Prevalence and factors associated with stunting among school children in Egypt

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Abstract

Background: Stunting adversely affects children's health and development. Few studies on the prevalence of stunting and factors associated with stunting have been done in Upper Egypt.

Aims: This study aimed to determine the prevalence of and factors associated with stunting in schoolchildren in Sohag, Egypt.

Methods: This was a cross-sectional study conducted in 2017 in Sohag governorate. Two public schools were randomly selected (one urban, one rural) and all children in these schools aged 4–12 years whose parents consented were included in the study. Parents were interviewed to collect data on child and family characteristics. The children were examined for vitamin deficiency, anaemia and parasitic infection, and body mass index was calculated. Multivariate logistic regression analysis was done to determine factors significantly associated with stunting; odds ratios (ORs) and 95% confidence intervals (CIs) are given.

Results: A total of 1786 children were included (response rate 69%), of whom 329 (18.4%) were stunted (−2 z-score and below). Factors significantly associated with stunting were: parasite infestation (OR = 1.8, 95% CI: 1.3–2.5), anaemia (OR = 1.7, 95% CI: 1.3–2.7), low body mass index (OR = 1.2, 95% CI: 1.1–1.3), frequent gastroenteritis (OR = 1.1, 95% CI: 1.06–1.2), first-cousin consanguinity of parents (OR = 1.3, 95% CI: 1.2–1.6) and familial short stature (OR = 1.5, 95% CI: 1.2–2.1).

Conclusion: Screening and treatment of parasitic infestation, provision of iron/multivitamin supplementation and education on healthy nutrition should be part of school health programmes to prevent stunting in schoolchildren in Sohag. Keywords: Stunting, schoolchildren, Egypt

Introduction

Stunted growth is defined as a height-for-age z-score of 2 standard deviations (SDs) or more below the global median according to the World Health Organization (WHO) references (1). Stunting affects up to 32% of children living in developing countries; it is hence an important public health problem with a great impact on child health and development in these countries (2). Stunting has been declared a global health priority with WHO calling for a 40% reduction in the number of children who are stunted by 2025 (3).

In stunted children, short stature is not just the problem in itself, but rather stunting syndrome (4) in which various pathological changes happen that result in a suppression of linear growth, impairment of a child's cognitive development and reduced physical capacity of a child. The long-term consequences of stunting include decreased work capacity and an increased risk of poor health in adult life – childhood stunting is positively associated with obesity, metabolic syndrome and cardiac diseases in adult life. Moreover, stunting has also a transgenerational effect as mothers who were themselves stunted as children tend to have offspring with stunted growth, leading to an intergenerational cycle of growth impairment (4).

Several risk factors for childhood stunted growth have been identified. Maternal malnutrition during pregnancy affects future child growth (5). Childhood malnutrition either as inadequate overall caloric intake or deficiency in certain micronutrients is associated with growth failure (6). Recurrent infections such as diarrhoea and parasitic infestations as a result of poor sanitary living conditions are main risk factors for stunted growth in children in developing countries (7,8). Despite numerous identifiable risk factors for childhood stunting, the effect of different risk factors varies in different regions and even in the same country (9,10). Therefore, identification of local and environmental factors is important to establish local preventive strategies against stunted growth. Few studies on the prevalence of stunted growth and local factors associated with it have been done in Upper Egypt. To address this gap, we aimed to determine the prevalence of stunting and identify factors associated with stunting in schoolchildren in Sohag district, Upper Egypt.

Methods

Study design and sample

This was a cross-sectional study carried out from January
Variables that were statistically significant in the univariate analysis, were included in a multivariate logistic regression analysis, and odds ratios (ORs) and 95% confidence intervals (CIs) are given. All P-values were two-sided and the significance level was set at less than 0.05.

**Ethical considerations**

The study was approved by the Ethical Committee of the Faculty of Medicine, Sohag University. We explained all the study details to the children's parents/guardians before taking informed consent.

**Results**

Of 2581 children aged 4–12 years in the two schools, 795 parents declined to give consent, giving a response rate of 69%. Thus, 1786 children were enrolled in the study, of whom 329 (18.4%) were stunted (–2 z-score or below), 95% CI: 17.98–18.48%. Of these 329 children, 76 (4.3%) children had more severe stunting (–3 z-score or below). The characteristics of the studied children and their parents according to stature, excluding the 76 more severely stunted children, are shown in Table 1: 127 (14.6%) of the boys and 126 (15.0%) of the girls were stunted. The mean age of the children with stunting was 8.01 (SD 2.9) years with age range between 4 and 12 years. As regards residence, 135 (15.4%) of the children in the rural area and 118 (14.1%) in the urban area were stunted. No statistically significant differences were found between the stunted and normal-stature children for sex, age, place of residence, parental level of education and parental job.

The sociodemographic characteristics the children with more severe stunting (–3 z-score or below) are shown in Table 2. These children were excluded from further analysis because many cofounders were likely for the severely stunted children. In addition, there may have been an underlining pathological cause for their short stature. We therefore advised the parents to visit a paediatrician for examination and assessment of possible causes for their child’s short stature.

Univariate analyses of associations between family and child characteristics and stunting showed that anaemia (P < 0.001), parasite infestation (P < 0.001), familial short stature (P < 0.001), signs of vitamin deficiency (P = 0.04), BMI (P < 0.001), first-cousin consanguinity (P = 0.002) and frequent gastroenteritis (P = 0.002) were significantly associated with stunting (Table 3). However, socioeconomic status and birth order were not (P > 0.05).

Factors significantly associated with stunting in the univariate analysis were evaluated in a multivariate logistic regression analysis (Table 4). Parasite infestation (OR = 1.8, 95% CI: 1.3–2.5; P < 0.001), anaemia (OR = 1.7, 95% CI: 1.3–2.7; P < 0.001), BMI (OR = 1.2, 95% CI: 1.1–1.3; P < 0.001), frequent gastroenteritis (OR = 1.1, 95% CI: 1.06–1.2; P = 0.003), first-cousin consanguinity (OR = 1.3, 95% CI: 1.2–1.6; P = 0.02) and familial short stature (OR = 1.5, 95% CI 1.2–2.1; P = 0.04) were independent factors associated with stunting in the children.
Discussion

Children’s growth is a complex process in which several genetic, nutritional and environmental factors are involved (12). The current study tried to assess the prevalence of stunting, and to explore some of the factors associated with stunting in schoolchildren in Sohag district.

We found that 329 (18.4%) of the children had a height-for-age z-score less than 2 SD. Although this prevalence is lower than that found in a study in 2011 on preparatory-school children aged 11–14 years in Cairo, Egypt, which found a prevalence of stunting of 34.1% (13), our finding is consistent with other studies in developing countries: 17.4% in a Nigerian study conducted on 570 children aged 5–19 years (14), 24.5% in a Kenyan study on 208 children aged 4–11 years (15) and 11.3% in an Indian study on 755 children aged between 4–16 years (16). The difference in the prevalence of stunting in different countries and even in different districts in the same country might be due to the effect of socioeconomic factors (15,17,18). In line with the findings of the study conducted on preparatory-school children in Cairo (13), we found that stunting was associated with a family history of short stature.

Age, sex, place of residence and parental education and job were not significantly associated with childhood stunting in our study. We also did not find an association between childhood stunting and the socioeconomic status of the family, which is in line with the result of the 2014 Egypt Demographic and Health Survey (19). These results indicate that stunting may not be a reflection of poverty and unavailability of food, but rather an indirect result of unhealthy nutritional habits and lack of family awareness about healthy nutrition required for growth of children.

Good nutrition is vital for children’s growth. A balanced diet, containing adequate calories from carbohydrates, fats and proteins, together with sufficient amounts of vitamins and minerals, is important for growth. Malnutrition is a main risk factor for stunting syndrome.

### Table 1: Sociodemographic characteristics of the studied children and their parents, by stature

| Variable                        | Short stature (–2 z-score) | Normal stature | P-value |
|--------------------------------|----------------------------|----------------|---------|
| **Age (years)**                 |                            |                | 0.23    |
| Mean (standard deviation)       | 8.01 (2.9)                 | 8.5 (5.9)      |         |
| Median (range)                  | 8 (4–12)                   | 8 (4–12)       |         |
| **Sex, no. (%)**                |                            |                | 0.830   |
| Male                            | 127 (14.6)                 | 742 (85.4)     |         |
| Female                          | 126 (15.0)                 | 715 (85.0)     |         |
| **Residence, no. (%)**          |                            |                | 0.450   |
| Rural                           | 135 (15.4)                 | 740 (84.6)     |         |
| Urban                           | 118 (14.1)                 | 717 (85.9)     |         |
| **Father’s education, no. (%)** |                            |                | 0.834   |
| Illiterate                      | 24 (12.6)                  | 166 (87.4)     |         |
| Read and write                  | 67 (14.7)                  | 388 (85.3)     |         |
| Basic education                 | 46 (20.1)                  | 183 (97.9)     |         |
| Secondary school                | 85 (13.4)                  | 550 (86.6)     |         |
| Higher education                | 31 (15.4)                  | 170 (84.6)     |         |
| **Mother’s education, no. (%)** |                            |                | 0.484   |
| Illiterate                      | 23 (12.2)                  | 166 (87.8)     |         |
| Read and write                  | 66 (14.2)                  | 399 (85.8)     |         |
| Basic education                 | 35 (12.5)                  | 245 (87.5)     |         |
| Secondary school                | 105 (17.6)                 | 491 (82.4)     |         |
| Higher education                | 24 (13.3)                  | 156 (86.7)     |         |
| **Father’s job, no. (%)**       |                            |                | 0.347   |
| Not working                     | 21 (13.2)                  | 138 (86.8)     |         |
| Unskilled manual worker         | 23 (17.8)                  | 106 (82.2)     |         |
| Skilled manual worker/farmer    | 77 (15.9)                  | 408 (84.1)     |         |
| Trade/business                  | 93 (14.4)                  | 555 (85.6)     |         |
| Semi-professional/clerk         | 25 (13.4)                  | 161 (86.6)     |         |
| Professional                    | 14 (13.6)                  | 89 (86.4)      |         |
| **Mother’s job, no. (%)**       |                            |                | 0.223   |
| Working                         | 92 (13.5)                  | 589 (86.5)     |         |
| Not working                     | 161 (15.6)                 | 868 (84.4)     |         |
| **Total**                       | 253 (14.8)                 | 1457 (85.2)    |         |

### Table 2: Sociodemographic characteristics of the more severely stunted children (–3 z-score or below)

| Sociodemographic characteristic | Value |
|---------------------------------|-------|
| **Age (years)**                 |       |
| Mean (standard deviation)       | 8 (2.2) |
| Median (range)                  | 8 (4–12) |
| **Sex, no. (%)**                |       |
| Male                            | 36 (47) |
| Female                          | 40 (53) |
| **Residence, no. (%)**          |       |
| Rural                           | 41 (54) |
| Urban                           | 35 (46) |
| **Father’s education, no. (%)** |       |
| Illiterate                      | 8 (11)  |
| Read and write                  | 21 (28) |
| Basic education                 | 36 (47) |
| Secondary school                | 4 (5)   |
| Higher education                | 7 (9)   |
| **Mother’s education, no. (%)** |       |
| Illiterate                      | 8 (11)  |
| Read and write                  | 10 (13) |
| Basic education                 | 42 (55) |
| Secondary school                | 7 (9)   |
| Higher education                | 9 (12)  |
| **Father’s job, no. (%)**       |       |
| Working                         | 65 (85.5) |
| Not working                     | 11 (14.5) |
| **Mother’s job, no. (%)**       |       |
| Working                         | 26 (34) |
| Not working                     | 50 (66)  |
| **Total**                       | 76 (100.0) |
in children in developed countries, where malnourished children usually have multiple macronutrient and micronutrient deficiencies that predispose them to impaired immunity and recurrent infections, resulting in stunting (6,20,21).

Our results show that stunted children had lower BMI. As BMI is a measure of nutritional status in children, this finding suggests that malnutrition is an important risk factor for stunting in children. We also identified that anaemia in our schoolchildren was associated with stunted growth (22). Several studies have found that multiple micronutrient deficiencies such as iron, zinc and vitamin A deficiency, are associated with short stature and stunting syndrome in children (5,21,23). However, there is no strong evidence that correction of these micronutrients deficiencies increases the height of children suggesting that the relationship between micronutrient deficiencies and stunting is not causal.

Our findings provide evidence that parasitic infestation is one of the factors associated with stunting in children. Unhygienic living condition, especially in rural areas in developing countries like Upper Egypt,

| Table 3 | Univariate analysis of factors associated with stunting |
|----------|--------------------------------------------------------|
| **Variable** | **Participants (%)** | **β coefficient (SE)** | **OR (95% CI)** | **P-value** |
| **Consanguinity between parents** | | | | |
| No consanguinity | 43.1 | 1† | | |
| First cousin | 23.7 | 0.345 (0.035) | 1.4 (1.1–1.7) | 0.002 |
| Second cousin | 27.7 | 0.264 (0.012) | 1.1 (0.78–1.4) | 0.215 |
| Other relative | 5.5 | -0.127 (0.143) | 0.92 (0.67–1.5) | 0.652 |
| **Familial short stature** | | | | |
| Yes | 51.8 | 0.513 (0.137) | 1.7 (1.43–2.2) | < 0.001 |
| No | 48.2 | 1† | | |
| Birth order | n/a | -0.044 (0.059) | 0.96 (0.86–1.1) | 0.453 |
| **Anaemia** | | | | |
| Yes | 50.6 | 0.791 (0.138) | 2.2 (1.5–2.9) | < 0.001 |
| No | 49.4 | 1† | | |
| **Parasite infestation** | | | | |
| Yes | 57.3 | 0.751 (0.140) | 2.1 (1.6–2.7) | < 0.001 |
| No | 42.7 | 1† | | |
| **Signs of vitamin deficiency** | | | | |
| Yes | 52.6 | 0.275 (0.136) | 1.3 (1.1–1.7) | 0.04 |
| No | 47.4 | 1† | | |
| Frequency of enteritis | n/a | 0.233 (0.042) | 1.3 (1.2–1.4) | 0.002 |
| Body mass index | n/a | 0.186 (0.013) | 1.2 (1.1–1.3) | < 0.001 |
| **Socioeconomic status** | | | | |
| Very low | 6.7 | -0.543 (0.123) | 0.3 (0.1–1.2) | 0.437 |
| Low | 41.6 | 1† | | |
| Middle | 38.3 | -0.348 (0.254) | 0.5 (0.2–1.4) | 0.215 |
| High | 13.4 | 0.217 (0.247) | 1.8 (1.3–2.2) | 0.652 |

SE: standard error, OR: odds ratio, CI: confidence interval, n/a: not applicable.
†Reference category.

| Table 4 | Multivariate logistic regression analysis of factors associated with stunting |
|----------|--------------------------------------------------------|
| **Variable** | **β coefficient (SE)** | **Adjusted OR (95% CI)** | **P-value** |
| Parasite infestation | 0.606 (0.158) | 1.8 (1.3–2.5) | < 0.001 |
| Anaemia | 0.564 (0.155) | 1.7 (1.3–2.7) | < 0.001 |
| Body mass index | 0.193 (0.015) | 1.2 (1.1–1.3) | < 0.001 |
| Frequent gastroenteritis | 0.247 (0.053) | 1.1 (1.06–1.2) | 0.003 |
| First-cousin consanguinity | 0.276 (0.017) | 1.3 (1.2–1.6) | 0.02 |
| Familial short stature | 0.440 (0.352) | 1.5 (1.2–2.1) | 0.04 |
| Signs of vitamin deficiency | 0.298 (0.142) | 1.2 (0.89–1.7) | 0.261 |

SE: standard error, OR: odds ratio, CI: confidence interval.
†Adjusted for all other variables.
Retard de croissance chez les écoliers en Égypte : prévalence et facteurs associés

Résumé

Contexte : Le retard de croissance nuit à la santé et au développement de l’enfant. Peu d’études sur la prévalence du retard de croissance et les facteurs qui y sont associés ont été menées en Haute Égypte.

Objectifs : La présente étude avait pour objectif de déterminer la prévalence du retard de croissance chez les écoliers de Sohag (Égypte), ainsi que les facteurs qui y sont associés.

Méthodes : La présente étude transversale a été menée en 2017 dans le gouvernorat de Sohag. Deux écoles publiques ont été sélectionnées de manière aléatoire (la première en zone urbaine et la seconde en zone rurale) et tous les enfants de ces établissements qui étaient âgés de 4 à 12 ans et dont les parents avaient donné leur consentement ont été inclus dans l’étude. Les parents ont été interrogés afin de recueillir des données sur les caractéristiques de l’enfant et de la famille. Les enfants ont été examinés pour détecter toute carence en vitamines, anémie ou parasitose, et leur indice de masse corporelle a été calculé. Une analyse de régression logistique multivariée a été réalisée pour déterminer quels facteurs étaient significativement corrélés au retard de croissance ; les odds ratios (OR) et les intervalles de confiance (IC) à 95 % sont indiqués.

Résultats : Au total, 1786 enfants ont participé à l’étude (taux de réponse de 69 %), dont 329 (18,4 %) souffraient d’un retard de croissance (correspondant à la valeur du Z, fixée à –2, ou à une valeur inférieure). Les facteurs significativement corrélés au retard de croissance étaient les suivants : infestation parasitaire (OR = 1,8 ; IC à 95 % : 1,3-2,5), anémie (OR = 1,7 ; IC à 95 % : 1,3-2,7), faible indice de masse corporelle (OR = 1,2 ; IC à 95 % : 1,1-1,3), gastro-entérites fréquentes (OR = 1,1 ; IC à 95 % : 1,06-1,2), consanguinité des parents avec un cousin de premier degré (OR = 1,3 ; IC à 95 % : 1,2-1,6) et petite taille des membres de la famille (OR = 1,5 ; IC à 95 % : 1,2-2,1).

Conclusion

The prevalence of stunting in Sohag district is a considerable problem in comparison with developed countries which have a lower prevalence of stunting; for example, United States of America (2.1% stunting), Australia (1.8%) and Germany (1.3%) (31). Family history of short stature, first-cousin consanguinity, anaemia, parasitic infestations, frequent gastroenteritis and low BMI were the most important factors associated with stunting in our sample of schoolchildren in Sohag. Therefore, we suggest that screening and treatment of parasitic infestation, provision of iron and multivitamin supplementations as well as education of children and parents about healthy nutrition should be a part of school health programmes to prevent stunting in schoolchildren.

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معدل انتشار التُقرم بين تلاميذ المدارس في مصر والعوامل المرتبطة به

أحمد حامد النحاس، أحمد حجاب، إيمان محمد

الاستنتاج:
ينبغي أن تتضمن برامج الصحة المدرسية تحري الإصابة بالأمراض الطفيلية، وتوفير الحديد/المكملات التغذوية المتعددة الفيتامينات، والتهاب المعدة والأمعاء المُتكرر، وفقر الدم والأمراض الطفيلية، كما حُسب منسوب كتلة الجسم لديهم. وأُجريت تحليل الارتداد اللوجستي المتعدد المتغيرات للوقوف على العوامل المرتبطة أساساً بالتقزُّم؛ وأُعطيت قيمة نسبة الأرجحية وفاصل ثقة قدره 95%.

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