

Level of Practice on Protein Rich Diet

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Abstract

A quantitative research approach and descriptive study design was followed for this present study. Non-random purposive sampling technique was followed to select 60 samples from the target population. Around 20 practice related Questionnaire was prepared along with demographic variables, the score and interpretation was 0-8 indicated poor practice, 9-14 indicated good/average practice and 15-20 indicates very good practice. Pilot study was conducted with 6 samples. The actual data was collected with over a period of one month. The data was compiled and analysed with help of descriptive and inferential statistics. The result shows that around 20% of samples were having poor practice in providing protein rich diet to their under-five children, Where as 46.7% of mothers are having satisfactory level of practice and 33.3% samples were having excellent practice. The mean score is 12.4 with the standard deviation of 4.1. It is clear that most of the mother were having good practice in providing protein rich diet to their under-five children. There is no association exist between demographic variables and level of practice.

Keywords: Protein; Under-Five Children; Amino Acid; Nutrition; Growth and Development.

Introduction

The latest edition of the Global Nutrition Report 2015 by the International Food Policy Research Institute, revealed that 29.4 per cent of children (aged less than three years) to be underweight (low in weight for their age), while 15 per cent were wasted (low weight for their height) and 38.7 per cent were stunted (low in height for age). On the face of it, this compares well with the NFHS-3 data, in which the corresponding figures were 40.4 per cent (underweight), 22.9 per cent (wasted) and 44.9 per cent (stunted). But in absolute terms, the current levels of underweight and stunted children are abysmally high [1].

During the period between NFHS 2 (1998-99) &

NFHS 3 (2005-06), decline has been observed for stunting and underweight among children under 3 years of age, whereas the percentage of children wasted has increased. However, it may be noted that, the degree of decline was very low for both categories of children (< 3 years) reported stunting and underweight as the per year decline were less than one percentage point in both cases. Further, the increase in the percentage of children wasted over years indicates a worsening situation, though the per year increase was less than one percentage point. Parents want a great start in life for their children. Education, security, health—these are the foundations for a strong beginning. And nutrition, including adequate protein, plays an important role for both physical and cognitive health of the child [2].

Proteins are one of the most amazing group of molecules in the human body. They are complex combinations of smaller chemical compounds called amino acids. These are like the bricks or building blocks of a building. Adequate protein is essential for maintaining the body's protein stores and keeping many bodily functions running smoothly. Due to

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the demands of growth and development, getting adequate protein is particularly important during infancy, childhood, and adolescence. Babies and toddlers are growing rapidly, so they need more protein per pound of body weight than older kids and adults [3].

Protein is important for infants because the body weight of a baby doubles by 6 months. Breast milk or formula supplies all the protein a baby needs until 4 to 6 months; protein-rich solid foods should supplement breast milk beginning at 6 to 8 months. Ohio State University Extension recommends feeding infants strained or chopped meats and mashed beans at 6 to 8 months and mashed egg yolks, cottage cheese and yogurt at 8 to 10 months. At 10 to 12 months, babies can eat the same protein-rich foods the rest of the family eats, though they should be soft and in small pieces. Babies should get protein every day because the body doesn't store protein the way it stores fat and carbohydrates.

Protein is important for toddlers because walking requires protein to power muscles, and brain cells need this nutrient to learn speech and language skills. Healthy 1- to 3-year-olds need 0.55 grams of protein per pound daily, which means the average 29-pound toddler should get 16 grams of protein each day. A cup of milk has 8 grams of protein, 3 ounces of meat have 21 grams, a cup of dry beans has 16 grams, an 8-ounce container of yogurt has 11 grams and 2 tablespoons of peanut butter have 7 grams of protein. Many plant foods have incomplete proteins, but certain combinations can make up complete proteins that provide all the essential amino acids toddlers need [3].

Skipping on protein can retard growth and development, decrease immunity, weaken the heart and lungs and sap the energy that babies and toddlers need to play and learn. Every cell in the body contains protein, it makes up enzymes needed for chemical reactions and 10 percent of a child's energy comes from protein. Dietary proteins are digested into amino acids that are used to make body proteins to grow and maintain the bones, muscles, blood, skin, hair and organs. Of the 22 amino acids, babies and toddlers can make 13 and must get the others from protein-rich foods, such as breast milk, formula, meat, eggs, dairy products and beans. This present study is focusing on mothers practice on providing protein rich diet to their under-five children [4].

Objectives

1. To assess the level of practice among mothers of

under-five children regarding protein rich diet in selected community at Jodhpur, Rajasthan.

2. To associate the selected demographic variables with level of practice among mothers of under-five children regarding protein rich diet.

Methods

A quantitative research approach and descriptive study design was followed for this present study with the target population of mothers of under-five children. The accessible population was mothers living in Jodhpur. Total sample was 60. Non-random purposive sampling technique was followed to select 60 samples from the population after getting concern. Questionnaire was prepared after extensive review, it includes 2 sections. Section I is demographic variables and section II is 20 questions on practice of giving protein rich diet. Reliability and validity of the tool was tested. The score and interpretation was 0-8 indicated poor practice, 9-14 indicated satisfactory and 15-20 indicates excellent practice. Pilot study was conducted with 10 percentage of sample. And feasibility of the study was assessed. It was found feasible. The actual data was collected with over a period of one month. The data was compiled and analysed with help of descriptive and inferential statistics.

Result

Table 1 shows that around 46.7% of mothers are having good practice and 33.3% samples were having very good practice. Only 20% of samples were having poor practice in providing protein rich diet to their under-five children. The mean score is 12.4 with the standard deviation of 4.1. It is clear that most of the mother were having good practice in providing protein rich diet to their under-five children.

Table 2 shows the frequency and percentage distribution of the samples. Regarding age there are 6.7% of samples are < 21 years and >35 years of age independently, around 36.7% samples were aged between 21-25 years, majority of the samples were (38.3) aged between 26-30 years, and 11.6 samples were aged between 31-35 yrs. The χ^2 is 1.55 and not significant

Majority of the mothers are having single children (43.4%), Very few samples like 3.3% were having 4 and above children. The χ^2 is 0.14 and not significant

Around 36.7 % of samples were having primary

Table 1: Interpretation of result

Level of practice	Score	Frequency	%	Mean	Median	SD
Poor	0-8	12	20	12.4	13	4.1
Satisfactory	9-14	28	46.7			
Excellent	15-20	20	33.3			

Table 2: Frequency and percentage distribution of demographic variables:

Demographic Variables	Frequency	Percentage	"P"	X ²
AGE:				
a) <21 Yrs	4	6.7		
b) 21-25 Yrs	22	36.7		
c) 26-30 Yrs	23	38.3	15.51	1.55
d) 31-35 Yrs	7	11.6		
e) >35 Yrs	4	6.7		
No of Children:				
a) 1	26	43.4		
b) 2	27	45	12.59	0.14
c) 3	5	8.3		
d) 4 and above	2	3.3		
Education				
a) Uneducated	1	1.6		
b) Primary	22	36.7		
c) Secondary	15	25	15.51	11.26
d) High Sec	5	8.3		
e) UG	17	28.4		
Place of Living				
a) Rural	21	35		
b) Urban	33	55	9.49	0.22
c) Sub Urban	6	10		
Religion				
a) Hindu	49	81.7		
b) Muslim	10	16.7	9.49	0.617
c) Christian	1	1.6		
Family Income Per Month				
a) 5000 Rs And Below	3	5		
b) 5001-15000 Rs	35	58.3		
c) 15001-25000rs	7	11.7	15.51	0.33
d) 25001-35000rs	9	15		
e) >35000 Rs	6	10		
Occupation				
a) House Wife	49	81.7		
b) Teacher	5	8.3	12.59	0.35
c) Health Care Professional	5	8.3		
d) Others	1	1.6		

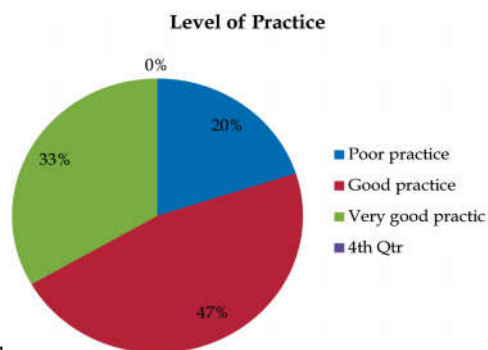


Fig. 1

education, only 1.6 % of mothers were uneducated. Remaining samples were having secondary, higher secondary and under graduate educations. The X^2 is 11.26 and not significant.

Regarding place of living most of the samples were belongs to urban area(55%), only 10% of samples live in semi urban area and around 35% of samples are living in rural area. The X^2 is 0.22 and not significant.

Regarding religion Hindu are found to be more

like 81.7%. Muslims are 16.7% and minority of sample belongs to Christian. (1.6). The X^2 is 0.617 and not significant.

Regarding the income of family per month majority of family income (58.3% is between 5001-15000 Rs/months. The X^2 is 0.33 and not significant.

Pertaining to occupation of the mothers most of the mothers were house wife (81.7%). Remaining samples were doing job. The X^2 is 0.35 and not significant.

The association between the demographic variables were found non-significant.

Discussion

A Studies on the nutritional status of children aged 0-5 years in a drought-affected desert area of western Rajasthan, India revealed growth retardation. The study was carried out in 24 villages belonging to six tehsils (sub-units of district) of Jodhpur District, a drought-affected desert district of western Rajasthan, during a drought in 2003. Stunting (malnutrition of long duration) was observed in 53% of children and underweight in 60%. Wasting, an indicator of short-duration malnutrition, was present in 28% of children. The extent of malnutrition was significantly higher in girls than boys ($P < 0.05$). Vitamin A and B complex deficiencies were found in 0.7 and 3.0% of children, respectively. Prevalence of marasmus (protein-energy malnutrition, PEM) was 1.7% (2.3% in boys and 1.1% in girls). Overall deficits in mean energy and protein intakes were very high (76 and 54%, respectively). Comparison of the present drought results with earlier studies in desert normal and desert drought conditions showed higher prevalence of PEM and higher dietary energy and protein deficiencies [5].

Our present study focused on assessing the level of practice among the mothers of under-five children. This study help us to predict the prevalence of PEM among under-five children in Jodhpur. The present study revealed, that around 46.7% of mothers are having satisfactory in their practice and 33.3% samples were having excellent practice. Only 20% of samples were having poor practice in providing protein rich diet to their under-five children. The mean score is 12.4 with the standard deviation of 4.1. it is clear that most of the mother were having satisfactory level in providing protein rich diet to their under-five children.

Conclusion

Giving children the best start in life requires offering nutrient-rich foods, including protein. People of all ages have food preferences specific to taste, texture, and aroma—children are no exception. Although motivated by different factors in each stage of childhood, picky eating is a hallmark of the toddler years. These childhood food preferences are important to consider along with the high physiological need for protein and other nutrients. The ups and downs of children's eating behaviours may seem like a roller coaster ride for caregivers. Feeding children requires balancing efforts to ensure nutritional adequacy, to encourage appreciation of a wide variety of flavours and textures, and to respect preferences. Protein needs, however, are based on body weight and may not increase with higher activity levels. Therefore, focus on variety from all food groups, protein choices at both meals and snacks, and encouraging children to eat enough to satisfy hunger. Promoting physical activity is important, and children need fuel to play. Parents are their children's role models and children learn how to eat well and in the right quantities by observing their parent's healthful behaviours. When children are offered a diversity of healthful foods, they will likely choose many of those foods. It is responsibility of parents to find right food to their children and children are taught to eat when they are hungry and stop when full to obtain optimum growth.

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