

Current Prevalence and Determinants of Anaemia in Under-five Children in Rural Bangladesh: A Cross Sectional Study

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Abstract: *Background:* Anaemia and its association with low physical and cognitive development in under-five children remain a common public health burden in developing countries including Bangladesh. Childhood anemia is significantly associated with age, rural residence, infant and young child feeding (IYCF) practices, infectious disease, maternal illiteracy etc. We have studied to identify the current prevalence and to explore associated socio-demographic, health, and nutritional factors of anaemia in under-five children of rural Bangladesh. *Methods and Materials:* A cross-sectional study was conducted at five remote northern districts of Bangladesh involving rural children aged 6 - <60 months. We used an interviewer-administered questionnaire for data collection. Potential study subjects were approached conveniently at selected rural health centres. The chi-squared test was the main statistical model to identify the association between explanatory variables and anaemia. A p-value <0.05 was considered significant. *Results:* The overall prevalence of anaemia (N=258) was 61.23% with mild, moderate and severe anaemia of 28.29%, 28.68% and 4.26% respectively. The prevalence of anaemia was the highest (72%) in the age group 6-24 months, which were followed by 63% in >24-36 months and 44.3% in >36-<60 months categories. The following explanatory variables showed statistically significant association with high anaemia: younger-age ($p<0.001$), low family income, and maternal education ($p<0.001$), exclusive versus non-exclusive breastfeeding ($p=0.02$), and timely versus delayed or early weaning ($p<0.001$). Non-consumption of animal proteins, fruits and green leafy vegetables were also significantly linked to high anaemia prevalence ($p=0.001$). Further, underweight, stunting, and wasting were significantly related to anaemia ($p=0.02$, 0.006, and 0.001 respectively). *Conclusion:* The prevalence of anaemia in under-five children of rural Bangladesh remains noticeably high. Age, maternal education, family income, consumption of animal protein, green leafy vegetables, and fruits along with underweight, stunting and wasting are inversely related to anaemia prevalence. Exclusive breastfeeding and timely weaning may reduce the risk of anaemia.

Keywords: Anaemia Prevalence, Childhood Anaemia, Determinants, Iron Deficiency, Under-five Children

1. Introduction

Anaemia is one of the major public health burdens in the world particularly for young and preschool children. Globally, nearly 50% of under-five children are suffering from anaemia [1]. Anaemia is linked to a wide range of childhood disorders such as cognitive development, low scholastic performance, insufficient physical growth and behavioral development and low immunity among others. Because of these adverse health and socio-economic consequences, anaemia prevalence of more than 40% in any population is identified as a serious public health problem [2]. Anemia is the second leading nutritional cause of diverse disorders with adverse effects on socioeconomic development [3]. Anemia is significantly associated with fetal low birth weight (LBW), sex, age, rural residence, infant and young child feeding (IYCF) practices, infectious disease (e.g., malaria, tuberculosis, intestinal parasitic infestation), under-nutrition (e.g., stunting, wasting, and underweight), poor socioeconomic status, household food insecurity, duration of lactation, poor dietary iron intake, maternal illiteracy and maternal anemia are reported as predictors of anaemia [4-7].

According to recent information from the South-Asian region, nearly 79% Indian children aged 6–35 months suffer from anaemia with a rural predominance [8, 9]. Anaemia still remains as one of the major cause of mortality and morbidity in many developing countries including Bangladesh [1]. In Bangladesh, several studies have reported that anemia among the under-five children is a considerable public health problem. Bangladesh Demographic Health Survey (BDHS) 2011 reported 51% anaemia prevalence in the total population [10]. An anemia prevalence of 33.1% was reported by National Micronutrient Status Survey in pre-school children with rural and urban prevalence of 37.0% and 22.8% respectively. Several studies found that the prevalence of anemia was higher in children aged <3 years among under-five children [11].

Timely starting of complementary feeding at age 6 months is an utmost importance for infant growth and nutrition. In Bangladesh, nearly 62% of children start delayed complementary feeding [10]. The suboptimal infant and young child feeding (IYCF) practices along with early or delayed weaning was found associated with high level nutritional anaemia [10]. Iron deficiency is the most common cause of nutritional anemia in young children [11, 12]. Folic acid and vitamin B12 deficiency are also not uncommon causes of nutritional anaemia [11]. Prevalence of iron deficiency anemia varies across countries with four-times higher in developing than in developed countries [5]. Empirically, iron deficiency anemia increases risk of morbidity and mortality from infectious disease [4, 9, 13]. To eliminate childhood nutritional anemia, particularly iron deficiency anaemia is a public-health priority and reportedly the most common cause of anaemia among under-five children with high prevalence among rural dwellers who occupy nearly 68% of the total population of Bangladesh [14].

However, there are very few studies and consistent data on the current prevalence of anaemia and its determinants in under-five children in rural Bangladesh to fight anaemia. Hence, we aim for such a study.

2. Objective

This study is aimed (i) to identify the current prevalence of anemia among under-five children in rural Bangladesh, and (ii) to assess if there are any associations of anemia with socio-demographic, health, food and nutritional factors in this target population.

3. Methods

A cross-sectional study was conducted in the rural areas of northern Bangladesh. Eleven Upazillas (sub-district) of five districts were selected purposively as the study settings (Table 1). The study districts and Upazilla represent typical and nearly homogenous socioeconomic, demographic and cultural contexts of rural Bangladesh. Nearly 85% population of the sample districts were rural residents. [10]

Table 1. Sample districts with corresponding sample upazillas.

| District | Corresponding upazilla* |
|-----------|--|
| Joypurhat | Panchbibi, Jopurhat Sador, Ketlal, Kalai, Akkelpur |
| Dinajpur | Hakimpur, Ghoraghat |
| Naugaon | Dhamuirhat, Bodolgachi |
| Gaibandha | Gobindogong |
| Bogura | Sibgong |

Under-five children aged 6 - <60 months were the target population. A sample size of 325 was calculated using Cockranch's formula (where N=Sample size, $z=1.96$ (95% confidence level), $p=33\%$ estimated prevalence of anemia in under-five population basing on available information, and $e=0.05$ at 5% margin of error). Rural children of aged 6 - <60 months whose guardians provided written consent were included in the study. Children who were living in urban, i.e., municipality area, in need of emergency care and hospitalization, and/or having history of blood transfusion within last three months from the date of data collection were not included. A questionnaire was prepared involving three researchers; any contradictions were solved by discussion. A piloting was conducted by the Principal Investigator (PI) involving parents of ten patients for testing mainly the qualitative variables and to develop skills of the PI. The questionnaire was finalized with minimum changes and contained the following four main section: particulars of the children, quantitative domains: nutritional anthropometry (height/length, weight) and laboratory reports (complete hemogram, ferritin level, Hb electrophoresis, Zinc level, Folate and vitamin B₁₂ assay); qualitative domains: socio-demographic variables (maternal education, income and occupation of household head, number of children, consanguinity), nutrition (breast feeding, IYCF, stunting, wasting, underweight, consumption of protein, fruits,

vegetable) and health (maturity at birth and birth size, and history of recent infection).

Data was collected consecutively from purposively selected 22 rural health facilities and EPI outreach centers in the study Upazilas. At first the PI (a child health specialist experienced in primary research), approached the under-five children presented at the out-patient department of the selected health facilities. The objectives of the study and the reason of collecting blood were explained. Parents/guardians were assured free of cost blood tests which would solely be used for the study. They were also assured access to the study findings with a guideline for the next treatment options, but without financial benefits. Following an initial face-to-face interview for collecting qualitative data, parents with eligible child were sent to the assigned laboratory. Five millilitre (ml) venous blood was drawn using a sterile syringe (3ml blood were preserved into ethylene diamine tetraacetic acid (EDTA) vial and the next 2ml into another test-tube for separating serum). The EDTA blood was analyzed on the same day with an 'Automated

Hematology Analyzer' (Nihon Kohden, Tokyo, Japan) for a Complete Blood Count (CBC; i.e., haemoglobin percentage, hematocrit), Red cell indices (i.e., MCV, MCH, MCHC, RWD), total count of white blood cell (WBC), differential count of WBC and total platelet count. The degree of anaemia was classified into three categories on the basis of hemoglobin level as defined by the World Health Organization. [3] Accordingly, mild anaemia was considered with a Hb% of 10.00 - 10.90 gm/dl, which for moderate and severe anaemia were 7.00 - 9.90 gm/dl and <7.00gm/dl respectively.

Basing on mean corpuscular volume (MCV), anemia were further classified as normocytic (MCV 80–96 fl), microcytic (MCV <80 fl), and macrocytic (MCV >96 fl). Serum Ferritin and/or Hb-electrophoresis were done in children with microcytic hypochromic anemia; whereas macrocytic anemias were evaluated assaying Vitamin B₁₂ and folic acid levels; and normocytic normochromic anaemia were investigated with Serum Zinc level to reach the etiological pattern of anemia (Figure 1).

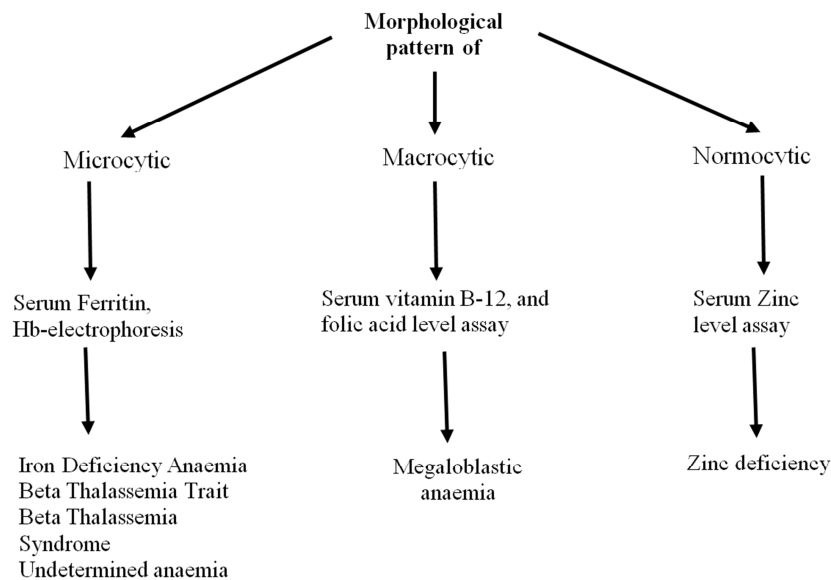


Figure 1. Laboratory diagnostic algorithm of anaemia.

Ethical clearance was obtained from the Institutional Animal, Medical Ethics, Bio-safety and Bio-security Committee (IAMEBBC) of the Institute of Biological Sciences, Rajshahi University (memo no: 83/320/IAMEBBC/IBSC, date: 27 August 2017). Informed written consents were taken from parents of the sample children. Data were computed and analyzed using SPSS (version 23.0). Univariate analysis and chi-squared tests were the main models to identify the prevalence of anaemia and to assess any association between the independent variables and anaemia. A p-value <0.05 was considered as significant.

4. Results

Because of time and resource constraints, it was possible to collect data from a total of 258 target children from a total of eleven sample upazillas of five districts (Table 2). 60% of the

total study subjects were male and the rest were female. Overall prevalence of anaemia was 61.23% (N=258). Of the total male children (n=154), nearly 65% were anaemic and that was 56% in female children (n=104).

Table 2. Distribution of sample children across the sample districts.

| District (No. of Upazilla) | Sampled children (% of total enrolled) |
|----------------------------|--|
| Joypurhat (5) | 90 (34.88%) |
| Dinajpur (2) | 59 (22.86%) |
| Gaibandha (1) | 38 (14.73%) |
| Naugaon (2) | 41 (15.90%) |
| Bogura (1) | 30 (11.63%) |

The gender difference in prevalence of anaemia was not significant (p=0.088). The majority (50%) children was in age group 6-24 months, which was followed by >36-60 months (34%) and >24-36 months (16%). The prevalence of anaemia was 72%, the highest, in 6-24 months group, which was

followed by 63% in age group >24-36 months and 44.3% in >36-60 months with a statistically significant association between age categories and anaemia ($p < 0.001$). Among the children, Muslims were from the majority 88.8% and the rest were from Hindu and indigenous population. The prevalence

of anaemia was the highest (63.3%) in Muslims, which was followed by 57.1% in indigenous group and 40.9% in Hindus. The association between religion and anaemia was not significant ($p = 0.12$) (Table 2).

Table 3. Socio-demographic characteristics of the participant children in relation to anaemia.

| Variables | Subject distribution (%) (N=258) | Prevalence of anaemia n=158 (100%) | Chi-square statistics |
|---------------------------------|----------------------------------|------------------------------------|--|
| Gender | | | |
| Male | 154 (59.7%) | 100 (64.93) | $\chi^2=791.22$; $p=0.08$ $\phi=-.092$ |
| Female | 104 (40.3%) | 58 (55.77) | |
| Age (in month) | | | |
| 6-24 | 129 (50%) | 93 (72.09) | $\chi^2=9.1$; $p=0.001$ $\phi=.257$ |
| >24-36 | 41 (15.9%) | 26 (63.41) | |
| >36-59 | 88 (34.1%) | 39 (44.31) | |
| Religion or ethnicity | | | |
| Islam | 229 (88.8%) | 145 (63.31) | $\chi^2=792.4$; $p=0.117$ $\phi=.129$ |
| Hinduism | 22 (8.5%) | 9 (40.90) | |
| Indigenous | 7 (2.7%) | 4 (57.14) | |
| Education level of mother | | | |
| Primary enrollment or below | 151 (58.5%) | 104 (68.87) | $\chi^2=783.31$; $p=0.001$ $\phi=.228$ |
| Secondary enrollment | 65 (25.2%) | 38 (58.46) | |
| Above secondary or higher | 42 (16.3%) | 16 (38.09) | |
| Number of children (parity) | | | |
| ≤ 2 | 235 (91.1%) | 146 (62.12) | $\chi^2=478$; $p=0.35$ $\phi=-.058$ |
| > 2 | 23 (8.9%) | 12 (52.17) | |
| Occupation of household head | | | |
| Service (public or private) | 89 (34.5%) | 54 (60.67) | $\chi^2=8.6$; $p=0.111$ $\phi=.153$ |
| Agriculture | 63 (24.4%) | 41 (65.07) | |
| Small Business | 91 (35.3%) | 50 (54.94) | |
| Day Labour | 15 (5.8%) | 13 (86.66) | |
| Monthly (family) income in Taka | | | |
| ≤ 5000 | 29 (11.2%) | (21) 72.41 | $\chi^2=811.62$; $p < 0.001$ $\phi=.318$ |
| 5001-10000 | 87 (33.8%) | 68 (78.16) | |
| 10001- 20,000 | 80 (31.0%) | 45 (56.25) | |
| $> 20,000$ | 62 (24.0%) | 24 (38.70) | |

Table 4. Nutrition and food related factors associated with the prevalence of anaemia (n=258).

| Variables | Subject distribution (%) (N=258) | Prevalence of anaemia | Chi-square statistics |
|---------------------------------|----------------------------------|-----------------------|--|
| Exclusive Breast feeding | | | |
| Yes | 186 (72.1%) | 106 (56.99%) | $\chi^2=5.074$; $p=0.016$ $\phi=.140$ |
| No | 72 (27.9%) | 52 (72.22%) | |
| Timely weaning/IYCF practice | | | |
| Yes | 169 (65.5%) | 89 (52.66%) | $\chi^2=15.186$; $p < 0.001$ $\phi=.243$ |
| No | 89 (34.5%) | 69 (77.52%) | |
| Animal protein intake regularly | | | |
| Yes | 210 (81.4%) | 113 (53.80%) | $\chi^2=26.257$; $p < 0.001$ $\phi=.319$ |
| No | 48 (18.6%) | 45 (93.75%) | |
| Plant protein intake regularly | | | |
| Yes | 93 (36%) | 50 (53.76%) | $\chi^2=3.425$; $p=0.064$ $\phi=.115$ |
| No | 165 (64%) | 108 (65.45%) | |
| Fruits intake regularly | | | |
| Yes | 141 (54.7%) | 70 (49.65%) | $\chi^2=17.61$; $p < 0.001$ $\phi=.261$ |
| No | 117 (45.3%) | 88 (75.21%) | |
| Green leafy vegetable regularly | | | |
| Yes | 150 (58.1%) | 77 (51.33%) | $\chi^2=14.81$; $p < 0.001$ $\phi=.240$ |
| No | 108 (41.9%) | 81 (75%) | |
| Underweight | | | |
| Yes | 40 (15.5%) | 31 (77.5%) | $\chi^2=5.27$; $p=0.022$ $\phi=.143$ |
| No | 218 (84.5%) | 127 (58.26%) | |
| Stunted | | | |
| Yes | 74 (28.7%) | 55 (74.32%) | $\chi^2=7.48$; $p=0.007$ $\phi=.170$ |
| No | 184 (31.3%) | 103 (55.98%) | |
| Wasted | | | |
| Yes | 29 (11.2%) | 26 (89.66%) | $\chi^2=11.11$; $p < 0.001$ $\phi=.208$ |
| No | 229 (88.8%) | 132 (57.64%) | |

Parity (i.e., mothers with ≤ 2 children (91.1%) versus >2 children (8.9%)) was found not significantly associated with anaemia ($p=0.23$). The distribution of small business and service were nearly equal of the children's family heads' occupation, 35.5% and 34.5% respectively and that the rest 24.4% and 5.8% were farming and day labour. Prevalence of anaemia in children belong to the day labour families was noticeably the highest (nearly 87%), which among the children in the other three family occupation groups were nearly equal ranging from 55% in small business family to 65% in farmer family. There was no significant association between anaemia and family occupations ($p=0.11$).

Among four categories of monthly family income, distributions of children were nearly equal in the middle two family income groups (i.e., 33.8% and 31% in 5,001-10,000 Taka (the Bangladesh currency) and 10,001- 20,000 Taka groups respectively). Notably, children of the lowest two family income groups had nearly equally the highest prevalence of anaemia; 78% and 72% in 5,001-10,000 Taka and $\leq 5,000$ Taka groups respectively (Table 1). Anaemia was found significantly associated with monthly family income ($p<0.001$) (Table 1). The majority, 58.5% of the total mothers' education level was below primary level. Maternal education was found significantly associated with children's anaemia ($p=0.001$) (Table 3).

Exclusive breast feeding children had nearly 18% lower anaemia prevalence than non-exclusive breast feeding group and the difference was statistically significant ($p=0.02$). Delayed or early weaning-practiced children had nearly 25% higher prevalence of anaemia than their properly weaning

counterpart with a statistically significant difference ($p<0.001$). Non-consumption of animal protein group were found almost 2 times higher anaemia prevalence than animal protein consumption group, which was statistically significant ($p=0.001$). Plant protein (pulses) intake group had nearly 10% lower anaemia prevalence than non-consumption group, which was not significant ($p=0.064$). Children with regular fruits intake had significantly lower prevalence of anaemia by 26% than non-consumption group ($p=0.001$). Children with regular intake of green leafy vegetables also had nearly 26% lower anaemia prevalence than in non-consumption group with a statistically significant difference ($p=0.001$). Underweight children had 1.5 times higher prevalence of anaemia than their normal counterpart with a significant difference ($p=0.022$). Stunted children were found 20% higher and significant risk of developing anaemia than their counterpart ($p=0.006$). Acute under-nourished children had nearly twice higher vulnerability of developing anaemia than normal children with a significant difference ($p=0.001$) (Table 4).

Parents' consanguinity status showed no significant difference in childhood anaemia ($p=0.373$). Pre-term children had nearly 4.5 times and 9 times higher anaemia prevalence than term and post-term babies respectively although the differences were not significant ($p=0.153$). Birth size of babies (normal/small/large) had no significant influence on the prevalence of anaemia ($p=0.69$). Children suffering from chronic illness or recent illness had 23% higher anaemia prevalence than apparently healthy children, which was statistically significant ($p=0.001$) (Table 5).

Table 5. Association of key health and social factors to anaemia (N=258).

| Variables | Distribution of subjects (%) (N=258) | Prevalence of anaemia (%) | Chi-square statistics |
|-----------------------------------|--------------------------------------|---------------------------|---|
| Consanguinity of parents | | | |
| Yes | 39 (15.1%) | 21 (53.84%) | $\chi^2=1.058$; $p=.373$ Phi=.064 |
| No | 219 (84.9%) | 137 (62.55%) | |
| Maturity level at birth | | | |
| Full term | 201 (77.91%) | 12 (5.79%) | $\chi^2=3.758$; $p=0.153$ Phi=.121 |
| Pre-term | 45 (17.44%) | 32 (71.11%) | |
| Post-term | 12 (04.65%) | 5 (41.67%) | |
| Size of baby at birth | | | |
| Normal | 148 (57.4%) | 5 (62.12%) | $\chi^2=0.724$; $p=0.69$ Phi=.054 |
| Small | 50 (19.4%) | 32 (64.00%) | |
| Large | 60 (23.2) | 34 (56.66%) | |
| Chronic illness or recent illness | | | |
| Yes | 97 (37.6%) | 73 (75.25%) | $\chi^2=12.867$; $p=0.001$ Phi=.223 |
| No | 161 (62.4%) | 85 (52.79%) | |

Among the anaemic children ($n=158$), mild (Hb% 10-<11 gm/dl) and moderate (Hb% 7-<10 gm/dl) degree of anaemia were nearly equally distributed 46.2% and 47% respectively, whereas severe anaemia (Hb% <7 gm/dl) was only 7%.

5. Discussion

The study was undertaken to assess the current prevalence of anemia and its association with socio-demographic, health

and nutritional factors in under-five children in rural Bangladesh.

The overall prevalence of anaemia (N=258) was 61.23% with proportion of mild, moderate and severe anaemia of 28.29%, 28.68% and 4.26% respectively. High prevalence of anaemia was found in some other studies in India, Tanzania, Kenya, and South Africa where the prevalence of anaemia was observed between (69% - 79%) in under-five children [18-20, 29]. The prevalence of severe anaemia (4.26%) was lower

than in similar settings; for example, Muoneke et al [15], reported a prevalence of severe anaemia of 9.7% in Nigerian under-five children. Nearly consistent trends of mild, moderate and severe anaemia and associated factors in under-five children of this study were found in a study of Simbauranga et al at Tanzania [16]. In their study, the mild, moderate and severe anaemia were found 16.5%, 33% and 27.7% respectively. In a study in India, the overall prevalence of anaemia in under-five children was found 69.5% with percentage of mild moderate and severe anaemia were 26.2%, 40.4%, 2.9% respectively [30] which is nearly consistent with our findings.

Mild and moderate anaemia in the total sample accounted nearly equally, 30% each, may be due to nutritional deficiencies and socio-demography related factors in rural Bangladesh. We found no association between gender and anaemia. Age is a significant factor of anaemia in under-five children with the highest prevalence (73%) in <24 months age group than their older counterparts. These findings is consistent with the study findings of Goswami and Das and the authors mentioned that high demand for nutrients to support the rapid body growth of the children at this age against a low supply might be the key underlying factor [17]. We also found that increasing trends of anaemia up to 2 years and then decreasing after 2 years may be relating to the children's ability to eat varieties of foods. This finding is consistent with the study of Gebreweld et al [18]. We found no significant link of ethnicity, religion or consanguinity to childhood anaemia which contradicts the findings of Goswami and Das [17]. In this Indian study among under-five children, the authors found significant difference in religion and all types of anaemia prevalence (severe, moderate, and mild) were higher among children of Hindu families than other religions. We found that higher the mother's level of education lower the anaemia prevalence in children. Children of mothers with higher/above HSC education level had nearly two times lower risk of developing anaemia than that in below HSC level mothers. This finding is agreed with the studies of Kuziga et al. [19]. And Leite et al [20]. We found that neither occupation nor parity is significantly linked to childhood anaemia. However, family income is a significant factor with an inverse relationship between income and prevalence of childhood anaemia. The similar observations were also noted in some previous studies [20-22]. This is may be due to the fact that higher income is linked to good maternal education and better nutritional protection to children.

Both non-exclusive breast feeding and delayed/early weaning were found significant factors of developing anaemia in children. Oppositely, EBF, timely weaning, regular consumption of animal protein, green leafy vegetables and locally available fruits were found protective to childhood anaemia. These findings are consistent with the study of Kejo et al [23]. Stunted, underweight and wasted children were found more anaemic, which is consistent with the study of Kisiangani et al [24]. Children with chronic illness and recent illness were nearly 1.5 time high risk of developing anaemia which is also comply with the findings of Kumari et al. [25]

However, it is not known if those disorders are causing anaemia or vice versa although synergistic effects on each other are well-known.

6. Limitations and Strengths

Because of time and resource limits, the sample size was smaller than expected. The study was confined in northern Bangladesh. However, in nearly a homogenous rural context of the country, this study finding is claimed as a reflection of the childhood anaemia scenario of rural Bangladesh. In regard to the associated factors of anaemia, only univariant analyses were done, but the variants did not put together in a regressive model to identify the potential predictors.

7. Conclusion

Prevalence of anaemia in under-five children of rural Bangladesh remains noticeably high. Age, maternal education, family income, consumption of animal protein, green leafy vegetables, and fruits along with underweight, stunting and wasting are inversely related to anaemia prevalence. Exclusive breast feeding, timely weaning and special care before the age of 3 years may reduce risk of anaemia. In addition, chronic and recent illnesses increase susceptibility to anaemia development. To explore the potential determinants of anaemia in early childhood, large sample size covering all region and multivariate analysis are needed and recommended.

List of Abbreviation

| | |
|-----------|---|
| BDHS: | Bangladesh Demographic Health Survey |
| CBC: | Complete Blood Count |
| LBW: | low birth weight |
| EDTA: | Ethylene-Diamine-Tetraacetic-Acid |
| EPI: | Expanded Programme on Immunization |
| Hb: | Hemoglobin |
| HKI: | Helen Keller International |
| HIV: | Human Immunodeficiency Virus |
| ICDDR, B: | International Centre for Diarrheal Disease Research, Bangladesh |
| IDA: | Iron Deficiency Anaemia |
| IPHN: | Institute of Public Health Nutrition |
| IYCF: | Infant and Young Child Feeding |
| MCH: | Mean corpuscular hemoglobin |
| MCHC: | Mean corpuscular hemoglobin concentration |
| MCV: | Mean corpuscular volume |
| ORC: | Out Reach Centre |
| PreSAC: | Pre-school aged children |
| RBC: | Red Blood Cell |
| RDW: | Red Cell distribution Width |
| UNICEF: | United Nations International Children's Emergency Fund |
| WHO: | World Health Organization. |
| UHC: | Upazila Health Complex |
| SAC: | School aged children |

Declarations

Ethics Approval

Ethical clearance was obtained from the Institutional Animal, Medical Ethics, Bio-safety and Bio-security Committee (IAMEBBC) of the Institute of Biological Sciences, Rajshahi University (*memo no: 83/320/IAMEBBC/IBSC, date: 27 August 2017*). Informed written consent were taken from the attending guardian of enrolled children.

Availability of Data and Materials

Data of this study will be made available from the corresponding author on rational request.

Competing Interests

All authors declare that they have no competing interests.

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