ASSESSMENT OF ANAEMIA IN ADOLESCENT GIRLS AGED BETWEEN 10-19 YEARS OLD ATTENDING St THERESE CLINIC

ABSTRACT

Anemia is one of the major public health problems worldwide and is associated with morbidity, mortality. Anaemic adolescent girls are at high risk of having physical and cognitive functional disorders. According to the WHO global database, anaemia affects 46% of school children globally. Because of health and socioeconomic problems, the prevalence of anemia is higher in developing countries than in developed ones with 50% in Africa where children, adolescent girls and pregnant women are the most vulnerable groups to anemia. In Rwanda, there is little national data on anaemia and its likely causes amongst adolescent girls. The aim of this study was to assess the extent of anaemia and associated risk factors among adolescent girls aged between 10-19 years old attending St Therese Clinic located in Eastern province in Rwanda. A cross sectional study design was conducted at St Therese Clinic in a period of 3 months (June to August 2018) and included 231 adolescent girls aged between 10-19 years old who were conveniently selected from the consented participants. The hemocue apparatus which uses modified azide-methemoglobin reaction was used to assay Hemoglobin (Hb) level in the whole blood. Pre-tested structured questionnaires were used to collect data on anticipated risk factors. The prevalence of anaemia was found to be 29% among adolescents girls. Among 67 anaemic girls (29%), 45girls (19.47%) had mild anemia while 18 girls (7.79%) had moderate anemia and 4grils (1.73%) had severe anaemia. It was found that malaria, menarche, educational status of their parents and meal intake frequency are significantly associated with anaemia, p value <0.05. Anaemia is highly prevalent in adolescent girls. Thus, policy makers has to prevent and control anaemia in this particular vulnerable group through but not limited to Iron/folic acid supplement, malaria eradication and promoting nutrition education programme targeting adolescent girls and their mothers, heads of primary and secondary schools mainly on the utilization of easily

available and affordable iron rich diet. In-depth studies with big sample size should be done to further investigate anaemia and its risk factors in Rwandan adolescent girls.

Key words: Anaemia, adolescence, malaria, menarche, education, iron and folic acid supplement.

1. Background of the study

Anaemia is a condition in which the number and size of red blood cells, or the hemoglobin concentration, falls below an established cut-off value, consequently impairing the capacity of the blood to transport oxygen around the body. Anaemia is an indicator of both poor nutrition and poor health (Nirojini *et al.*, 2014). Hemoglobin is a conjugated protein in the blood that carries carbon dioxide from tissues to the lungs and oxygen from the lungs to tissues. Usually in most anaemic patients, oxygen deficiency is behind all signs and symptoms. The word "adolescence" is delivered from Latin word, "adolescence": meaning "to grow to mature" (Nirojini *et al.*, 2014). According to WHO, adolescence is as a period of life between the ages of 10 to 19years for both sexes. Nutritionally, the adolescent This period of life is nutritionally the most vulnerable due to augmented growth and development.

According to the recommendations of UNICEF/WHO report, which classifies adolescent girls as a vulnerable group to anaemia, all countries are encouraged to assess rapidly the prevalence of anaemia and its associated factors in these vulnerable groups. There are about 1.2 billion adolescents in the World, which is equal to one-fifth of the World's population and their numbers are increasing. Out of these, five million adolescents are living in developing countries. In Rwanda, Adolescents counted 24.2 percent of total population in 2012. Anaemia is a global public health problem affecting both developing and developed countries with major consequences for human health as well as social and economic development (WHO, 2005). Globally anaemia prevalence was between 22.9% and 26.7% (about 1.62 billion people) and the major associated factors are medical history like age at menarche, history of worm infestation, excessive menstrual bleeding in the past 3 months and dietary history. Anaemia occurs at all stages of the life cycle. Generally, 50% of all anaemia is attributable to iron deficiency. Iron need increases during adolescence period because of onset of menstruation and adolescent growth spurt (WHO, 2008).

In adolescents, it has a direct and immediate effect on productivity, cognitive functioning lowers school achievement and lowers physical working capacity (WHO, 2011). For example, a school-based cross sectional study conducted by Mohammed*, et al* in 2017 among adolescent School Girls in Kebena District, Southwest Ethiopia showed that the anaemia prevalence was 12% with 95% of anaemic status impacting their academic performance.

According to the World Health Organization (WHO) global database, anaemia affects 46% of school children globally (ACC/SCN, 2000). Because of health and socioeconomic problems, the prevalence of anemia is higher in developing countries with 50% in Africa where children, adolescent girls and pregnant women are the most vulnerable groups to anemia (Sandra LH, *et al.*, 2001). In Asia and Africa, the prevalence of anaemia among adolescent girl was high compared to America and Europe (Nelima, 2015). Pakistan showed the prevalence of 60% (Talpur *et al*., 2012). In Nepal, the study showed the prevalence of 42% (Dubey *et al*., 2013). In Saudi Arabia, the prevalence was 25.9% (Al-sayes *et al*., 2011). The study carried in India showed the prevalence of 83% (Amudha, 2016). Due to many previous studies that showed the elevated prevalence of anaemia among adolescent girls, India tried a program of weekly iron-folic acid supplementation for adolescent girls that were piloted in fifty-two districts in thirteen states. After one year of implementation, this program showed an impact of 24% reduction in the prevalence. Due to this reduction, the project was expanded to cover eleven entire states by the end of 2011. In 2013, the government of India introduced the national implementation of weekly iron-folic acid supplementation to approximately one hundred and twenty million adolescent girls (WHO, 2012).

In Africa, the prevalence of anaemia in adolescent girls was carried out in different countries. In Ghana, the study done yielded the prevalence of 41.5% (Egbi *et al*., 2014). In Egypt, the study showed the prevalence of 35.9% (Tawfik *et al*., 2015). This country took control of this problem by distributing iron-folic acid supplements. In this program, 200 mg ferrous fumarate and 300 mg folic acids were given to individual girl weekly. In Kenya, the study carried out at secondary schools showed the prevalence of 26.5% (Nelima, 2015). In Ethiopia, the studies showed 30.1% prevalence (Assefa *et al.,* 2014). In Uganda, the study showed the prevalence of 45.9% (Isingoma, 2013).

In Rwanda, anaemia was gradually reduced from 2005 to 2015, where the prevalence of anaemia among children was 54% in 2005 and 38% in 2010. Among pregnant women, the prevalence of anaemia was 35% in 2005 and 20% in 2010. Rwanda Demographic Health Survey (RDHS) reported the overall prevalence of anaemia of 11.5% and prevalence in pregnant women of 14.5% (Boy, 2015). This shows a great reduction of anaemia compared to other African countries as well as global prevalence. This decline in anaemia was probably due to multiple interventions like availability and quality of health services, long lasting insecticide nets for both women and children for fighting malaria, iron-folic acid supplementation for pregnant women. Despite the efforts, the coverage has not reached the World Health Organization recommendation of 180mg iron-folic acid supplements for pregnant women (USAID, 2010). Therefore a significant work is needed to increase the coverage of iron intake, both in food and supplements, expand helminths control and malaria control.

Anemia is one of the major public health problems in children, adolescent girls and pregnant women and is associated with lost schooling, physical and cognitive functional disorders, low weight babies and even fatal complications during delivery, once pregnant (Siva *et al.*, 2016)(Jamison *et al.*, 2006). According to the World Health Organization (WHO) global database, anaemia affects 46% of school children globally (ACC/SCN, 2000). Because of health and socioeconomic problems, anemia is highly prevalent in developing countries than in developed ones with 50% in Africa (Sandra *et al.*, 2001). Several large surveys have yielded the prevalence estimates for anemia in adolescent girls in many different countries, where it was only 2% in the United States of America (USA) (Christel *et al.*, 2002) whereas it was 25.9% in Saudi Arabia(Al-sayes *et al.*, 2011), 26.5% in Kenya (Nelima, 2015), 30.1% in Ethiopia (Assefa *et al.*, 2014) and 45.9% in Uganda(Isingoma, 2013). The prevalence of naemia in Rwanda was gradually reduced from 2005 to 2015, where among children it was 54% in 2005 and 38% in 2010 and among pregnant women was 35% in 2005 and 20% in 2010(Boy, 2015). Despite these efforts to reduce the anaemia in other vulnerable groups in Rwanda, there are no programs directed to fighting anaemia in adolescent girls. This is mainly because there is no data on the extent of anaemia and its likely causes amongst adolescent girls for that reason this study aimed to assess anemia and its associated risk factors among adolescent girls aged between10-19years attending St Therese Clinic.

2. Methodology

2.1 Study design

The study was conducted at St Therese Clinic which is located in the Eastern province, Rwamagana district, Kigabiro sector. St Therese Clinic is a private health facility that provides possible quality healthcare services to the population of but not limited to Rwamagana district. A descriptive cross-sectional study was carried out. Target population for this study were all adolescent girls aged between 10-19years old who attended St Therese Clinic during this study period. Adolescent girls who were under iron, and folic acid supplement and those ones who did not consent to participate in this study were excluded from this study.

2.2 Sample size

The estimated sample size was 384 people, however the sample size achieved during the current study period was 231 adolescent girls.

In this cross-sectional study where data were collected at a specific point in time, the following formula was used:

Formula $$n = \frac{z^2 p(1-p)}{d^2}$$

Where

n is sample size,

z: is a statistic for the level of confidence, 1.96 on 95% confident interval

P: prevalence ever recorded since there is no prevalence, we assume that it is 50%

d: precision, if 5% is equivalent to 0.05

Sample size= $\frac{1.96^2 X 0.5(1-0.5)}{0.05^2}$= 384.16≈ 384 adolescent girls aged between 10-19years old.

This formula assumes that P and d are decimal values, but would hold correct also if they are percentages, except that the term (1-P) in numerator would become (100-P). In the above equation **(**Arya *et al*., 2012**).**

2.3 Sampling strategy

Convenient sampling strategy was used. The study included voluntary adolescent girls aged between 10-19years old who attended St Therese Clinic during data collection. Capillary blood was collected and used in hemoglobin level estimation by Hemocue analyzer.

2.4 Data collection instruments

Hemoglobin level was estimated by Hemocue analyzer. Questionnaire was tested and used to collect information on common associated risk factors with anaemia.

2.5 Procedure hemoglobin measurement by hemocue apparatus

To perform a test using capillary blood, the cuvette was put in loading position. The middle or ring finger for sampling was selected for each patient. Fionger was cleaned using a disinfectant and was allowed to dry. The Puncture of the finger was done using a lancet and wiped the first two to three drops, after which the pressure was reapplied towards the fingertips until another drop of blood appeared. When the blood was enough, microcuvette was filled in one continuous process by avoiding air bubbles. Filled microcuvette were placed in the in cuvette holder contained in hemocue apparatus and gently slided the cuvette holder to the measuring position. After 15 to 60 seconds, the hemoglobin value of the sample was displayed. (Nkrumah *et al,* 2011). Normal Value of Adolescent girls: 12.0 – 16.0 g/dl (Nirojini *et al,* 2014*)*.

Haemoglobin concentration less than the cut-off of 12.0 g/dl was used to define anaemia in non-pregnant girls (WHO, 1998). Severity of anaemia in adolescent girls was classified at three levels: mild anaemia (Hb 10.0-11.9 g/dl), moderate anaemia (Hb 7.0-9.9 g/dl), and severe anaemia (Hb less than 7.0 g/dl) respectively.

2.6 Data analysis

Data was analyzed with computer using statistical program for social sciences (SPSS) statistics 17.0 and Microsoft excel 2010. The extent of anaemia was in percentages. The associations between anaemia and risk factors were determined using multivariate analysis.

2.7 Ethical consideration

Data was collected after getting Ethical clearance from Mount Kenya University and granted the permission by the administration of St Therese Clinic to collect data. The participants were

explained about the study, and those who accepted to participate signed a consent form, the ones under 18 years old were given assent form for their parents to sign for them. Data was collected from those who consented to participate in the study. The participant's confidentiality was guaranteed by using a code label and their informations and results were kept away from anyone else.

3. RESULTS

This cross sectional study came up with an overall prevalence of anaemia of 29% among 231 adolescent girls aged between 10-19 years who attended St There clinic during the study. The mean haemoglobin level was 12.2 g/dl.

3.1. **The prevalence of anaemia in adolescent girls**

Table 3.1 The prevalence of anaemia in adolescent girls

Anaemia status	frequency	Percentage
Normal	164	71%
Mild	45	19.47%
Moderate	18	7.79%
Severe	4	1.73%
Total number of anaemic girls	67	29%

The Table 3.1 illustrates the extent of anaemia and its classification according to their hemoglobin levels in 231 adolescent girls who participated in this study.

Overall, the adolescent girls free from anaemia comprised 71%. Among anaemic girls; the mildly affected occupied the highest portion which is approximately one fifth of the participants, whereas only 4 adolescent girls (1%) were evinced to be severely anaemic, and around 7% of the participants were moderately anaemic.

3.2. Anemia and Menarche

Table 3. 2. Anemia and Menarche

Risk factor		Anaemic (%)	Non-anaemic (%)	p-value
Menarche status	attained	65(97.02)	140(85.36)	0.003
	Not attained	2(2.98)	24(14.64)	

From results of Table 3.2, the current study showed the impact of menstrual bleeding on anemia which is statistically significant with p-value = 0.003.

Table 3.3. Anemia in adolescent girls and Educational status of their mothers

Risk factor		Anaemic (%)	Non-anaemic (%)	p-value
Educational status of their mothers	None	45(67.16)	56(34.14)	0.001
	Primary	20(29.85)	77(46.95)	
	Secondary	2(2.98)	18(10.97)	
	University or more	0(0)	13(7.92)	

From Table 3, Educational status of their mothers showed significant association with anaemia (p=0.001).

Table 3.4. Anaemia and Malaria

Risk factor		Anaemic (%)	Non-anaemic (%)	p-value
Malaria status in the last 6 weeks	Experienced	19(28.35)	14(8.53)	0.008
	Not experienced	48(71.64)	150(91.46)	

As shown in Table 3.4, Malaria was found to be statistically associated with anaemia (p=0.008).

Table 3.5. Anaemia and Iron/ Folic acid Supplement

Risk factor		Anaemia present (%)	Anaemia absent (%)	p-value
Iron/Folic acid supplement	Yes	0(0)	0(0)	-
	No	67(100)	164(100)	

Table 3.5 shows the impact of Iron/Folic acid supplement on anaemia, however during this study no participant was taking these supplements.

Table 3.6. Anemia and Meal frequency per day

Risk factor		Anaemia present (%)	Anaemia absent (%)	p-value
A meal per day	Once	18(26.86)	14(8.53)	0.048
	Twice	43(64.17)	113(68.90)	
	More than twice	6(8.95)	37(22.56)	

From Table 3.6. Meal per day showed a significant with a p-value of (p=0.048).

Table 3.7. Anemia and Specific food intake frequency

Risk factors		Anaemia present (%)	Anaemia absent (%)	p-value
Beans intake	Daily	54(80.59)	117(71.34)	0.599
	Weekly	0(0)	0(0)	
	Occasionally	11(16.41)	32(19.51)	

	Never	2(2.98)	15(9.14)	
Green vegetable intake	Daily	30(44.77)	102(62.19)	0.228
	Weekly	0(0)	2(1.21)	
	Occasionally	32(47.76)	49(29.87)	
	Never	5(7.46)	11(6.70)	
Meat intake	Weekly	21(31.34)	78(47.56)	-
	Occasionally	44(65.67)	77(46.95)	
	Never	2(2.98)	9(5.48)	
Poultry intake	Weekly	3(4.47)	9(5.48)	1.000
	Occasionally	43(64.17)	78(47.56)	
	Never	21(31.34)	77(46.95)	
Fruits intake	Daily	0(0)	0(0)	-
	Weekly	22(32.83)	77(46.95)	
	Occasionally	43(64.17)	77(46.95)	
	Never	2(2.98)	10(6.09)	

Table 3.7 displays the association between different food intake and anaemia. However, none of them showed a statistically significant association with all p-value higher than 0.05.

4. Discussion

This study showed that among 67 anaemic girls, 65 (97.02%) have attained menarche. This finding highlights the impact of menstrual bleeding on hemoglobin level. These findings are in line with a study conducted in India where anaemia was highly prevalent (86.75%) in participants who had attained menarche (Premalatha *et al.*, 2012).

The educational status of the adolescent girls' mothers showed to have a considerable effect on the anaemia status of their children where in all anaemic adolescent girls, 67.16% had uneducated mothers. Although, a similar study conducted in Kenya came up with a prevalence of 35.7% having uneducated mothers which is approximately a half of ours, the association between the Level of mother's education and anaemia was significant (Oscar N., Henry M., 2014). This is to mean that, mother's education level has a protective effect on the chance of the child being diagnosed with anaemia. Children whose mothers' has secondary, and higher levels of education, are less likely to be anaemia positive. In addition to that, most of non-educated mothers have low income and low knowledge about the appropriate food for their girls to compensate the loss during menstrual bleeding.

This survey demonstrated the association between Malaria status and Anaemia in adolescent girls whereby among 67 anaemic girls, 19(28.35%) girls experienced it in last 6 weeks. This finding is beyond no doubt due to the fact that it is a common knowledge that malaria is an haemolytic infection which reduces red cells and consequently favour anaemia and it was undoubtedly found to be statistically associated with anaemia ($p=0.008$). These results are in line with the findings of CDC in 2008 where malaria was the strongest cause of anaemia in adolescence. The findings of this study went hand in hand with a study conducted in Kenya by Damaris. N, in 2015 on the prevalence and Determinants of Anaemia among Adolescent Girls in Secondary Schools, where the presence of malaria parasitemia increased the risk of one developing anaemia by three times.

Anaemia is induced by lower levels of the consumption of dietary iron derived from foods such as meat, beans, poultry and less intake of the nutrients involved in iron metabolism. This assumption is in line with the findings of this study where the frequency of food intake was shown to be a risk factor of anaemia. On the other hand, specific food intake was not a predator of anaemia in this study which went against the results of a study done in Kenya in 2015 by Damaris N where among the anaemic respondents 60.7% had inadequate iron intake. This disparity can be explained by the low sample size. In 2008, De Benoist B, et al also demonstrated that vitamins and minerals are required for the proper production of hemoglobin hence, RBCs. Deficiency in any of these micronutrients may cause anemia because of inadequate production of RBCs.

CONCLUSION

From the findings of this study, the overall prevalence of anemia was found to be 29%. It is seen that malaria, menarche, educational status of their parents and meal intake frequency are significantly associated with anaemia. Considering this alarming prevalence of anemia in girls during adolescence in this study, there is need for anemia prevention, and control. Efforts should be made to prevent adolescent anemia and its damaging consequences using an appropriate mix of interventions that address the multiple causes of anemia in adolescent girls.

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