] mainly due to the Agricultural practices of the local community. Milk is the stable diet of the local people.

Mbale:

Found in Vihiga county in Western Province. The area is also hilly with hot and wet climate. The average rainfall is 250 mm per month. This combined with fertile loam soil favours the growth of various food crops. The main food crop is maize, which is also the stable food. Most residents depend on food bought at the market due to scarcity of land in the area.

There are two rainy seasons in the study areas: the long rains occur from March to May and the short rains from October to December. While malnutrition is believed to be an important health problem, especially in months before the harvest, estimates from these areas have not been fully described.

Amukura:

Situated in Busia county, Teso South District, Amukura Division, Amukura Location Western Kenya bordering Uganda.

Turbo:

Found in Uasin Gishu County close to Eldoret town. The constituency population is 208,583 whereas the area in sq. km is approximately 365.60.

Burnt Forest:

Situated in Uasin Gishu County and quite close to Eldoret town in Rift Valley province and Eldoret East District, Uasin Gishu. Division: Ainaikoi, Location: Olare, SubLocation: Burnt Forest and Constituency: ELDORET EAST

Nambale:

Situated in Busia County Western Kenya has a population of 174,752. Constituency Area In Sq. Km (Approx.): 237.90

Study design

Cross-sectional surveys were carried out. Cluster sampling technique was used with each health centre as the sampling unit.

Anthropometry:

The parameters considered included Age (in months), Weight (Kgs), height (cms) and the mid-upper arm circumference (cms). Anthropometric parameters were performed according to standard WHO procedures. [2,13]. Children aged < 6 months were undressed and weighed in plastic weighing pants to the nearest 10 grams using a 10 Kg \pm 10g hanging weighing scale (Salter, UK). Weight of older children, wearing light clothes only was measured to the nearest 100gms, using a 25Kg \pm 100g hanging weighing scale (CMS,UK). The weighing scales were calibrated daily. Standing height was measured in children from 2 years of age to the nearest 0.1cm, using a tape measure. Height and length were measured when children were barefoot and after removal of headgear [14] Mid-upper Arm Circumference (MUAC) was measured to 0.1 cm using specialised non-stretchable measuring tapes (Zerfuss insertional tapes, Ross Ltd, USA). Analysis of anthropometric nutritional data was carried out using Epi-info 2000 computer program to determine the Z- score values from anthropometric data [15, 16]

Malaria:

For malaria the study was retrospective. Health Centre records were analysed for prevalence of malaria for the months preceding the COBES placement. This was carried out in all the 16 centres. Laboratory diagnosis of malaria in all the health centres had been carried out using the standard field stain method. This was additional to clinical diagnosis carried out at each of the Health Centres.

Consent

Consent was sought from the guardians of the children prior to taking anthropometric measurements. This was because all the children studied were < 5 years of age and could not give consent on their own.

Ethical considerations

Prior to commencement of community diagnosis programme of COBES 2 of Moi University, permission was sought from the Institutional Research and Ethics Committee of Moi University School of Medicine. Permission was also sought from District Medical Officers of Health from the counties under which the COBES Health Centres fall.

RESULTS

Demography:

a total of approximately 700 children from 7 selected COBES Centres were sampled. The age ranged from 5 to 60 months

Anthropometry:

various centres showed mixed prevalence values in the three surveys as shown (Figures 1, 2 & 3). In Figure 1, Kabuchai showed Moderate stunting value of 13.6 % and severe stunting at 12.7%, Moderate underweight of 4% and severe underweight at 2,5%. Makunga showed Moderate stunting at 9.7% and severe stunting at 4.9%, Moderate underweight prevalence was 8% while severe underweight was 4.9%.

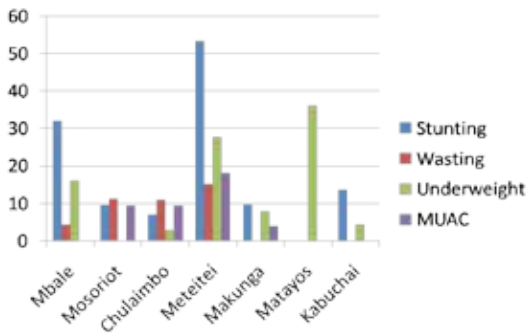


Figure 1. Percentage (%) -Y axis, Nutritional status of children < 5 years in selected COBES Health Centres-X axis..

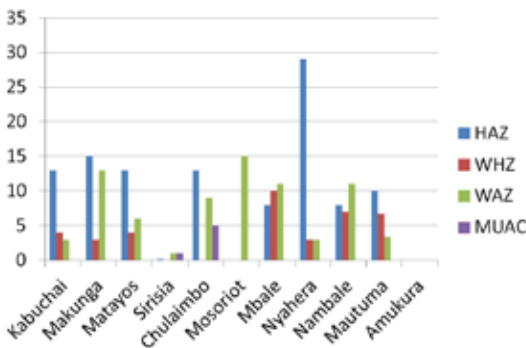


Figure 2. Summary of the comparative anthropometric measures for stunting, wasting, underweight and MUAC and severe cases (), for eleven COBES centres for the period March to May, 2010.

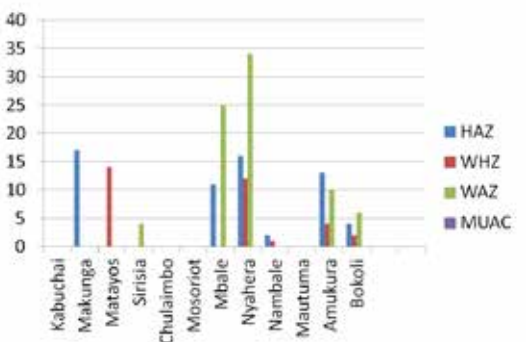


Figure 3 Summary of the comparative anthropometric measures for stunting, wasting, underweight and MUAC and severe cases (), for eleven COBES centres for the period March to May, 2011.

Table 1: Summary of prevalence of malaria in the Health centres. * shows an AMPATH centre.

Health Centre	% Prevalence	Rank out of top 10 diseases
Chulaimbo *	89	1 st
Burnt Forest*	83	1 st
Turbo*	17	2 nd
Matayos	84	1 st
Makunga	89	1 st
Kabuchai	27	1 st
Mbale	60	2 nd
Mautuma	20	1 st
Bokoli	88	1 st
Amukura*	-	1 st
Nyahera	88	1 st
Sirisia	52	1 st
Nambale	87	1 st
Bukura	92	1 st
Mosoriot*	55	1 st
Meteitei	20	1 st

DISCUSSION

According to WHO [2], 32.5% of pre-school children under 5 years of age are malnourished [5]. In Kenya the major study reporting prevalence of PEM nationally was carried out [7] and still stands to the present moment. Several studies have been carried out since then showing prevalence of malnutrition in different national regions [8 , 17]. The present study specifically looked at prevalence of malnutrition in COBES health centres (Both AMPATH and non-AMPATH) in three surveys from 2008 to 2011. This kind of work has been carried out on annual basis but has not been comprehensively documented. From the study, Anthropometry showed majority of the children to have normal nutrition based on underweight, stunting and wasting (WAZ, HAZ and WAH > -2), This represented about 60% of the children studied. Prevalence of Stunting was extremely high in some areas such as Mbale and Meteitei that were non-AMPATH as compared to the national and regional values. The results from the other COBES centres were consistent with work earlier reported for the region [8]. Wasting was highest in Meteitei while underweight was highest in Matayos, both being non-AMPATH centres. Prevalence of severe (acute) malnutrition at the COBES Centres at the time of study showed a similar trend to mild or moderate malnutrition although this was not carried out in all the seven health Centres where data was collected. The National figures for Western Province still stand at 30% stunting, 20% underweight and 5% wasting [7, 8]. It is surprising that stunting levels at Mosoriot were slightly higher (9.5%) than Chulaimbo (7%) both being AMPATH centers. The reasons for this are not yet so clear. This indicates that the nature of malnutrition in these two areas points at both chronic and long term malnutrition. These results agree with similar work carried out elsewhere [5]. Under normal circumstances, this would not have been the result but given that these measurements occurred immediately after post election unrest resulting in scarcity of food at some of the Centres, thus describing the acute phase and the prevailing annual drought in the areas at that time of the year, representing the long term phase, this could explain the outcome recorded. The data available to support malnutrition in these areas of COBES placement needs to be regularly updated for proper management and control of this chronic problem in the areas. So many factors may be pointers for the malnutrition trends obtained apart from presence or absence of AMPATH at the Health centre. Such factors include; demography, socioeconomic as well as genetics, breastfeeding, immunization, birth weight and other childhood illnesses such as measles, diarrhoea, malaria and many others. All these were not considered in this particular study since health centre records could easily be accessed for reference in all the 7 centres.

All COBES Centres assessed for malaria showed it to be the leading cause of morbidity and mortality except for Turbo and Mbale where respiratory tract infections were ahead. The other top ten diseases considered were: URTI's, Accidents and injuries, dental illnesses, Intestinal worms, Eye infections, Pneumonia, Skin diseases, STI's as well as Diarrhoea. The high prevalence of malaria could be due to misuse of insecti-

cide treated bed nets usually supplied free of charge to children below 5 years and expectant mothers. Many people used them for protection of their kitchen gardens and protection of their chickens amongst other forms of misuse.

Other causes of high malaria prevalence could be due to poor drainage, stagnant water as well as bushy surroundings.

CONCLUSION

The prevalence of malnutrition was high in some Centres during the period of study. Metetei which is non-AMPATH showed the highest malnutrition prevalence of 53% which poses a major public health concern. In a subsequent cross sectional survey (2013) the prevalence in Metetei remained high at 44%. The reason could not be immediately evident but one of the possibilities could be due to absence of health education facilitated by AMPATH as well as dependence on tea as a major cash crop at the expense of food crops or due to data mismanagement. The current national figure for malnutrition stands at 30% as well as in Western province. Prevalence of malnutrition in Chulaimbo which is also an AMPATH centre was the lowest maybe due presence of

additional health benefits from AMPATH and also due to mixed farming practised in the area or successful health education in the population. Prevalence in other centres was within the normal range. Improved nutritional practices could be recommended in areas with high malnutrition although poverty was the major cause of the problem in Kenya as well as other developing parts of the world. The way forward would be to expand the health benefits given by AMPATH to all the COBES health Centres. Presence or absence of AMPATH had no effect on prevalence of malaria in all the centres studied.

ACKNOWLEDGEMENT:

We are grateful to the students who participated in data collection from the Centres mentioned and their Tutors. We thank the Guardians of the children who participated in the study as well as the staff of the Health centres where data was collected. We would also like to thank the COBES committee, Dean school of Medicine and the University for facilitating data collection. Financial assistance from Swedish International development Agency (SIDA) for COBES field activities is highly acknowledged.

REFERENCES

1. WHO/FAO. Diet, nutrition, and the prevention of chronic disease. Report of the Joint WHO/FAO expert consultation, Geneva, 2002. | 2. WHO. Progress Report. Nutrition for Health and development. A global agenda for combating malnutrition, Geneva, 2000 | 3. De Onis M, Monteiro C, Akre J and G Clugston The worldwide magnitude of protein energy malnutrition: an overview from WHO Global Database on child growth. FAO/ UN/WHO: International conference on Nutrition, world declaration & plan of action for Nutrition, Dec, 1992. Unpublished WHO/FAO document ICN/92/2, Rome, 1992. | 4. Gardner G and B Halwell "Underfed and Overfed: The Global Epidemic of Malnutrition", World Watc Institute Paper 150, March, 2000. | 5. Al-Mekhlafi HMS, Surin J, Atiya AS, Ariffin WA, Mohammed Mahdy AK and H Che Abdullah Current prevalence and predictors of protein-Energy Malnutrition among school children in rural peninsular Malaysia. South Asian J Trop Med Pub Health:2008; 39:922-931. | 6. Friedman JF, Kwena A, Mirel LB, Kariuki SK, Terlouw DJ, Phillips-Howard PA, Hawley WA, Nahlen BL, Ya Ping Shi and FO Ter Kuile Risk factors for Protein-Energy Malnutrition among young children in an area of intense perennial malaria transmission in Western Kenya: Results of cross sectional survey: Am J Trop Med Hyg; 2005; 73(4): 698-704. | 7. Ngare DK and JN Muttunga Prevalence of malnutrition in Kenya. East Afr Med J 1999; 7: 376-380. | 8. Kwena A, Terlouw DJ, de Vlas SJ, Phillips-Howard PA, Hawley WA, Friedman JF, Vulule J, Nahlen BL, Sauerwein RW, and FO ter Kuile. Prevalence and severity of malnutrition in pre-school children in a rural area in Western Kenya. Am J Trop Med Hyg 2003; 68(4) : 94-99. | 9. Baliddawa JB and A Kwena . The role of community based education and services (COBES) in peace and reconciliation. 2nd International Moi University symposium on peace. 'Youth empowerment for peace, reconciliation and development'. May, 2010; Abstract 1:19: 30. | 10. Baliddawa JB and A Kwena . The Role of Community Based Education and Services (COBES) in promoting interdisciplinarity of sustainable integral development. Cross cutting symposium of the 6th Annual Moi University Conference, 7th-11th Sept,2010; Abstract 4.5-21: 202. | 11. Kwena, A. and Baliddawa J. (2012). Nutritional status of children aged 6 to 59 months in community based education and service (COBES) programme at selected health centres in Western Kenya. African Journal of Food, Agriculture, Nutrition and Development (AJFAND). May 2012(3):6229-6244 | 12. Government of Kenya (GOK). Strategic plan for the implementation of the National population policy for sustainable development. 2005-2010. | 13. WHO. Use and interpretation of anthropometric indicators of nutritional status. Bull World Health Organization 1986; 64: 929- 941. | 14. Hautvast JLA, Tolboom JJM, Kafwembe EM, Musonda RM, Mwanakasale V, and WA Staveren. Severe linear growth retardation in Zambian children: the influence of biological variables. Am J. Clin Nutr 2000; 71: 550-559. | 15. WHO. Physical status: The use and interpretation of anthropometry. World Health Organization, Geneva, 1995; 182. | 16. Government of Kenya. Ministry of Health booklet on mother and child, MOH 216, 2009. | 17. Nyakeriga AM, Troye-Blomberg M, Chemtai AK, Marsh K and TN Williams. Malaria and nutritional status in children living on the coast of Kenya. Am J Clin Nutr, 2004; 80: 1604-1610. |