

**Child malnutrition: Perceptions and experiences of
mothers of children admitted at St Patrick's Hospital in
Bizana, Eastern Cape.**

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Declaration

I hereby declare that this is my original work and that it has never been submitted at any other university. The use of others' work in this study has been acknowledged.

Signature:.....

Date:.....

DEDICATION

This study is dedicated unto God Almighty, to my honourable husband Dr M.V. Macabela, my lovely children Mzolisi, Siseko, Natasha, Sesamaswazi and Usivelele, my only sister Bulelwa Nkungu and her children, my niece Nonzuzo and my grand-children Sibonelo, Yonela and Amahle.

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Abstract

Malnutrition refers to the condition caused by an improper balance between what an individual eats and what he requires to maintain health. This can result from eating too little (sub-nutrition or starvation) but may also imply dietary excess or an incorrect balance of basic foods staff such as protein, fat, and carbohydrate. Child malnutrition is a serious problem and worldwide. Mothers play an important role in child care and this is preventing and dealing with child nutrition.

This study aimed to explore the perceptions and experiences of mothers whose children with malnutrition were admitted to a public hospital in a rural district of Bizana in the Eastern Cape. Bizana is the very disadvantaged area with high rates of poverty and unemployment.

The study addressed four questions: How do the mothers understand malnutrition? What are the mothers' experiences of caring for their child who is malnourished? How do the mothers access and experience various government and other structures in addressing malnutrition? How do they think that medical, social and economic support structures should assist them?

A qualitative research paradigm guided the study and the research design was exploratory and descriptive. Ten mothers of children admitted to children's ward participated in this research. The participants were between 20 and 41 years of age and were "long stay" patients at the ward. Data was collected by in depth interviews using an in-depth-interview guide.

The results demonstrate that the mothers came for poor socio-economic backgrounds. They were dependent the social security and had little family support. The lack of resources on the environment also impeded their ability to care for their children. Poor education and a lack of knowledge had resulted in them not feeding the children correctly. The mothers were distressed about the ill health of their children and worried and anxious about coping.

The study makes recommendations for more support to be provided to mothers, especially in this rural area.

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CHAPTER ONE: INTRODUCTION

INTRODUCTION

This study aimed to explore the perceptions and experiences of mothers whose children with malnutrition were admitted to a public hospital in a rural district of Bizana in the Eastern Cape. Bizana is a very disadvantaged area with high rates of poverty and unemployment. Many parents are not employed, some children are from child headed families and some mothers are single parents. The Child Support Grant (CSG) was introduced to provide support for the needy children, but there also seem to be problems in parents accessing this grant. In addition, South Africa has had an Integrated Nutrition Programme since 1995 but the number of children admitted to hospital for malnutrition continues to be a cause for concern. It is not clear why there continues to be problem of child malnutrition, and this is why this study seeks to explore the factors contributing to this. Specifically, it seeks to understand the perceptions and experiences of mothers of malnourished children.

This chapter begins by providing an overview of child malnutrition and an explanation of the terms associated with malnutrition. It then outlines the context of the study and provides information regarding the Bizana district. The research problem and rationale for the study is then presented and the research aims and objectives are discussed. The theoretical framework, which is the eco-systems perspective, is described and research methodology is briefly presented. The chapter ends with the presentation of contents.

CHILD MALNUTRITION: BACKGROUND AND EXTENT OF THE PROBLEM

The term “malnutrition” can be used to refer to both under-nutrition and over- nutrition (Blossner and de Onis, 2006). In South Africa, both forms of malnutrition co-exist and obesity and its impact on health is becoming a problem worldwide (Kimani- Murage, 2013). In this study, however, the term “malnutrition” is only used in the sense of under-nutrition.

Child malnutrition is a serious problem and, worldwide, is responsible for the death of 3.5 million children under the age of five each year (le Roux, le Roux, Comulada, Grecko, Desmond, et al 2010:1). Walraven (2011) estimated that 20% of children under the age of

five in poor countries can be considered to be underweight. The highest proportion of these children was found in South Central Asia and Africa. Child malnutrition has serious effects in developing countries and results in high levels of mortality and morbidity. Children under the age of five years are particularly vulnerable to the adverse effects of malnutrition. At this age, children require hygienically prepared and nutritious feeds in order to develop physically and psychologically (Blossner and de Onis, 2005).

The World Health Organisation (2010) stated that the infant mortality rate and under-five mortality rate are leading indicators of the level of child health in a country. Bradshaw, et al, (2004) explained that infant mortality rate (IMR) is the number of children per 1,000 live births who died before their first day of life. The under-five mortality rate is the number of deaths among children before reaching the age of five years, per 1,000 live births.

The 2012 Global Hunger Index (IFPRI, 2012) estimated that South Africa is ranked 9th in the world in terms of high hunger levels. Stunting and underweight remain the most common nutritional disorders in South Africa affecting one out of five children and almost one out of 10 children respectively (UNICEF, 2010). According to the General Household Survey (Stats SA, 2007), about 15% of South African children experienced hunger compared to 30% in 2002. About 2.5 million African children in South Africa lived in households that reported with child hunger. The total number reported was approximately 17% of the African children, 11% were Coloured children, 1% from Indian families, and 0, 1 % White, were all experienced hunger.

In addition to this, Eastern Cape where this study is located, has been reported with high rate of poverty and hunger that ranged at 21% in 2007, and there was also high rate of children that were raised by unemployed parents (Statistic South Africa, 2003; 2008). Unemployment has an impact on high birth rate and also in high death rate. It has been observed that unemployed people in the Bizana area often have many children but due to lack of resources the children become victims of poverty and hunger and many of these are multi admitted at the hospital because of malnutrition.

The long term effects of malnutrition are serious and children with malnutrition are likely to have diminished immune functioning and greater susceptibility to diseases as well as degenerative diseases later in life (le Roux et al, 2010; Iversen, 2011). Poor nutrition may

also result in poor cognitive and developmental outcomes and negative school performances (le Roux et al, 2010; Iversen, 2011). It is thus understandable that Walker, Chang, Younger, Grantham-McGregor (2010) state that it unlikely that children who are malnourished will attain their potential.

The South African government has recognised that despite improvements, hunger and poverty remain critical problems and has introduced several programs to address these problems. The Department of Health (2011) realised that the Medium-term Strategic Framework for 2009-2014 needed to be revised to adopt an outcome based approach with a view of improving service delivery and accountability to the public. These measures will be further discussed in Chapter Two.

DEFINITION OF TERMS ASSOCIATED WITH CHILD MALNUTRITION

The following section provides an explanation of the terms used in this study.

Child malnutrition

According to Concise Medical Dictionary (2003:410), “Child malnutrition refers to the condition caused by an improper balance between what an individual eats and what he requires to maintain health.” This further explains that it can also result from “eating too little (sub-nutrition or starvation) but may also imply dietary excess or an incorrect balance of basic foodstuff such as protein, fat, and carbohydrate. A deficiency (or excess) of one or more mineral, vitamins, or other essential ingredients may arise from mal-absorption of digested food or metabolic malfunction of one or more parts of the body as well as from unbalanced diet.”

A further definition is, according to Food and Agricultural Organisation (2011:13), “Malnutrition is an abnormal physiological condition caused by inadequate, unbalanced or excessive consumption of macronutrients that provide dietary energy (carbohydrate, fats and proteins) and micronutrients (vitamins and minerals) that are essential for physical and cognitive growth and development.” In other words, it is a condition that results from eating a diet which does not have sufficient nutrients or when there are too many that it causes health problems.

Hunger

Hunger is defined as a “condition in which people lack the basic food intake to provide energy and nutrients for fully productive lives” (Hunger Task Force, 2003 cited in Food and Agricultural Organisation, 2011:13). With regard to the above statement, hunger is measured in terms of availability, meaning that people eat food as much as it is available to them without looking at the disadvantages of taking too much foods; and access depending at the age of that particular person, sex and activities they are engaged in. It is further stated by Hunger Task Force (2003, 2003 cited in Food and Agricultural Organisation, 2011:13), “Food can relieve hunger and provide macronutrients and it is discovered that not all types of foods can fight with malnutrition; it depends to the validity type of that particular food.” Hunger Task Force, (2003, 2003 cited in Food and Agricultural Organisation, 2011:13) further explains, “Some forms of malnourishment were relieved by reducing calories (e.g., obesity), others by reducing debilitating health stresses such as parasites. Under-nutrition with regard to macro and micro nutrients historically has been and continues to be the dominant nutritional problem in developing countries, other forms of malnutrition in particular those that lead to obesity and diets heavy in fats are an increasing public health concern.”

Kwashiorkor

Kwashiorkor is a form of malnutrition and is caused by an unbalanced diet containing very low protein. It usually occurs to the children that are between one and three years of age. According to Berk (2001:128), “It is common in areas of the world where children get enough calories from the starchy foods, but protein resources are scarce.” Those diagnosed with kwashiorkor are usually below the 3rd percentile of weight for age. Peripheral oedema is characterised with skin changes, fine pale sparse hair and the potential high mortality is evident.

Marasmus

Another form of malnutrition is marasmus, which is a wasted condition of the body caused by a diet low in all essential nutrients. According to Berk (2001:128) stated that, “It usually appears in the first year of life when a baby’s mother is too malnourished to produce enough breast milk and bottle-feeding is also inadequate. Her starving baby becomes painfully thin and is in danger of dying.” Children with marasmus are under 60% of the expected weight

for age or less than 3 standard deviations (<70% expected weight to height). Severe wasting, loss of muscle bulk and subcutaneous fat are obvious symptoms.

Stunting

Stunting may also occur in child malnutrition. This refers to low height-for-age (being too short for one's age). According to Semba and Bloem (2008:117) stunted growth "reflects a process of failure to reach linear growth potential as a result of suboptimal health and/or nutritional conditions." These children are characterised with being too short than their ages, for example, a two year old child can be seen as an eight month old baby. High levels of stunting are the result of poor socio-economic conditions and increased risk of illnesses and frequent admissions that lead to early exposure infectious diseases e.g. HIV/AIDS and more especially if the mother of the child is applying inappropriate feeding practices. Semba and Bloem (2008:117) further stated that the worldwide variation of the prevalence of low height-for-age is considerable; ranging from 5% to 65% among the less developed countries and that a "decrease in the national stunting rate is usually indicative of improvements in overall socio-economic conditions of a country."

According to Victora, Adair, Fall, Hallal, Martorell, et al (2008:13), "Stunting causes long-term deficiencies that affect the child psychologically and delays thinking skills." It also affects physically development in terms of height and weight. In the long term, children that were stunted during their childhood had poorer educational performance and this reduced their income as adults. It is further stated by the above authors "Stunting is known as a primary indicator of under-nutrition since it captures life-long burden of under-nutrition, the vulnerable children are under 5 years of age." (Victora et al, 2008:13), This is also reported by UN Standing committee on their 5th Report on World Nutrition Situation (2005) saying, "Almost one third of all children experience stunted growth. Stunting is a particular problem for children in Sub- Saharan Africa which at 43% is the highest rate of stunting in the world (Teller and Alva, 2008).

Wasting

According to Food Agricultural Programme (2010) another characteristic with child malnutrition is low weight-for-height. Children affected by this have tiny bodies, weight loss and is all of this is associated with poverty and hunger. Furthermore, children who are affected with wasting may develop weak immune system and may easily develop

opportunistic diseases. Wasting is also known as wasting syndrome and refers to the process in which a debilitating disease causes muscles and fat tissues to ‘waste away’. It is also referred to as ‘acute malnutrition’ because it is believed that episodes of wasting have a shorter duration than of stunting. Acute malnutrition in low- and middle-income countries was easily seen or observed at the child’s first years of development when children have a high demand for nutrients and there are limitations in the quality and quantity of their diets, including inadequate breast-feeding practices. There can also be less severe wasting. According to Black (2008), 10% of children from low and middle income countries suffer from moderate wasting, also called moderate acute malnutrition.

CONTEXT OF THE STUDY

The research was conducted at St Patrick’s Hospital which is situated in the rural district of Bizana in the Eastern Cape, South Africa. South Africa is divided into nine provinces and the Eastern Cape is the one of the poorest that has a large population with large percentage of people living in rural areas. According to Statistics SA (2010), in 2010, it constituted 13.5% or 6 743 800 of South Africa’s population of 49 991 300. The rural areas in South Africa are home to 70% of the country’s poorest households. The Eastern Cape is divided into six district councils with 39 local municipalities and six health districts. The majority of population in this area are black Xhosa-speakers with 63% living in rural villages and homesteads (Statistics South Africa, 1999).

Kruger, Swart, Labadarios, Danhauser and Nel (2007) reported that 61% of the population in the Eastern Cape still depend on candles for lighting. Kruger et al’s (2007) research at Mt Frere in Eastern Cape showed that the prevalence of under-nutrition was very high in this rural area. According to the results, 18% of children were stunting, 14% were underweight, 3% were wasting and 6% were overweight.

According to the Integrated Development Plan for Mbizana Municipality, Bizana is ridden with low levels of education and unemployment that resulted in highly level of poverty. According to the community survey based on the 2007 census, it is about 279 736 people living in 48 407 households make up this area. The numbers have increased and by 2010-2011, Mbizana Municipality had an estimated population of 281 905 people living 48 447 households. It was also found that on average there were 5.8 persons per household (Stats

SA, 2011). Pertaining to the Draft 2014-15 Review, “The largest population group in Mbizana is Black Africans at 99.58% followed by Coloureds at 0.17%, Indians or Asians at 0.11%, Whites at 0.09% and others at 0.04%. The majority are females (54%) and youth ages 0 -35 (77%). Mbizana is 98% rural.” Only two per cent of households have access to piped water, the lowest percentage in the country.

Education plays a fundamental role in the community development and the South African Constitution (1996) states that every child has a right to education. Education services also include the Adult Basic Education. According to IDP (2012), only 45% of population in the district is economically active. Approximately 76% people have no income and 18% have income and some are dependent on social grant. The low level of education has an effect on low level of income and unemployment.

The pre-planning phase of the Integrated Development Plan review formulation involved a gap analysis. Key indicators showed that unemployment is high at about 56%, up from about 42% in 2002. Poverty is wide spread with a dependency ratio of 99% for children to economically active persons. Government services and domestic service (55%) as well as retail (19%) account for the majority of jobs in the market, followed by finances (11%). An HDI of 0.35 indicates very poor lifestyles across the municipality.

The Municipality also has a high HIV/AIDS prevalence rate which is mainly driven by socio-economic factors such as poverty and lack of job opportunities which already affected the malnourished children (Alfred Nzo News, vol.5-2014). The Deputy Minister, Mr Obed Bapela visited the government departments at Bizana including the St Patrick’s Hospital, evaluating and monitoring the assessment practices in government departments and others. The delegation discovered that majority of units were not functioning optimally. According to a report in the Alfred Nzo News (2014, Volume 5), there were many accusations of negative staff attitudes and this required that the board of management spends a lot of time with community members attending to complaints.

Health services are provided by two hospitals, one in a rural area and the other in the urban area (which is St Patricks where the study took place). There are also 22 clinics spread throughout the district. Although there are these clinics, many people still find it difficult to access them because of poor roads and the hilly terrain.

In the South African context, poverty and unemployment remain structurally inter-linked. According to Labour Force Survey 2000-2008, it shows that since 2001 the rate of unemployment in South Africa is still very high. “The estimated average at the national level was approximately at 43%. Although the rate of unemployment in 2000 was at 29%, by 2009 the rate changed and reported at 24% for a change and that a slightly difference which leaves the rate of unemployment being still high in South Africa. The statistics of the survey shows that females were the most affected ones” (Quarterly Labour Force Survey, 2009)

Poverty and underemployment are linked and they result in poor socio-economic levels that lead to malnutrition because children are unable to consume healthy diets and their parents receive insufficient money to support their families. Poor socio-economic status therefore had an impact on child malnutrition rates that result from hunger and poverty (District Health Information System, 2010). On top of that, Statistics South Africa 2003; 2008 and General Household Survey 2000; 2007 counted several factors that affected the children’s health which were the basic for the child to survive.

These factors included perfect measurement of baby food and thorough cooking as well as access to clean water with which to prepare food. A safe environment is also important and children need to be at a free and safe environment, away from abuse and violence. In order to assist these children, the primary health care system needs to be well equipped and staff should be well trained and professional. It should be a centre where there is sufficient medication and it should be easily accessible to the community members (UN Committee on Economic, Social and Cultural Rights, 2000).

Since 1996, primary health care has been free to all (District Health Information System, 2010) and considerable progress has been made in reducing poverty largely as a result of a significant income transfer programme and a massive reallocation of pro-poor expenditure, e.g. housing, water, electricity and sanitation. However, it is clear that problems still remain and children continue to suffer from malnutrition.

RESEARCH PROBLEM AND RATIONALE FOR THE STUDY

The researcher is employed as a social worker at St Patrick’s Hospital and part of her duties includes working with malnourished children and their families. According to the hospital

records, the number of children admitted with malnutrition increased from 672 in 2010 to 946 in 2012 and 730 in 2013. Many mothers only bring the children to the hospital when their condition is very bad. This results in the death of some children - in 2010, 17% of the children admitted with malnutrition died and this was reduced to 15, 7% in 2012. In addition, it is of concern that some children are admitted more than once.

The statistics from the children's ward shows that 61% of mothers are unemployed and 63% had not completed high school. Of these, one mother had never attended school at all. This may contribute to the number of malnourished children admitted to the ward. Some children are from child headed families and 11% of mothers are single.

Mothers clearly play an important role in nurturing and raising children and in ensuring that they are adequately nourished. In addressing the problem of child malnutrition it is therefore important to understand the perceptions and experiences of mothers. Two previous studies in this area have been done in KwaZulu- Natal. A study in a Durban hospital (Naidu, 2000) investigated the factors contributing to malnutrition and the socio-economic conditions of the caregivers. Another study by Buthelezi (2011) looked at the perspectives of caregivers at a different Durban hospital. In both these studies, poverty was found to be a major factor. The present study adds to the body of knowledge concerning mothers as it focuses specifically in a poor rural area.

It was thus hoped that this study would shed more light on how mothers whose children suffer from malnutrition perceive their situation. The results of this study could inform policy development and implementation to ensure that the mothers' needs are taken into account when addressing the problem of malnutrition.

RESEARCH AIM AND OBJECTIVES

The aim of the study was to explore perceptions and experiences of mothers whose children have been admitted to St Patrick's Hospital because of child malnutrition.

Objectives

The objectives of this study were:

1. To explore the mothers' understanding of child malnutrition

2. To explore their experiences in accessing resources and interventions in fighting child malnutrition
3. To explore their expectations about the role that medical, social and economic structures should play in addressing their challenges.

The research questions therefore were:

1. How do the mothers understand malnutrition?
2. What are the mothers' experiences of caring for their children who were malnourished?
3. How do the mothers access and experience various government and other structures in addressing malnutrition?
4. How do they think that medical, social and economic support structures should assist them?

THEORETICAL FRAMEWORK

The study was guided by the ecological systems theory. Berk (2001:25) states, "Urie Bronfenbrenner's ecological framework for human development applies socio-ecological models to human development and views the person as developing within a complex system of relationships affected by multiple levels of the surrounding environment." Environmental factors can influence how children are raised and can thus have an effect on whether a child becomes malnourished. Environmental factors include the social, economic, and psychological factors. Social factors include socio-culture, norms and beliefs which affects the whole system or family when the child gets sick. Economic factors can both contribute to the problem and influence the intervention and solution to the problem. Psychological factors take into account the stress and confusion mothers may experience when taking care of the ill child. Looking at child malnutrition, the child is the main affected person but the mother is also affected.

Payne (1997) referring to Bronfenbrenner and Morris (1998) explained the whole ecological system in which the child grows needs to be considered in order to understand human development. Furthermore, development is moulded by the joining of the child's biological dispositions with environmental factors. This would also apply to understanding how the child becomes malnourished, the impact that this has on the mother and how she responds to

the problem. Using Urie Bronfenbrenner's theory, it becomes clear that in order to understand the perceptions and experience of mothers the entire ecological system in which the child malnutrition occurs need to be taken into account. The ecological model also stresses systems thinking, which is the process of understanding how things influence one another within a whole and how the different systems impact on each other.

Ecological systems theory describes four systems that are used in this research study. Firstly, there is micro-system that is concerned about the relations between the affected person and immediate environment. Secondly, there is the meso system that looks at connections among immediate settings. Thirdly is the exosystem that looks at the wider community system, and the final one is the macro system that consists of the values, laws, customs, and resources of a particular culture.

The micro-systems level: The micro-systems level refers to the “activities and interactions in the person's immediate surroundings” (Berk, 2001:26). The family, and especially the mother who is generally the primary caregiver, play an important role in the development of the child and how to protect children from malnutrition. The support system from the family members can groom the child nowhere to a higher destiny. These family member need to provide the child with basic needs in life, like home as place of belonging, hygienic food, and education. Love and compassion follows to support the above mentioned needs.

In the case of a malnourished child, his or her development will be affected in all spheres of life. This in turn may also the affect how the mother feels about the child and how she provides care.

Mesosystems level: This refers to the “connections between micro-systems that foster development” (Berk, 2001:26). This can include the neighbourhood which is the social environment in which the family carries out its daily life. According to Rogers (2010), the meso system is the norm-forming component where interpersonal relations take place. The neighbourhood can play an important role in the care and well- being of children. It can provide resources that support positive child care practices or it can lack resources and so contribute to problems such as malnutrition. In the old days, there was ‘Ubuntu’ where the community members were looking after each other. For example, they gave and exchanged

foods. A rich family might employ a poor neighbour's boy child to milk the cow in exchange for milk. This then helped to reduce hunger and malnutrition.

Exosystems level: The exosystem consists of social settings that the individual is not part of but which influence the individual (Berk, 2001). Wider community systems such as health, welfare, employment, justice and educational systems can provide positive support to the individual or they can lack resources and so hinder the development and well-being of the individual.

Macro systems level: The macro system refers to the "values, laws, customs and resources of a given culture" (Berk, 2001:26). According to Rogers (2010), macro systems therefore function to regulate the environment in which other systems exist." The macro system provides the policy context in which child malnutrition can be understood. Government policies can provide resources to support families which can impact on the immediate environment making it more conducive to good child care.

There are other concepts related to ecological systems theory which are relevant for this study. In particular, the concept of "person-in-environment" and "goodness of fit" are important. Kirst-Ashman (2008) explains that this assesses the extent to which the environment is able to accommodate and meet the needs, rights and wishes of the individual. Kirst-Ashman (2008) also makes the point that individuals and systems are interdependent and interconnected with each influencing the other.

RESEARCH METHODOLOGY

The study was conducted within a qualitative paradigm. The reason for using this paradigm was because the study aimed to understand the views of the mothers. According to Babbie and Mouton (2007:270), "Qualitative researchers attempt always to study human action from the perspective of the social actors themselves. The primary goal of the studies using this approach is defined as describing and understanding, rather than explaining human behaviour." Rubin and Babbie, (2013:40) add, "Qualitative research methods are more to tap the deeper meanings of particular human experiences, and generate theoretically richer observations that are not easily reduced to number."

The research was primarily exploratory and descriptive in nature. According to Bless and Higson-Smith (2000:41), “exploratory research is to gain a broad understanding of a situation, phenomenon, community or person, whereas it is further explained that description is used to test statements that do not relate two or more variables but express fact about the world.” While a considerable amount of research has been conducted in the medical field regarding malnutrition, research from a social work and from the mothers’ perspective and research in the area of the study is scarce.

Purposive sampling (specifically availability sampling) was used and ten mothers whose children were admitted due to malnutrition and were admitted as “long stay” patients at the hospital were interviewed using in-depth-interview guide. “In-depth interviews allowed the interviewee enough time to develop their own accounts of issues important to them” (Green and Thorogood, (2009:94). The interviews were conducted over a one month period in 2014. “In-depth individual interviewing is understood as the process through which the content of the conversation comes into being” (Babbie and Mouton, 2004:310). The interview was done in Xhosa and tape recorded with the participant’s permission.

The data was analysed by the researcher. This entailed transcribing the interviews and then translating them into English. Transcripts were checked by a third party for accuracy of translation. Content analysis was used to develop themes and categories.

Further details regarding the methodology of the study are discussed in Chapter Three.

PRESENTATION OF CONTENTS

The dissertation is divided into 5 chapters.

This chapter, Chapter One, is the introductory chapter that began with an overview of child malnutrition and an explanation of the terms associated with malnutrition. It then outlined the context of the study, the research problem and rationale for the study, the research aims and objectives, theoretical framework, research methodology and the presentation of contents.

Chapter Two is the literature review. It begins with an introduction, and then goes on to discuss factors associated with child malnutrition, the effects of malnutrition, policies, and intervention strategies.

In Chapter Three, the methodology of the study is described. It begins with the research design, then goes on to discuss purpose of the study, sampling, data collection and data analysis. It also explains issues of trustworthiness, ethical issues and the limitations of the study.

The analysis of the findings is presented in Chapter Four. The findings are presented in terms of themes and are illustrated by verbatim quotes from the research respondents.

Chapter Five is the final chapter and presents the conclusions and recommendations of the study.

CHAPTER TWO: LITERATURE REVIEW

INTRODUCTION

Chapter One provided an introduction to the study and presented the background and rationale for the study. The research objectives were presented and the eco-systems theory which forms the theoretical framework for the study was outlined.

This chapter reviews the literature in respect of child malnutrition. It begins by discussing the factors contributing to malnutrition and then goes on to discuss the effects of malnutrition, policies that address malnutrition, and intervention strategies.

FACTORS CONTRIBUTING TO CHILD MALNUTRITION

In this section, the factors contributing to child malnutrition will be discussed. These include factors at the micro, meso, exo and macro levels of the environment. A review of studies that considered risk factors will also be included in this section.

UNICEF (1990) developed a causal framework for child malnutrition which still provides a useful framework for analysing factors contributing to this problem. According to this framework, the immediate causes of child malnutrition are insufficient dietary intake and disease. These factors in turn are influenced by maternal and child care practices, household food security and access to health services and a healthy environment. These underlying causes are in turn influenced by knowledge and attitudes which are shaped by what the framework describes as “basic” causes. These include: The quantity and quality of human, economic and organisational resources and how they are controlled; political, economic, cultural, religious and social systems and potential resources such as technology, people and nature. The framework shows the inter-connectedness of the factors and fits in well with the ecological systems theory which guides this study.

Several South African researchers (Chopra, 2003; Saloojee, de Maayer, Garenne and Kahn, 2007; Mahaven and Townsend, 2007; Magadi, 2011; Kimani- Murage, 2013) have studied risk factors associated with child malnutrition. These studies will now be summarised.

Chopra (2003) examined the risk factors associated with underweight and stunting in children in a rural district of KwaZulu- Natal. The study included 868 children under the age of five. Significant risk factors included the absence of the father, a home built out of traditional materials, low birth weight of the child and lack of breast-feeding. Poverty and unemployment were widespread in this area with most people reliant on social grants for income. In addition, poor infrastructure limited access to resources.

Saloojee, de Maayer, Garenne and Kahn (2007) compared 100 children with malnutrition with 200 healthier children in the Limpopo Province of South Africa. Statistically significant risk factors for malnutrition included evidence of HIV infection in the family (either parents or children), poor weaning practices such as a lack of exclusive breast-feeding and the early introduction of solids, parental death, male sex and higher birth order. It was interesting to note that in this study, only one third of the children in the malnourished group were receiving the child support grant while more than half of those in the control group were receiving it. Poorer households were thus more at risk.

Mahaven and Townsend (2007) conducted research in the Mpumalanga province. IN this study, compromised nutrition was associated with the death or non- residence of the mother and lack of support by the father. This study demonstrated the importance of children being cared for by supportive kin and how the absence of the mother places the child at risk.

Magadi (2011) examined risk factors for malnutrition in children whose mothers who HIV positive. HIV infection poses a double risk for malnutrition in children as they might themselves be infected and thus more vulnerable to disease and their mothers' illness may impact on her ability to care for them. Magadi's (2011) study found that children aged one boys were more at risk for malnutrition. Birth circumstances that multiply or in the case of twin births, and babies who were smaller than average at birth were at greater risk of developing malnutrition. In terms of the mothers' characteristics, those mothers who had no education were more at risk of having children develop malnutrition. It was further found that the greatest risk came in poorest or single parent households.

Kimani- Murage's (2013) study was conducted in the Mpumalanga province. The child's positive HIV status, as well as low birth weight was significant risk factors for malnutrition.

Other risk factors included the age of the mother with younger mothers more likely to have children with malnutrition. This study also found that children from villages populated by foreigners (in this case, Mozambiquans) were more likely to suffer from malnutrition. It seemed that these people had less access to employment and social services which impacted negatively on their ability to care for their children.

These studies all demonstrate the inter-connectedness of factors associated with child malnutrition. In terms of factors associated with the child, low birth weight and HIV infection are risk factors (Magadi, 2010; Kimani- Murage 2013). Another researcher, Le Roux, (2010) says that the longer the child remains malnourished the more the child is at a risk of infections, long term effects and other developmental deficits.

In terms of child care practices, infants who were exclusively breastfed were less likely to be malnourished (Bourne, 2007). There are however a number of factors that may influence the practice of breast-feeding. She may decide to stop because of her own illness (Saloojee, et al 2007). In addition, the HIV/AIDS pandemic may have influenced breast-feeding practices as HIV positive mothers have in the past been discouraged from breast-feeding to reduce mother to child transmission (Swart, Sanders and McLachlan, 2008). A Soul City report on nutrition and South Africa's children (undated) stated that HIV positive mothers can safely breast feed their babies but it must be exclusive breast-feeding for the first six months. In addition, they must be closely monitored by health professionals to ensure good breast health and the babies must be monitored detect and treat any oral lesions which could enable the HI virus to enter the baby.

Unhealthy eating practices and early weaning were also risk factors. Both Saloojee, et al (2007) and Kimani- Murage (2013) found that the mothers of malnourished children were likely to be younger. It may be that their lack of maturity also influences their child care practices.

At an exo-systems level, the education of the mother also seems to play a role in whether the children become malnourished. Mothers therefore need to be educated since maternal education has been found to be an important risk factor for child malnutrition (Marins and Almeida, 2002, Sakisaka, et al, 2006, Shah, et al, 2003). This shows that most seriously affected children are those in rural areas whose mothers have relatively little education.

Wachs, Creed-Kanashiro, Cueto and Jacoby (2005) stated that both direct and indirect maternal education acts as preventative measure for child malnutrition. The above authors point out that educated mothers have better knowledge of how to prepare good food for their children and they understand better the advantages of including breast-feeding. They may also be more likely to attend prenatal care and therefore be exposed to healthy pre- and post-pregnancy behaviours for themselves and their new-borns. The same educated mothers find it important for them to attend prenatal care and expose themselves to healthy pre and post pregnancy behaviours that help them and their coming babies. Mothers that are attending prenatal care have an opportunity to get information that fits both the mother and the child about health nutrition and also helps mothers that obtained lower level of education.

The high rate of HIV infections in South Africa also contributes to the problem of child malnutrition. Some authors point that children who were infected with HIV mostly get it during pregnancy and that it comes from vertical mother-to-child transmissions which predispose them to illness and disease and that increased risks of child malnutrition illness and mortality (Bunn, 2009; Fergusson, et al, 2009; Nalwoga, et al, 2010). Those new-borns whose mothers were infected with HIV have higher rate of foetal malnutrition than new-borns of HIV zero-negative mothers (Gangar, 2009). Some studies have shown that malnutrition is a problem in children infected with HIV. Hendricks, Bourne and Eley (2006) reported on a study that showed that more than 50% of children with HIV become underweight and that about 20% develop marasmus. It shows that pregnant woman have to attend the perinatal care to protect their unborn foetuses but in areas where the infrastructure is poor, access may be limited. In addition, young, single mothers may delay seeking care because of embarrassment and stigma.

Poverty seems to be the underlying factor that influences whether children will be malnourished or not. The study done by two hospitals of Eastern Cape and KwaZulu Natal, (Schoeman, Adams, Smuts, Faber, Ford-Ngomane, et al, 2010) shows that, poverty was demonstrated in both provinces in the areas where they never accessed to basic services. In many cases, households were still dependent on river water for consumption, meaning that the RDP services were not in place like water taps and electricity as they were still using an open fire to cook food. Other rural areas still have large forest for cutting woods that used in cooking and serves as substitute for light when dark. The lack of basic services limits the impact of nutrition interventions that address childhood malnutrition, e.g. poor sanitation and

a lack of safe drinking water increase the risk of diarrhoea and childhood malnutrition. Rivers in rural areas are not fenced and are used by many animals like pigs, cows, horses and other as their drinking pool and even when it rains all dirty particles and foreign bodies flow towards the river. It is estimated that two-thirds of all the episodes of diarrhoea in children could be avoided through readily available and inexpensive interventions to improve hygiene (Curtis, Cairncross, 2003, Bateman et al, 1995). For example, water should be boiled before use and food should be prepared hygienically.

The Eastern Cape (which is the context for this study) has poor road conditions and an inadequate public transport system which hinders the access of people to health facilities. The common transport that was mostly used in rural areas was donkeys and horses, which were used to transport the ill people and dead ones when going and coming from mortuaries. This form of transport was economic for them, due to lack of employment and poor socio-economic status. Furthermore, when visiting health facilities, overcrowded and the long queues that determined the long waiting times which limits people to gain interest to attend health facilities (Smith et al, 2005).

The literature (Schoeman, et al 2010) further explained that the sources of income that people were dependent on were Child Support Grant (CSG) and Old Age Pensions (OAP) and that these were the main sources of income in both provinces. Those that were not receiving Child Support Grant were of large percentage of households, 63% of Eastern Cape households and 86 % from KwaZulu Natal. In the Eastern Cape, children were affected by the waiting periods made by local councillors and ward committees that were claiming to be linked with SASSA. The researcher herself has observed many admissions and the death rate increased due to this waiting period. Strategies should be put in place to ensure that all eligible households have access to these grants and that the money is spent responsibly.

The high birth rate among teenagers and many live schools due to teenage pregnancy are another cause for concern. Monde and Udjo (2006) reported that analyses that existed on the national data, showed that there was no relationship between teenage fertility in South Africa and the child support grant, but the authors did state that specifically designed studies are needed to address this issue conclusively. Many people continue to believe that the child support grant encourages young girls to fall pregnant. All this happens because people are in need of money without looking at consequences of caring for a child. There should be some

skills development that would help the existing generation in order to generate income and create job opportunities for each household to get cash. The higher the income generation, the better it becomes for each household to access nutritious food.

Smuts et al (2006, cited in Schoeman et al, 2010) explained that the greater scale of poverty was further underlined by the high dominance of unemployed husbands in the Eastern Cape that comprises at 50%, which was double than the number of unemployed husbands at KZN. In both provinces it was discovered that approximately 20% of the husbands were migrant labourers. Migration is a social phenomenon common to South Africa that affects family structures and facilitates the spread of sexually transmitted diseases from urban to rural areas. The reason behind this is that, husbands who are migrant labourers meet with other female and wait a long time being far away from their wives (Smuts et al, 2006, cited in Schoeman, et al, 2010). There is a belief that they fail to use contraceptive whilst away from their partners and when they come back it is difficult for them to disclose and use protection with their wives, then the rate of HIV and AIDS increased and at the end of the day the child become the main victim.

Summarising problems at a macro-level, Saloojee et al (2007) pointed out that poor quality services and access to relevant institutions, family that is controlled with violence, insufficient access to child support grant and other services all contributed to child malnutrition.

Also at the macro level, Blossner and de Onis (2005) describe how adverse environmental conditions impact on child malnutrition. Things such as the destruction of natural ecosystems, the loss of bio-diversity, and climate change increase health hazards for people and affect the nutritional status. Over-population in some areas also reduces the ability of people to produce sufficient food from the land and this undermines food security.

THE EFFECTS OF MALNUTRITION

Some of the effects of child malnutrition have already been discussed in Chapter One. This section, however, provides a more detailed discussion of these effects. The physical and medical effects, the social effects and the psychological effects, the effects on the mothers of malnourished children and the effects on the health care system are discussed.

Physical and medical effects on the child

According to Black et al (2003) about 50-60% of all child deaths can be linked to malnutrition. These authors point out that severely malnourished child comprise a significant proportion of paediatric deaths especially in hospitals in developing countries. They suggest that this could be due to unacceptably high case-management guidelines to improve the quality of hospital care and reduce child deaths. This is of concern because babies who have a poor start are further compromised and in some cases, lose their caregivers because their mothers die.

Swart, Sanders and McLachlan (2008) explained that the effects of malnutrition in early childhood can be short term and long term. In the short term, malnutrition affects brain development, body composition and muscle growth and the metabolic programming of glucose and lipids. In the longer term, this affects the child's cognitive and educational performance, the immune system is compromised and the child is at risk for developing conditions such as diabetes, obesity, heart disease, high blood pressure, cancer, stroke and aging.

Due to child malnutrition serious physical disabilities can develop, such as learning delay that are more predominant among children who were having low birth weight as infants, these children are characterised with lower levels of intelligence, that is discovered when a child wants to perform writing and reading, and will be notified by being vulnerable in repeating the classes. Children that are born with low birth weight are also at the key risk factor for infant mortality and period observed for their death is within the first 28 days of life.

Poverty can influence other child developmental stages, which is the cognitive ability and school achievement. Poor children mostly experienced the increased rates of low birth weight and raised blood levels when compared with rich children. Therefore these children experience the conditions have been related with reduced IQ and this definitely affects the child's cognitive functioning as the child grows older. The consequences of low birth weight are associated with the increased rates of learning disabilities as it was mentioned before, grade retention and end up being school dropout. This child cannot cope with difficult situations because of being affected physically and psychologically in the stage of adulthood.

Social and psychological effects on the child

Some studies (Ciaccio and Brophy, 2000) have suggested that malnutrition may have negative social and psychological implications for children. For example, children who are malnourished may develop depression, anxiety, inadequacy and isolation because of the environment in which they are raised. It has also been reported that sometimes children who have suffered from malnutrition may develop aggressive or impulsive behaviour. These children are likely to display emotional difficulties due to how they grow and their appearance amongst others. There is also a possibility to develop negative self-esteem which can block the motivation of learning, they usually fail in class and mixed with children of the younger age than theirs. They may also become socially withdrawn which is the result of low self-esteem.

The environment often lacks the comprehensive resources that are conducive to the development of children. In addition, it has been noted that in some cases, there may be poor resource management or lack of support for the family.

The number of studies agreed that nutritional deficiencies are among the key risk factors leading to children not being able to attain their development potential (Walker, Chang, Vera-Herna'ndez, and Grantham-McGregor, 2011a; Walker, et al, 2007, 2011b). Other literature continue and explained that the majority of children because of nutritional deficiencies which are estimated at 35% of all under-five child who dead worldwide and is counted at 36 low and middle-income (LAMI) countries (Black et al, 2008a). Karolis, Jackson, Ashworth, Sogaula, McCoy, et al (2007:198) added and said that "severely malnourished children undergo physiological and metabolic changes to conserve energy and preserve essential processes, including reduction in the functional capacity of organs and slowing of activities." It is possible that these children could compare themselves with their peers and the realisation that their growth and progress is slower could affect their self- esteem and lead to them dropping out of school.

These deficiencies can be seen as a persistent risk factor that continues to threaten healthy development of the children who are the victims of malnutrition (Walker, et al, 2007, 2011b). There are signs and symptoms that can be identified in a child experiencing nutritious deficiencies. By the age of two years, the child can be identified with retarded growth or

stunting, for example the age of the child will be estimated at half of his/her age and unable to attain to Piaget's stages of development. It has already been mentioned that these children develop poor cognitive development and children may need to be admitted to the special school. This has negative implications for both the child and mother who may suffer from low self-esteem.

Effects on the mother of the malnourished child

Literature in respect of this aspect is limited. A study in Malawi (Steward, Bunn, Vokhiwa, Kauye, Tomenson, et al, 2010) examined maternal distress when children were admitted to hospital with malnutrition. Certain factors were closely correlated with higher levels of maternal distress. These included: no close relationship with a spouse, the sick child was an older child, having had a previous child die and when the sick child had diarrhoea. Some mothers in this study were so distressed that they reported having considered suicide in the weeks prior to the admission of their child. It was evident that having a malnourished, sick child caused a great deal of distress to mothers and the distress may have been linked to a general feeling of not being able to cope with the circumstances. Steward, et al (2010) commented that it is important to consider maternal distress during treatment. They suggested that mothers may not be able to grasp feeding and other child care advice if they are distressed. The recommendation was that more psycho-social care services should be made available to mothers. This could include support groups and on-going follow up and support.

Buthelezi's (2011) study was located in Durban and showed that mothers of children admitted to hospital for malnutrition were generally poor and dependent of others for financial security. Because of this they did not have much control over spending patterns and were unable to take control of buying correct food for the children. Those who were receipt of the child support grant used the grant to support the whole family rather than a specific child and thus the money was insufficient for the needs of the whole family. Lack of money also prevented them from accessing health services as they did not have bus fare. The mothers also experienced the health system as unsupportive and little knowledge about malnutrition and how to address it. The study showed that the mothers were very worried about how they would cope when their children were discharged from hospital as their economic circumstances had not changed. The study pointed to the huge burden facing mothers as they tried to care for their children.

Graves and Ware (1990) pointed that the hospitalisation of a child is stressful for parents. They may feel uncertain because they do not understand the hospital routine or the treatment regime. In addition, seeing their child ill adds to their stress. These authors also pointed out that parents may feel guilt and embarrassment, and that their role as parents changes as the hospital staff take responsibility for certain aspects of the child's care (Graves and Ware, 1990). It seems reasonable to expect that mothers of children who are hospitalised because of malnutrition will experience similar feelings.

Effects on the health care system

Buthelezi (2011) explained that malnutrition is a major public health problem and is an underlying factor in the deaths of children who die from preventable diseases. The fatality rate for children with malnutrition is three times higher than the overall mortality rate (Department of Health, 2010). The number of children being admitted to hospital had also increased from 6% of the total admissions in 2005 to 9% in 2007 (Department of Health, 2010).

Treating children with malnutrition requires specialist attention and the large number of children requiring treatment places a strain on hospitals. Ashworth, Sanders, Chopra, McCoy, and Schofield (2004) are of the opinion that hospital based care has limitations especially when the hospital resources are poor and where there are inadequate beds. Hendricks and Bourne (2010) point out that poor management of cases malnutrition in hospitals are the result of high turnover of staff, errors in management and lack of supervision.

Prevention of malnutrition should therefore be a priority.

POLICIES

In this section, relevant South African policies at national, provincial and district levels to address malnutrition will be discussed.

The overall legislative and policy framework

The South African Constitution provides for the right to health care and the protection of children. For example, Section 27 of the Constitution of South Africa stipulates that

“everyone has the right to have access to health-care services;” section 28(1) (c) gives children “the right to basic nutrition and basic health care services”. South Africa thus has a strong commitment to the rights of children and children have the right to basic nutrition. The Constitution places an obligation on the state to adopt policies that give meaning to these rights.

These provisions are in keeping with the African Charter on the Rights and Welfare of the Child. Article 14(1) of this charter states that, “every child shall have the right to enjoy the best attainable state of physical, mental and spiritual health” and Article 14(2) states that the state should take measures to “ensure the provision of adequate nutrition”. The United Nations Convention on the Rights of a Child also deals with the issue of health care for children and Article 24 says that State Parties should recognise “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. It obliges the State to take measures “to diminish infant and child mortality” and “to combat disease and malnutrition”. All of these policies were formulated for the purpose of protection the child worldwide.

The Integrated Nutrition Programme (INP)

Soon after the first democratic elections in 1994, the Minister of Health appointed a committee to develop a more comprehensive nutrition strategy for South Africa. This resulted in the adoption of the Integrated Nutrition Programme (INP). The INP differed from previous nutrition programmes in South Africa which just focused on the immediate causes of malnutrition and provided food to the needy. The INP emphasized the need to address all the causes of malnutrition and stressed the need for all sectors to work in an integrated manner (Saitowitz and Hendricks, undated)

According to Saitowitz and Hendricks, (undated), the overall aims of the INP are to:

- “Enable all women to breastfeed their children exclusively until six months of age and thereafter to continue breast-feeding in addition to the introduction of appropriate complementary foods, until twenty-four months of age and beyond.
- Ensure optimal growth of infants and young children.
- Promote the health of women and in particular pregnant and lactating women
- Prevent an increase in mortality due to diseases of lifestyle.

- Improve the capacity of communities to solve the problems of malnutrition and hunger.
- Improve inter-sectoral collaboration and community ownership of nutrition programmes.”

The INP was intended to be broad nutritional strategy which focuses on children under six years old, at-risk pregnant and lactating mothers as well those suffering from communicable and chronic life style diseases (Bourne et al, 2007). The vision of INP is “optimum nutrition for all South Africans (INP, undated: 3) and it rests on the principle that good nutrition is a basic human right. It acknowledges the interconnectedness of factors contributing to malnutrition and thus adopts an integrated holistic approach in which different sectors and stakeholders are expected to co-operate and work together. The INP is therefore implemented at various levels – community sites, households, health facilities and schools (Iversen et al, 2012).

The INP is administered by a Cabinet appointed Inter-Ministerial Committee (IMC) on food security, jointly led by the Ministers of Social Development and of Agriculture, Forestry and Fisheries, aimed at fighting food insecurity, hunger and malnutrition” (Strategic Plan 2012-2015 DSD).

A number of programmes form part of the INP. These include:

Primary School Nutrition Programme: This was started as a Presidential Lead Project in 1994 and was initially located in the INP initiative. According to Iversen et al (2012), its main aim was to address short term hunger and so improve the capacity of children to learn. Iversen et al (2012) commented that this programme has been evaluated several times. In 2000, it was recommended that the programme be continued but improved and that clarity be given on whether it was a nutritional, educational or social relief intervention. It was also found that the goals had not been met and that in many areas of the country the scheme was not working well. A study by Hendricks and Bourne (2009) found that targets had been reached in many areas with more than six million learners in over 18 000 schools receiving food. In addition, about 4000 schools had food gardens. According to Iversen et al (2012) many of the problems with the implementation of this scheme are related to poor management, a lack of capacity, inefficient and inappropriate management systems, poor

infrastructure and corruption. Currently the programme is known as the National School Nutrition programme and is located in the Department of Education.

Nutrition Therapeutic Programme: This was previously known as the “Nutrition Supplementation Programme” and “aims to correct under-nutrition by providing nutrition supplements as well as nutrition education and counselling” (Iversen et al, 2012: 5932) uneven results have emerged from evaluation studies of this programme. Hendricks et al (2003) reported that about 38% of children in the Eastern Cape who received supplements showed good progress. However, in the Northern Cape, only about 10% of children moved back into the normal weight category (Hendricks, Roux, Fernandes and Irlam 2003). A study conducted Andersen, Wandel, Eide, Herselman and Iversen (2009) in Cape Town revealed problems with the implementation of the programme. Despite mothers being given breast milk substitutes, porridge and energy drinks, malnutrition was effectively addressed. These studies suggested that a lack of staff training, incorrect distribution of supplements and ineffective counselling and education of caregivers resulted in poor delivery of services. Iversen et al (2012:5932) comment that “despite huge efforts and funds allocated to execute this programme, it is yet to undergo a full evaluation”

Baby friendly facilities: South Africa has 232 baby friendly facilities out of a possible 545 (Iversen, et al, 2012). Baby friendly facilities are maternity ward and clinics where practices promote breast-feeding. For example, mothers and their infants are not separated. These facilities implement a modified “Ten steps to successful breast-feeding” which were initially adopted by WHO/UNICEF in 1989.

The South African Infant and Young Child Feeding Policy: This was adopted in 2008 and aims to standardise messages about infant feeding practice and to ensure health care providers provide consistent advice about how to feed infants and young children. (Iversen et al, 2012).

In conclusion, it would appear that South Africa has good policies in place to address malnutrition but that the implementation of these policies is problematic. In addition, vigorous evaluation seems to be lacking.

Policy on Food and Nutrition Security

The Integrated Food Security Strategy was approved in 2002 (Department of Social Development and Department of Agriculture, Forestry and Fisheries, 2013). This was an attempt to integrate the various food security programmes at the time. In 2013, the Departments of Social Development and Agriculture, Forestry and Fisheries proposed a new Food and Nutrition Security Policy. They identified the following problems in the existing policies: inadequate provision for those people unable to meet their immediate food needs especially in times of disaster; inadequate knowledge about good food choices; poor framing methods; inadequate access to markets; the impact of climate change; and inadequate information on food security. The policy thus seeks to provide efficient information, control and management systems. It is hoped that these efforts would result in adequate, stable, safe and accessible supply of food.

Other policies that indirectly address malnutrition

Reducing poverty, unemployment and inequality remain South Africa's greatest challenge and there are numerous policies and programmes aimed at making a significant contribution to the government wide-fight against poverty which affects millions of South Africans, including children, youth, families, people with disabilities, and elderly people. This is in line with National Development Plan 2030 which calls for the strengthening of social protection to ensure that no household lives below a predetermined social floor, and that all areas of vulnerability are addressed.

Martin, Moench-Pfanner and Dora (2003) explained that the South African government has adopted the specific approach to poverty. The approach includes cash transfers that help to support needy households and provide the means for them to meet their basic needs. There are many families that depend on the government grant such as Old Aged Grant, Child Support Grant, Foster Care Grant, Disability Grant and Care Dependency Grant. By March 2012, 15, 2 million social grant beneficiaries were approved and the number increased to more than 15, 9 million by 21 December 2012 and it is expected that they will reach the target of 17, 2 million at the end of March 2016. The aim of reaching these targets is to fight against child malnutrition and to relieve poor households.

Clinic-based, free primary health care (PHC) has also been introduced. These clinics can provide specific treatment for illnesses but also play a role in preventing problems but

monitoring the growth of children and providing immunization services (Swart, Sanders and McLachlin, 2008). In addition, there is compulsory education of the children of 7 - 13 years of age with many schools being declared non fee paying and providing school feeding programmes. All of these measures help to provide support for the poor which in turn should assist in fighting malnutrition.

The Department of Finance also has policies that contribute to food security and so help to address child malnutrition (Swart, Sanders and McLachlin, 2008). For example, there is no VAT (value added tax) on basic foodstuffs whereas there is heavy tax on alcohol and tobacco products. People below a certain income are also exempt from paying annual tax.

The Medium Term Strategic Framework (MTSF, 2009–2014) identifies the development challenges that are facing South Africa and also outlines the medium-term strategy in order to improve the living conditions of South Africans. It meant to guide the government planning and resource allocation across all spheres of government. Therefore the national and provincial departments have to develop their strategic plans and budget that will equip for about the period of five years and also taking into account the medium-term imperatives. Even the municipalities are expected to adjust their integrated development plans to be in line with the national medium-term priorities, one of these plans includes halve poverty and employment rate by 2014 (MDG S.A. Country report, 2010).

In conclusion, it is interesting to note that none of the policies specifically mention the role of mothers in addressing malnutrition. However, mothers are the beneficiaries of many policies such as the social security and free health care.

INTERVENTION STRATEGIES

In this section, different types of interventions are discussed. Some of these interventions focus specifically on the child while others include the mothers.

Medical interventions

When children present with malnutrition, they need medical intervention as it can be considered to be a medical emergency. This consists of improving the nutritional status of the child through proper feeding and supplements. The World Health Organisation (WHO) as

developed a 10 step programme for the treatment of severely malnourished children admitted to hospital (Ashworth, Kharnum, Jackson and Schofield, 2003). These 10 steps provide very clear guidelines for the treatment of malnourished children. They are:

1. Treat/prevent hypoglycaemia
2. Treat/prevent hypothermia
3. Treat/prevent dehydration
4. Correct electrolyte imbalance
5. Treat/prevent infection
6. Correct micronutrient deficiencies
7. Start cautious feeding
8. Achieve catch-up growth
9. Provide sensory stimulation and emotional support
10. Prepare for follow-up after recovery

According to the 10 steps (Ashworth et al, 2004), the child needs to be stabilised initially within the first three days and rehabilitation can then can up to six weeks before the child can be discharged. The dosages of nutrients and the intervals for feeding are specified very clearly in the 10 steps and the correct percentages of sodium and potassium need to be given. Anti-biotic may also need to be given if the child presents with infections. During the rehabilitation phase, the child continues to receive specific additional nutrition in addition to what would be “normal” feeding. If the child is breast-fed, mothers are encouraged to continue with this although breast milk will not be sufficient to make up for the deficits experienced by the child.

In a study of KwaZulu Natal hospitals (Biggs, 2013), it was found that there was some resistance to the WHO guidelines and some clinicians expressed concern that the conditions were not always conducive to mixing feeds hygienically in accordance with the guidelines. They felt that ready to use, commercially available products might be better than specially mixing formulas in the hospitals. Biggs (2013) also raised concerns that the guidelines regarding cautious feeding (Step 7) were often omitted.

Another important medical intervention to prevent malnutrition may also be to ensure healthy pregnancies. According to Victora et al (2008), “given the possibility that many women in low and medium income countries may face risks of co-exposure to multiple micronutrient

deficiencies, in recent years, more attention has been paid to intervention during pregnancy with multiple micronutrient supplementation rather than individual micronutrients.”

Community interventions

Chopra (2003) points out that traditionally food intervention programs consisted of feeding programs located at schools, clinics, crèches and soup kitchens. He further points out that the results of these programmes have been disappointing. He postulates that a possible reason for this may be that these types of intervention programmes are too narrowly focused and do not address the wider socio-economic conditions.

An example of how a school feeding programme combined with an advocacy programme was successful in reducing undernourishment in children is provided by Joulaei, Nwagwu, Nasihatkin, Azadbahkt, Shenavar et al (2013). This study was conducted in Iran. Children at school were provided with healthy, balanced, nutritious “snack” baskets. Combined with this was an advocacy programme. This consisted of preparing educational booklets for children which informed them about healthy eating choices. Meetings were also held with parents to inform them of the study and to provide additional education. At the same time an extensive media campaign was undertaken with 15 talk shows and 12 newspaper articles about healthy diet, the importance of breakfast and the role of the family in good food practices. This combination of interventions appeared to be successful in addressing some of the wider issues associated with concerns about the nutritional status of the children.

Another example of a community based intervention comes from Jammu, India (Gupta and Kumar, 2013). This intervention targeted mothers of children under the age of 5 and consisted of individual counselling and group education and support sessions. Mothers were visited in their homes once per month and attended an intensive group education programme for four weeks. This educational programme used pictorial methods, role plays and case studies to educate the mothers about breast-feeding, personal hygiene and child care. The post intervention results demonstrated an improvement in the nutritional status of the children.

A similar intervention programme which focussed on home visits to mothers was implemented in Cape Town to improve the rehabilitation of malnourished children (le Roux, et al, 2010). Mentors were trained to visit mothers whose children were malnourished and to

offer them support and advice on a regular basis. More children in the intervention group (43%) were rehabilitated than children in the control group (31%). In addition, rehabilitation for the intervention group happened sooner than for children in the control group. The researchers (le Roux et al, 2010: 9) concluded that community peers who offer home visiting programmes with supervision and support could “provide a sustainable mechanism for addressing health needs in low resource settings.”

Preventive interventions

Because the child malnutrition can have long term effects and continues to disturb the growth and the development of the child as growing older, early intervention is necessary. Previous studies demonstrated that children at their pre-school age are most vulnerable group to get infectious diseases as they growth (Kwena et al, 2003, Marins and Almeida, 2002, Bloss et al, 2004, Maleta, et al, 2003) and to prevent the latter, the interventions strategies and they can be done before the child can enter or start schooling to avoid long-term effects. It can be done through improving their nutritional state. These children should be targeted to boost their education, behavioural approach and physical consequences of adverse health in school age.

Nutritional deficiencies need to be prevented at the early stage of development to ensure good physical growth only but also to ensure the future development of the child. This means that, the healthy child determines the coming healthy adult, but the weak child determines the weak South African citizen of tomorrow. Moreover as it has already mentioned by other studies, children growing up in disadvantaged communities may face a number of risks, which can make them more vulnerable to nutritional deficiencies, such as poverty, poor water and sanitation conditions and infections.

Preventive interventions are therefore important. Prevention aims at preventing healthy children from becoming malnourished as well as preventing the condition malnourished children from becoming worse. According to Langendorf, Roederer, de Pee, Brown, Doyon et al (2014) prevention strategies can include large scale distribution of nutritious supplementary food, or food and/or cash transfers to households. Cash transfers such as grants are intended to enable the household to purchase sufficient food and to provide for themselves. In fact, the child support grant in South Africa was initially introduced to provide support for young children at a time when they were most vulnerable (Lund, 2008).

In a study in Niger where there is an annual “hunger gap” during the rainy season when food is more scarce and conditions are more conducive to diarrheal disease and malaria, Langendorf et al (2014) compared the effectiveness of cash transfer and supplementary food provision in preventing malnutrition. These researchers concluded that combining supplementary food and a cash transfer had better results than either a cash transfer or supplementary food on its own.

Supplement programmes

According to Bhutta et al (2008) “Supplementation includes addressing micronutrient deficiencies. Iron, iodine, zinc and vitamin A supplementation may reduce risk of mortality, burden of disease and some deficits in growth and early development.” Therefore mothers need to breastfeed their babies to support their nutritional status and promote their development of the children as well as protecting them from anaemia.

Pena-Rosas and Viteri (2009) in a review of studies for the Cochrane Collaboration highlighted that fact “the guidance for supplementary iron or iron + folic acid should be considered as effective in preventing anaemia and iron deficiency at term, although there is no significant effect of supplementation on the incidence of substantive maternal and neonatal adverse clinical outcomes such as (Low Birth Weight) LBW, delayed development, preterm birth, infection, and postpartum haemorrhage’. Programme guidance is on what, why and how to develop and implement nutrition programmes brings together the rights-based and evidence-based guidance modalities.”

According to Bhutta et al.(2008) and Guidelines for Management of HIV in children (2010), anaemia is common in HIV infected children and may be due to acute illnesses such as malaria, nutritional deficiency, opportunistic infections and others, therefore the mothers are encouraged to give their children as much animal iron sources as possible. Vitamin C is important and it helps in the absorption of all types of iron. This means that all mothers who are pregnant need to check their nutritional status at their maternal stage for the benefit of the child.

WHO (2001) cited in Scrimshaw (1990) explains that, “iron deficiencies adversely affect the cognitive performance, the behaviour and the physical growth of the infant, pre-school and school-aged children; the immune status and mobility from infections of all age groups; the

use of energy sources by muscles and thus physical capacity and work performance of adolescent and adults of all age groups.” Moreover, during pregnancy iron deficiency increases the perinatal risk for mothers and neonates and increase overall infant mortality. It is estimated that 40% of all maternal perinatal deaths are linked to anaemia. Information cited from Bothwell (1981) indicates that, “favourable pregnancy outcomes occur 30-45% less often in anaemic mothers, and their infants have less than one half of normal iron reserves.” Also Llewellyn-Jones (1965) encourages that “ such infants require more iron than is supplied by breast milk, at an earlier age, than do infants of normal birth weight,” and also explains that if the pregnancy is induced, iron deficiency cannot be corrected, therefore both the mother and the child will suffer all the consequences already mentioned before.

There are intervention measures that are needed to prevent nutritional deficiencies. Firstly, window of opportunity concerning prevention needed during conception to the first 2– 3 years of life when the child’s brain started developing fast, therefore early nutrition intervention have to take place to reduce the occurrence of nutrition-related risk factors that lead to poor survival, growth and development. Moreover, “Child development interventions, which promote quality caregiver/infant interactions, learning, social–emotional and behavioural development are the most effective during this period of rapid brain development” (Engle, et al, 2011; Walker, 2011). This can reduce the risk factors that lead to poor survival.

Secondly, it is also mentioned that, “there are common pathways that mediate outcomes of poor child growth and development. In addition to nutritional deficiencies, poor sanitation and hygiene, childhood illnesses, low maternal literacy, increased maternal depression and inadequate stimulation in the home environment mediate suboptimal growth and development outcomes” (Grantham-McGregor et al, 2007).

Importance of breast-feeding

Breast-feeding is a protective factor and is an adequate evidence that the child who breastfed develop properly and grow well. Walker et al (2011). In addition, breastfed babies are more likely to resist any attack and if critically ill are more likely to survive. “Exclusive breast-feeding reduced under-five mortality rate by 13%, and breast-feeding contributed to child’s health which protects the infants from morbidity and mortality,” (Jones et al, 2003). In a study done by Edmond et al (2006), it was revealed that 16% of neonatal deaths could be

saved if all infants were breastfed from day one and 22% if breast-feeding is done within first hours of birth. The long term effects of breast-feeding are also evident and a systematic review of studies (Arenz, Ruckerl and Koletzko, 2004) showed that breast-feeding had a positive effect against obesity in childhood. Writing in 2009, Turck, Agostoni and Braegger (2009), made similar claims regarding the protective benefits of breast-feeding.

This means that breast milk plays a big role in protecting a child and child development and should be promoted. Bhuta (2000) says that breast-feeding must be promoted and nothing should detract from this, especially in communities where the availability and safety of breast milk substitutes cannot be guaranteed. However, in the context of HIV/AIDS with the fear of mother to child transmission, this is not always possible.

Unfortunately, South Africa has made little progress in promoting exclusive breast-feeding. The majority of 82% babies of mothers were breastfed in 2003 except 39% of mothers who did not initiate breast within one hour of birth South Africa's breast-feeding practices, 1998-2003. Breast milk substitutes are available but in South Africa, are often not prepared correctly. Living conditions are often not conducive and hinder safe adequate feeding (Dept. of Health, 2006). Of concern, was a study conducted by Bergstrom et al (2004), which found that in South Africa over 60% of infants formula fed were contaminated with pathogenic bacteria, even in good conditions of hygiene and sanitation.

Mixed feeding has been found to be problematic. "Fifty per cent of infants younger than six months in the Eastern Cape and 29% in KwaZulu-Natal received mixed feeding, which has been reported to have a higher risk of HIV transmission than breast-feeding" (Coutsoudis et al, 2001). Considering that the commonness of HIV infection in pregnant women in both provinces was high, the findings revealed that the mixed feeding of infants needed to be discouraged (Koniz-Booher et al 2004). Although mothers maybe educated about the risks of mixed feeding, they fear that their children are not going to be well fed. Problems arise when feeding bottles are contaminated with harmful bacteria and when the incorrect dilution of bottle feeds is practised. (Bergström, 2003, Faber, Benadé, 2006). Contamination may occur because of poor hygiene and incorrect dilution takes place because of the costs involved in buying milk substitutes and mothers try to make it last longer.

UNICEF (2004) suggests that a comprehensive approach to improving hygiene should be followed. This would include things like installing electricity so that people have access to stoves and fridges. It would also include improving the infrastructure so that people have easier access to resources. Promoting health behaviours in respect of food preparation must be seen in the total context of the society. Government structures and municipal departments therefore need to provide and maintain the basic services and they should know that it is the first priority.

Strategies to promote exclusive breast-feeding can include the use of peer counsellor. (Engebretsen, Jackson, Fadnes, Nankabirwa, Diallo et al, 2014). In a study involving Burkina Faso, Uganda and South Africa, peer counsellors were provided with one week of training on how to promote and support exclusive breast-feeding. A problem however was their relatively low educational levels and the lack of infrastructure and support in the areas where they operated. The intervention demonstrated small improvements in the growth of children in all three countries.

CONCLUSION

South Africa is really faced with the burden of child malnutrition that results in high rate of mobility and morbidity. The study explores the experiences and perception of mothers taking care of malnourished children. The researcher discovered that there is a gap in the literature concerning the perceptions and the experiences of mothers. Most studies focus on malnutrition and its consequences. Factors of child malnutrition, the policies and intervention strategies were addressed. While some strategies focus on mothers, many of the policies do not pay attention to the needs of mothers of children who are malnourished.

CHAPTER THREE: METHODOLOGY

INTRODUCTION

This chapter deals with the methodology of the study. The research design, the sample and sampling method, data collection method and data analysis are described. In addition, consideration is given to the, ethical considerations of the study and trustworthiness of the study is considered.

RESEARCH DESIGN

The research study adopted a qualitative approach research. Qualitative researchers attempt always to study human action from the perspective of the social actors themselves. The primary goal of the studies using this approach is defined as describing and understanding, rather than explaining human behaviour, (Babbie and Mouton, 2007). Qualitative research methods are intended to tap the deeper meanings of particular human experiences, and generate theoretically richer observations that are not easily reduced to numbers (Rubin and Babbie, 2013). This approach was considered suitable for the study as the aim was to understand child malnutrition from the perspective of the mothers of affected children.

The research was exploratory and descriptive in nature. Bless and Higson-Smith (2000: 41), states that, “exploratory research is to gain a broad understanding of a situation, phenomenon, community or person”. This is relevant for this research study as previous studies have focussed mainly on the medical aspects, risk factors and interventions. The perspectives and experiences of mothers living in a rural area have not been widely studied. In keeping with the qualitative nature of the research, this study aimed to provide rich descriptions of the mothers’ perceptions and experiences.

SAMPLE AND SAMPLING METHOD

The population is the complete set of events, people or things to the research findings are to be applied (Bless, 2000), and as Higson-Smith and Bless (1995) said, the entire set of objects and events or group of people which is the object of research and about which the researcher wants to determine some characteristics is called ‘population’. The number of malnourished

children in the Bizana community is unknown and so the researcher used the purposive sampling (specifically availability sampling). In purposive sampling, researchers purposely choose subjects who, in their opinion, are relevant to the project (Sarantakos, 2005).

Mothers whose children were admitted to hospital because of malnutrition were selected for the study. The criteria for selection were as follows:

- Mothers that were admitted with their children that were diagnosed with severe malnutrition and were “long stay” patients at the hospital. “Long stay” means that the mothers and children were expected to be in hospital for more than a month
- Mothers were between the ages of 20 to 45 years of age.

The manager of the ward assisted the researcher to identify mothers who met the criteria for the study. The assistance of the ward manager was sought because most documents, patient’s card, immunisation cards and other information concerning the mothers of the children, were under the control of this person.

Ten mothers were available for inclusion in the research study during the period of the research. These mothers were from the local areas of Bizana and all had severely malnourished children who had been admitted for treatment.

DATA COLLECTION METHOD

In-depth interviews were held. An in-depth interview allowed the interviewer enough time to develop their own accounts of issues important to them (Green and Thorogood, 2009). In-depth individual interviewing is understood as the process through which the content of the conversation comes into being (Babbie and Mouton, 2004).

The researcher visited the children’s ward and talked to the sister in charge in order to assign the staff member that would look after the children at the time of interview as each respondent attends the interview session. The assigned nurse helped in taking care of the children whilst their mothers were busy. Each mother could therefore concentrate on the interview and not worry about her child during this time.

Interviews were conducted in a vacant office which had been arranged by the ward manager. The office was comfortable and conducive to interviewing. There were no disruptions during the interviews. The researcher was thus able to ensure confidentiality and respect.

Since the researcher works at St Patrick's hospital, the mothers were encouraged to be open in expressing themselves because the information they give would help them together with their children as well as the staff of St Patrick's hospital. Before the interview took place, the researcher read the informed consent form with each participant. She made sure that they understood the contents and gave them time to ask questions.

An in-depth interview guide was developed to guide the interview (See Appendix A). The interview ensured that all relevant aspects were explored but allowed for flexibility in the timing of questions. For example, during the interviews, the mothers sometimes answered questions before they were asked. The actual wording could also be flexible and relevant to the immediate situation. The questions were mainly open ended and allowed the researcher to probe for more information when necessary. This also allowed the mothers to explain more when responding as they were free to express themselves about how they feel about being parents to the ill children. An interview guide, rather than a questionnaire, was thus an appropriate data collection tool.

The choice of themes to explore was guided by the theoretical framework which is ecological systems theory. The interview thus considered elements of children's development needs (micro) in relation to each element of parenting capacity as well as wider family (meso) and environmental circumstances (exo and macro). The researcher aimed to explore the understanding of mothers about child malnutrition, their experiences and perceptions on taking care of their children, and find out about their expectations from different stakeholders to fight against malnutrition. The researcher began with questions about the mother's identifying particulars such as age, and her family composition. These answers to these questions provided background information about the mothers' circumstances which would provide a deeper understanding of the challenges they may face in terms of caring for their children. This was then followed with the questions about the child concerned, its age, and health status. The interview then explored the experiences of the mothers, their perceptions about their child's condition, as well as their expectations of the different service providers.

The interviews were done in Xhosa and tape recorded with the participant's permission. None of the mothers objected to the tape recorder. Smith et al (1999) as cited in de Vos et al (2011) mentioned that a recorder allows a much fuller record than notes taken during the interviews. In terms of the ethical conditions at the University of KwaZulu Natal, the tape recording will be kept for five years in a secure container at the University.

The time spent with each mother was 45 to 60 minutes. Some of the interviews were quite emotional as some of the mothers blamed themselves for the role they thought they played in the admission of their children. Others revealed their HIV status and were suspecting that the reason of multi-admissions was because of who they are. Some felt that they and their children were a disgrace to them, their families as well as their community. The researcher therefore had to be sensitive to the pain they were experiencing and used her social work counselling skills to offer support and help to the mothers.

METHODS OF DATA ANALYSIS

Each participant was given opportunity to answer the questions in their own language (isiXhosa). After the interviews, notes in English were recorded in respect of the different questions. The interviews were then transcribed and then translated into English. Transcripts were checked by a third party for accuracy of translation. The researcher's husband obtained the PhD in African languages and literature and he helped the researcher in interpreting and translating the interviews from Xhosa to English.

The data was then analysed according to themes and sub themes. Braun and Clarke (2006) defined data analysis as a method for identifying, analysing and reporting patterns (themes) within data. In order to do this, the researcher listened to the tapes, read the transcripts and her notes. In this way, she immersed herself in the data.

Whittaker (2012) explained that the process of coding data involves breaking the data down into their smallest parts or codes before rebuilding them into major themes, and also looks at how the codes can be grouped together and relate themes to each other. The amount of the data recorded down from the in-depth interview guide and data collected by tape-recording interviews and responses was therefore noted and analysed. The different responses were then collated into themes keeping in mind, Braun and Clarke (2006) advice to ensure that

data within themes cohere together meaningfully, and that there should be clear distinctions between the themes.

The researcher had to repeat the process of listening to the tape and reading the transcripts several times to make sure that all then data was captured and the research questions were all answered.

ETHICAL CONSIDERATIONS OF THE STUDY

Ethical approval for the study was obtained from the University of KwaZulu- Natal Biomedical Research Ethics Committee (See Appendix D). In order to gain this approval the researcher and her supervisor had to complete an on- line ethics course. This ensured that careful consideration was given to ethical issues. In addition, consent to conduct the study was obtained from the Hospital manager (See Appendix C).

The rights of the participants need to be considered by the researcher in order to comply with ethical principles. Specifically, the following ethical guidelines were followed:

Informed consent and voluntary participation: The participants were given sufficient information that included an explanation about the purpose of the research, the duration of the participation of the mother as well as the procedures to be followed (Royse, 2004). Grinnell and Unrau (2008:37) highlight that, “respect for persons requires that subjects be given the opportunity to choose what shall not happen to them”. An informed consent letter (See Appendix B1) was read and informed consent form (See Appendix B2) was signed by the participant after being explained. They were invited to participate and they were informed that there would be no sanction for declining to participate and their participation had no incentives.

According to Rubin and Babbie (2005) said participation should be voluntary and no one should be compelled to participate in a research project. The researcher was aware of her more powerful position vis-à-vis the mothers and understood that some mothers may feel reluctant to refuse because they might have feared a loss of services and support for them and their children. This matter was thus thoroughly discussed with the mothers who all agreed to participate. At the end of the interviews, the all mothers said that, they had appreciated the

opportunity to talk in detail about their experiences. From the interviews the research picked some participants for the follow up concerning their problems.

In addition, care was taken that participants were not deceived in any way. The participants were informed that the researcher was a social worker at the hospital as well as a student at the university and that the research was so that she could get a degree. The supervisor's details were provided as further proof that the study was being conducted for degree purposes.

Privacy and Confidentiality: Confidentiality means that the private information is being applied in order for the participant to understand that the identity will be known by the researcher only (Royse, 2004). Whereas de Vos et al (2011) explains that, privacy, the right to self-determination and confidential can be viewed as being synonymous. The interview was done at safe and closed office. The information written down and the one on the tape recorder are kept at safe place. The information about the researcher's supervisor revealed to the participants in order for them to do follow up where they were not satisfied.

No harm to the participants: The researcher was aware of the sensitive nature of the research topic and realised that the mothers may feel guilty and unhappy about the diagnosis of malnutrition in their children. The researcher therefore made sure that the interview and participation would not bring further distress to the mothers. Before the interview started she engaged in a process of building rapport by greeting the mother in a culturally appropriate way and by asking her how she was. She adopted a friendly, respectful and non- judgemental attitude and demonstrated this by positive non- verbal behaviour as well as kind and comforting words. Ensuring that no identifying details (for example, names, places of residence) are published further protects the participants and ensures no harm to them.

ROLE OF PRACTIONER/RESEARCHER

As stated previously, the researcher is also the social worker at the hospital where the study was carried out. This had advantages in respect of the fact that researcher had knowledge of the hospital structure and systems and established relationships with staff. She also knew many of the patients. As a qualified social worker, she was able to use appropriate relationship building skills and interviewing skills. She was also able to work within the

value framework of the social work profession which requires social workers to be respectful, accepting, and non-judgemental. All these factors facilitated the research study.

A possible negative aspect was that the roles of practitioner and researcher might become conflated and that the objectivity required by the researcher may be compromised. Every effort was made to avoid this danger by reflecting on the interviews and data analysis with the research supervisor.

TRUSTWORTHINESS OF THE STUDY

In qualitative studies, issues of validity and reliability are best described by the concept of “trustworthiness”. Every effort made to ensure that the study was trustworthy. Trustworthiness is about how an inquirer can persuade his or her audiences that the findings of an enquiry are worth paying attention to or worth taking account to (Babbie and Mouton, 2004). To ensure the valid results and truth values, de Vos et al (2011) state that trustworthiness has to be considered, following the four steps as to enhance trustworthiness:

Credibility asks if there compatibility between the constructed realities that exist in the mind of the respondents and those that are attributed to them? Lincoln and Guba 1999 cited in de Vos (2011:359) emphasize the “prolonged engagement and persistent observation in the field, triangulation of methods and data sources, peer briefing and members checks ensure credibility in qualitative research”.

In this study, prolonged engagement, persistent observations, peer debriefings and member checks were used. Prolonged engagement was gained through purposive and intensive contact with the mothers in the ward. The process for contacting and working with the mothers has been documented in this chapter. Persistent observation means to consistently pursue interpretations in different ways, in conjunction with a process of constant and tentative analysis. At the time of an interview facial expression could be observed. For example, it became evident that some mothers found some topics sensitive and responded differently. Every participant signed the consent form to allow the researcher to proceed with the researcher and recording with tape recorder. Others were excited with type of the interview. Peer debriefing means a colleague will help in reviewing perceptions, insight, and analyses. One of the nurses at the children’s ward played a big role in assisting at the time of

the interview process, arranging for someone to look after their children whilst on interviews. Member check means that the researcher can check with the research participant to ensure that she has correctly understood the information given. When anything was not clear, the researcher went back to the research participant to get clarity.

Transferability refers to the extent to which the findings can be applied in other contexts or with other respondents. There are two strategies under transferability: thick description means that transferability depends on similarities between sending and receiving contexts, “the researcher collect sufficiently detailed descriptions of data in context and reports them, with sufficient detail and precision” (Babbie and Mouton, 2004:277). On the other side, Grinnel, Unrau (2011) point out that in the qualitative study, transferability to other settings may be the problem. This is the first time the study of this nature being done at St Patricks Hospital and so the results may not be transferable to other settings. However, the detailed descriptions about the setting and the results will assist any reader to determine whether the results are helpful in other settings. Detailed descriptions were facilitated by recording the interviews.

Purposive sampling means that qualitative research seeks to maximize the range of specific information that can be obtained from and about that context, by selecting the locations information that differs from one another. The researcher decided to interview the key informants who were mothers of the children not the aunts or care givers. These mothers are the ones that can offer adequate and useful information that will give picture to the problem of child malnutrition.

Dependability shows that an inquiry provided its audience with evidence that if it were to be repeated it findings would be the same. De Vos et al (2011) indicate that dependability is the qualitative alternative to the quantitative construct of reliability, in which the research attempts to account for changing conditions in the phenomenon chosen for the study as well as changes in design created by an increasingly refined understanding of the setting. The in-depth interview guide was used as an instrument to collect the data at the same time the information were tape recorded.

Confirmability is “the degree to which the findings are the product of the focus of the inquiry and not of the biases of the researcher.” (Babbie and Mouton, 2004: 278). Detailed records were kept during the research process and the interviews were discussed fully during

research supervision. This ensured that the findings of the study can be confirmed by other person/s. The interview records and the cassettes are kept in the safe place should any need for follow up arise.

LIMITATIONS OF THE STUDY

There were several limitations to the study which must be considered when examining the results of the study. Firstly, this was a small scale study located in a particular area. It is hoped that the results will be useful to others in similar settings but generalisations must be made with caution. Secondly, the sample was restricted to mothers whose children were hospitalised and the experiences of these mothers may not be representative of all mothers of malnourished children. Thirdly, while every effort has been made to ensure accuracy in translation, some of the richness of the data may have been lost. To reduce this limitation, quotes from the interviews are provided in both Xhosa and English. Fourthly, the possibility of responder bias must be noted. The researcher is a social worker at the hospital and feels strongly about the issue of child malnutrition and is very sensitive to the plight of mothers. During the interviews, however, she tried to be objective and to focus on the research questions.

CONCLUSION

The study went well in the use of qualitative research method since the study was exploratory. The use of the in-depth interview schedule made participants to feel free on giving the best information as they can. The study was conducted ethically and every attempt was made to ensure that the study was trustworthy. The next chapter presents the results of study.

CHAPTER FOUR: FINDINGS AND DISCUSSION OF THE STUDY

INTRODUCTION

This chapter presents the findings and discusses the results in connection with the experiences and perceptions of mothers concerning child malnutrition. The researcher will comment on how the findings relate to theory and previous research. The chapter begins with an overview of the themes and sub-themes identified and the results are then presented in term so of these themes and sub- themes. The discussion is illustrated by verbatim quotations from the participants that are in IsiXhosa and each quote is followed by English translation.

OVERVIEW OF IDENTIFYING PARTICULARS, THEMES AND SUB THEMES

Table one: Themes and sub-themes

Themes	Sub-themes
Characteristics of the mothers	Identifying particulars: Age Marital status Number of children Type of accommodation Location of home Educational status Economic status
Characteristics of affected child	Identifying particulars: Age Gender Duration of admission History of admission Other health issues in the family
Mothers' understanding of the child's condition	Symptoms that led mothers to seek help Understanding of the medical diagnosis, including the causes of the illness Mothers' feelings about the child's illness
Mothers' experiences of caring for the children	Lack of family support Lack of resources
Mothers' experiences of accessing help	Primary health care Social security Use of traditional healers Community work programme Treatment oat the hospital
Mothers' expectation of service providers	Caring for the child at home Expectation of hospital services Expectations in respect of social security

CHARACTERISTICS OF THE MOTHERS

The researcher assured all the respondents that their names would not be divulged. The numbers therefore represent their identities.

Participant 1 is a house wife, married and is 33 years of age and was admitted in August 2014 with her six month baby boy. She has five children and is dependent on Child Support Grant. She stays at a 2 X 2 roomed flats and a rondavel. She resides at Nqabeni location in the Bizana district. She obtained standard 9 (Grade 11).

Participant 2 is a single woman of 23 years of age who was admitted in September 2014 with her 11 months old male child. She has two children and stays with 12 family members at home in an eight roomed house with six bedrooms at Nomlacu location. She gets the Child Support Grant and is supported by her own father. She finished standard 9 (Grade 11). One child stays with her while the child lives with the paternal family.

Participant 3 is also a single woman of 28 years of age who has four children and admitted in September 2014 with her 13 months old female baby. She resides at Mngungu location in a two roomed flat. She is dependent on a Child Support Grant of her four children and she obtained standard 5 (Grade7).

Participant 4 is a single woman of 21 years of age and was admitted in September 2014 with her 23 months baby girl. She has six children, five girls and one boy. She stays at Madadana location in a roomed flat, a one roomed flat and a rondavel. She obtained grade 8 and is dependent on the Child Support Grant for one child.

Participant 5 is a married woman of 34 years of age and was admitted in September 2014 with her 13 days male child. She has three children and is dependent on Child Support Grant (CSG) for two of the children. Her last grade at school was standard 7 (Grade 9). She stays at Mngungu location.

Participant 6 is a married woman of 40 years, who was admitted in October 2014 with her two months old baby girl. She has four children and dependent on the Child Support Grant for three of the children. She lost the identity document whilst she was pregnant and found it

difficult to register her last born. She last attended school at Sub A (Grade 1) and she resides at Nkantswini location in two rondavels.

Participant 7 is a married woman of 23 years of age, admitted in October 2014 with a seven months old baby boy. She has three children and is dependent on the Child Support Grant for all three children. She resides at Amantshangase Administrative area at Qhabangeni location. Her home is composed of 2 X 2 Roomed flats. She obtained Grade 9.

Participant 8 is a single woman of 29 years of age, admitted in October 2014 with her only child, a 15 month old female. She gets her Child Support Grant for this child. Her home is at Luthulini location and is comprised of four rondavels and a two roomed flat and she obtained standard 8 (Grade 10).

Participant 9 is a single woman of 28 years of age, admitted in September 2014 with her 13 month old boy child. She has seven children, five boys and two girls. Her home is situated at Lukholo location, and consists of a three roomed flat. She ended her schooling at standard 3 (Grade 5). She depends on the Child Support Grant for five of the children together with the Old Age Pension that her mother receives.

Participant 10 is a single woman of 24 years of age, admitted in October 2014 with her only child, a three month old baby girl. She stays at Amantshangase location and her home is composed of a rondavel and two flats with one room each. She completed grade 12.

Specific aspects of the mothers will now be discussed.

Age of the mothers

Table two: The age of the mothers

AGES	NO. OF MOTHERS
20- 24	4
25-30	3
31-40	3
TOTAL	10

The mothers who participated in the study were between the ages of 20 and 40 years. The youngest mother was 21 years of age and the oldest was 40 years of age. The average age of the participants was 28.3 years.

Marital status

Table three: Marital status of mothers

MARITAL STATUS	NO. OF MOTHERS
Single mothers	6
Married mothers	4
TOTAL	10

The table above demonstrates that there were more single women than married woman in the study. This has implications for the support available for the mothers and will be discussed further in a later section of the chapter.

Number of children per mother

The number of children per mother ranged from one to seven. The highest number of children any mother had was seven. One mother had six children and one had five children. Two mothers had four children and another two had three children. One mother has two children and two mothers had one child each. The large numbers of children that some mothers had is cause for concern as they lack the resources to care for them. The age of some of the mothers was also cause for concern. Participant 4 for example was only 21 years of age and already had four children. She was single and had had her first baby when she was 17.

Type of accommodation and location

Five of the mothers stayed in rondavels which are common in the rural areas of this district. Four were staying at in flats and only one lived in a house. The participants were from the different areas in the Bizana district: Nqabeni, Nomlacu, Mngungu, Madadana, Nkantswini, Amantshangase, and Lukholo location.

In order to understand how the location might impact on mother's abilities to care for their children and to ensure adequate nutrition, a description of each of the areas where the mothers live is now provided. Nqabeni is a rural area that is situated +/- 15 km away from a tarred road. This area only is in process concerning municipal report on housing. No RDP houses in plan concerning these other areas. These locations Nqabeni and Mngungu have

clinics available in their areas depending on the distance travelled by the participants. These areas are far away from town, they use vans as transports to town due to the condition of the roads. They are still dependent on woods to make fire when they want to cook, no fixed taps, and then use river water. Nomlacu, is allocated along the tarred road they have access in electricity and clean water taps. Madadana, is a deep rural place with bad road, most of their people use to walk a long distance to reach the clinic, transport is scarce. They get it in the morning and come to the area in the afternoon. It is difficult to assist sick people.

Madadana and Lukholo are using the same clinic although Lukholo is along the tarred road and its 20 km to town. Nkantwini, is the most disadvantaged location, where people are still using candles and wood fire for light. They are the most people that still believe in traditional medication rather than clinics or hospital. If they need any health care they travel for about +/- 35 km to seek for help and the transport is scarce. When they need to travel, they use horses and donkeys. They are also dependent on agricultural farming, large mielie fields, large cattle stock, goats and sheep. Amantshangase location, have a clinic and is along the tarred road, and they have access in electricity and clean water. Transport is available.

Mbizana Local Municipality agrees that, “Almost three quarters of the households in Mbizana (74.4%) live in traditional dwellings. About 15.1% (or 7296 households) live in a formal house on a separate stand. Informal dwellings are occupied by only 189 households (0.6%).” (IDP Review (2014-15: 119), and also added that, the signs of poverty amongst our communities are characterized by less education, low income status of each household and lack of access to employment opportunities and that is seen as serious challenge that faced the Mbizana Municipality. People at the rural areas are unemployed, but there is high birth rate counted to them than to literate ones. These children are fed with mealies and in the olden days there was a root that was used to feed the baby, that root was called “isaqoni” which was usually used by an elderly people in order to measure correctly.

The report from Mbizana Local Municipality understands that, “Most households are not yet have access to electricity; they live in rural areas by old traditional ways where woods, paraffin, gas, animal dung, coal and solar systems are used for cooking and lighting.” (IDP Review 2014/15:150)

In conclusion “MDG, consist of quantified targets to address extreme poverty in its many dimensions viz. poverty, hunger, disease, lack of adequate shelter, and exclusion whilst promoting gender equality, education, and environmental sustainability. At the same time the

goals also represent basic human rights i.e. the rights of each person on the planet to health, education, shelter, and security.” (IDP Review (2014-2015:203).

Educational status of the mothers

Table four: The educational status of the mothers

	SCHOOL GRADE COMPLETED	NO. OF MOTHERS
Secondary School	Grade 12	1
	Grade 11	2
	Grade 10	1
	Grade 9	2
	Grade 8	1
Primary School	Grade 7	1
	Grade 5	1
	Grade 1	1
TOTAL		10

Seven mothers had some high school education while three had only primary school education. None had any post school education. Only two of the mothers had completed school. Interestingly, they had a fewer number of children with Participant 2 having two children and Participant 10 having only one child. The least educated mother was also the oldest mother (Participant 6) and this might relate to the lack of educational services available in this rural area prior to 1994.

Economic status of the households

The major source of income was child support Grant to support most families; others got the support from their own fathers and from fathers of their children. Other participants were under the care of a grandmother and were dependent on the old age pension.

CHARACTERISTICS OF THE CHILDREN CONCERNED

The researcher focused on the mothers of children admitted at children’s ward because of malnutrition. These children were affected with long term diseases e.g. kwashiorkor, marasmus and other related diseases that affects them for the rest of their lives. These children were from poor families where the support systems are scarce.

Children's ages and gender

Table five: Ages and gender of the children who were in hospital

PARTICIPANT	AGE OF THE CHILD	GENDER OF THE CHILD
1	6 months	Male
2	11 months	Male
3	13 months	Female
4	23 months	Female
5	13 days	Male
6	2 months	Female
7	7 months	Male
8	15 months	Female
9	13 months	Male
10	3 months	Female

The ages of the children concerned ranged from 13 days to 23 months. There were five girls and five boys.

History of admission and duration

The procedure followed for admission was that a child begins at the Out- Patients Department or at Casualty. The child was examined by the doctor before the admission approved. Children may also be referred from their local clinics, where they have been seen and referred to the hospital for further management.

Table six: Length of admission at time of interview

Participant	Length of admission at time of interview
1	One month, also had a previous admission
2	10 days, previously admission of four months
3	One month
4	Three weeks
5	10 days
6	Two weeks

7	Two weeks
8	Two weeks
9	One month, previously admitted to hospital in Umtata
10	Two weeks

The children of the mothers who were selected to participate in the study were expected to be for at least one due to the condition of the children. They were suffering from: coughs, pneumonia, tuberculosis, malnutrition, diarrhoea, kwashiorkor , loss of enegy, vomiting and HIV. Some of the babies were already on Anti Retro Viral medication. According to Barnett and Whiteside (2002), these therapies were used when the CD4 Count falls and their immune system fails. The mother becomes the treatment supporter of her own child and required to ensure that the treatment regime is implemented correctly.

Three children had already been in hosital for one month. One child had been there for three weeks, while four had been there for two weeks. The other two children had been in hospital for 10 days, although one had previously been in hospital. This child (Participant 9's baby) had been admitted to St Patrick's Hospital and was subsequently transferred to the regional hospital in Umtata due to his serious condition. He was then transferred back to St Patrick's hospital when his condition improved. He was stunting and was the size of six months old baby rather than the 23 months of age. At the time of interviews, the mother was waiting to go back to Umtata for the second time since the condition of the child was deteriorating. St Patrick's Hospital is a district Hospital, therefore there are no specialists, that is why certain cases are transferred to the provincial hospital where doctors are available for that specific illness.

The children who were had been in hosptial for 10 days to three weeks were considered to be "long stay" and their conditions were still being evalauted and it was clear that their admission will be pro-longed. They also had the the following illnesses: underweight, jaundice, loss of weight, running stomach, kwashiorkor, vomiting, loss of energy, sugar diabetis, malnutrition, tuberculosis, HIV, low birth weight, sores and swelling of the body.

There was one child (Child of Participant 5) that was admitted at three days after birth (he had been in hospital for 10 days at the time of the interview). The problem with the child was

that he was under-weight and premature, having being born at the seventh month of pregnancy. The mother disclosed that she was HIV positive.

The other child who had been there for 10 days, admitted for four months with the same problem (Participant 2). He had previously also been admitted to Albert Luthuli Hospital, a specialist hospital in Durban for the same problem. The other children that were 2 weeks were admitted at the hospital, they were affected with different illnesses whereas others shared some similar diagnosis. It was confirmed that the children that were one month admitted were having something in common: kwashiorkor, and were mostly affected with diarrhoea and TB. The researcher discovered that HIV and TB had an effect in these children's illness; and as a result, they developed a weak immune system.

It was of concern to note that three children had repeated admissions for malnutrition. This seems to indicate that the mothers were unable to cope with the children and were unable to provide them with the sufficient nutrition. In the case of participant 2, the child had been staying with the paternal relatives but came back to the mother when the child was ill.

Other related problems

The mothers also discussed other problems that they experienced at home. Four of the participants disclosed that they were HIV positive. Participant 1 knew that her child was also HIV positive while the others were awaiting results. One participant (participant 8) lived with her grandmother and was dependent on her for care. Participant 1 also talked about the violence at home and lack of support from family member. Some of these problems are discussed further in the next section.

THE MOTHERS' UNDERSTANDING OF THE CHILD'S CONDITION

According to Payne (1997), the principle cited from Pincus and Minahan (1973) specifies that people depend on systems in their immediate social environment for a satisfaction in their lives, such as informal system, formal system and societal system. These children are from their families, communities and societies. Children may sometimes become helpless if their parents cannot be able to support with necessary or appropriate resources. Gray, Midgeley and Webb (2012) concurs with the notion when they say, "Systems theory can be useful in understanding the interactive nature of some family problems, it is also important in helping to take account of the natural history, social system, and environmental context of children's

problems in relation to their developmental stages.” If each parent comes to an understanding of her child’s condition, that becomes helpful to the health workers to help the child.

It is important for mothers to understand the condition of their children in order for them to provide the correct care that they need. The study therefore explored the mothers’ understanding of the child’s condition.

The child’s illness

Each mother had sought medical assistance when the child presented with certain symptoms. These are summarised in the table below.

Table seven: Symptoms that led the mothers to seek help and medical diagnosis of child

PARTICIPANT	SYMPTOMS THAT LED TO SEEKING HELP	MEDICAL DIAGNOSIS
1	Coughing, vomiting and had no appetite	Severe acute malnutrition
2	Loss of weight and diarrhoea	Marasmus
3	Vomiting, weak, and diarrhoea	Acute Gastro Enteritis (AGE), marasmus and HIV positive
4	Not eating well and a swollen stomach	Acute Gastro Enteritis
5	Pre-mature baby born at 7 months and was underweight	Failure to Thrive
6	Vomiting and diarrhoea	Underweight for age (wasting)
7	Loss of energy	Severe acute malnutrition
8	Loss of weight and sores all over the body	Severe acute malnutrition
9	Unspecified illness	Severe Acute Malnutrition, Lower Respiratory Tract infection and Pulmonary Tuberculosis (PTB).
10	Diarrhoea, coughs and swelling of the body.	Severe acute malnutrition

The mothers all knew that something was wrong with their children and thus brought them either to the primary health care facility or the hospital. Five of the children had diarrhoea and/or vomiting which were obvious symptoms of something wrong. In several cases, the

mothers also recognised that their babies were not eating well, had lost weight and were lethargic. None of them however at the time attributed the children's illness to malnutrition.

It was also interesting that Participant 9 was unable to specify what was wrong with her baby and said she brought him to the hospital because of her own illness as she was HIV positive. This baby was very ill and had previously been admitted to hospital. She may have been embarrassed to admit that the baby was very ill and she may have believed she should have brought him in earlier. It would appear that many of the parents delay coming to the hospital or a clinic in order to get immediate help when they notice strange things in their children.

One mother explained how her child became ill. She said:

“Ndakhe ndamncancisa... ndanikezwa i *nevarophine*... ndaqukwa kukugula ndamyekisa umntwana, ndamnika ubisi i ‘infacare’.”

“I once breastfed the baby... and given nevaropine... suddenly I got ill and I stopped breast-feeding, and given her an infacare formula.” Interview, (participant 10, 10/10/2014).

The participant was concerned about her own health and believed that she could no longer breastfeed. Clearly, she was not given sufficient advice on breast-feeding when she was given the medication for the HIV infection. She also may not have felt comfortable to ask for advice. It is important that “when the clients seek the service, workers provide a welcoming, courteous, support environment and encourage clients in their problems,” (Payne, 1997). The participant was in need of the support from the clinic or hospital staff in order to make a good decision. There are formulas that are good for babies and there are those that are sold for the profit.

Emanating from the discussion above, the mother stopped breast-feeding and the child was eventually admitted to the hospital. Some literature elaborates on breast-feeding, looking at the advantages of taking breast-feeding rather than formula. In the study by Saloojee et al, (2007) findings revealed that, “If breast-feeding is being stopped before 12 months or shortly after birth, had a strong risk factor of severe malnutrition and stopping breast-feeding can open an opportunity for a mother to get pregnant living the present child ill, living or dying.” Therefore, breast-feeding is suggested as a strong preventative measure of that support protecting children from severe risks of malnutrition. Furthermore, it is stated, “A limited

number of studies have also shown long-term benefits of breast-feeding on the development of the child.” (Kramer et al 2008). The child who got breast milk survives more than the one with no breast-feeding. Whereas Yousafzai et al (2013) added that, “Further studies are needed in investigating on how to get longer term consequences on development and as well as on the academic performance on children of low birth weight.” This means the mothers need to take breast-feeding into consideration to help their baby’s further development.

During the interviews the mothers were asked if they understood what was wrong with their children. Eight participants understood what was wrong to their children. They identified that improper feeding played a big role in their illness. They also explained that lack of education lead to a lack of understanding on how to prepare feeds. The poor socio-economic status of each household also played a role in them not being able to prepare proper food. Most of the mothers were dependent on the child support grant. In addition, Participant 5 understood that because her baby was premature, he had additional problems. She thought that the fact that she was HIV positive had contributed to this situation.

Participant 3 explanation sums this up. She explained what she knows about her child that:

“Kuthiwe umntwana akondlekanga futhi andimniki ngendlela ukutya.”

“They said the child is malnourished and is not well fed.” Interview, (Participant 3, 08/10/2014).

Participant1 gave the following explanation. She said,

“Inoba into eye yamgulisa kukuba xa ndixabana notate wakhe bendidikwa ndibone ndisela ibhotile nokuba zimbini ndilale phandle, kunokuba zizinto aphume nazo ngaphakathi njengokuba kuthiwa akufuneki umntu alusebenzise xa ekhulelwe.”

“I think what made the child become sick is that, when we were quarrelling with her father I became sick and tired, and decided to take 2 bottles and sleep outside, may be these illnesses came out with them from my womb as we are though not to take alcohol when pregnant.”

However, some participants did not understand. Participant 2 for example, said she was unaware of why her child was admitted. She claimed that no explanation had been given to her during the admission or subsequently. She said,

“Andichazelwanga nto, qha ndixelelwe ukuba umntwana uyalaliswa.”

“Nothing was explained, I was told that the child is get admitted.”

Participant 6 expressed her opinion and said,

“Bendicinga ukuba ndiyamondla kanti ukudla ndikwenza manzi.....ndicinga nokuba uneplate (inyoni), ndamcima ndambona ukuba uyohlulakala.”

“I thought I correctly fed my child without knowing that the feeds were weak...and also thinking that the child was attacked with traditional illnesses “plate/nyoni,” I used anenema (traditional medicine) but he became weak.”

This mother had thought she was doing the right things and would not have brought her child to hospital if he had not become weak. This demonstrates how a lack of knowledge about the correct way to prepare food can have serious implications.

Feelings of the mothers

The mothers expressed a range of feelings towards the illness of their children. Every parent plans best for her children and no parent becomes happy if her child is ill. Payne, (1997) explained that often people may feel that the world is unresponsive to their needs if they have gone through many negative life experiences. This seemed to be the case in this study and Participant 9 summed up the feelings of many mothers when she said:

“Ndiziva ndingammandanga intliziyo ibuhlungu... Kuba umntwana egula (kusihla ilizwi) ... ndithanda onwabe njengabanye.”

“I do not feel right and my heart is painful.... because my child is ill (lowering the voice)... I like my child to be happy like others.” Interview, participant 9 (09/10/2014)

Participant 1 had problems in adjusting to the child’s illness and hospitalization. She absconded from the hospital and left the child for three days. She had heard rumours that her husband was spending the household money on other women and she left to sort this out. She was concerned about her other children who had been left at home and who had nothing to eat. She began to quarrel with her husband and came back with scars. She returned to the hospital being under the influence of liquor. She explained her actions as follows:

“....umyeni ubengenamava kwaleloyokuba uyagulelwa ngumntwana, ukuze ndidendizoshiya umntwana apha esibhedlela ndilandela yena engasezi (elila), ndisiva

kuthiwa uhleli namadikazi udla imali..... ndamshiya intsuku ezintathu umntwana, kwafoanelwa udadewethu ukuba azekumgcina.”

“.....my husband was not having any feeling that his child is ill, it is when that I left the child at the hospital following him and was no available at all (crying), hearing the rumours that he is busy wasting the money with other women.....I left for about three days and the health workers phoned my sister to take care of the child.”

Therefore at the end of the day the hospital is not accountable of the parent who refuses hospital treatment except she absconded. The procedure for the client who absconds followed by the social worker for the sake of the child, although any client/patient who absconded; the case is taken into consideration with immediate effect. Most adults will stress that they are not coming back and they are supposed to sign the RHT (Refusal to Hospital Treatment), but for child it is a different case, the mother is supposed to come back with the child.

Other parents had their own stresses and experiences that were affecting them directly. One mother said:

“Ndandiness stress ngomntwana wam ogulayo... washeshiswa wafakwa izinto... ndalala sele noko e right.”

“I was stressed about my child who was ill... they quickly attended her... I slept well knowing that my child was in good hands.” Interview, participant 3 (05/09/2014)

Parents become stressed when thinking of their children’s lives, they easily appreciate and the same applies when the things are not going well. Participant 4 supported by saying she was affected emotionally with deep thoughts, stressful, and staying at the hospital for a long time. She also said:

“Kukungarholi komntwana, ndingazi ukuba ndizozithenga ngantoni izinto zomntwana.”

“My child is not getting a grant; I wonder how I can buy anything for the child.” Interview, participant 4 (08/10/2014)

Participant 8 despaired about the child’s illness and explained how she suffered both physically and spiritually. She said:

“Iye ingqondo yam yangathi imile... nasemzimbeni ndiziva ndilula... emoyeni ndikhathazekile.”

“My mind seems to be blocked... my physical body becomes light...and spiritually I am devastated.” Interview, participant 9 (09/10/2014)

Painful feelings were also expressed by Participant 10 who said:

“Kukuba wikhi komntwana wam... ndimcingela ukuba angachaphazeleka sisifo sam... ndingabuhlungu kakhulu xa engachaphazeleka.”

“It’s because of my child’s weakness... I am afraid that my child can get infected as I am... It will be very painful to me if that can happen to her.” Interview, participant 10 (04/11/2014)

Another participant expressed her distress towards how she feels about her child and said:

“Kubuhlungu ukugulelwa ngumntwana ube ungamazi ukuba uzophila nini.”

“It’s painful to have a sick child without knowing when the child will recover.” Interview, (participant 4, 08/10/2014)

These expressions of distress and pain illustrate how the children’s condition had a negative impact on the mother’s emotional well-being. This participant showed the lack of hope and emotional brokenness. Furthermore the need for close monitoring and counselling for the mother became evident. Educational therapy and group sessions of the parents that share the same problem may be a way of addressing this. Zastrow (2003) suggest that clients who are in a depressed state may become very quiet. They need to develop trust in the helper so that they can share their feelings.

Staying in hospital was also experienced as difficult for some mothers. One of the participants stated:

“Ukungabikho ekhaya..., nalento yokuba umntwana engaphilanga...bendingenathemba.”

“To be far away from home... and that the child is ill... I was hopeless.” Interview, (participant 8, 09/10/2014)

Having an ill child requires the mother to stay at the hospital looking after her ill child day and night, which is traumatic to the mother because of the child’s condition.

The participant expressed her feeling:

“Bendibuhlungu kuba bendingazi ukuba ndizomthini... ndingenamali.”

“I was so agonized, not knowing what to do with my child... without money.”
Interview, (participant 3, 08/10/2014).

According to micro-systems theory, the healthy personality of the child influenced by the caring relations occurs between the child and her/his parent. The above participant got her first born when she was 17 years of age and had 4 children at the age of 28 years. She was not employed, less educated and raising her children as a single parent. The mother displayed frustration and confusion with the present situation. The high the number of children determines the number of problems per child that cannot be solved with the R320 Child Support Grant of one child. The house alone has its own demand like maintenance and others. Each child needs education from 3 years after demanding a lot from feeds and doctor fees if he or she is ill and for a mother to travel to the clinic every month for child's immunisation. The CSG is not a salary but a support from the government that needs to be used as catered for.

The participant expresses her experience about how she feels when staying at the hospital for a long time:

“Ndingalali sisi... nezinto obokufanele ndiyazenza... kunzima (ngomoya ophantsi).”

“I spent sleepless night's sister... and thinking about other things that I was supposed to do...it's difficult (very depressed).” Interview, participant 2 (08/10/2014)

To address the stresses experienced by the mothers, services such as group work and support groups that engage mothers and enable them to share their problems are provided by the social worker. These activities equip mothers with skills that enhance them for future. These groups also provide them with an opportunity to open up about other problems they may be experiencing. The social worker provides counselling immediately after the case is identified. Aboud and Akhter (2011), states that in supporting the mothers, they should be encouraged to feed and play with their babies. This can play an important role in proving security for the child and helping the child to recover.

The parents at the children's ward had not been provided with any beds or mattresses for their comfort because they were taking care of their children day and night. The hospital recommends that each mother must sleep closer to her child using her own blankets. They

came to hospital being fine but at their discharge they had aching bodies and others became ill due to sleepless nights. There are times whereby a mother becomes ill and leaves the child at the ward after being admitted. The new arrangements are done for the child's care, a relative will come to take care of the ill child and to do frequent visits to the mother at the ward in order to update her about the condition of the child.

Self-blame was evident among the participants. For example, Participant 1 blamed herself. She explained that her child was affected with pneumonia because she got drunk and slept outside with the child some nights. She said she used to get drunk because she was jealous that her husband because of jealousy, her child was affected with pneumonia, coughs, TB and malnutrition. Therefore this participant was continuously blaming herself and that was condemning her in supporting her child she even absconded at the hospital for 3 days. In addition to this, participants 3 and 8 blamed themselves for the fact that they were unable to give their children proper milk. Participant 6 was embarrassed at not being able to feed her child correctly as she had fed her plain porridge.

The mother always thinks about her child day and night, the focus and blame is within her. People, who are from disadvantaged families, always blame themselves also undermining or under-estimating themselves concerning the problem they are faced with and according to Zastrow (2003), mothers will often grieve and feel sad for what they have had to give up or for what they do not have.

The poor households had an effect to the children's development, children as they grow are unable to identify their effort in whatever they are doing e.g. if the child knows the answer in the class, it will be difficult for the child to raise the hand and give the correct answer; the child will be punished but may be appreciated when she performs writing then comes with the correct answer. These children are always under-estimating themselves because of their background. However, as Zastrow (2003) also point out, people who have been victimised can be seen as active and developing individuals who, despite their poor circumstances, can learn skills and develop personal attributes that help them cope with future struggles. It is therefore important that we intervene to assist children who are malnourished and their mothers.

Gray et al (2012) also agree that “Parenting education or training programmes seem to be a response to a demand for a variety of support like information, child development knowledge and skills development in managing children with diverse physical and psychological abilities.” Whereas on the other side this mother agrees that she was abusing alcohol and she needs thorough education. Ambrosino et al (2008:54) explain, “Many abusers of alcohol/substance abuse deny the fact that alcoholism and abuse has an effect in their families.”

THE MOTHERS’ EXPERIENCES OF CARING FOR THEIR CHILDREN

In this section, the mothers’ experiences of caring for their children will be discussed. The aspects that are highlighted are the lack of family support and the lack of resources they experienced. These aspects had implications for their inability to care adequately for their children.

Lack of family support

It appeared that all mothers lacked family support to care for the children. When a person lacks support, there are many things that affect her/him in life, Ambrosino et al (2012: 55) mention the fact that micro-system looks at “individual level of functioning, intellectual and emotional capacity.” This means that at the end of the day there should be some intervention strategy in place. Engle (2009) expatiated that there are intervention strategies that can improve the child’s growth and development that could win their mother’s social and emotional well-being.

One participant had grown up in child headed house-hold and she explained that:

“Phaya ekhaya asinabazali...akululanga ukuba oobhuti basinike imali ngokwaneleyo kuba sebenamakhosikazi.”

“At home there are no parents...it is not easy for our brothers to give us enough money since they are already married.” Interview, participant 10 (04/11/2014)

This mother was still depending on others although she was having her own child. While some young people get educated and reach higher education, it is difficult for others to further their studies due to poor socio-economic status. This young mother had lost her parents, and then became a parent herself. She had no parental support and her siblings were unable to provide sufficient support as they were themselves married and had responsibilities.

According to Richardson and Ritchie, (1989) it is highlighted that, “Ecological systems theory emphasizes that, relatives especially husbands are trusted to take care of their children and social support to come from family and friends.” Everyone when faced with difficult situations expect people next to them to provide support.

One participant (1) felt bad about her child who is different from the children of his age (stunting). Her family was informed about the child’s illness, but only her eldest son and the in-laws that visited them at the hospital. The father of the child had only visited a few times. This was the father who was rumoured to be having affairs and he seemed not be concerned about his wife and child. Saloojee et al (2007) explains that, “Many cohabited with their spouses but never married because of their inability to pay a ‘lobola’ or dowry to the women’s family.” The four who said they were married were in traditional partnerships and were not legally married.

None of the mothers received financial support from the fathers of the children. However, Participant 2 received some support from her own father who helped her care for the child. Also Participant 9 received support from her mother-in-law who received an old age pension.

At an interview, it was rare for a participant to mention anything about her husband/ partner except for a few and the one that presented her husband as a perpetrator of abuse. She accused her husband of being in multi-relationships that led him not to take care of his family. An issue for the single parents who were being supported by the paternal families might be that the child finds it difficult to relate to the mother and the maternal family. This might cause further distress in the future. These parents can identify a list of everything happening to them and the difficulties they encounter in life and they always sound as if they are ‘giving up’ in whatever they do.

There were other participants who had some terrible feelings about their relatives and future plans.

One participant expressed her feelings about her admission and said:

“Andiva kakuhle cause kulonyaka uphelileyo i 2 *months*...ngoDisemba... ndayeka esikolweni wangena esibhedlela... nakulonyaka andifundi (elila).”

“I am not feeling well because last year about 2 months... in December... I never went to school because the child was admitted.....even this year I am not schooling.” (Crying). Interview, participant 2 (08/10/2014)

This mother sounded as if she felt isolated without anyone to relieve her and take care of the child on behalf her education. Other participants also had problems. The first participant was a married mother but with a pain of not getting the joint support from her husband, and the second one was a single mother who got pregnant and never finished schooling. She hoped that she would be able to finish school during the year 2013 but unfortunately her child had been coming and going out of the hospitals for about a year. Her relatives were present at the time of admission to the hospital with the hope that there will a person to relieve her and take care of the child mean while she attends school, but as the time went on she felt distressed, thinking about what her future would be if she didn't finish schooling. At the same time, she had no-one to help her with the child so she felt hopeless and helpless.

According to Coovadia and Wittenberg (2009), “Growth and development are products of constitutional and hereditary factors on the one hand, and the environment, experience, and circumstances to which the individual is exposed on the other.” Not only does the malnutrition affect the child, but also the mother and in turn the mother's attitude and feelings towards the child will affect how the child grows up. If the mother is bitter because she couldn't finish school because of the child's illness, it may be that the relationship between her and the child will not a strong and this will impact on the child,

Some family members were present at the time of admission and others were telephonically informed. Despite this, many of them did not come to visit to give support to the mother and the child. Other participants did not feel good, had lost self-esteem and hope, since they were not comfortable to stay for a long time at the hospital and felt very bad and stressed. Most families were informed whilst they were visiting the clinic before admission; and at the admission they were also informed about the children's condition. There were some mothers that were not visited at all, but some did receive occasional visits. One participant narrated how she felt when she received her first visitor after she had been in hospital for 10 days. She also expressed sadness and worry about being far away from home. The combination of these factors, in that she was worried about her sick child, led her to feel depressed and anxious.

One participant was worried about the impact of caring for a child had on the rest of the family. She said:

“Ndaziva ndingekho *right* ngokuba eyamathina imali bendingenayo... imali kagogo ayonelanga kuba sibaninzi ekhaya.”

“I did not feel right because the money to buy tins (formula) was not available... my grandmother’s grant is not enough because we are many at home.” Interview, participant 8 (09/10/2014)

Each person needs love, respect and being treated with dignity because she is unique. The whole family knew about the child’s condition and the mother who stays at the hospital but having no one to support her. The most family members were depending on the child support grant for their survival.

Lack of resources

Each house-hold has its basic needs in order to survive. These resources may include finances, housing, clothing and as well as food supplements. Gitterman and Germain (2008:51) states that, “the profession of social work has consistently been concerned with helping people and promoting responsive environments that support human growth, health, and satisfaction in social functioning.” Above all the main resource is always money that plays as a stepping stone in every success. In this research study, it became evident that many of the mothers came from households that were unable to provide resources to meet the basic needs of family members.

Saloojee et al (2007:104) explained that, “Poor households and individuals are unable to achieve food security, have inadequate resources for care, and are less able to avail themselves of modern health service (sometimes using traditional healers instead).” The finding reveals that the participants were from poor households and were affected economically. All the mothers were from poor households and all the mothers were getting a child support grant that was R320 per child and they get the support for some of their children.

Participant 6 said that due to poor socio-economic status she tried to economise when preparing the food for the child, and that affected her baby’s health. Whereas another

participant explained that, due to poor socio-economic status, she was feeding her child with a plain porridge and she was also aware why the child was malnourished.

Participant 9 said that the child was diagnosed with TB, his stomach was pumped, blood, faeces and sputum taken to the laboratory. VCT (voluntary counselling and testing) done to the mother and she knew that she was HIV positive and the mother knew the status of the child. Poor socio-economic status was the main problem in her family. On top of that she added by saying:

“Akukho mntu osebenzayo... sihlala endlwini enye... sibaninzi.”

“There is no one working...we are staying in one room...and we are many.”

Interview, participant 9 (09/10/2014)

There were also other mothers that were not feeling good, who were getting support from the elderly persons together with their siblings. Some mothers were thinking about their children that were left alone without any person to support them.

One mother said:

“Le mali ayikho... akukho mntu ondincedisayo, ndicinga ukuba balambile.”

“This money is not enough.....there is no one helping me, and I think they are hungry by now.” Interview, participant 6 (09/10/2014)

The researcher could hear how the mother was expressing herself; the expression comes out of a sorrowful person who feels the burden of raising her children depending on the Child Support Grant. This mother stays at two rondavels and that means there is no source of income except the Child Support Grant of three children, the present one has no birth certificate and the delays are at Home Affairs. The mother lost an Identity document and is still waiting for the new one; therefore the child has no birth certificate because of that. She also revealed that she gave birth late (40 years of age) and she was unable to measure the formula for her child.

Another one added and said:

“If ndingafumana imali okanye umsebenzi, okanye intliziyo yam ingayeka ukuba buhlungu.” *“If I can get money or job, maybe my heart can be healed.” Interview, participant 7 (09/10/2014)*

Another participant explained how she feels about her child:

“Ndicinga ukuba umntwana uguliswa kukungondleki... imali endiyifumanayo incinane notate wakhe akasebenzi.”

“I think my child is ill because of malnutrition... the money I get is not enough and the father of the child is not working.” Interview, (participant 7, 5/10/2014).

The above extract can specify how stressed the mother of the child is, looking at the condition of the child. Ambrosino et al (2008:169) highlight that, “Poverty and dependency are linked in the public mind.” The participant lacked the self-esteem and hope due to the situation of the child she presented. According to ecosystems theory, aimed to help people perform life tasks, as this participant admits that the child is malnourished; alleviate distress, find means of how to get money in order to support her children and this can lead the parent to achieve aims and value positions with the help of the Social worker. “Social worker’s main concern is to look at the relationships of ‘private troubles’ to public issues” (Payne, 1997). Moreover, in this case the Social Worker after the interviews, arranged some sessions with the participant to attend closely to the problem concerned.

Gray et al (2012) illustrate that, “Children for whom parent education is unlikely to be a sufficient response to child-management difficulties are those which feature maternal depression, socio-economic disadvantage, and social isolation of the mother.” The main factor for malnutrition is the poor socio-economic status, which is the umbrella as well as education of the mothers and it has had an effect. Moreover Gray et al (2012) highlight that, “Parenting education or training programmes seem to be a response to demand for variety of support, including information, child development knowledge, and skills development in managing children of all ages with diverse physical and psychological ability.” If the parents are not educated they experience difficulties in terms of job seeking, performance when employed, support their families and that result to family violence.

The finding revealed that most participants are unemployed and the level of education is too low. Parents are affected with HIV and AIDS, as well as other related problems. Other mothers were from child-headed families and most of them were dependent on Child Support Grant. In these circumstances, the possibility of the mothers gaining meaningful employment are low and social security becomes an important factor in enabling these families to survive.

MOTHERS' EXPERIENCES OF ACCESSING HELP

This sub-section seeks to understand the mothers' experiences of accessing help. Their experiences of the primary health care and social security systems, the role of traditional healers, and their treatment at the hospital are discussed.

Primary health system

During the interviews, the mothers were asked if they attended their local clinics and whether their children were up to date with their immunizations. Six of the mothers had attended the clinic regularly and this was confirmed by the children's files. The cards showed that the children had been losing weight and that growth monitoring had taken place. However, in order to clarify matters, the sister in charge of the ward explained that despite the mother taking the child to the clinic, the clinic card showed that the clinic had not attended to the mother and provided advice. The sister was of the opinion that this was a failure on the part of the clinic to pick up problems and make appropriate early interventions.

In the other four children, the clinic cards were not up to date. The reasons for this appeared to be varied. Participant 1 was abusing alcohol and had two children within 18 months. Her personal problems led her to neglect to take the child to the clinic. The participant explained the gaps in the immunization card and said that, at the health centre she was told that if the child is sick cannot come for immunisation. It is of concern that the mother did not attend the clinic with the sick child to get advice on how to deal with the child. Instead, she remained at home, the child became more ill and only then did the mother bring the child for medical attention. This child had been admitted to a hospital in Durban. Participant 4 said that as she was still attending school, the child was with paternal grandparents. She did not know why they had not taken him to the clinic. Participant 6 claimed to believe mostly in the tradition medications and had less understanding of monitoring the immunisation dates. In addition, the clinic is far from her home and not very accessible.

Social security

The mothers had all been successful in obtaining child support grants from the South African Social Security Agency. In eight cases, the child support grant was the only income for the

whole household. The mothers complained that the amount of the child support grant was insufficient for the whole family. In addition, there seemed to be problems with the mothers getting the full grant. Money for air time was being deducted from the grant. This is a problem generally in Bizana and SASSA is attending to it as it seems to be a fraudulent activity on the part of the company deducting the air time without the consent of the recipients.

There were also some complaints about the money received and how the increment is done, they complained about the additional amount that is added per year by the government. The CSG supported mostly the big families, in feeding, clothing and education. One participant said:

“Makunyuselwe imali ye *grant*...kubhaliswe izomiso... ndifuna ukugqibezela izifundo zam.”

“May the Child Support Grant increase... provision of food parcels...? I want to finish up my studies.” Interview, participant 8 (09/10/2014)

The Department of Home Affairs and SASSA have faced many difficulties after discovering that many people were fraudulently receiving grants. There is now a link between the hospital and two said departments before a child can get a birth certificate. There are also offices of home affairs at the hospital to fast track the problem of birth certificates. However, if mothers have no identity documents at their delivery they are unable to obtain birth certificates for their children.

One participant explained:

“Xa ufuna I- *birth certificate* yomntwana abakwazi ukukwenzela bazofuna incwadi ye *councillor* yayendise lapha esibhedlele... kuba ndazala ixesha lingekoneli.”

“If you need the birth certificate of the child, it is difficult because they will need the councillor’s letter whereas I am still at the hospital... it’s because I gave birth early.”

Interview, participant 5 (08/10/2014)

This statement relates to the problems that others who gave birth home had in receiving services from Home Affairs. Because of the problem “Amakati” (false children), they ask for proof which includes the councillor’s letter. Therefore before issuing any document by Home Affairs they do some investigations and these delays the application for the child support

grant. These problems all contribute to the lack of resources to care for the child and in this case they child became malnourished and was admitted.

Use of traditional healers

In addition to that, the mother was suspecting traditional illness called “inyoni” and used the traditional medication to the child before bringing her to the hospital. The mother of the child explained immediately arriving at the hospital that, at home she used traditional medication in order to get help. This did not help the mother and the child too; the medication was drained from her stomach.

Community work programme

In order for the mothers to expand their knowledge, around Bizana there are Community Worker’s Programme (CWP) that are called ‘oonomakhaya’, they visit people that have a burden at their homes. If they can involve themselves in the above program or involve these community worker in their homes and can gain a lot. According to Swick (2004), “The family is the child’s early micro-system for learning how to live.” The child develops depending on how the mother perceives about her child. If the mother has positive views about her child during conception, through those perceptions the mother can fight by all means to defend her child.

They work hand in hand with Agriculture and clinics to view the needs of the people in the community. In some homes they plot the vegetable garden and provide seeds and plants at a well fenced garden sponsored by Lima, they help work in groups according to their communities in feeding the ill persons, fetch and administer medication and wash the patient and belongings where there is no man-power. They also used to do the follow ups to the homes where they implemented vegetable garden, but unfortunately at the following year, the same gardens will have no one to take care of; meaning that government services are drained down by the community.

None of the mothers in this study had had contact with the community work programme. This seems to indicate that the clinics were not referring the mothers appropriately but also that the mothers had not taken the responsibility to seek help for themselves.

Treatment at the hospital

Most children got the treatment as individuals and treated with dignity. Babies were well fed and given medication as per requested by the Doctor. Tests were done accordingly and the results were read for each mother whose child got tested. Injections and drip were administered to children who were in need of. In fact most children that suffer from malnutrition are in need of drip since they become dehydrated.

Those that were affected by diarrhoea were treated and as a result, the mothers commended the hospital for the good progress. The milk for the babies was administered timeously. One parent said that:

“Umntwana wam ndafika naye kunzima ngale mini ndandifika ngayo... akasafani nangokuya ndandifikanaye.”

“When I arrived at the hospital, my child was very ill....but now my child is better than the day we arrived.” Interview, participant 9 (09/10/2014)

This ensures that mothers get satisfied towards the services rendered to their children, and even their cooperation played a crucial role in the process of healing. They displayed positive attitudes towards the health worker and that made them easy to assist positively.

They were also receiving help from the dietician as evidenced on the following quote:

Participant 10 said, ‘I-dietician ifikile yabuza abantwana ukuba badla ntoni? Yacacisa ukuba I Nana yikho apha esibhedlele...’

“The dietician came and asked what formula do the children use? She explained that; the Nan/ Perlagon is unavailable at the hospital.” interview, participant 10 (04/11/2014).

The mothers were satisfied about the care the children were receiving. However they found it difficult to stay at the hospital. For example they do not have a bed but sleep on a chair next to the child’s cot and they have to provide their own blankets. Also because they children are ill and restless, it means that the mothers often do not have a good night’s sleep. They also found it difficult to adapt to the hospital environment and the hospital routine, as well as having to deal with different staff and different people in the ward.

EXPECTATIONS OF SERVICE PROVIDERS

The mothers all had some ideas about what they expected in the future in terms of caring for their children.

Caring for the child at home

It is vital for the mother to be able to cope at home with the child in order to prevent a recurrence of the malnutrition. Mothers were therefore asked about their plans for caring for the children once they left hospital. The mothers appear to have benefitted from the education they were receiving from the nurses. They all said they would make sure to do the following when they got home. Each time the mother will wash hands before preparing the child's feeds and after changing the nappies. They understood how to sterilize the feeding cup or a bottle. One mother decided to change from the feeding bottle and use the feeding cups, since it is easier to wash. They understood that they must make sure to prepare food properly according to the instructions on the tin of food. They also realised how it important it was to administer medication correctly and to ensure that the children were immunised according to the schedule on the clinic cards.

“Exhausted parents are less able to provide the stimulation, nurturance and care that their babies need.” (Steyn, Labadarios, Maunder, Nel and Lombard, 2005). Steyn et al (2005) also reported that “Undernourished children who are in long term may contribute to maternal depression since mothers experience increased feelings of guilt and incompetence.” It is really important therefore to address these issues when the mothers are in hospital. For these mothers, being in hospital seemed to help them gain some degree of confidence and self-esteem and they were encouraged in taking care of their children carefully.

One mother said, “Ndifuna ukumnika amayeza... nokutya kangangoko ndinako... ndingomise kungabikho mgomo azoweqa.”

“I want to give my child medication... and give my child food as much as I can... and I will make sure that my child gets the immunisation properly.” Interview, participant 10 (04/11/2014)

Expectations of service providers

Ecological systems theory suggests that there is “goodness of fit” when the environment provides sufficient support and resources for the individual to meet their needs. Gray et al

(2012) explained that “Ecological theory helps social workers to understand the way in which all of the different elements of people’s lives, at individual, family, neighbourhood, and society levels of influence, interact together to shape their behaviour and circumstances.” Understanding what the needs of the mothers are and what they want will help organisations to provide appropriate help. Lounsbury and Mitchell (2009) point out that a “holistic organising framework helps the social worker and other health workers like dieticians and welfare practitioners to see what is and is not within the scope of individuals, families, or communities to control, pointing the way towards what are likely to be the most appropriate and effective forms of interventions.”

It was clear from the responses of the mothers that their needs were not being met. In the interviews, they were asked about what would help they would like to ensure that they could cope better in the future.

All of the participants were expecting a lot from the St Patricks staff and from other stake holders outside the Hospital, such as government departments and even from Non-profit organisations. The case of this participant was taken into consideration immediately after interviews, individual and family counselling done.

One participant delivered her message by saying:

“Ndithanda abasebenzi bezempilo bandincedise ngomntwana, ngokuba ngokundiyohlulakala... I mean bathathe lo umncinci bamnike indodakazi yam iyohlala naye ndiyinike nemali yomrholo...batsho ukuba ndiyibize indokazi kuba ndiyohlulakala (elila).”

“I would like the hospital workers to help me with my baby, I am over loaded... I mean, they must take the admitted child and place him under my sister-in-law’s custody and I will release the child support grant... they must give me mandate to call my sister-in-law because of the overload.” Interview, participant 1 (05/09/2014)

The mother of the child finally requested that the child must be taken from her care and that she be released to support her one year old child who was at home. Since the researcher was also the hospital social worker, she followed up this request. She called a family meeting to discuss the case. The in-laws were present and the maternal relatives attended the case. The decision was taken by the mother of the child and she selected the person from the paternal

family to care for the baby. Everybody who was there was satisfied with the decision. The child was then left with the sister-in-law who was the sister to the father of the child. The mother was relieved as she had not been coping. She was the one who had been abusing alcohol and had also absconded from the hospital. The solution to place the child with a family member was considered to be in the best interests of both the child concerned as well as the mother.

Most participants also requested the provision of the child's food because the money they received from the child support grant was not enough. Some also said that the family as a whole needed food parcels and some wanted to get support with their education and completing school.

One participant also said:

“Ndifuna bandincede ngalendlela babonangayo umntwana wam xa egula. Bandincede ngento ababona ukuba bangandinceda ngayo ezomenza abe *right*.”

“I want the workers to assist, the way they can to help my child... and they must help with whatever that will make my child right.” Interview, participant 3 (08/10/2014)

Although the statement is quite vague, the above participant opened her heart to the health staff to do whatever they could to help the child. Many of the mothers used a common word and that was the word “help”. Gill et al, (2000) cited in Berk (2001) demonstrates by saying, “Social support can be provided by a wide range of different people, including relatives, partners, neighbours, work colleagues and lay and professional helpers.”

Other participants wanted to be sure about their children's HIV status. They were concerned about how they would deal with their own situation as well as their child and asked for help with this.

Sorting out identity documents and dealing with problems related to the deductions that were being made to the child support grant were also issues that they wanted to be addressed. One participant said:

“Xa bengandinceda nge ID ndikwazi ukukhawuleza ndiyifumane... imali ye grant ingapheli... ithathelwa i airtime ubewena ungazange wathenga airtime.”

“If the workers can assist in fast-tracking my Identity Document... Child Support Grant not terminated... an airtime deducted without your consent eliminated.”
Interview, participant 7 (09/10/2014)

CONCLUSION

This chapter attempted to analyse the data. The researcher wanted to explore the perceptions and experiences of mothers of children admitted at a Children’s ward, St Patricks. Their perceptions and experiences have been explored. Most mothers had experienced stress as well as depression, low self-esteem, isolation and trauma. The mothers’ understanding of child malnutrition has been explored and their expectations in terms of the help and services they require have been addressed.

The educational status of the mothers had great impact on the problem of child malnutrition. Their knowledge of nutrition was poor. Eight mothers were unable to prepare meals for their babies and one from the said number was unable to see that her baby cannot be fed with the same porridge that used to be consumed by everyone in the family.

The trend of young single mothers with many children was of concern. It would appear that these mothers are unable to cope but are also not making use of family planning services. This indicates that there was a mismanagement of anti-natal care during pregnancy and the walking distances to clinics can contribute to poor attendance.

All the participants had stressful situation in their lives at time of taking care of their babies. They explained their feelings about the situation and expressed themselves that they lack self-esteem, stress, sleepless nights, and poor socio-economic status, lack of support from the loved ones, painful hearts, very depressed, and despair.

CHAPTER FIVE: CONCLUSION AND RECOMMENDATIONS

INTRODUCTION

This study was conducted with the aim of exploring the perceptions and experiences of mothers whose children with malnutrition were admitted to a public hospital in the rural district of Bizana in the Eastern Cape. The data was collected through in-depth interviews with ten participants who were all mothers of children admitted for long stay at the hospital. The face-to-face interviews were conducted and the interviews were captured with the tape recorder.

This chapter provides an overview of the study conclusions and recommendations. It begins with a summary of the findings and these are based on the objectives of the study which were to explore the mothers' understanding of child malnutrition; to explore their experiences in accessing resources and interventions in fighting child malnutrition; and to explore their expectations about the role that medical, social and economic structures should play in addressing their challenges.

SUMMARY OF THE MAIN FINDINGS

Summary of findings in relation to the objectives

The study had three main objectives which were:

1. To explore the mothers' understanding of child malnutrition: The findings revealed that once the mothers were in hospital they understood that poor feeding practices led to their children being malnourished. This in turn was affected by their poor socio economic status = the mothers were all in receipt of social security which was often the only source of income for the family. However, it was of concern to note that none of the mothers identified malnutrition as a problem when their children first presented with medical problems.
2. To explore their experiences in accessing resources and interventions in fighting child malnutrition: The findings revealed that while the mothers had been successful in accessing the child support grant, they experienced problems caused by unavailability of Identity documents and birth certificates. This delayed the process of getting the child support grant.

Problems arise when mothers do not attend anti-natal care and have home deliveries, in addition, the fraudulent actions of some parents also affected many mothers as additional controls have had to be put into place thus further delaying the application process. Some of the mothers had long standing problems with birth certificates with one child having the wrong sex on its birth certificate. As far as possible, these problems were resolved while the mother was in hospital. This reduced the mothers travelling costs resulting in them being satisfied by the help they had received.

3. To explore their expectations about the role that medical, social and economic structures should play in addressing their challenges: The findings revealed that the mothers had expectation in the following categories:

Medical sphere

The mothers' expectations were addressed and it was clear that the medical practitioners and nurses played a big role in helping malnourished children. In summary they expected that:

- The children would be cured and discharged home.
- The medical officers and nurses would pay attention to their sick children.
- They would be informed of how their children were progressing and also of their child's HIV status

It was interesting to note that the mothers interpreted treatment with drips as indicating that special care was being taken of their children.

Social service sphere

The Social worker conducted individual counselling as well as group counselling depending on that specific case identified during interviews. The mothers expected the social worker to attend to their problems and to have knowledge of standards and practices professionally. In their case, their children were at a critical condition and were expecting a person who would bring hope and comfort. They were thus in need of a person who could listen and pay attention to them, observe their condition and use proper interviewing skills. The mothers expressed a desire to be re-united with their family members and to be assisted in their needs and engage them in efforts to resolve their problems. They also expected to be treated in privacy and with confidentiality.

Dietician

The dietician visited the wards and supplied supplements accordingly and also provided education to each mother. The mothers expected to get education on how to prepare properly and feed their children and to be educated about the exact type of food suitable for their children.

Economic structures

The challenges of delayed applications were addressed to SASSA and Home Affairs, and then all mothers who had problems during interviews were referred to the relevant stakeholders with immediate effect. The mothers all asked for on- going help to deal with their situation. They expected to get quick consideration from these departments as they already observe the critical situation.

Challenges, experiences and factors that affected mothers and children

All the mothers experienced difficult home circumstances. Financial difficulties were a major problem. None of the mothers were employed and the major source of income was the Child Support Grant, all the mothers were receiving the grant. Some households received additional support from their fathers not the fathers of their children and from the old age pension of their grannies. It would thus appear that all the mothers were dependent on social security.

The mothers experienced a range of problems. Four mothers were HIV positive. Two of them were still waiting the results of their children and two were aware of the results and both of them were on ARVs. Domestic violence at home was a problem for one participant who was involved in violence that led her to abuse alcohol, to sleep out with her baby, to quarrel back with her husband. The pressures of inadequate income to support three children added to the family problems. Identity documents were also a problem. Two mothers had no Identity documents: one obtained the wrong Identity Document that identifies her as a male, and the other one had lost her identity document, she is waiting for the second one.

The mothers had used different coping strategies, hoping that their children would be healed without attending the hospital. After the admission they realised that their childrens' lives were at stake, and only then participant 6 and participant 9 disclosed that they used traditional medication with their children but one child had sores all over her body and the other one had big stomach with bloody stools. These research participants stated that they believe in

traditional medication, and the other one before coming to the hospital she initially utilized the traditional medication to check what is called “Inyoni”. She believe that ‘Inyoni’ has similar signs of kwashiorkor where-by a child develops big stomach and thin legs as well as yellow hairs, then she will first treat that sickness before taking the baby to the hospital.

Mostly, the traditional medications are dangerous to the children because their immune system is still weak and HIV positive children plus TB cases are not supposed to be administered with traditional medication that can add other side effects to their bodies.

Another factor is that, most of the mothers had homes that were overcrowded and had too small accommodation for the large number of people living there. Only one participant that came from an eight roomed house but she nevertheless still was lacking support from her family members.

The study thus provided the answers to the research questions. The research questions were as follows: how do the mothers understand malnutrition? What are the mothers’ experiences of caring for their children who are malnourished? And how do the mothers access and experience various government and other structures in addressing malnutrition? The findings of this study support previous findings. For example, Saloojee et al, (2007) said that, “Factors contributing to severe child malnutrition were socio-economic risk factors; nutritional risk factors, factors linked with HIV/AIDS, and associated morbidity.” Factors that affected mothers and their children from this study mostly related to poor socio-economic status of each household.

The following summary of findings addressed the above mentioned research questions. The study revealed that child malnutrition is a serious illness that has long-term effects. The families of these children were from poorly resourced rural areas. These children lack support from their family members due to poor socio economic status. Most mothers were depending on Child Support Grant and few of them were under the care of the elderly person, others were from child headed families. Researcher participants stated that most of them were affected with poor socio-economic status that made the failure to attend to their children, with food, medication, as well as love and care. If the parent lacks resources, lack the interest and love of caring for her children. Money is the source of everything. Few mothers were helped by grandmothers and others sent their children to the paternal grannies for support as others

were supported whilst staying with their mothers. “Every people are in need of social and material resources that include health food, housing, education and responsible parents” (Tudge et al, 2011).

The low rate of unemployment and lack of education played a big role causing mothers not to be able to take adequate care of the children. As revealed by the participant, educational status had an effect on the mothers in raising their children. Only two mothers who obtained grade 12 and others ended at the lowest grade. There was one mother who ended at grade 1 and explained that it was difficult for her to prepare formula for her child, although she said, she thought of economising when using few scoops of formula to a bigger measurement, and that resulted to the admission of the child.

As stated by the participants that, taking care of malnourished child changes or delays the plans that the mother has had, like schooling and seeking of jobs. Although child needs to attach with her/his mother and there is a difference between a mother and caregiver. Brazelton and Greenspan (2000) motivated with the fact that attachment is important between a child and a parent who results to mutual trust and intimacy building experience. Mostly mothers who attend school and take care of their children at the hospital became school drop-outs.

The research participants stated that some children have been admitted for one month at the time of an interview and others were admitted from ten to three weeks. Their illnesses differed according to the chronic effect of that certain child. These children were admitted due to loss of energy and weight, jaundice, running stomach, TB, HIV, sores all over the body, swelling of the body, vomiting, sugar diabetic, kwashiorkor and malnutrition. These were diagnosis at the entry point (OPD). At the ward further management by the doctors gave the actual diagnosis of each child and that revealed that they were already affected with Severe Acute Malnutrition (SAM), which showed that the child had reached the chronic stage; Acute Gastro Enteritis (AGE), Marasmus and HIV, Failure to Thrive, Underweight of Age (Wasting), Low Respiratory Tract (LRT), Pulmonary Tuberculosis (PTB). It is when the mothers of these children realised that their children were seriously ill.

While the mothers were generally satisfied about the care of the children in the hospital, being in hospital was difficult for them. These mothers are not given a bed at the ward, and

therefore they spend the night sitting next to the cot. Since the children too were very ill, it meant that they mothers did not sleep much. It was also hard for some of them to adapt to new people, new staff and new environment.

The research participant stated that lack of family support had an effect on them together with their children. Family means a lot at the time of difficulties. A person who looks after an ill child needs people that are closer to her. Few participants were married and had difficulties to get support from their husbands; others were single parents, while others got the support from the fathers of their children although others were depending on siblings that were not bothering themselves about their responsibilities.

As stated by the participants, most mothers developed low self-esteem, lack of hope towards their children, emotionally broken. Looking at the child and being transferred to and fro to Umtata made the mother to develop hesitation. Social Workers, dieticians and other stake holders were involved in fighting child malnutrition.

Research participants stated that, family violence, alcohol, unemployment had affected them as well as their families at large. Children that were the victims of violence from birth end up in violence themselves and these children become affected physically, psychologically and socially. Mothers who experienced abuse at home were unable to give their children love and care. One participant absconded several times from the hospital and coming back under the influence of liquor. She was from violent home and had no time of looking after her child.

This shows that the foundation of raising the child is love. Mothers who knew their HIV status were worried of their children's growth. Kimani-Murage (2013) added and said that mothers of HIV –infected children faced barriers in taking care of their children because of financial barriers, poor access to health services and compromised physical abilities to provide care due to their own poor health.

Children need the treatment supported in order to get the treatment perfectly. In terms of HIV and AIDS condition, depending on the physical ability of the mother the child becomes affected. The same applies to the TB patients' mothers, getting it difficult to take care of their children and were afraid of multi-infecting them, their children were almost affected. One participant revealed that the families understand the sickness but never bother themselves about the admitted ones.

One of the participants was attending school at the time of admission, although her admission with the child started last year. This participant dropped out of school since last year and the condition of her child demands admission now and then. Mothers that have no relatives are experiencing difficulties of taking care of their children no matter how they attend school. Mothers with relatives draw a roster of looking after their children whilst at the hospital, the relative comes at the ward in the meantime the mother is attending school at the middle of the week; then during the week end the mother of the child comes to the hospital to take her routine.

Strategies for fighting child malnutrition

Looking at the findings, the researcher feels that there should be an awareness campaigns that need to be done firstly: to the family member that are affected with malnutrition; secondly: to include the community at large without omitting the teachers that are dealing with these children every day. Thirdly: It will be of good idea to involve stake holders that are directly involved in the program. Finally: The close monitoring and support is needed to these families and to see themselves as of first priority in any development that involves their community.

The mothers were educated at the ward by the dietician on how to prepare meal for their babies after being discharged. They were also encouraged to check themselves during pregnancy so that they must eat perfect healthy diet, then to check for HIV and AIDS. It was discovered that even TB has effect on child malnutrition; most children that were malnourished were vulnerable to different diseases including TB. There are other factors that helped in fighting child malnutrition by washing hands before preparing the child's meals or feeds, wash bottle and sterilise it before use, boil water and keep it at a safe place. The mothers were told to prepare measured feed or meal per child and make it sure that child gets the fresh feeds or meal every time. Mothers were also encouraged to immunise their babies in order to see whether the children were losing or gaining weight.

Breast-feeding was encouraged to the mothers and it is cheap and hygienic. Mixed feeding is not allowed in managing the child. It is better for a mother from birth to select either breast-feeding or exclusive breast-feeding. "With respect to mothers or household socio-economic risk factors, children of educated mothers were in less risk of malnutrition than others."

(Griffiths et al, 2004; Smith et al, 2005; Boyle et al, 2006; Fotso, 2007). The findings revealed that, really the children of the educated mothers were at less risk than others. Only two mothers out of 10 participants, who ended at Grade 12 that were admitted at the children's ward because of malnutrition and the rest, had lower classes.

Views of the mothers and their expectations

The research participants seek for assistance from different stake holders, such as SASSA and SAPS and Home Affairs. Most of the documents are certified before being processed at SASSA or Home Affairs, for example age estimation to the mothers who had wrong identity documents need a certified document from SAPS before being processed by Home Affairs. On top of that, the medical practitioner has to confirm the age of that particular person. Other children got wrong registration concerning their sex status, therefor the medical doctor and SAPS has to be involved in the process. They also mentioned the delay that happens at Home Affairs when they are in need of birth certificate and Identity Documents. The hospital has designed the process that involves Home Affairs immediately the child is born. Each mother was discharged with birth certificate of her child.

Mothers that delivered their children at home find it difficult to do birth certificate. They need to consult the councillor first to get the letter that confirms the ward. Those that got the road to health cards and lost them, were required to visit the hospital and get the maternal letter that confirms that she delivered the baby at the said date before she can apply for the birth certificate. The mother is supposed to apply for the maternal letter to the relevant hospital where she delivered her baby and the province is underlined.

There were other cases where the mother got the wrong ID and discovered that when applying for a birth certificate of her child that she was registered as a male, there are also difficulties and long routes that need to be taken to get the right application. Therefore these participants asked for the decrease in waiting period of the IDs because the delay of an ID affects the birth certificate of the child and the child cannot get CSG without any relevant documents.

Participants complained about the grant that is deducted by an unknown company that sells airtime without the consent of the participant. They ask the Government to take the matter into consideration. They said sometimes the whole grant was deducted and the person left

with no cent. They also raised the concern that Child Support Grant got less increment; therefor the Government must revisit its increment. There are circumstances whereby all members of the family depend on one grant, when the time of the unknown deduction comes this affects everybody including the child. That is why the rate of child malnutrition is very high and this also shows that there are many adults that are malnourished due to the present circumstances.

Other participants, who were still willing to go to school, asked for the opportunities that Government can provide for them to proceed with their studies. They made mention of the bursaries available to help them. Others asked for food parcels that can support them whilst waiting for the Identity Document or the processes of grant applications. Others were willing to get job opportunities if they can be available at their level of education. Alston and Bowles (2013) added by saying that there are intangible indicators of poverty, which are feelings of well-being, levels of anxiety and experience of hopelessness. They cannot be identified with numbers but they need each participant to express herself. All of these participants had lost the hope in their lives and towards their children; they are in a state of 'confusion.'

Relevance of the ecological systems theory for the study

Ecological theory has been useful in the study and has provided a framework for understanding the multiple factors that impact on the mothers' experiences and perceptions concerning child malnutrition. The theory connects the individual through micro-system to the family (micro), with the outside world (macro). The researcher explored the individual's well-being through ecosystem as mothers were taking care of their ill children in the ward. These mothers developed low self-esteem, depression and lack of confidence due to lack of resources and lack of support from their loved ones. The system approach encourages other stake holders to assist in fighting child malnutrition. Lack of education amongst the participants had an impact on the admission of the children. They were supposed to get support and education from the clinic sisters but this did not seem to happen resulting in the children becoming malnourished and being admitted to hospital. Missing identity document, poor socio-economic status, large family members, negligence, substance abuse and family disputes were experiences that they the mothers had and which affected their ability to care for their children.

In this study micro-systems approach incorporate the mothers of the children looking at the level of functioning, the ability to survive with the small amount they have as a family. How they cope with the challenges that they experienced during admission. This also helps in avoiding long-term consequences to the mothers who closed up for some time having no one to express what they feel.

Ecological systems theory helped the researcher as the person who facilitated the change amongst the participants; targeting what was the most risk factors that were affecting them as well as their families. The study would have effect amongst the participant for gaining knowledge for staying at the hospital; develop attachment with their children and to strategize how to fight with hunger and poverty next time. In addition, the involvements of other stakeholders hope to improve one's life or the standard of living in maar future. The participant learnt to organise for themself on a regular basis and developed positive attitude towards the situations or challenges coming to them and how to fight against child malnutrition.

Ecosystems theory also looks at the culture and values of these mothers. Due to the fact that women are not allowed to seek for a job at the rural areas, this made the mothers to get oppressed and see themselves dependent on grant only. Most of the times, if the lady gets married, immediately get out of school, the little education they have never worked for them.

RECOMMENDATIONS

In terms of practice, it is recommended that interventions take place at all levels of the individual's eco-system. At a micro-system level, mothers must be empowered to take care of their children. This includes ensuring that they are educated in good child care practices, that they have the necessary skills and that they receive sufficient support. Meso systems level intervention includes ensuring that all community services are accessible and sensitive to the needs of mothers of children who are malnourished and to mothers in general to prevent malnutrition. At the exo systems level, community resources such as education, health, welfare and security need to function optimally to provide a supportive environment. At the macro systems level, it means that policies must be implemented effectively and efficiently and that the results of programmes must be evaluated. It is at this level, that the general living conditions of people must be improved.

An immediate recommendation that could be implemented is that the hospital should provide a more conducive environment for mothers to stay with their children. Assistance could be sought from private sector to fund this in the short term. In the long term, the hospital management should plan for improved conditions that are conducive to mothers.

Specifically, the following stakeholders should be involved in providing support to mothers:

Social workers: Social workers in the government service as well as in the child welfare and NGO sector should provide intervention strategies that are conducive to clients e.g. provide counselling and education to individuals, groups and communities. Group and individual counselling can help individual mothers with personal problems, teaching them coping skills and educate them on how to care for their children. These services can also provide support and encouragement which will help mothers not to feel isolated.

Social workers should also speedily approve care dependency grant and foster care grants for eligible children which will increase the financial resources available and provide food security to the individual households.

Follow up visits after mothers and their malnourished children are discharged from hospital would help mothers to understand their important role in caring for the family. This would also enable the social workers to monitor the home circumstances and provide relevant intervention immediately.

In child headed households additional support should be provided to ensure that children are well cared for. There are children that survive in a violence situation and others under different forms of abuse, physical abuse, emotional abuse, psychological abuse and even sexual abuse. All these forms of abuse contribute to the results of child malnutrition and timeous intervention is necessary.

Community interventions to capacitate and strengthen women are also recommended. Women could be helped to develop income generating projects which could provide them with additional financial resources to care for their children.

The Department of Health and medical personnel: Doctors and nurses, especially those in the primary health care system need to be sensitive to the needs of mothers and provide the support they need to care for their children. An effort should be made to make clinics friendlier and control the long waiting periods. On-going training of personnel would ensure that medical personnel have the most up to date information about how to deal with malnutrition but also how to help mothers do a better job. Programmes that provide supplementary feeding should be evaluated to ensure that they are effective.

The Department of Education and educators: The role of educators is also important and children should be provided with education in order to develop a civilised and developed coming generation that will cope with every aspect of life. This is mentioned because lack of education played a big role in contributing to child malnutrition. Mothers that are not educated find it difficult to be support treatment for their children as they do not understand the information being given to them. This is particularly the case when children require HIV treatment as it can be quite complex.

The Department of Education should ensure that the food feeding schemes are well run and that nutritious food is made available to children.

Municipality: Municipalities have the responsibility to provide services that decrease the level of diseases and promote communities by providing clean tap water, accommodations (RDP houses) for needy people, toilets, electricity, infrastructures, and roads for our communities to access relevant facilities e.g. clinics and schools.

The Department of Home Affairs: This government department needs to fast-track applications for identity document and birth certificates. At Home Affairs, they have to reduce the three months waiting period after ID application to avoid child malnutrition. Most mothers give birth to their children without the ID documents and that puts a child at risk of malnutrition if the mother has no ID. Some hospitals have a Home Affairs office at the maternity ward to help mothers after delivery to get their certificates at the same day and this should be made available to all hospitals.

South African Police Service: The SAPS needs to protect women and children against violence, rape, and any other form of abuse. The elderly and those who are mentally

challenged clients also need protection against rape, physical, emotional and psychological abuse. Some children are born out of rape nor matter is a normal or mental challenged person, the child suffers at the end of the day.

Correctional Services: While this was not specifically addressed in this study, it is known that some parents are in prison and so prisons need to educate the inmates and conduct rehabilitation programmes that will help them to gain love and restore their self-esteem before bonding with their families again. Education about caring for children could also be included in these programmes and this would help them to assume better responsibility for their children when they are released.

This study was exploratory in nature and one of the aims of exploratory research is to raise questions for further study (Marlow, 1998). In terms of further research, the following recommendations are made:

- This study involved a small sample of Xhosa speaking woman from a rural area whose children had been admitted to hospital for malnutrition. Similar studies with more representative groups of mothers would provide a fuller picture of the problems facing mothers.
- A follow up study of the mother involved in this study should be undertaken. This would shed light on whether mothers are able to prevent further malnutrition and the challenges they face as they continue with their child rearing responsibilities.

CONCLUSION

The chapter has highlighted the various issues that emerged from the limitations of the study, findings, and policies. Several limitations in this study were considered, such as the area of the study, the specific mothers hospitalised with their children who experience long stay at the hospital with their malnourished children.

The findings revealed that, ten mothers, all from the rural area of Bizana, participated in this research. They were from poor households and only two of them had completed their schooling. They were also mostly the main breadwinners at home. Some mothers were HIV positive and were bold enough to disclose their status in order for their children to get help.

They were broken hearted due to the condition of their children. They developed low self-esteem; they were depressed, stressed, weak and confused. It was clear that the mothers suffered a great deal and that intervention programmes to address their needs are vitally important if the problem of child malnutrition is to be successfully addressed.

The policies from national, provincial and of district addressed, which highlighted the rights to basic needs of the child as South African citizen and what other Ministers address in terms of the issue of child malnutrition and the intervention strategies. Programmes were discussed that are conducive in the child rearing and the strategies of preventing child malnutrition. Supplementation underlined as of important to reduce the risk of mortality. However, breast-feeding was mentioned and considered to be a most important method of protecting the child and contributing to its growth.

This study has made recommendations about the way forward and it is hoped that the findings of this study will assist the relevant stakeholders to implement more helpful programmes for mothers whose children suffer from malnutrition in the future.

REFERENCES

About, F., and Akhter, S. (2011). A cluster-randomized evaluation of a responsive stimulation and feeding intervention in Bangladesh. **Pediatrics**, 127, e1191.

Alfred NZO News vol. 5, 2014/2015. Available at: lmahlaka@mbizana.org.za

Alston, M., and Bowles, W. (2013). **Research for social workers**. (3rd ed). New York: Taylor and Francis Group.

Ambrosino, R., Heffernan, J., Shuttlesworth, G., and Ambrosino, R. (2012). **Social work and social welfare**. (7th ed). Canada: Brook/Cole.

Ambosino, R., Ambrosino, R., Emeritus, H.J., and Emeritus, S.G. (2008). **Social Work and Social Welfare: An introduction**. (6thed). Belmont, CA: Thomson Brooks/Cole.

Arenz S, Ruckerl R, Koletzko B et al. (2004) Breast-feeding and childhood obesity: a systematic review. **International Journal of Obesity**, 28:1247–1256.

Ashworth A., Sanders, D., Chopra, M., McCoy, D. and Schofield, C. (2004). Improving quality of care for severe malnutrition. **The Lancet**, 363(9426): 2089-2089.

Ashworth, A., Khanum, S., Jackson, A., and Schofield, C. 2003. **Guidelines for the inpatient treatment of severely malnourished children**. WHO publication, Geneva. Available at: http://www.who.int/nutrition/publications/guide_inpatient_text.pdf

Babbie, E. and Mouton, J. (2004). **The practice of social research**. Cape Town: Oxford University Press.

Babbie, E., and Mouton, J. (2007). **The practice of social research**. Cape Town: Oxford University Press.

Babbie R., and Rubin, A., (2013). **Research methods for social work**. (7thed). Belmont: Brook/Cole.

Barnett, T., and Whiteside, A., (2002). **The AIDS in the twenty-first century, diseases and globalization**. New York: Palgrave Macmillan.

Bateman, O.R., Jahan, S., Brahman, S., Zeitlyn, S., and Laston, S. (1995). **Prevention of through diarrhoea improving hygiene behaviours: the sanitation and family education (SAFE) pilot project experience**. Bangladesh: CARE- ICDDR/B, EHP Joint Publication no 4

Bergstrom E. **Bacterial Contamination and Nutrient Concentration of Infant Milk in South Africa**. A sub-study of National PMTCT Cohort study. June 2003

Bergstrom E., Rollins, N., Sturm AM., and Greiner T. (2004). **Bacterial contamination and nutrient concentration in infant milk in South Africa**: A sub-study of the national prevention of mother to child transmission cohort study. International.

Berk LE. (2001). **Development through the life-span**. 2nd edition. Boston: Allyn and Bacon.

Bhutta, Z.A., Ahmed T., Black R.E., Cousens S., Dewey K., Giugliani E., Haider B.A., Kirkwood. Morris S.S., Sachdev, H.P.S. (2008). What works? Interventions for maternal and child under 5 - nutrition and survival. **The Lancet**, 371: 417–440.

Biggs, C. (2013). Clinical dietetic practice in the treatment of severe acute malnutrition in a high HIV setting. **Journal for Human Nutrition and Dietetics**, 26:175-181.

Black R. Nutrition interventions that can accelerate the reduction of maternal and child under-nutrition. **SCN News**. 2008; 36:17-20.

Black, R.E., Allen, L.H., Bhutta, Z.A., Caulfield, L.E., de Onis, M., Ezzati, M., Mathers, C. and Rivera, J. 2003. Maternal and child under nutrition: Global and regional exposures and health consequences. **The Lancet**, 371(9608): 243–260.

Bless, C., and Higson- Smith, C. (2000) **Fundamentals of social research methods an African perspective.** (3rded). Cape Town: Juta.

Bloss E., Wainaina F., Bailey RC. (2004) Prevalence and predictors of underweight, stunting and wasting among children aged 5 and under in western Kenya. **Journal of Tropical Pediatrics**, 48:416-24.

Blössner, M, de Onis, M. **Malnutrition: quantifying the health impact at national and local levels. Geneva, World Health Organization, 2005.** (WHO Environmental Burden of Disease Series, No. 12).

Bourne, L.T., Hendricks, M.K, Marais, D. and Eley, B. (2007).Addressing malnutrition in young children in South Africa.Setting the national context for paediatric food-based dietary guidelines. **Maternal and Child Nutrition**, 3: 230-238.

Boyle, M. H., Racine, Y., Georgiades, K., et al (2006). The influence of economic development level, household wealth and maternal education on child health in the developing world. **Social Science and Medicine**, 63:2242-2254.

Bradshaw D, Nannan N, Laubscher R, Groenewald P, Joubert J, Nojilana B, Norman R, Pieterse D and Schneider M (2004) South African National Burden of Disease Study 2000 – Estimates of Provincial Mortality. Cape Town: South African Medical Research Council, Burden of Disease Unit.

Braun, V., and Clarke, V., (2006). Using thematic analysis in psychology. **Qualitative research in psychology**, 3(2): 77-101.

Brazelton, T., B., and Greenspan, S. (2000). **“The irreducible needs of children.”** George Washington University of Medical School: Da Capo press.

Bunn, J.E.G. (2009). Severe acute malnutrition and HIV in African Children. **HIV therapy** 3:595-611.

Buthelezi, N. (2011). **Understanding malnourished children at a public hospital in Durban: perspectives of caregivers.** Unpublished Master's dissertation. University of KwaZulu-Natal, Durban.

Chopra M. (2003) Risk factors for under nutrition of young children in a rural area of South Africa. **Public Health Nutrition**, 6:645-52

Ciaccio, L., and Brophy, L. (2000). A teacher's chance for immortality. **The education digest**, 65,6, 44-8. .

Concise Medical Dictionary (2003). 6th edition, Oxford University Press

Coovadia, H.M., and Whittenberg D.F. (2009). Paediatrics and child health: **A manual for health professions in developed countries.** (5th ed). Cape Town, South Africa: Oxford University Press.

Coutsoudis A, Pillay K, Kuhn L, et al. methods of feeding and transmission of HIV-1 from mother to children by 15 months of age: prospective cohort study from Durban, South Africa. **AIDS**, 2001. 15: 379-387

Curtis V, Cairncross S. (2003) Effect of washing hands with soap on diarrhoea risk in the community: a systematic review. **Lancet Infectious Diseases** 2003(3):275–281.

Department of Health (2006). **Integrated Nutrition Programme.** A foundation for life. Issue 5.

Department of Health (2010). **Guidelines for the Management of HIV in Children.** 2nd Edition.

Department of Social Development. **Strategic Plan 2012-2015.** Mbizana, Eastern Cape

De Vos, A. S., Strydom, H., Fouche, C.b., and Delport C.S.L. (2011). **Research at grassroots for the social sciences and human services professions.** (4thed) Pretoria: Van Schaik publishers.

District Health Information System in the Department of Health, 2010. Available at: www.health-e.org.za

Edmond K.M, Zandou, C., Quigley, M.A., Amenga-Etego, S., Owusu-Agyei, S. and Kirkwood, BR. et al, (2006). Delayed Breast-feeding Initiation Increases Risk of Neonatal Mortality. **Pediatrics**, 117:380-386

Engelbrechtsen, I.M., Jackson, D., Fadnes, L.T., Nankabirwa, V., Diallo, A.H et al. (2014). Growth effects of exclusive breast-feeding promotion by peer counsellors in sub-Saharan Africa: the cluster randomised PROMISE EBF trial. **BMC Public Health**, 14: 633. Open access at: <http://www.biomedicalcentral.com/1471-2458/14/633>

Engle, P. (2009). Maternal mental health: Program and policy implications. **American Journal of Clinical Nutrition**, 89, 963S–966S.

Engle P.L., Fernald C.H., Behrman, J.R., O’gara, C., Yousafzai, A., De Mello, M.C., and Group, T.G.C.D.S. (2011). Strategies for reducing inequalities and improving developmental outcomes for young children in low- income and middle-income countries. **The Lancet**, 378: 1339– 1353.

Faber, M. and Benadé, A.J.S. Breast-feeding, complementary feeding and nutritional status of 6-12-month-old infants in rural KwaZulu-Natal. **South African Journal of Clinical Nutrition**, 2006(20):16–24.

Fergusson P., Tomkins A and Kerac M., (2009). Improving survival of children with severe acute malnutrition in HIV-prevalent settings. **International Health**, 1, 10-16.

FAO. (2010). **Food-Based Approaches for Improving Diets and Raising Levels of Nutrition**, *Concept note*. International Symposium on Food and Nutrition Security: FAO, Rome, 7–9 December 2010. Rome.

FAO. 2011. **Evaluation of FAO's Role and Work in Nutrition. Final Report.** PC 108/6. Rome

FAO. **Right to Food Methodological Toolbox.** Rome: FAO, 2010, 2011c.

Fotso, J., Kuate-Defo, B. (2005). Measuring Socioeconomic Status in Health Research in Developing Countries: Should We Be Focusing on Households, Communities or Both? Vol. 72, No. 2

Fotso J. C. (2007) Urban-rural differentials in child malnutrition trends and socioeconomic correlates in sub-Saharan Africa. **Health and Place**, 13, 205-223

Gangar, J. (2009). Nutrition assessment of new borns of HIV infected mothers. **Indian Paediatrics**, 46:339-341.

Gitterman, A. and Germain, C.B. (2008). **The life Model of Social Work Practice: Advances in Theory and Practice**, 3rd ed. New York: Columbia University Press

Grantham-McGregor, S., Cheung, Y.B., Cueto, S., Glewwe, P., Richter, L., Strupp, B., and Group, T.I.C.D.S. (2007). Developmental potential in the first 5 years for children in developing countries. **The Lancet**, 369:60–70.

Graves, J.K. and Ware, M.E. (1990). Parents and health professionals' perceptions concerning parental stress during a child's hospitalisation. **Children's Health Care**, 19(1):37-42.

Gray.M.,Midgley, J. and Webb, S.A. (2012).**The Sage Handbook of Social Work.** SAGE Publications LTD.

Green, J., and Thorogood, N., (2009). **Qualitative methods for health research.** London: Sage Publishers.

Griffiths, P. Madise N., Whitwork A. and Matthews Z. (2004). A tale of two continents: a multilevel comparison of the determinants of child nutritional status from selected Indian region. **Health and Place** 10:183-199

Grinnell, J.R., and Anrau, Y.A. (2008). **Social work research and evaluation. Foundations of evidence-based practice:** Oxford: Oxford Press.

Gupta, S. and Kumar, D. (2013). An intervention study in malnutrition among under five children in a rural area of Jammu. **JK Science**, 15(2):73-76.

Hendricks, M. and Bourne, L. (2010). An integrated approach to malnutrition in childhood. In: M. Kibel, L. Lake, S. Pendlebury and C. Smith. **South African Child Gauge**. Cape Town: University of Cape Town.

Hendricks, M., Bourne, L. and Eley, B. (2006). Child nutrition. **South African Health Review**, 203-220.

Hendricks, M., Roux, M., Fernandes, M and Irlam, J. (2003). Evaluation of a nutrition programme in the Northern Cape Province of South Africa. **Published Health Nutrition**, 6:431-437

Huy, N.D., Le Hop, T., Shrimpton, R., and Hoa, C.V. (2009). An effectiveness trial of multiple micronutrient supplementations during pregnancy in Vietnam: Impact on birth weight and on stunting in children at around 2 years of age. **Food and Nutrition Bulletin**, 30(4 Suppl.): S506–516.

IFPRI, (2012). **Global Hunger Index/ International food Policy**. Available at : <http://www.ifpri.org/ghi/2012>

Integrated Nutrition Programme 2002- 2004. www.hst.org.za

Iversen, P.P., Marais, D., du Plessis, L. and Herselman, M. (2011). Addressing nutrition intervention programmes that addressed malnutrition among young children in South Africa between 1994-2010. **Africa Journal of Food, Agriculture, Nutrition and Development**, 12(2): 5928-5945.

Jones, G., Steketee, R.W. et al (2003). For the Bellagio Child Survival Study group, how many child deaths can we prevent this year? **The Lancet**, 362: 65-71

Joulaei, H., Emeka, N., Nasihatkon, A., Azadbahkt, L., Shenavar, R., et al. (2013). To assess the effects of nutritional intervention based on advocacy approach on malnutrition status among school-aged children in Shiraz. **Journal of Research in Medical Sciences**, 18:739-745.

Karolis, N., Jackson, D., Ashworth, A., Sogaula, N, et al. (2007). WHO guidelines for severe malnutrition: are they feasible in rural Africa? **Archives of Disease in Childhood**, 92(3): 198-204.

Kimani-Murage, E.W. (2013). **Exploring the paradox: Double burden of malnutrition in rural South Africa**. APHRC Campus, Kenya.

Kramer, M.S., Fombonne, E., Igumnov, S., Vanilovich, I., Matush, L., Mirinova, E. and Platt, R.W. (2008). Effects of prolonged and exclusive breast-feeding on child behavior and Maternal adjustment: Evidence from a large randomized trial. **Pediatrics**, 121:435–440.

Kruger, H.S., Swart, R., Labadarios, D., Dannhauser, A., and Nel, J.H. (2005). Anthropometric status. In: Labadarios D. **National food consumption survey: fortification baseline**: South Africa.

Kwena, A.M., Terlouw, D.J., De Vlas, S.J, et al. (2003) Prevalence and severity of malnutrition in pre-school children in a rural area of western Kenya. **American Journal of Tropical Medical Hygiene**, 68:94–99.

Langendorf, C., Roederer, T., de Pee, S., Brown, D., Doyon, S. et al. (2014). Preventing acute malnutrition among young children in crisis: A prospective intervention study in Niger. **PLOS Medicine**, 11(9). Available on-line at: www.plosmedicine.org.

Le Roux, I.M., Le Roux, K., Comulada, W.S., ...et al. (2010). Home visits by neighbourhood Mentor Mothers provide timely recovery from childhood malnutrition in South Africa: results from randomized controlled trial. **Nutrition Journal**. Available at:

<http://www.nutritionj.com/content/9/1/56>.

Lounsbury, D.W., and Mitchell, S.G. (2009). Introduction to special issue social ecological approaches to community health research and action. **American Journal of Community Psychology**, 44:213-220.

Lund, F. (2008). **Changing social policy: The child support grant**. Cape Town: HSRC.

Magadi, M.A. (2010). **A cross-national analysis of the household and community HIV/AIDS determinants of child malnutrition in sub-Saharan Africa: evidence from the DHS**. Social Research Methodology Center Working Paper, SRMC 2010/02.
Magadi 2011

Mahavarn, S., and Townsend, N. (2007). The social context of children's nutritional status in rural South Africa. **Scandinavian Journal of Public Health Supply**. 2007 August; 69:107-17

Maleta, K., Virtanen, S.M., Espo, M., Kulmala, T. and Ashorn, P. (2003). Childhood malnutrition and its predictors in rural Malawi. **Paediatric Perinatal Epidemiology**, 17:384–390.

Marins, V.M. and Almeida, R.M. (2002). Undernutrition prevalence and social determinants in children aged 0-59 months, Niteroi, Brazil. **Annals of Human Biology**, 29:609–618.

Marlow, C., (1998). **Research Methods for Generalist Social Work**. (2nd ed), USA: Brook/Cole Publishers.

Martin, W. B. Moench-Pfanner, R. Dora Panagides (Eds). **Health and Nutritional Surveillance for Development**. Singapore: Helen Keller Worldwide, 2003.

Mbizana Local Municipality Integrated Development Plan (IDP) (2012-2017). Available at: www.mbizana.gov.za

Mbizana Local Municipality Integrated Development Draft (IDP) (2014-2015) Review.
Available at: www.mbizana.gov.za

Millennium Development Goal: Country Report (2010). Available at: www.pmg.org.za

Monde, M. and Udjo, E. **Is the Child Support Grant associated with an increase in teenage fertility in South Africa? Evidence from national surveys and administrative data.** Pretoria: Human Sciences Research Council; 2006.

Naidu, C. (2000). **Factors that contribute to malnutrition in children aged under five: An investigation into the psycho-social conditions of families in Chatsworth.** Unpublished Master's dissertation. University of KwaZulu- Natal: Durban.

Nalwoga, A. Maher, D. Todd, J. Karabarinde, A. Biraro, S., and Grosskurth, H. (2010). Nutritional status of children living in a community with high HIV prevalence in rural Uganda: a cross-sectional population-based survey. **Tropical Medicine and International Health**, 15:414-323.

Payne, M. (1997). **Modern Social Work Theory.** Second edition, Macmillan Press LTD.

Richardson, A. and Ritchie, J. (1989). **Developing friendship: Enabling People with Learning Difficulties to make and maintain friends** (London, Policy Studies Institute).

Rodgers, A., and Pilgrim, D. (2010). **A sociology of mental health and illness.** (4th ed.), Buckingham: Open University Press.

Royse, L. (2004). **Research methods in social work.** (4th ed.), USA: Brook/Cole

Rubin, A., and Babbie, E. R. (2005). **Research methods for social work.** USA: Brook/Cole.

Rubin, A. and Babbie, E. (2013). **Essential research methods for social work.** (3rd edition), USA: Brook/Cole.

Saitowitz, R. and Hendricks, M. (undated). **Policy summary: The national integrated nutrition programme.** Nutrition Group, Child Health Unit in collaboration with the National Nutrition Directorate, Department of Health.

Saitowitz R, Hendricks M, Fiedler J, le Roux I, Hussey G, Maman B. (2000). A proposed vitamin A supplementation programme for South Africa - design, coverage and cost. **South African Medical Journal**, 91(9): 755-760

Sakisaka, K., Wakai, S., Kuroiwa, C., Cuadra, F.L., Kai, I., Mercedes, A.M. and Hanada, K. (2006). Nutritional status and associated factors in children aged 0–23 months in Granada, Nicaragua. **Public Health** 120:400–411.

Saloojee, H., Maayer, T.D., Garenne, M.L. and Khan, K. (2007). **What's new? Investigating risk factors for severe childhood malnutrition in high HIV prevalence South African setting**. Taylor and Francis: South Africa

Sarantakos, S., (2005). **Social research**. (3rd ed.), New York: Palgrave MacMillan

Schoeman, S., Adams, V., Faber, M., Smuths, C.M., Ford-Ngomane, M., Laubscher, J.A., and Dhausay, M.A., (2010). Adverse social, nutrition and health conditions in rural district of kwaZulu-Natal and Eastern Cape province, South Africa: Original research. **South African Journal of Clinical Nutrition**, 23 (3):140-147.

Shah, S.M, Selwyn, B.J., Luby, S., Merchant, A. and Bano, R. (2003) Prevalence and correlates of stunting among children in rural Pakistan. **Pediatrics and International Children's health**, 45:49–53.

Single Parent Center. "What Do Single Parent Statistics Tell Us?". 3 August 2011. Retrieved 7 December 2011.

Smith, L.C., Ruel, M.T. and Ndiaye, (2005). Why is child malnutrition lower in urban than rural areas? Evidence from 36 developing countries. **World Development**, 33:1285-1305.

Statistics South Africa, **Income and Expenditure Survey**, 2000 and 2005. Available at: www.statssa.gov.za.

Statistics South Africa (2003; 2008) General Household Survey 2002; General Household Survey 2007. Pretoria, Cape Town: Stats SA. Analysis by Double-Hugh Marera and Katharine Hall, Children's Institute, UCT.

Statistics South Africa (2007, 2011). **Household income and expenditure survey 2005/6**www.statssa.gov.za.

Statistics South Africa, **Community Survey**, 2007: Interactive data, www.statssa.gov.za

Statistics South Africa, **Quarterly Labour Force Survey**, 2009-2010. Available at: www.statssa.gov.za.

Steward, R.V., Bunn, J., Vokhiwa, M., Umar, E., Kauye, F., et al. (2010). A prospective study of psychological distress among mothers of children admitted to a nutritional rehabilitation unit in Malawi. **Child: Care, Health and Development**, 37(1): 55-63.\

Steyn, N.P., Labadarios, D., Maunder, E., Nel, J. and Lombard, C. (2005). And Directors of the NFCS. Secondary anthropometric data analysis of the National Food Consumption Survey: the double burden. **Nutrition** 21, 4-13

Steyn, K., Fourie, J., Temple, N. (2006). **Dietary changes and health transition in South Africa: implications for Health policy**. South African Medical research Council: Cape Town.

Strategic Plan 2012-2015. Department of Social Development. Mbizana, Eastern Cape

Swart, R., Sanders, D. and McLachlan, M. (2008). Nutrition: A primary health care perspective. In: P. Barron and L. Roma-Reardon. **South African Health Review**. Durban: Health Systems Trust.

Swick, K. (2004). **Empowering parents, families, schools and communities during the early childhood years**. Champaign, IL: Stipes.

Tudge, J., Mokrova, I., Karnik RB. and Hatfield, BE. (2011). Use and misuses of Bronfenbrenner's bioecological theory of human development. **Journal of Family Theory and Review** 1:198-210

Turck D, Agostoni C, Braegger C et al. (2009) Breast-feeding: a commentary by the ESPGHAN committee on nutrition. **Journal of Pediatric Gastroenterology and Nutrition**, 49:112–125.

United Nations Economic and Social Council (2000). **International Covenant on Economic, Social and Cultural Rights, Article 12: The Right to the Highest Attainable Standard of Health: General comment No. 14**. Geneva: Committee on Economic, Social and Cultural Rights
United Nations (2003) Millennium Development Goals (MDGs).

[http://millenniumindicators.un.org/unsd/mdg/Resources/Attach/](http://millenniumindicators.un.org/unsd/mdg/Resources/Attach/Indicators/OfficialList.pdf) Indicators/OfficialList.pdf

United Nations Children's Fund (UNICEF). (2010). **The state of the world's children 2010, special edition: Celebrating 20 years of the convention on the rights of the child**. New York: United Nations Children's Fund (UNICEF).

Vaughan, J.P., Mogedal, S., Kruse, S., Lee, K., Walt, G. and de Wilde, K. (1996). Financing the World Health Organisation: global importance of extra budgetary funds. **Health Policy**, 35:229–245.

Victora, C.G., Adair, L., Fall, C., Hallal, P.C., Martorell, R., Richter, L., and Sachdev, H.S. (2008). Maternal and child under nutrition: Consequences for adult health and human capital. **The Lancet**, 371(9609):340–357.

Wachs, T.D., Creed-Kanashiro, H., Cueto, S. and Jacoby, E. (2005). Maternal education and intelligence predict offspring diet and nutritional status. **Journal of Nutrition**, 135:2179–2186.

Walker, S.P. et al. (2007). Child development: Risk factors for adverse outcomes in developing countries. **The Lancet**, 369:145–157.

Walker, S.P. (2011). **Promoting equity through early child development interventions for children from birth through three years of age.** In H. Alderman (Ed.), No small matter (pp. 115–179). Washington, DC: World Bank.

Walker, S.P., Chang, S.M., Younger, N., and Grantham-Mcgregor, S.M. (2010). The effect of psychosocial stimulation on cognition and behavior at 6 years in a cohort of term, lowbirth weight Jamaican children. **Developmental Medicine and Child Neurology**, 52: e148–e154.

Walker, S.P., et al (2011b). **Inequality in childhood: Risk and protective factors for early child development.** *Lancet*, 378, 1325–1338.

Walraven G. (2011). **Health and poverty.** London: Earthscan.

Whittaker A. (2012). **Research skills for social work.** 2nd edition. London: Learning Matters.

"Working Mothers". **Caring for Your Baby and Young Child: Birth to Age 5.** American Academy of Pediatrics. 2004. Retrieved 23 October 2011.

Yousafzai A. K. Rasheed, M.A. and Bhutta, Z.A.et al (2013). Annual Research Review: Improved nutrition-a pathway to resilience. **The Journal of Child Psychology and Psychiatry**, 54(4): 367-377.

Zastrow C.H. (2003). **The practice of social work.** 7 Edition, Canada: Brooks/Cole.

APPENDIX A
INTERVIEW SCHEDULE

Interview

1. Identifying particulars:

Participant:

Age:

Marital status:

Family (household) composition:

Type of house and location of home:

Highest educational standard:

Income: (Amount and sources)

Child:

Age:

Gender:

When was child admitted?

History of hospital admissions:

Other health concerns in the family:

2. Understanding of child's condition

Explore:

What made you bring your child to the hospital?

What was explained to you about your child's condition?

What do you think is the cause of your child's illness?

How did you feel about the child's condition?

What did you tell other family members/people about the child?

3. Experiences

Explore:

What are some of the challenges you have experienced in caring for this child? (physically, psychologically, socially)

What sort of help is available to you?

4. Expectations

Explore:

What will you do to ensure that your child remains healthy in future?

How would you like the staff at the hospital to help you?

What sort of help would you like from other organizations or government departments?

APPENDIX A (Translation)

Uhlelo Lwemibuzo

Imibuzo

1. linkcukacha zomzali

Usingaye:

Iminyaka:

Utshatile:

Usapho:

Uhlala kwi khaya elinjani, liphi:

Amabanga emfundo:

Ingeniso:

Umntwana:

Ungakanani:

Isini:

Wangena nini esibhedlela:

Inkcukacha ngokugula kwakhe:

Ezinye izinto ezinichaphazelayo nilusapho:

2. Ulwazingokugula komntwana

Chaza:

Yinto ekwenze wazisa umntwana wakho esibhedlela?

Uchazelwe ntoni ngengulo yomntwana wakho?

Ucinga ukuba umntwana wakho uguliswa yintoni?

Uzive unjani ngokugula komntwana wakho?

Utheni ukwazisa usapho nabanye abantu ngemeko yomntwana?

3. Imvakalelo

Chaza:

Ziziphi izinto ezibe ngumceli mngeni ngexesha unakekela umntwana wakho? (emzimbeni, engqondweninasemoyeni)

Luhloboluniloncedooluziswakuwe?

4. Iziphumo/Iziqhamo

Chaza:

Yinto ozakuyenza ukuqinisekiswa ukuba umntwana uhlala esempilweni kwixesha elizayo?

Uthanda abasebenzi bezempilo bakuncede njani?

Loluphi uncedo ongalufuna nakwa manye amasebe karhulumente okanye angaphandle azimeleyo ?

APPENDIX B1

INFORMED CONSENT: LETTER FOR MOTHERS

Dear Parent

My name is NdilekaMacabela and I am a social worker here at St Patrick's Hospital. I am also a student at UKZN in Durban where I am doing a Master's degree in social work. As part of my studies I am doing a research project. The name of the research project: **Child Malnutrition: *Perceptions and experiences of mothers of children admitted at St Patrick's Hospital in Bizana, Eastern Cape.***

The reason for my visit to you is to ask you to take part in the research. As the mother of a child who has been admitted to hospital for malnutrition, your views are important to help us understand more about the problem. Speaking to you about your problems and difficulties in caring for your child and getting the help you need, will help us to understand what we can do to make things easier in the future. There will be no payment for taking part in the research.

Your participation in the research is voluntary. You do not have to take part nor do you have to give me any reason for saying no. You and your child will continue to receive care here at the hospital whatever you decide regarding the research.

If you take part, I will interview you and ask you some questions about what you know about malnutrition, about some of the problems you have had in caring for your child and what you think should happen to make sure your child doesn't get sick again. The interview will be about an hour long but if you get tired or you don't want to continue, that will be okay. I would also like to audio tape the interview so that I can remember exactly what you say. If however, you would prefer me not to use the tape that will be in order.

When I am finished the research I have to write a report. In the report however, I will not mention your name so no-one will be able to identify you.

My supervisor at the university is Dr Simpson and she can be contacted on 031 2601208 or you could email her at simpson@ukzn.ac.za. You can also contact the research office at UKZN for further information. The name of the person to contact is Ms P Ximba and you can phone her on or email her at

Mrs N Macabela.

Phone number: 073 172 3253

Email: macabelan@gmail.com

APPENDIX B1 (Translation)

Informed consent: Letter for mothers

Mzali obekekileyo

Ndingu Ndileka Macabela osebenza apha esibhedlela nje ngoNontlalontle. Ndibhalise njengomfundi e UKZN e Thekwini ndisenza amabanga aphakamileyo kweNtlalontle (Masters in Social Work). Ndenza uphando phantsi kwe ngongoma ethi: Child Malnutrition: Perceptions and experiences of mothers of children admitted at St Patrick's Hospital in Bizana, Eastern Cape.

Isizathu sokuza kunikukunicela ukuba nithathe inxaxheba koluphando. Njengoko abantwana benu bebanjwe apha esibhedlela, imibono yenu iyakunceda ekuqondeni imeko le esijongene nayo. Ukuthetha nani nokwazi ezona nzima nihlangabezana nazo, iyosenza lonto nathi sifikelele ekuqondeni emasikwenze ukuhlangabezana nengxaki ibelula. Akukhontlawulo ngokuthabatha inxaxheba kudliwano-ndlebe.

Umntu ngamnye uzathabatha inxaxheba ngokuzinikela. Akulindelekanga nokuba ungadeubeke izizathu ngokungathabathi inxaxheba. Wena nomntwana wakho niyakuqhubeka nihoyiwe sisibhedlela nokuba niyithabathile nokuba anithabathanga nxaxheba kodliwano-ndlebe.

Xa uthabatha inxaxheba, ndizakukubuza imibuzo ngolwazi onalo ngokungondleki komntwana, nengxaki ohlangabezana nazo ekongeni umntwana wakho nokuba zeziphi izinto ezingenziwa ukuze umntwana angasagula kwakhona. Udliwano-ndlebe lunga yiyure ubude kodwa ukuba ufuna ukuphumla uvumelekile ukwenza njalo. Ndingakuvuyela ukusebenzisa isithathi-mazwi ukuze ndazi ncakasana into nganye obe uyithethile, kungenjalo ndingayisebenzisi ngokwemvume yakho.

Ndakuba ndigqibile uphando ndizokwenza ingxelo, kulo ngxelo akukho gamalakho lizofakwa akukho bani ongazi ukuba ingxelo ibisuka kuwe.

Umphathi wam e University ngu Dr Simpson yaye angafumaneka kwazinamba 031 260 1208 nakule email engusimpson@ukzn.ac.za. Kwakhona ungaxhumana necandelo lezophando kwase UKZN xa kukhonto ufuna ukuyiqonda. Nanku ke umntu onoku thetha naye Ms Ximba.

Ozithobileyo

Mrs N. Macabela

0731723253

macabelan@gmail.com

APPENDIX B2

INFORMED CONSENT FORM

I understand:

- The purpose of the research
- That my participation is voluntary
- That I will not be paid for the interview
- That the interview will be about an hour long
- That I can withdraw from the research at any stage with no negative consequences
- That my identity will be kept confidential

I also give consent/do not give consent for the interview to be audio taped.

Name:

Signature:

Date:

APPENDIX B2 (TRANSLATION)

INFORMED CONSENT FORM

Mnandiyaqonda:

- linjongo zodliwano-ndlebe.
- Ukuthabatha kwam inxaxheba akusosi nyanzeliso
- Andizufumana mvuzo
- Ubude bodliwano-ndlebe loba ngange yure.
- Ukuba ndingayeka ukuthabatha inxaxheba kungekho bubi bolandelana nam.
- Ukuba akuzuvezwa gama lam.

Ndiyayinika/andiyiniki/ imvume yokwenza uvavanyo ngesithatha-mazwi.

Igama:

Intsayino:

Usuku:

APPENDIX C



Province of the
EASTERN CAPE
HEALTH

ST PATRICK'S HOSPITAL • MBIZANA • EASTERN CAPE
Private Bag X 531 • BIZANA • 4800 • REPUBLIC OF SOUTH AFRICA
Tel.: +27 (0)39 251 0236 • Fax: 039-2510272.

TO	MRS N. MACABELA
FROM	HOSPITAL MANAGER : ST PATRICK'S HOSPITAL
SUBJECT	REQUEST TO CONDUCT A RESEARCH ON CHILD MALNUTRITION : PERCEPTIONS AND EXPERIENCES OF MOTHERS OF CHILDREN ADMITTED AT ST PATRICK'S HOSPITAL IN BIZANA, EASTERN CAPE
DATE	27 MARCH 2013

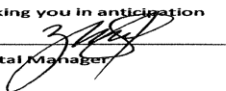
Dear Mrs. Macabela

Your request to conduct research at St. Patrick's Hospital has reference;

After deliberations between hospital management and the ethics committee, your request to conduct research on the said topic dated 25th march 2013 has been granted.

We wish you well, hoping that your research will have positive impact towards service delivery.

Thanking you in anticipation


Hospital Manager

Date: 27/03/2013