

**CAREGIVERS' VIEWS ON THE CONTRIBUTING FACTORS OF MALNUTRITION  
AMONG CHILDREN BENEFITING FROM THE CHILD SUPPORT GRANT**

**By**

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## **ABSTRACT**

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The scourge of malnutrition in children under the age of five remains a worldwide problem resulting in deaths that could have been prevented with a proper paediatric diet.

Despite various national nutrition and primary health care programmes in South Africa over the last 10 years, recent studies show that child malnutrition has contributed to the deteriorating health of children below the age of five. At national level, stunting and underweight remain the common nutritional disorders affecting one out of five children in South Africa.

Very limited research has been done on the role of caregivers in reducing the scourge of malnutrition. The study focused on exploring and describing the views of caregivers on the contributing factors of malnutrition among children who are under the age of five benefiting from the Child Support Grant.

A qualitative, explorative study was conducted, with the following objectives:

- To conceptualise malnutrition as a social phenomenon and to explore strategies of alleviating malnutrition with specific emphasis on the Child Support Grant.
- To determine caregivers' understanding of malnutrition among children

as a social phenomenon.

- To determine caregivers' views on contributing factors of malnutrition among children who are benefiting from the Child Support Grant.
- To explore the challenges experienced by caregivers who receive the Child Support Grant.
- To make recommendations for combating malnutrition among children under the age of five who are beneficiaries of the Child Support Grant.

Ten caregivers whose children were diagnosed with malnutrition while benefiting from the Child Support Grant and were given treatment at Chris Hani Baragwanath Academic hospital in 2015, were purposively selected to form the sample of the study. Semi-structured interviews were conducted to collect data from the participants.

The main conclusions drawn from the research findings were that caregivers experienced economic challenges mainly due to unemployment and lack of reliable sources of income. These identified challenges were the main contributing factors of malnutrition among children who are under the age of five benefiting from the Child Support Grant.

The study was also concluded with some useful and relevant recommendations from the caregivers' responses on how to mitigate malnutrition among children who are under the age of five benefiting from the Child Support Grant. One of the crucial recommendations drawn from the findings of this research study was that more information sessions to caregivers regarding malnutrition should be conducted regularly at the Chris Hani Baragwanath Academic hospital

## **Key Words**

Nutrition

Malnutrition

Child Support Grant

Caregiver

Child

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## CHAPTER 1

### GENERAL BACKGROUND INFORMATION OF THE RESEARCH STUDY

#### 1.1 INTRODUCTION

Diouf (2008:179) indicates that six million children under the age of five years die throughout the world due to treatable diseases such as diarrhoea, pneumonia, malaria and measles, which they would have survived if their bodies had not been weakened by malnutrition. The scourge of malnutrition in children under the age of five remains a worldwide problem resulting in deaths that could have been prevented with a proper paediatric diet, good hygiene practices, and comprehensive development of basic infrastructures (Bizourne, 2005:19). Hunt (2009) says without concerted action, 140 million children under five years will be underweight in the year 2020. The World Health Organization (2010:17) adds that more than 180 million children under the age of five, nearly one in three, are stunted and up to 40% are growing up with insufficient vitamin A.

Most of these severe cases of malnutrition and preventable deaths are located in South Asia, and in about a dozen countries in Sub-Saharan Africa. In India in both urban and rural areas, according to Siddamma (2005:2), 47% of children below the age of five are underweight, 46% stunted and 16% wasted. A study by Feed the Babies Fund (2009) revealed that in South Africa 50% of preschool children suffer from severe malnutrition, and nearly one in five have stunted growth caused by inadequate nutrition, while 6.5% showed severe stunting.

Children under the age of five with mild, moderate or severe malnutrition are respectively 2.5 times more likely to die (Bizourne, 2005:23). Bizourne elaborates by saying “most of these deaths hit mild and moderate underweight children, not the visually ruined victims of famine”.

Hunt’s (2009) study indicates that about 100 million children in South Asia and the referenced 12 Sub-Saharan countries are the core target for reducing child underweight, stunting, and related preventable child mortality. This would make a great

contribution to reaching the Millennium Development Goals' (MDGs) number one goal, which is reducing poverty in children, and goal number four, which is reducing child mortality.

In 1998 the Government of South Africa started the implementation of one of its poverty alleviating strategies which aims to ensure that children in poverty stricken families are able to meet their basic subsistence needs by introducing the Child Support Grant (CSG) (Department of Social Development, 2012). To qualify to receive the CSG, Hall (2012:12) outlined two key criteria:

- (1) The child must be below the age of 17.
- (2) The monthly income of his/her parents or caregivers combined must be R1100 or less in urban areas and R800 in rural areas or informal settlements.

However, despite the implementation of the CSG, malnutrition in children under the age of five years is still a serious problem (Feed the Babies Fund, 2009). Therefore this study intended to explore and describe the views of caregivers on the contributing factors to malnutrition among children under the age of five years who are benefiting from the South African CSG.

## **1.2 DEFINITION OF KEY CONCEPTS**

### **Malnutrition**

The Food and Agricultural Organization (2010:16) defines malnutrition as “a condition that develops when the body does not get the right amount of vitamins, minerals and other nutrients it needs to maintain healthiness”.

### **Child Support Grant**

According to the Department of Social Development (2011:16), the CSG is “financial support extended by the government to families through an assessment (means test) which caters for children between the ages of 0-17”.

## **Child**

The Children's Act (No. 38 of 2005) defines a child as "a person under the age of 18 years". The United Nations Children Fund (UNICEF, 2008) considers a child as "every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier". In the context of this study the focus will be on children under the age of five years.

## **Caregiver**

A caregiver is a person who takes care of someone who cannot care for themselves (Drentea, 2007). The Children's Act (No. 38 of 2005) defines a caregiver as "any individual other than a parent or guardian, who literally cares for a child". In the context of this study the concept caregiver refers to a person who takes care of a child under the age of five years.

### **1.3 LITERATURE REVIEW**

The literature reviewed gives the analysis of respective researchers who studied the phenomenon of malnutrition around the globe. The effort of key stakeholders such as international organisations, different countries and non-governmental organisations (NGOs) involved in combating malnutrition will be covered. However, there is very limited research on the role of caregivers in reducing the scourge of malnutrition and this is what the current study will be focusing on.

In Africa over the last 10 years, recent studies show that child malnutrition rates and health has deteriorated. At national level, stunting and underweight remain the common nutritional disorders affecting one out of five children in South Africa. The report adds that two out of three children had a poor vitamin A intake and 45.3% of children had an inadequate zinc status (Health System Trust, 2011)

### **1.3.1 Main causes of malnutrition**

Klugman (2002:18) outlined causes of malnutrition as poverty, ignorance, faulty feeding practices, food scarcity, consumption of food of low nutrient density, and the low bio-availability of food nutrients. DeLange (2004:13) lists the immediate causes of childhood malnutrition as insufficient diet as well as stressed caregivers, trauma, and poor psychosocial care.

Adding to the above list, Torún and Chew (1994:95) noted that the basic causes, also called root causes, of malnutrition include poor availability and control of resources, environmental degradation, poor agriculture, war, political instability, urbanisation, population growth and size, distribution, conflicts, poor trade agreements, natural disasters, and religious and cultural factors. In this regard Vorster and Hautvast (2003:8) add landlessness and migrant labour as causes of malnutrition, as well as market failures due to economic decline, and conflict and political upheavals that lead to a reduction in food yields and price increases.

Bizourne (2005) refers to psychological and anthropological aspects of child malnutrition as individual urbanisation of the mother, which may result in an abrupt loss of support by extended family members and compromised quality care. A study conducted by Ditebo (2010) in Botswana refers to the following factors that contribute to malnutrition: “lack of knowledge about malnutrition, wrong perceptions of malnutrition by mothers, illiteracy and unemployment as well as cultural factors like taking a child to a traditional healer instead of a medical health facility for treatment”.

### **1.3.2 Effects of malnutrition**

The effects of malnutrition on young children can be life-threatening. In this regard Bhutta, Tahmeed, Black, Cousens, Dewey, Giugliani, Haider, Kirkwood, Morris, Sachdev and Shekar (2008:54) reports that iodine and iron deficiency during infancy can cause mental retardation even after the deficiencies have been treated. Depending on the severity of the deficiency, the consequences of malnutrition include growth stunting, kwashiorkor, marasmus and failure to thrive.

Furthermore, malnutrition is considered to be a leading cause of child mortality in developing countries. The immune systems of affected children get weaker and they die of diseases which they could have survived if they were not malnourished (UNICEF, 2008:15). The World Bank (2006) confirmed that protein-energy malnutrition (PEM) is a major contributor to higher mortality diseases such as pneumonia, malaria, diarrhoea and measles in the developing world. Among infants and preschool learners, the prevalent forms of malnutrition are deficiency in iron, vitamin A, iodine and protein energy (World Bank, 2006).

UNICEF (2008:14) emphasises that stunting in children below the age of five is an indicator of chronic malnutrition which is common in India, South America and in Asian Pacific regions, and is closely linked to child mortality.

Pediatric Oncall (2009:21) states that malnutrition results in an impaired immune response and increased infections. In addition, when acute malnourishment and hunger occurs among infants and toddlers in the first 1000 days of life, it sets up the child for an unhealthy life for the future; effects are long-lasting even after treatment.

A South African study by Bourne, Hendricks, Marais and Eley (2007:2) reported that households at risk or experiencing hunger tended to be of the informal dwelling type, had the lowest monthly income, and spent the least amount of money weekly on food. Mothers from these households also had a lower standard of education. From this study it was evident that poverty and poor nutritional intake are significant causes of high levels of poor infant and child physical growth and development. This has been confirmed by UNICEF in De Lange (2004:38) who referred to the fact that poor nutrition has been implicated in delayed cognitive development; the long-term damaging effects include poor intellectual and psychological development and severe susceptibility to infections.

### **1.3.3 Strategies and programs to address malnutrition**

On an international and national level different strategies and programmes are

implemented to combat malnutrition among young children. Efforts to combat the scourge of malnutrition, according to the Burden of Disease Research Unit (2012:17), should include access to food and health services and good care. Furthermore, comprehensive service delivery across sectors could contribute to malnutrition reduction, for example recognising that water, sanitation and access to health services are largely connected to child health and nutrition. De Lange (2004:39) also emphasised that the drive for improved nutritional status of children has to involve how it will be influenced by the HIV/AIDS epidemic.

Gupta (2012:29) outlines a community-based malnutrition programme implemented by Save the Children Fund International in the Philippines, in the year 2000. Children from the ages of six months to five years and their caregivers were enrolled to improve their health and nutritional status by rehabilitating malnourished children, sustaining the rehabilitation, and preventing future malnutrition in the community. However, in April 2009 Save the Children Fund withdrew their funding and Kraft Foods, a local organisation in the Philippines, rendered further financial support under the “Making Food Go Further Project”. Gupta (2012:32) assessed the project and concluded that there was little self-sustainability due to the foreign approach which kept the beneficiaries away from their natural setting.

Another malnutrition evaluation programme was carried out by Kasirye (2010) under the auspices of UNICEF, focusing on central African countries, namely Kenya, Rwanda, Uganda and Tanzania. The objective of the programme was to improve the nutritional status of children aged five years and below. It relied on low cost approaches such as nationwide vaccination, nutritional supplements and maternal education. According to Kasirye (2010:5) the results were however minimal.

In the South African context Bourne et al. (2007:2) refer to the National Integrated Nutrition Programme as a strategy to address malnutrition. The on-going National Integrated Nutrition Programme is a comprehensive nutrition strategy that focuses on children below six years of age, at-risk pregnant and lactating women, and those affected by communicable and non-communicable diseases. Within this programme focus areas relevant to preschool children include disease-specific nutrition treatment,



support and counselling; growth monitoring and promotion (GMP); micronutrient malnutrition control; breastfeeding promotion, protection and support; contributions to household food security; nutrition interventions among HIV-infected children; and nutrition promotion, education and advocacy.

The South African National Integrated Nutrition Programme has brought together key stakeholders essential to ensuring that the programme serves as a mechanism for communities to involve the Government in developmental activities. The programme therefore has managed to “move beyond nutrition into development-oriented interventions” (Health Systems Trust, 2011). However, despite the success of the programme, certain areas are still presenting cases of malnutrition among children who are five years and below in South Africa.

In another attempt to address malnutrition the South African Government has developed a poverty alleviating strategy in 1998 by implementing the CSG. The aim of the CSG is to transfer cash to low income families with children between the ages of 0-17 unconditionally, in order to ensure that those children’s basic subsistence needs are met. This is unlike the Oportunidades programme in Mexico which makes grants conditional upon a school and clinic attendance chart (Aguero, Carter & Woolard, 2006:18).

A study on the implementation of the CSG by Hall, Woolard and Smith (2012:13) indicates that if enrolled in the early months of life, cash grants directly reduce poverty and inequality. Beneficiaries of the grant have an increased likelihood of food intake and dietary diversity which improves the nutritional status and cognitive development of the child, which is associated with human capital development. However, the report falls short of measures to monitor and reinforce the spending of the grant.

In 2012 the Department of Social Development and UNICEF (2012) outlined the progress made and challenges encountered since the inception of the CSG. One of the most prominent challenges is the high number of cases of malnutrition among children below the age of five treated at Chris Hani Baragwanath Hospital while benefiting from the CSG. Therefore this study will focus on an exploration of the contributing factors of

malnutrition among children benefiting from the Child Support Grant as viewed from the caregivers' perspective.

#### **1.4 THEORETICAL FRAMEWORK**

This study was grounded in the ecological systems theory. The ecological systems theory is an approach in social sciences that gives a meaning to the complex transitions between people and their multifaceted environment (Tamas, 2000:4). As per this theoretical construction, the environment in which the child is born and brought up offers him/her a point of reference to the world.

The ecological systems theory makes clear the need to view “people and environment as a unitary system within a particular cultural and historic context” (Kirt-Ashman & Hull, 2006:10). Both person and environment can be understood in terms of their inter-relationship, in which each continually influences the other within a particular context. Within the context of this study it implies that caregivers and the children who they are caring for live in an inter-relationship with their environment, e.g. family members as well as economic and political structures in the environment. If there is, for instance, a positive support system from family members and the economic and political structures are stable, the effects of such a positive environment trickle down and improve the caregiver's ability to care and provide for the child. However, in the context of this study it seems as if the constant interaction between caregivers and their environments resulted in a negative influence on the process of providing care for children below the age of five. Transactions such as living far away from the family as a single mother, divorce, or fathers that do not contribute towards the maintenance of a child could be interactions with the environment system which negatively affect child rearing (Bronfenbrenner in Santrock, 2011).

The ecological systems theory views people in the context of their environments in the widest possible holistic manner and emphasises the continuous and reciprocal influence with the environment (Maguire, 2002:90). Human freedom is embedded in the process of adaptation between human beings and their physical and social environment which is a “goodness of fit.” These interactions are dynamic, resulting in a

synergistic cycle of the influence between the changing individual and the changing environment (Zide & Gray, 2001:9).

According to Hepworth, Rooney and Larsen (2006:7), the ecological systems approach focuses predominantly on the satisfaction of human needs and the mastery of developmental tasks, which require adequate resources in the environment and positive transactions between people and their environments. Key issues emphasised by this approach is that there needs to be adequate resources in the environment. Any gap in the availability of resources in the environment, the ability of individuals to make use of these resources, or the dysfunctional transactions between the individuals and the environmental systems may threaten or block the fulfilment of the individuals' needs and will result in stress and/or impaired functioning.

The prevalence of malnutrition in South Africa despite the social assistance of the CSG could be linked to limited resources in the environment which may block the fulfilment of the children's needs that caregivers are responsible for. It is thus clear that there is a reciprocal interaction between the environment and the relevant role players, in this case caregivers and children. However this interaction is dynamic and should be investigated from the holistic ecological perspective (Zastrow, 2003:18-19).

## **1.5 RATIONALE AND PROBLEM STATEMENT**

Different strategies and programmes on an international and national level focus on the causes, effects and alleviation of malnutrition among children (UNICEF, 2008). However, a research gap was identified in that limited information existed on caregivers' views regarding malnutrition among young children who were benefiting from the CSG as a poverty alleviation programme. Therefore, this study aimed to explore and describe the views of caregivers regarding the contributing factors of malnutrition among children under the age of five years, who were benefiting from the CSG, and treated at Chris Hani Baragwanath Hospital. The study was thus guided by the following research question:

**What are the views of caregivers on the contributing factors of malnutrition**

## **among children under the age of five who are beneficiaries of the Child Support Grant?**

Due to the fact that the findings of this study could help service providers to understand malnutrition as a social phenomenon from the caregiver's perspective, it has the potential to contribute to the alleviation of malnutrition and to improve care for children below the age of five. Furthermore, the study could further help in the development of policies pertaining to the alleviation of malnutrition among children.

### **1.6 GOAL AND OBJECTIVES OF THE STUDY**

#### **1.6.1 Goal**

The goal of the study was to explore and describe the views of caregivers regarding the contributing factors of malnutrition among children under the age of five, who were benefiting from the CSG, and admitted at Chris Hani Baragwanath Hospital.

#### **1.6.2 Objectives of the study**

The objectives of the research study were:

- To conceptualise malnutrition as a social phenomenon and to explore strategies of alleviating malnutrition with specific emphasis on the Child Support Grant.
- To determine caregivers' understanding of malnutrition among children as a social phenomenon.
- To determine caregivers' views on contributing factors of malnutrition among children who are benefiting from the Child Support Grant.
- To explore the challenges experienced by caregivers who receive the Child Support Grant.
- To make recommendations for combating malnutrition among children under the age of five who are beneficiaries of the Child Support Grant.

## 1.7 RESEARCH DESIGN AND METHODOLOGY

A qualitative approach was adopted in this study as the focus was to explore, describe and understand a social problem (Delport, Fouché & Schurink, 2011:298), namely malnutrition among young children and caregivers' views about the contributing factors of malnutrition, despite the fact that they receive the CSG. Babbie and Mouton (2005:53) refer to a qualitative research paradigm as an approach towards getting an insider's view. In the context of this study the researcher focused on obtaining the caregivers' views on the contributing factors of malnutrition among children who were below the age of five while benefiting from the CSG. The type of study was applied research. Hale (2011:2) gives the characteristics of applied research as seeking a solution to a problem in practice. In this study it referred to the problem of malnutrition among children below the age of five.

The research design applied to this study was the collective case study design focusing on a small number of caregivers whose children had been diagnosed with malnutrition. Fouché and Schurink (2011:320) postulate that a collective case study design is able to draw interest to what can be gathered from a small number of cases in order to obtain a personal experience within their social worlds.

Babbie (2011:186) considers a study population as the collection of essentials from which a sample was actually selected. The characteristics of the population in this study were all the caregivers who care for children who are below the age of five, benefiting from the CSG, diagnosed with malnutrition, and admitted at Chris Hani Baragwanath Hospital during 2014 up till the time that the empirical part of the study was conducted. The population were caregivers who did not receive services from the researcher. A sample of 10 participants was selected, namely caregivers who care for children below the age of five, benefiting from the CSG, diagnosed with malnutrition and admitted at Chris Hani Baragwanath Hospital during 2014 up till the time that the empirical part of the study was conducted. Purposive sampling, according to Strydom and Delport (2011:392), is about choosing a case to be studied because it consists of the characteristics which are of interest to the researcher. In the context of this study the

researcher selected the 10 caregivers who adhered to the following criteria:

- Caregivers caring for children below the age of five years and who were receiving the Child Support Grant.
- Caregivers who take care of children that were diagnosed with malnutrition and admitted at Chris Hani Baragwanath Hospital during 2014 up until the time that the empirical part of the study was conducted.
- Caregivers referred to the researcher by social workers rendering services in the paediatric medical wards of the Chris Hani Baragwanath Hospital.

The goal of this study was to extract rich, comprehensive material that can be used in analysis (Greeff, 2011:342). In order to collect rich information the researcher utilised semi-structured interviewing as a data collection method. Kvale and Brinkmann, in Creswell (2011:162), note that a semi-structured interview is characterised by probing and as a result of what the respondent said, the researcher developed themes to be explored which was influenced by the research topic. The interview was guided by a set of predetermined questions on an interview schedule and was tape-recorded (Greeff, 2011:352).

During the interviewing process the researcher had a face-to-face encounter with participants in which a rapport was established. Greeff (2011:342) adds that the validity of the information shared during the interview depends on the good judgment and the resourcefulness of the interviewer in accepting and managing the relationship. The study was qualitative in nature and as a result the researcher analysed the data narratively, interpreting the meaning assigned by the participants to their situation and the observations made by the researcher while conducting the interviews. Data analysis was done as described by Creswell, as cited in Schurink, Fouche and De Vos (2011:403). The researcher analysed and interpreted the data, which lead to thematic analysis.

A detailed description of the methodology in this research study will be outlined in Chapter 3.

## 1.8 LIMITATIONS OF THE STUDY

The main limitation of the study was the following:

- Although valuable information was collected, the lack of availability of participants led to the fact that the researcher interviewed only a small sample of 10 participants, with the implication that findings cannot be generalised to the whole population of caregivers.

## 1.9 CONTENTS OF THE RESEARCH REPORT

The research report will consist of the following:

- **Chapter 1:** This chapter focuses on the introduction and the context of the study; a brief literature review; the theoretical framework of the study; the rationale and problem statement; goal and objectives of the study; the research question; and a brief description of research methods utilised in the study; and limitations of the study.
- **Chapter 2:** This chapter will cover the relevant literature pertaining to malnutrition as a social phenomenon, as well as strategies to alleviate malnutrition with specific emphasis on the CSG.
- **Chapter 3:** The focus of this chapter will be on the research methodology and the results of the study.
- **Chapter 4:** This chapter will focus on the key findings, conclusions and recommendations.

## CHAPTER 2

### LITERATURE REVIEW: MALNUTRITION AS A SOCIAL PHENOMENON

#### 2.1 INTRODUCTION

As the goal of the study was to explore caregivers' views on the contributing factors of malnutrition among children under the age of five who are benefiting from the CSG, this chapter will primarily focus on a literature review regarding malnutrition as a social phenomenon.

The literature reviewed gives the analysis of respective researchers who studied the phenomenon of malnutrition around the globe, with specific emphasis on the prevalence, causes and effects thereof. The effort of key stakeholders, such as international organisations, different countries and NGOs, involved in combating malnutrition will also be covered.

Furthermore, attempts by the Government of South Africa and other stakeholders involved to address malnutrition with a specific focus on the CSG will be discussed. However, there is very limited research on the role of caregivers in reducing the scourge of malnutrition, and thus the study aimed at exploring the views of caregivers in relation to combating malnutrition.

In order to understand the phenomenon of malnutrition it is first of all important to discuss the concept of malnutrition.

#### 2.2 THE CONCEPTUALISATION OF MALNUTRITION

The *Medical Dictionary* (2009) describes malnutrition as: "A condition that develops when the body does not get the right amount of the vitamins, minerals and other nutrients it needs to maintain healthy tissues and organ function".

Feed the Babies Fund (2009) describes malnutrition as a condition in which the body does not get sufficient nutrients for proper functioning. It can be as a result of an



inadequate intake of calories, or lack of one particular nutrient such as Vitamin C. Whereas UNICEF (2011) considers malnutrition to be “a medical condition whereby the individual’s system cannot digest and absorb nutrients from the food consumed. The condition may range from mild, to severe and life-threatening”.

The World Health Organisation (2008) concurs with the above by considering malnutrition as:

Impaired health is caused by a dietary deficiency, excess, or imbalance support to human life. Energy from fat, carbohydrate and protein, water and more than 40 different food substances must be obtained from the diet in appropriate amounts. Chronic intake of any of these substances at levels above or below ranges result to malnutrition, but commonly the term refers only to deficient intake.

It is thus clear that malnutrition has certain major effects which will be discussed in the next section under clinical features.

### **2.3 THE CLINICAL FEATURES OF MALNUTRITION**

Lancet (2003) describes the signs of malnutrition amongst young children as follows:

Growth failure is an obvious sign, reduced activity in that the child becomes listless and apathetic or irritable. Because of this irritability, communication between the child and the parents is reduced. There is also discoloration of hair and skin, anaemia of varying severity, signs associated with deficiencies, and the presence of infection.

The Department of Health (2008) notes that protein energy malnutrition which is a condition characterised by an increased susceptibility to infection due to long-term intake of inadequate energy and protein to meet the child’s physiological needs, often results in repeated infections. It is important to note the fact that the body will use nutrients to first meet energy requirements. If energy intake is insufficient the protein

consumed may be used to supply energy needs and not the protein functions, giving rise to Protein Energy Malnutrition (Department of Health, 2008).

The Department of Health (2008) further reports that children with severe Protein Energy Malnutrition present with clinical diseases known as kwashiorkor and marasmus. Due to the seriousness of these conditions in relation to the study, the researcher will briefly discuss each in relation to children below the age of five. Kwashiorkor and marasmus are severe forms of malnutrition representing only the 'tip of the iceberg' of the condition in a population. Evidence suggests that malnutrition can considerably impair physical growth and slow down the brain's growth processes to different extents, depending on the time of onset, duration and severity. Permanent damage can be caused if malnutrition occurs during the time of maximal brain growth (Lancet, 2003).

Development can thus be impaired as a result of the inability of an undernourished child to respond to learning opportunities due to a lack of energy and specific micronutrients, according to the World Health Organisation (2008). It is thus clear that malnutrition during infancy and childhood has a profound effect on growth and development, as well as a child's susceptibility to infectious diseases.

As mentioned above, due to the seriousness of these conditions and specifically the clinical diseases known as kwashiorkor and marasmus, the researcher will briefly discuss each of these diseases.

### **2.3.1 Kwashiorkor**

UNICEF and World Health Organisation (2008) stipulate that kwashiorkor usually occurs when there is a sudden change in both the quality and quantity of the child's diet, especially during the weaning period. It is characterised by underweight with oedema (fluid retention), weakness, skin lesions, and a change in hair colour. Lancet (2003) highlights that: "kwashiorkor presents with failure to thrive, oedema, apathy, anorexia, diarrhoea and discoloration of the skin and hair." The general appearance may be that of a typical "sugar baby", with chubby features and a bloated body. At the time parents

may think the child is doing well, and they cannot be convinced that he is malnourished. Failure in growth is remarkable and weight is reduced in spite of the presence of oedema (chubby features and bloated body). Varying degrees of muscle wasting are present. The discoloration of hair and skin gives the child a characteristic "red baby" look (World Health Organisation, 2008).

### **2.3.2 Marasmus**

According to the Department of Health (2008) marasmus is a form of severe malnutrition that develops over a long period of time and is characterised by extreme underweight, wasting (loss of muscle and fat under skin so that the bone structure becomes visible), irritability and nervousness. Lancet (2003) and UNICEF (2008) add that sufferers of marasmus appear skeletally thin, and that the disease usually occurs in younger children accompanied by failure to thrive. Affected children are thinner and smaller for their age. In appearance they are shrunken and wrinkled due to lack of required fat. Kwashiorkor had aroused maximum interest and attention as a condition linked with malnutrition in children, but it is now increasingly realised that marasmus is a fast-growing disease in the large urban slums and informal settlements of the cities of developing countries.

Since marasmus usually occurs at a younger age, its long-term effects are more severe. Recognition at an early stage is important in order to avoid the serious after-effects of established malnutrition and as a result there has been great interest in the classification and accurate identification of the early signs of this disease.

## **2.4 PREVALENCE OF MALNUTRITION**

Despite the declaration by the World Health Organisation (2005) that malnutrition is a global public health problem linked to an increase in the risk of mortality and morbidity, malnutrition remains a challenge in developing nations. The prevalence of malnutrition will be discussed first on an international level, and then within the South African context.

### **2.4.1 Internationally**

UNICEF (2008) postulates that globally 165 million children under the age of five were stunted in 2011. About 36% of these children live in Africa and 27% are inhabitants of Asia. Childhood malnutrition is a massive crisis caused by a combination of factors and it remains a major public health problem which does not get enough recognition. The World Health Organisation (2010) has estimated that eight children under the age of five die in sub-Saharan Africa every five minutes. In the 46 countries in the African region, 36 have under-five mortality rates (U5MRs) of above 100 per 1000 live births. Eight countries have U5MRs of at least 200 per 1000 live births and five countries have had static U5MRs in the past 15 years, while in nine countries the U5MRs have reversed.

Two thirds of the under-five deaths in the African region are due to preventable causes perpetuated by malnutrition. The World Health Organisation (2010) emphasises the chief causes of death as neonatal situation and acute respiratory infections, mainly pneumonia, malaria, diarrhoeal diseases, measles and HIV/AIDS, most of which are complicated by malnutrition that accounts for one third of all deaths in children under five years of age. Under-five deaths, most of which occur in the African region, increased to 43% globally in 2005 from 31% in 1990. According to the World Health Organisation (2010), an estimated 10.6 million under-five children die each year, 4.6 million of whom die in the African region.

### **2.4.2 South Africa**

The Department of Health (2008) conducted a national survey in South Africa of the nutritional status of preschool children, which showed that one in every four children suffers from chronic malnutrition. The prevalence of malnutrition differs greatly across the South African provinces, with the Limpopo Province, Eastern Cape and Free State having the highest prevalence. The report further indicated that a large number of children below the age of five consumed a diet low in energy and of insufficient nutrient density to meet their dietary needs. This pattern of intake appears to affect more rural areas. According to the Department of Health's (2008) report "the prevalence of stunting was higher in rural areas by 26.3% and especially so in commercial farming

areas by 30.8 %. Younger children aged 1-5 years old were also more affected by stunting than older children by 25.5%”.

More recently a study conducted by the Burden of Disease Research Unit (2012) showed that underweight contributed to 12.3% (11,808) of deaths and 10.8% of disability in children under five years of age. Furthermore, iron deficiency anaemia accounted for 7.3% of prenatal deaths, while 28% were from diarrhoea and 23% from measles.

## **2.5 THE MAIN CAUSES OF MALNUTRITION**

In order to mitigate the alarmingly high prevalence rates of malnutrition among children, it is important to also give attention to the causes of malnutrition. Different scholars identified different causes of malnutrition. Klugman (2002:18) refers to “poverty, ignorance, faulty feeding practices, food scarcity, consumption of food of low nutrient density and low availability of food nutrients” as important causes of malnutrition. DeLange (2004:13) lists the immediate causes of childhood malnutrition in South Africa as insufficient diet, stressed caregivers, trauma, and poor psychosocial care.

UNICEF (2008) has shown that nutrition is usually influenced by the following interrelated factors: political instability; poverty/inequality; ineffective development and health policies; climate/environmental change; and inadequate and poorly administered food security.

Adding to the above list, Torún and Chew (1994:95) noted that the basic causes, also called “root causes”, of malnutrition include poor availability and control of resources, environmental degradation, poor agriculture, urbanisation, population growth and size, distribution, conflicts, poor trade agreements, natural disasters, and religious and cultural factors. In this regard Vorster and Hautvast (2003:8) add landlessness, conflict and political upheavals that lead to a reduction in food yields and price increases.

Considering the interrelatedness of each of these causes the key contributing factors, namely poverty and inequality, poor childcare practises, insufficient resources, and lack of education, will be discussed in detail focusing on their impact on child malnutrition.

### **2.5.1 Poverty and inequality**

According to Steyn (2008) poverty and lack of food security are the primary reasons why malnutrition occurs in developing nations. In these developing nations 10% of all members of low-income households do not always have enough healthy food available to eat. Steyn (2008) elaborates on how a low income results in an inability to buy store food, which leads to nutritional deficiencies. Pregnant women, infants and children are most at risk for inadequate dietary intake because their nutritional requirements are relatively high.

The World Health Organisation and UNICEF (2008) highlight that Sub-Saharan Africa has one of the leading low birth weights due to poor nutritional intake by expecting mothers. The exclusive breastfeeding rate is also low and complementary foods are insufficient and unsuitable in the region. Blakeman (2002:13) adds the issue of gender inequality in the region, which places women in a situation where they cannot make decisions about their bodies in terms of the use of family planning to limit the number of children in order to manage them well.

On a national level, Sharma (2012) refers to the fact that inequality in South Africa has a complex relationship with economic growth, poverty and race. In this regard the South African economy has witnessed positive growth post-apartheid and poverty is declining, yet the economic growth gains have not been equitably redistributed. Inequality has shown an increasing trend. Sharma (2012) notes that income shares are concentrated in the top 10% of the population, with the lowest 5% of the population getting hardly any income.

This situation of inequality and poverty can lead to the problem of malnutrition, as confirmed by the Burden of Disease Research Unit (2012) who adds that the most significant immediate cause of malnutrition is inadequate food intake, as a large part of

the population comes from low-income households. Furthermore, the Burden of Disease Research Unit (2012) postulates that in South Africa there are a number of contradictions regarding food security reports. While some studies have indicated that there is sufficient food available nationally, large sectors of the population experience hunger and food insecurity. For instance, the Department of Health (2008) conducted a study and found that a high percentage of children lived in low-income, poor households. The study also reflected a slowdown in income increase resulting in poverty since 2002. It can thus be concluded that poverty, lack of resources and inequality can be considered as contributing factors to malnutrition.

### **2.5.2 Poor childcare practices**

Steyn (2008) refers to the psychological and anthropological aspects of child malnutrition as urbanisation/migrating of the mother due to rural poverty, which may result in an abrupt loss of support by extended family members and compromised quality care. The presence of poor support systems and caregivers' living conditions, which are characterised by informal dwellings and shacks in urban areas, greatly increase the risk of child malnutrition.

The World Health Organisation (2012) says in terms of dietary intake, only 12% of infants younger than four months were exclusively breastfed in 2003, while 20% were never breastfed as a result of mothers who work far away from home and leave the baby in alternative care. Karsiye (2010:18) confirms the rapid decline in breastfeeding which has contributed to the increase in the incidences of marasmus. In older children, less than half consumed the recommended energy and micronutrient intakes. These intakes were significantly lower for rural children below the age of five years.

DeLange (2004:13) added other causes of malnutrition as insufficient diet, stressed caregivers, trauma, and poor psychosocial care. Gender inequality places women in a situation where they cannot make decisions about their bodies in terms of the use of family planning to limit the number of children in order to manage them well. In a study by Torún (2006:883) it was reported that households at risk or experiencing hunger

tended to be of the informal dwelling type, had the lowest monthly income, and spent the lowest amount of money on food weekly.

### **2.5.3 Insufficient resources**

According to Lancet (2003), malnutrition is a critical risk factor in most countries, and nutrition and food security remains a fundamental challenge to child survival. There are multiple constraints in health systems that hamper the effective scaling up of child health interventions. Insufficient human, financial and material resources coupled with limited managerial capability are some of the factors that lead to poor service delivery and/or low coverage of interventions, Kasirye (2010) adds. Financial resources for child survival programmes are far from adequate and not every community in every district is being reached with low-cost interventions.

### **2.5.4 Lack of education**

Blakeman (2002:51) mentions lack of education as another major contributing factor to malnutrition, because most caregivers are illiterate and they lack knowledge about nutrition, breastfeeding and parenting. This was confirmed in a study conducted by Ditebo (2010) in Botswana where it was found that “lack of knowledge about malnutrition, wrong perceptions of malnutrition by mothers and illiteracy” are contributing factors of malnutrition.

## **2.6 EFFECTS OF MALNUTRITION**

The Burden of Disease Research Unit (2012) and the Department of Health (2008) present different effects of malnutrition according to socio-demographics. However, for the purpose of this study the researcher will focus on a discussion of mortality, iron deficiency and reduced growth as crucial effects of malnutrition.



### **2.6.1 Mortality**

One of the most devastating effects of malnutrition is its linkage to high mortality rates amongst young children. The Department of Health (2008) indicates that in 2000 the main cause of under-five mortality in South Africa was HIV/AIDS related illnesses, while low birth weight, diarrhoea, lower respiratory infections, and malnutrition accounted for 30% of all under-five deaths. The Burden of Disease Research Unit (2012) confirms that the malnutrition-infection cycle is a key driver of child mortality, because children who are underweight are at an increased risk of infectious diseases.

Furthermore, UNICEF (2008:14) emphasises that stunting in children below the age of five is an indicator of chronic malnutrition which is common in developing nations, and is closely linked to child mortality. Pediatric Oncall (2009:21) states that malnutrition results in an impaired immune response and increased infections. In addition, when acute malnourishment and hunger occur among infants and toddlers in the first 1000 days of life, it sets up the child for an unhealthy life and the effects are long-lasting even after treatment.

Malnutrition is considered to be a leading cause of child mortality in developing countries. The immune systems of affected children get weaker and they die of diseases which they could have survived if they were not malnourished (UNICEF, 2008:15). The World Bank (2006) confirms that protein energy malnutrition is a major contributor to higher mortality diseases such as pneumonia, malaria, diarrhoea and measles in the developing world (National Development of Health, 2003:8).

### **2.6.2 Iron deficiency**

The second important effect of malnutrition that can be life-threatening is iron deficiency. In this regard Bhutta et al. (2008:54) reports that iodine and iron deficiency during infancy can cause mental retardation even after the deficiencies have been treated. Depending on the severity of the deficiency, the consequences of malnutrition include growth stunting, kwashiorkor, marasmus and failure to thrive.

Iodine deficiency is considered by Bhutta et al. (2008) as the world's greatest single cause of mental retardation and brain damage at an early age, which can lead to reduced physical and mental development during childhood. UNICEF (2008) confirms that Iron deficiency impedes cognitive development in children age 6 - 24 months.

According to UNICEF (2008) lack of vitamin A weakens the immune system of the sufferer and makes the child vulnerable to diseases. A deficiency in vitamin A, for example, increases the risk of diarrhoea, measles and malaria by 20-24 percent among 140 million preschool children in 118 countries. It is also a leading cause of child blindness across developing countries. UNICEF (2008) adds that among infants and preschoolers, the more prevalent nutrient deficiencies are iron, vitamin A, iodine, protein, energy, riboflavin, calcium and zinc. According to international agencies, millions of children suffer from deficiencies of iron, iodine and vitamin A. The incidence of these problems is markedly higher in developing countries; however, infants in industrialised countries are not spared. Iron deficiency has no borders and in industrialised countries approximately 15% of infants consume insufficient amounts of dietary iron (Klugman, 2002:32).

### **2.6.3 Reduced growth**

Bhutta et al. (2008) discusses reduced growth as a consequence of adaptation to lack of food and it also affects height. Weight can swing up and down, but obviously this is not the case with height. All that happens is that growth in height slows down and the individual will remain short. Those children whose height is less than the mean height of children in their age group are called “stunted”. A study by the Burden of Disease Research Unit (2012) found that catch-up growth in both height and weight can occur if the slowing of growth was temporary, for example after an acute illness. If dietary deficiency is prolonged, full catch-up does not occur and the deficit in height becomes fixed and permanent. Thus deficits in height indicate long-standing malnutrition.

Literature reported that poverty and poor nutritional intake are significant causes of the high levels of poor infant and child physical growth and development. This has been confirmed by UNICEF (2004:38) who refers to the fact that poor nutrition has been

implicated in delayed cognitive development and long-term damaging effects, including poor intellectual and psychological development and severe susceptibility to infections.

The Department of Health (2013:15) declares nutrition as the children's right to survival and development and if not attended to it could perpetuate a cycle of intergenerational poverty. UNICEF (2012) regards focusing on adequate nutrition for mothers and children as a contributing factor to achieving the Millennium Development Goals (MDGs) that relate to improving child survival (MDG 4), reducing malnutrition (MDG 1) and ensuring maternal health (MDG 5).

## **2.7 STRATEGIES AND PROGRAMMES TO ADDRESS MALNUTRITION**

On an international and national level different strategies and programmes are implemented and still needed to combat malnutrition among young children. Existing strategies developed to alleviate the scourge of malnutrition will be discussed below, starting with the international arena and then followed by the approaches implemented by South Africa.

### **2.7.1 International strategies and programmes to address malnutrition**

Various international organisations suggest different strategies and programmes to address malnutrition. For instance Egli (2011) discusses bio-fortification; a strategy that was recommended by the World Food Programme (WFP), which focuses on increasing the level of essential nutrients in edible parts of crops by conventional plant breeding. Conventional plant breeding has been the primary approach to enhancing staple food crops with iron, zinc and pro-vitamin A. Rice, wheat, maize, pearl millet, the common bean, sweet potato and cassava are the main targeted crops for the process. The World Food Programme (2000) lists the following three prerequisites to make bio-fortification successful:

- a bio-fortified crop must be high yielding and profitable to the farmer;

- the bio-fortified crop must be shown to be efficacious and effective reducing micronutrient malnutrition in target populations, and
- the bio-fortified crop must be acceptable to farmers and consumers in target regions(Hotz & McClafferty, 2007).

Other strategies to mitigate malnutrition according to the World Food Programme (WFP) (2000), are sustaining the quality and quantity of food a person eats and ensuring adequate health care and a healthy environment. In this regard the World Food Programme's role in fighting malnutrition is to give malnourished people the food and nutrients they need, but also to prevent malnutrition by acting where there is a threat of poverty. The WFP has the mandate to address moderate malnutrition, which is technically called moderate acute malnutrition. By treating moderate acute malnutrition, according to the World Food Programme (2000) and the Department of Health (2008), children are prevented from slipping into severe acute malnutrition.

Hotz and McClafferty, in Igli (2011), confirm these developments by stipulating that progress in foods for preventing severe malnutrition has worked as a catalyst for the development of special foods for other forms of malnutrition too. It includes, for instance, new strategies such as home-fortification with multi-micronutrient powder also known as 'sprinkles'. Home fortification means that beneficiaries themselves sprinkle the powder over food after they have cooked it. It is a viable option when households already have some food, but the food they have lacks important micronutrients (World Food Programme, 2000). The new strategies, which include ready-to-use supplementary foods (RUSFs) for treating children with moderate acute malnutrition, and complementary food supplements to complement the diet of young children (6-24 months) with the highest nutritional needs, are also supported by Kasirye (2012:23). In cases of severely malnourished children the new ready-to-use therapeutic foods (RUTFs) have also been developed (Burden of Disease Research Unit, 2012:17).

Efforts to combat the scourge of malnutrition, according to the Burden of Disease Research Unit (2012:17), should include access to food and health services and good child care practices. Furthermore, comprehensive service delivery across sectors could

contribute to malnutrition reduction, for example recognising that water, sanitation and access to health services are largely connected to child health and nutrition.

Bramley (2013:10) focuses on addressing malnutrition on an international level by outlines recommendations cited by the G-20 conference. In this regard the G-20 conference views food-price instability as one of the leading contributing factors to an increase in global poverty. The members of the G-20 conference committed to focus on better regulating markets; improving market information and transparency; and preventing and managing the effects of price instability through inventories and insurance. Furthermore, Bramley (2013:10) recommends a short- and long-term goal to deal with the growing demand for agricultural commodities. The G-20 member countries have committed to promoting responsible agricultural investment, fostering smallholder agriculture, advancing trade liberalisation, and investing in and co-ordinating research on agricultural productivity and innovation in order to increase agricultural output. Public and private investment in agriculture is encouraged, as is the provision of an enabling regulatory framework. The importance of dealing with the challenge of climate change and growing concerns over access to farmland has also been prioritised in the G-20 as an important dimension of increased productivity.

Bramley (2013) adds that governments need to develop appropriate risk-management instruments for firms and farmers to build capacity to manage and mitigate the risks associated with food-price unpredictability. Klugman (2002) emphasises the recognition of the need to regulate agricultural financial markets appropriately, an aspect that is considered key for both well-functioning physical markets and risk management. It is the view of the researcher that controlling food affordability could address the felt need by low-income earners and those relying on state grants.

It is the researcher's argument that if the majority of the world's population can embark on effective and productive agricultural activities fully supported by the respective governments and private sector through subsidised inputs and water harvest in good summer months to provide irrigation systems, food security would no longer be a threat resulting in reducing malnutrition among younger children.

Gupta (2012:29) reports on a community-based malnutrition programme implemented by Save the Children Fund International in the Philippines. In the year 2000 children from the ages of six months to five years and their caregivers were enrolled to improve their health and nutritional status in a rehabilitation centre where they were given skills on basic child care, thus preventing future malnutrition in the community.

Kasirye (2010) evaluated a programme by UNICEF on the nutritional status of children aged five years and below in central African countries, namely Kenya, Rwanda, Uganda and Tanzania. The objective of the programme was to improve the nutritional intake among children from 0-60 months. It relied on low cost approaches such as nationwide vaccination, nutritional supplements and maternal education. The results were however minimal.

Globally, nutritional intake has gained consideration as a basic pillar for social and educational development. The reduction of malnutrition in infants and young children is essential to achieving the MDGs, especially those in line with the reduction of extreme poverty and hunger (UNICEF, 2012).

Recent findings from the Lancet (2003) have highlighted evidence-based interventions that positively influenced a decrease in malnutrition. In this regard the following is noted:

.....a group of effective nutrition interventions, including breastfeeding, complementary feeding, vitamin A and zinc could save 2.4 million children each year. There are now proven interventions and technologies to tackle under-nutrition and micronutrient deficiency, and growing evidence on how to implement cost-effective and affordable programs on a large scale. The challenge is collective action by public, private and civil society to focus on investments to improve the broader environment to integrate and prioritize nutrition more effectively.

## 2.7.2 South African strategies to address malnutrition

The Department of Health initiated the Integrated Nutrition Programme (INP) to address and prevent malnutrition with the vision of optimal nutrition for all children. It did so through a comprehensive approach to address the underlying causes of malnutrition through direct services, such as nutrition education and promotion; micronutrient supplementation; food fortification; and disease-specific nutrition counselling and support. The programme was supported by the following systems: nutrition information system, human resource plan, and financial and administrative system, which combined could alleviate poverty resulting in the eradication of malnutrition (*The Social Assistance Act 1992*).

The INP targets nutritionally vulnerable communities, groups and individuals with children under the age of five and at-risk pregnant and lactating women. Hendricks and Bourne (2006:46) spell out several programmes in nutrition and child health in the public sector in South Africa that are linked to health facility-based nutrition interventions at the primary level of care. According to the Department of Social Development (2011) the INP has the following main focus areas:

- (i) maternal nutrition;
- (ii) infant and young child feeding;
- (iii) youth and adolescent nutrition;
- (iv) micronutrient malnutrition control;
- (v) disease-specific nutrition support, treatment and counselling;
- (vi) nutrition promotion, education and advocacy;
- (vii) food service management; and
- (viii) community-based interventions.

It is clear that the on-going National Integrated Nutrition Programme is a comprehensive nutrition strategy that focuses on children below 5 years old, at-risk pregnant and lactating women, and those affected by communicable and non-communicable diseases. Within this programme focus areas relevant to children include disease-specific nutrition treatment; support and counselling; micronutrient

malnutrition control; breastfeeding promotion, protection and support; contributions to household food security; nutrition interventions among HIV-infected children; and nutrition promotion, education and advocacy (Department of Social Development, South African Social Security Agency & UNICEF, 2012).

The National Integrated Nutrition Programme (INP) has brought together key stakeholders essential to ensuring that the programme serves as a mechanism for communities to involve the government in developmental activities. The programme therefore has managed to “move beyond nutrition into development-oriented interventions” (Health Systems Trust, 2011).

Progress has been made in terms of the provision of basic services combined with initiatives that inform and empower women to ensure adequate nutritional intake by children. However, despite the success of the programme certain areas are still presenting cases of malnutrition among children who are five years old and below in South Africa (Labadarios, 2005).

The Department of Health (2008) outlined a number of reviews and assessments of the INP over the last decade, wherein a number of recommendations to further improve and strengthen the INP have been put forward. The INP has a unique opportunity to reassess its progress in line with these recommendations in order to accelerate South Africa’s progress to reduce malnutrition and meet the MDGs.

In addition to the INP, the Department of Health (2008) also recommends counselling which is provided through the provincial Paediatric Case Management Guidelines focusing on appropriate baby feeding practises and care.

Furthermore, Labadarios (2005) discussed micronutrient deficiencies and the approach to eliminate the condition. He describes the approach as follows:

The provision of supplements which is a short-term strategy to address micronutrient deficiencies among a specified target group. The South African vitamin A supplementation programme should form part of the routine



immunisation programme, maternal health, and the integrated management of childhood illnesses.

In this regard Gillespie and Mason (1994) mention that food fortification is important. Food fortification refers to the addition of micronutrients to accessible and affordable foods that are regularly consumed by a significant proportion of the population at risk. The World Trade Organization identified the most commonly consumed foods, which would be the most appropriate vehicles for fortification. Fortification of two staple foods, namely maize meal and wheat flour was legislated in October 2003 in South Africa. In extending the reinforcement of vitamin A and iron, it became mandatory to iodise household salt through revised legislation in December 1995.

Growth monitoring and promotion, and the control of micronutrient deficiencies such as vitamin A, iron, iodine and zinc deficiencies has thus been considered as an effective strategy to combat malnutrition. Several of these interventions are delivered through the Integrated Management of Childhood Illness (IMCI) strategy at primary health care facilities. Evidence shows that the promotion of breastfeeding, the complementary feeding of vitamin A and zinc, and the appropriate management of severe malnutrition are able to reduce child mortality by a quarter, and stunting by a third when implemented at a larger scale (Department of Health, 2008).

It is of paramount importance that child care practices be enhanced as an approach to reducing malnutrition. UNICEF (2004) outlines that in most societies the mother constitutes the main resource for care, but also experiences the most constraints. The status of the women in the community is therefore fundamental.

Care practices have been proposed in the Initiative Care Manual which was published by UNICEF in 1997, which include care for women who are breastfeeding and psychosocial care. Food preparation, hygiene practices and home health practices also need more emphasis according to UNICEF (2008). In this regard De Lange (2010) mentions that some of these care practices, such as preparing meals as well as hygiene and health practices, are already taken into account mainly through food security surveys and health and hygiene education programmes. On the other hand some

aspects, especially psychosocial care, are less well-known and less frequently studied (De Lange, 2004). It is important that the quality of care practices should also focus on the development of an effective mother and child relationship because it is related to nutrition, growth and health. Furthermore, quality of care practices should correlate with the child's development, including intellectual development.

In the last instance, an important strategy to mitigate malnutrition is to focus on the eradication of poverty. In this regard the Department of Social Development, South African Security Service Agency and UNICEF (2012) reported on measures to eradicate extreme poverty in South Africa, including the social assistance grants, which increased from R10 billion in 1994 to R37.1 billion in 2004, with beneficiaries growing from 2.6 million to 7.9 million during the same period. Other interventions that were successful include the Expanded Public Works Programme (EPWP), the Agricultural Starter Pack Programme, and the Comprehensive Agricultural Support Programme (CASP) which Bourne, Hendricks, Marais and Eley (2007:2) refer to as the National Integrated Nutrition Programme. A study by the Department of Health (2008) concluded that the multiple causes of malnutrition among South Africa's children require a permanent multi-sectorial approach and collaboration among all the government departments at provincial and national levels (Department of Health, 2008).

One of the most important social assistance grants to eradicate poverty and by implication malnutrition is the Child Support Grant (CSG) which will be discussed in more detail in the section below.

## **2.8 THE SOUTH AFRICAN CHILD SUPPORT GRANT**

As the goal of this study was to explore and describe the views of caregivers regarding the contributing factors of malnutrition among children under the age of five, who were benefiting from the CSG, and admitted at Chris Hani Baragwanath Hospital, it is important to discuss in more detail the CSG.

The CSG is one of the policies the South African Government implemented in 1998 to curb child poverty and enable the caregiver to meet the child's basic subsistence needs

(Department of Social Development, 2012). The CSG is a financial assistance given to eligible caregivers as stipulated by the Social Assistance Act (No. 59 of 1992). It targets children between the ages of 0-17 years, and the criteria to qualify are the following:

- The caregiver and the child must have a South African Identity Document.
- The applicant must be the caregiver of the child who will be the beneficiary of the grant.
- The caregiver has to pass the means test in relation to his/her financial status.

Furthermore the Social Assistance Act (No. 59 of 1992) adds the following guidelines for the utilisation of the CSG:

- The grant should be used towards the relief of child poverty.
- The grant has to contribute to the costs of child upbringing.
- The centre of the grant is the child not the caregiver; as a result the grant follows the child regardless of the identity of the caregiver.

Aguero et al. (2006:18) present the CSG as a monetary transfer paid to caregivers after going through a means test with no conditions attached; it targets the South African population living in rural and urban areas with limited income. This is unlike the Oportunidades programme in Mexico, which makes grants conditional upon a school and clinic attendance chart.

To qualify to receive the CSG, Hall et al. (2012:12) outlined two key eligibilities:

- The child must be below the age of 17 and born to South African parents.
- The monthly income of parents or caregivers combined must be R1100 or less in urban areas and R800 in rural areas or informal settlements.

The South African Constitution (1996) enshrines children's rights, stating that all children should live a decent life and that their basic needs should be met. A child's physical and cognitive development depends on receiving appropriate nutrition in the first few years after birth (Department of Social Development, 2012). Taking into

account the relevance of nutrition in the development and survival of children, the Government of South Africa thus introduced the CSG which, according to the Department of Social Development (2011), is direct evidence of an investment in human capital development as it intends to provide food for infants and children within the crucial developmental stage of life. The CSG is one of the 10 main South African programmes aimed at advancing the child's social services and social assistance, as outlined by Coetzee and Streak in (Brynard, 2009).

A study by the Department of Social Development (2008) shows that a fifth of recipients of the CSG (22%) indicated that since they started receiving the grant they could afford to use more electricity than before, which benefits the child directly. A larger proportion of CSG recipients living in rural or informal urban areas reported increased spending on school uniforms and personal care, while recipients in urban areas were more likely to report increased spending on child care. Based on the findings by the Department of Social Development (2008), most of the caregivers do not consider child nutrition as a priority when spending the CSG. About 70% of the participants alleged that they use the grant to meet the entire family's needs, the report adds.

In a more recent national study conducted by the Department of Social Development, South African Social Security Agency & UNICEF (2012), it was confirmed that the CSG formed an important source of income for the broader family. This was reflected in the discussions in the North West, where younger recipients indicated that they had applied for the grant because of unemployment in the home, and getting the grant was a way of 'helping in the house' or supporting the family (Department Social Development, 2012). In Limpopo, a recipient spoke of getting the grant so that "you can help buy food at home". Several participants spoke of using the money to buy groceries for the household or to pay expenses such as electricity, because of the lack of other sources of income. Another participant in KwaZulu-Natal noted that due to the low cash value of the grant, she alternates each month: "If you have bought clothing for the child this month, you will buy groceries the next month." The study concluded that it seems as if the CSG makes a sustainable contribution to the total income of the recipients' household and is often used to meet the entire needs of the child (Department of Social Development, 2011).

Hall et al. (2012:13) indicate that if enrolled in the early months of life, cash grants directly reduce poverty and inequality. Beneficiaries of the grant have an increased likelihood of food intake and dietary diversity which improves the nutritional status and cognitive development of the child, which is associated with human capital development.

## **2.9 PRIMARY CAREGIVERS**

As the focus of this study is on caregivers' views regarding malnutrition, it is important to know the meaning of the concept caregiver. In the United States a caregiver is defined as "someone over the age of 18 who provides care to another. It is a person who is responsible for the direct care, protection, and supervision of children in a family home or in a child care home (U.S. Legal, 2001). In the South African context the Children's Act (No. 38 of 2005) defines a caregiver as "any individual other than a parent or guardian, who literally cares for a child". For the purpose of this study the concept caregiver refers to a person who takes care of a child under the age of five years.

According to Cooper (1999) nurturing and supportive parenting during the first years of a child's life has positive effects on the child's social, emotional and intellectual development, but families under stress often struggle to provide this which places children at risk of maltreatment.

The importance of psychosocial support to caregivers and children cannot be overstated. A number of studies show that many caregivers living in poverty are affected by depression as a result of the hardships they have to endure on a daily basis (Cooper, 1999). Therefore interventions to provide psychosocial support to caregivers is essential, not only to promote the wellbeing of the caregiver, but also to reduce the risk of neglect and malnutrition in the young child, as De Lange (2004:21) pinpoints.

## 2.10 SUMMARY

UNICEF (2008) views malnutrition as not only an urgent global health issue, but also an impediment to productivity, economic growth and poverty eradication. It is estimated that 32% of the global burden of diseases would be removed by eliminating malnutrition, including micronutrient deficiency. It is for this reason that in 1990, 189 United Nations member states committed themselves to a set of eight MDGs comprising 18 targets that were later adopted in 2000 by the United Nations as part of the Millennium Declaration. The first MDG is directly related to eradicating hunger and malnutrition, but many of the MDGs, such as improving education; reducing child mortality; improving maternal health; and combating HIV and AIDS, malaria and other diseases, all require good nutritional status if they are to be achieved efficiently.

In this chapter the researcher has discussed malnutrition as a social phenomenon focusing on the concept malnutrition, the prevalence of malnutrition, the causes and effects of malnutrition as well as strategies to combat malnutrition. Attention was also given to a brief discussion of the Child Support Grant and the meaning of the concept caregiver.

The next chapter will focus on the research methodology used to conduct this study and the empirical findings of this study.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY AND EMPIRICAL RESEARCH FINDINGS**

#### **3.1 INTRODUCTION**

The scourge of malnutrition in children under the age of five remains a worldwide problem resulting in deaths that could have been prevented with a proper paediatric diet, good hygiene practices, comprehensive care, and the development of basic infrastructure according to Bizourne (2005:19). In addition, children living in poverty are deprived and often struggle with the added stress of poor parenting which results in malnutrition. Feed the Babies Fund (2009) states that around the globe half of the deaths of children under five is as a result of malnutrition related illnesses.

A number of strategies have been developed and implemented by governments and NGOs to curb malnutrition among children. In South Africa the CSG is one of the key social assistance programmes developed by the Government, which transfers cash to parents whose combined income is R1100 a month in urban areas and R800 in rural areas. In spite of this financial support, there are still cases of malnutrition among beneficiaries of the CSG. This study thus investigated cases of children diagnosed with malnutrition while benefiting from the CSG, who were treated at Chris Hani Baragwanath Hospital in 2014 and the time that the empirical part of the study was conducted. The goal of this study was therefore the following:

To explore and describe the views of caregivers regarding the contributing factors of malnutrition among children under the age of five who are benefiting from the Child Support Grant and who were admitted to Chris Hani Baragwanath Hospital.

In order to obtain the goal the following objectives were formulated

- To conceptualise malnutrition as a social phenomenon and explore strategies of alleviating malnutrition, with specific emphasis on the CSG.
- To determine caregivers' understanding of malnutrition among children as a social phenomenon.

- To determine caregivers' views on the contributing factors of malnutrition among children who are benefiting from the CSG.
- To explore the challenges experienced by caregivers who receive the CSG.
- To make recommendations for combating malnutrition among children under the age of five who are beneficiaries of the CSG.

Based on the above goal and objectives of the study, the following research question guided the study:

What are the views of caregivers on the contributing factors of malnutrition among children under the age of five who are beneficiaries of the Child Support Grant?

## **3.2 RESEARCH METHODOLOGY**

This section will focus on a detailed discussion regarding the research approach, type of research, research design and methods used in the study, as well as the ethical issues considered in the study.

### **3.2.1 Research approach**

A qualitative research approach has been adopted in this study as the focus was to explore, describe and understand a social problem (Delpont, Fouche & Schurink, 2011:298) namely malnutrition among young children and caregivers' views about the contributing factors of malnutrition, and the way they make sense of their experiences of malnutrition.

Babbie and Mouton (2005:53) refer to a qualitative research paradigm as "an approach towards getting an insider's view". In the context of this study the researcher focused on obtaining the caregivers' views on the contributing factors of malnutrition among children who are below the age of five while benefiting from the CSG. The researcher pursued the process in the natural setting where the caregivers experience the problem.



The qualitative approach enabled the researcher to interact with the participants face-to-face and obtain their views based on their culture and experiences of malnutrition (Creswell, 2011:44).

### **3.2.2 Type of research**

The type of study used was applied research. Hale (2011:2) gives the characteristics of applied research as seeking a solution to a problem in practice. The study investigated the caregivers' understanding of malnutrition among children below the age of five who receive the CSG. This study was applied in nature as the results will inform a set of recommendations leading to further reducing malnutrition among young children.

### **3.2.3 Research design**

The research design used in this study was the collective case study design, focusing on a small number of caregivers whose children have been diagnosed with malnutrition.

Fouché and Schurink (2011:320) postulate that a case study design is able to draw interest to what can be gathered from a small number of cases in order to obtain a personal experience within their social worlds. In the context of this study the researcher interviewed a number of cases (caregivers) to obtain their views on the contributing factors of malnutrition among children under the age of five who are benefiting from the CSG and admitted to Chris Hani Baragwanath Hospital.

### **3.2.4 Study population and sampling**

#### **3.2.4.1 Population**

Babbie (2011:186) considers a study population as “the collection of essentials from which a sample is actually selected”. The characteristics of the population in this study were the caregivers who care for children below the age of five, who benefit from the CSG, were diagnosed with malnutrition, and were admitted to Chris Hani Baragwanath Hospital between 2014 and the time that the empirical part of the study was conducted.

Due to ethical considerations the respondents were not directly receiving services from the researcher. The population consisted of caregivers referred to the researcher by social workers rendering services in the paediatric medical wards of the Chris Hani Baragwanath Hospital.

#### **3.2.4.2 Sample**

A sample of 10 participants was selected, namely caregivers who care for children below the age of five, who benefit from the CSG, were diagnosed with malnutrition, and were admitted to Chris Hani Baragwanath Hospital between 2014 and the time that the empirical part of the study was conducted.

#### **3.2.4.3 Sampling method**

Purposive sampling was used to select the sample. Purposive sampling, according to Strydom and Delport (2011:392), is about “choosing a case to be studied because it consists of the characteristics which are of interest to the researcher”. In the context of this study the researcher selected 10 caregivers who adhered to the following criteria:

- Caregivers caring for children who are below the age of five and who are receiving the CSG.
- Caregivers who take care of children who were diagnosed with malnutrition and admitted to Chris Hani Baragwanath Hospital between 2014 and the time that the empirical part of the study was conducted.
- Caregivers referred to the researcher by social workers rendering services in the paediatric medical wards of the Chris Hani Baragwanath Hospital.

#### **3.2.5 Data collection method**

For the purpose of this study, semi-structured interviewing was used as the data collection method in order to gain a detailed picture of participants’ perceptions of the contributing factors of malnutrition among young children benefiting from the CSG. The goal of extracting rich, comprehensive information that could be used in analysis has

been achieved (Greeff, 2011:342). Kvale and Brinkmann, in Creswell (2011:162), note that a semi-structured interview is characterised by probing what the respondent says and then developing themes to be explored, which are influenced by the research topic. The interview was guided by a set of predetermined questions on an interview schedule and was tape-recorded (Greeff, 2011:352).

During the interviewing process the researcher had a face-to-face encounter with participants in which a rapport was established. Greeff (2011:342) adds that the validity of the information shared during the interview depends on the good judgment and the resourcefulness of the interviewer in accepting and managing the relationship. The researcher applied the skills and values of social work by being sensitive, empathetic, and able to establish a non-threatening environment in which participants felt comfortable.

### **3.2.6 Data analysis**

The study was qualitative in nature and as a result the researcher analysed the data narratively, interpreting the meaning assigned by the participants to their situation and the observation made by the researcher while conducting the interviews. Data analysis was done as described by Creswell, in Schurink et al. (2011:403):

- **Preparing and organising the data**

The researcher communicated the purpose of the study and the procedure that would be followed to the participants in order to enable the collection of credible data. Furthermore, the researcher took into consideration what Schurink et al. (2011:404) emphasise, namely the importance of labelling audio records in a professional manner, recording in a quiet space, and making field notes immediately after the interviews while the researcher's memory is still fresh.

- **Data collection and preliminary analysis**

Schurink et al. (2011:405) consider data collection and analysis as going hand-in-hand in a qualitative study. The researcher followed that process, because it would have been overwhelming to wait and analyse data at the end of the

process. Collecting and analysing data at the same time presented the opportunity to fine-tune information while in the process of data collection, leading to credible findings. Schurink et al. (2011:405) add that data collection and analysis, when conducted simultaneously, lead to identifying the emerging ideas and themes requiring attention. During data collection the researcher also actively observed and made field notes on the current activity.

- **Managing the data**

Upon leaving the field the recorded data was typed in transcript format and saved on a computer to afford the researcher an opportunity to immerse herself in the data.

The researcher organised the data by filing transcripts and field notes, as well as by manually creating a computer filing system which was labelled according to each interview. The researcher analysed and interpreted the data which led to thematic analysis (Schurink et al., 2011:408). The analysis was guided by the research question.

- **Reading and writing memos**

At this stage the researcher read and re-read the transcripts to gradually internalise the information before beginning the process of writing memos, which Schurink et al. (2011:409) say helps the researcher in the process of exploring the collected data. The researcher wrote memos in the margins of transcripts and field notes, which formed the basis for analysing data in the research report.

- **Generating categories and coding data**

At this stage of analysis the researcher read the research question and put together similar themes assigned by the participants. Grinnell and Unrau, as cited in Schurink et al. (2011:410), mention that this stage is a “combination of identifying meaning in units, fitting them into categories and assigning codes”. The researcher thus identified themes and sub-themes that emerged from the participants’ views. These identified themes were then coded using key words.

- **Visualising, representing and displaying the data**

According to Schurink et al. (2011:418) in the final phase of the spiral the researcher should present the data in text, tabular or figure form. In the case of this study, data was presented in text form.

### 3.2.7 Trustworthiness

Trustworthiness in this research was upheld by outlining the findings according to the views of the participants on the contributing factors of malnutrition among children below the age of five while benefiting from the CSG. Lietz, Langer and Furman (2006) postulate that “trustworthiness is established when findings as closely as possible reflect the meanings described by the participants”.

The researcher has ensured trustworthiness by using the following strategies:

- **Reflexivity**

Horsburg, in Lietz et al. (2006:447), defines reflexivity as “active acknowledgement by the researcher that her own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation.”

Throughout the study the researcher refrained from influencing the findings with her own values and life experiences. In instances where neutrality could not be upheld the researcher has acknowledged this. The researcher recognised actions and decisions that could impact upon the meaning and context of the phenomenon during the study.

The researcher discussed with her supervisor the process to be followed during the study in order to identify possible bias and subjectivity, which led to transparency and honesty.

- **Peer Debriefing**

The use of reflexivity and an audit trail were applied as part of enforcing the trustworthiness of the study when analysing data (Lietz et al., 2006:449). The process entailed involving other researchers by enabling them to audit the researcher's findings. Considering that the researcher is working in an academic hospital where research is part of the services, the researcher identified colleagues from the research unit to peer review the analysed data and comment on it. The researcher's supervisor was also part of the team that worked closely with the researcher in enforcing the trustworthiness of the project.

### **3.2.8 Ethical considerations**

Ethics in this study refers to the moral integrity of the researcher in the process of data collection. The researcher has been honest in developing a general agreement with participants and she kept to that agreement. Labuschagne (2006:78) notes that ethical issues in qualitative research are often more indirect. The researcher identified the following ethical issues as having a direct impact on the study:

- **Deception of participants**

The information about the study was not deceitful to participants. The researcher outlined the purpose and procedures of the study to the participants and assured them that they would not be judged due to the children's diagnosis, nor were they going to benefit in any way by taking part in the study. They were afforded an opportunity to ask questions for clarity prior to continuation of the interviews. The researcher fully disclosed her identity as an assurance that the process is meant for academic reasons and informed participants that there were no direct benefits for participation (Resnik, 2001:77).

- **Confidentiality and privacy**

The researcher considered the Research Council's (2008:7) assertion that "participants' privacy should not be violated and that participants must be afforded self-determination". Confidentiality in social research refers to not revealing the identity of the participants. Information shared between the

researcher and participants during the data gathering process has been restricted to the study. In the report and during the discussions the names of participants have not been revealed (National Health Research Ethics Committee, 2004).

- **Informed consent**

Garber (1996:234) says informed consent is the right of the participants to be given information regarding the nature of the study, including the benefits and risks, before consenting. The population of caregivers were not referred to the researcher for service delivery. The researcher made participants aware that they may withdraw from participating whenever they want. A consent letter with all the information, which also notified participants of the use of a audio recorder, was signed by each participant before interviews were conducted.

- **Avoidance of harm**

In a situation where certain information shared during data collection might result in harmful feelings for participants, the researcher intended to refer them to a local clinic where there are social workers for counselling. However the process went on with no need to refer any participant. Furthermore, the researcher informed participants of possible emotional risks involved in disclosing information regarding their experiences and the option of withdrawing from the study was also explained.

- **Debriefing**

Debriefing was in the form of a meeting between participants and the researcher at the end of each interview. During the debriefing the information, conclusions and recommendations were discussed in order to ensure correct understanding and interpretation by the researcher (National Health Research Ethics Committee, 2004).

- **Researcher's competence**

The researcher was competent to take up the study following theoretical training, experience, and constant supervision. There has been quality control

through detection and monitoring during and after data collection (Whitney, 2001:71). The researcher assured that the findings are reported objectively and the content has been accurate based on the data collected. All sources have been acknowledged.

### **3.3 EMPIRICAL FINDINGS**

This section presents the findings of the study following the analysis and interpretation of the data collected after interviewing 10 caregivers of children below the age of five, who were admitted to Chris Hani Baragwanath Hospital after being diagnosed with malnutrition while benefiting from the CSG. Data analysis according to Schurink et al. (2011:397) is the process of getting key information from a large amount of data collected, sieving the important facts from the junk, identifying the common themes, and finally producing a report that gives the results of the findings.

While the patients (young children) were still in hospital, the caregivers were asked to participate by interviewing them. The interviews were audio recorded, transcribed and analysed by identifying themes and sub-themes. This allowed the researcher to find out the views of the participants regarding the contributing factors of malnutrition among young children benefiting from the CSG who were diagnosed with malnutrition at Chris Hani Baragwanath Hospital

The empirical findings will be presented into the following two sections:

- Section 1: The biographical profile of the participants.
- Section 2: Qualitative findings according to themes.

Each theme will be discussed according to a summary of findings, quotations to verify the findings, and an integration of literature.

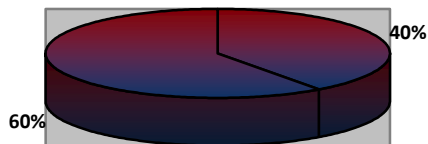


### 3.3.1 Section 1: Biographical profile of participants

The biographical profiles of the participants were compiled according to the following variables: caregivers' relationship to the child, gender of the caregiver, employment/source of income, marital status, highest educational qualification and type of housing.

- **Caregivers' relationship with the child**

Figure 3.1 reflects the caregivers' relationship to the young children.

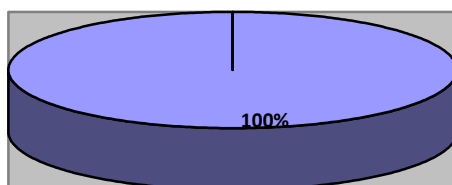


**Figure 3.1: Caregivers' relationship to the child**

Figure 3.1 indicates that 40% of the participants were non-biological mothers, but members of the extended families and 60% were biological mothers.

- **Gender of participants**

Figure 3.2 displays the gender of the participants.



**Figure 3.2: Gender of the participants**

From Figure 3.2 it is clear that 100% of the participants were female.

- **Marital status of participants**

All the participants (100%) indicated that they were not currently married. However, 30% indicated that they live with their partners and 70% revealed that they had no relationship with the fathers of the children involved in this study.

- **Educational qualification**

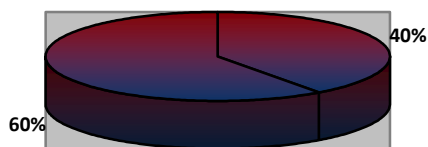
All the participants (100%) indicated that they had no post-matric education qualification. It implies that the participants had a low level of literacy.

- **Source of income**

All the participants (100%) revealed that they had no other source of reliable income except for the CSG. It seems thus as if the CSG is the only reliable source of income for the participants.

- **Type of housing**

The type of housing of the participants are captured in Figure 3.3



**Figure 3.3: Type of housing**

The majority of the respondents (60%) live in family shacks while nearly half of the participants (40%) live in Rapid Development Project (RDP) houses which

belong to a family member. None of the participants were paying rental for accommodation.

### 3.3.2 Section 2: Qualitative findings according to themes and sub-themes

Section 2 will outline the themes that emerged from the process of data analysis. Table 1 displays a summary of the identified themes and sub-themes in this study.

**Table 1: Summary of identified themes and sub-themes**

<b>Theme</b>	<b>Sub –Themes</b>
<b>Theme 1:</b> Participants’ understanding of the Child Support Grant.	1.1 Purpose of the Child Support Grant. 1.2 Benefits of the Child Support Grant.
<b>Theme 2:</b> Participants’ understanding of malnutrition.	
<b>Theme 3:</b> Participants’ views on the contributing factors of malnutrition.	
<b>Theme 4:</b> Participants’ views on the consequences of malnutrition.	
<b>Theme 5:</b> Participants’ views on the challenges experienced.	
<b>Theme 6:</b> Participants’ recommendations on combating malnutrition.	

Each of the above themes and sub-themes will be discussed in accordance of the following structure:

- Summary of findings
- Quotations to verify findings
- Integration of literature

### **3.3.2.1 Theme 1: Participants' understanding of the Child Support Grant**

The researcher wanted to explore the participants' understanding of the CSG. All the participants viewed the CSG as financial assistance from the government to caregivers in order to meet the children's needs. UNICEF (2008) describes the CSG as follows:

The Child Support Grant (CSG) is the state's largest social assistance programme in terms of the number of beneficiaries reached. The primary objective of the grant is to ensure that caregivers of young children living in extreme poverty are able to access financial assistance in the form of a cash transfer to supplement, rather than replace, household income.

The following two sub-themes regarding the participants' understanding of the CSG were identified:

- Purpose of the Child Support Grant
- Benefits of the Child Support Grant

Each sub-theme will be discussed separately.

#### **Sub-Theme 1.1: Purpose of the Child Support Grant**

The sub-theme focused on exploring the participants' understanding of the purpose of the CSG. All the participants considered the CSG as meant to assist the caregiver in meeting the basic needs of the children who they care for. The following are quotations from the participants to illustrate their understanding of the purpose of the CSG:

- "To help the caregiver to provide for the child".
- "The CSG helps to provide in my child's basic needs".

It seems as if the participants understood the purpose of the CSG, because it correlates with UNICEF's (2008) explanation that the CSG was meant to give an additional income

to help provide and care for young children (primarily their food requirements). The grant was to be provided together with other poverty alleviation and developmental measures.

### **Sub-theme 1.2: Benefits of the Child Support Grant**

In relation to the benefits of the CSG all the participants were of the opinion that the grant benefits the caregiver in meeting the basic needs of the young child, for instance buying the child's milk and diapers. However, a few of the participants also indicated that they use the CSG to meet other family members' needs due to the fact that they have no other reliable source of income. In this regard all the participants mentioned that they were unemployed and those who live with partners indicated that their partners also do not have formal jobs, but only part-time employment. As a result the CSG is a reliable source of income for the whole family in meeting their basic needs. The participants' views were revealed by the following comments:

- "It helps a lot if my partner gets a piece job, but if not we use the grant money to buy something we all need".
- "The CSG enable me to buy nutritional food for the baby and nappies".

The participants' views correlate with a study conducted by the Department of Social Development (2008) which revealed that the grant appears to be primarily used to buy essential food. Given the modest value of the grant it is not likely that it can be used to cover a wide range of expenditures, such as clothes or shoes, if there is no other source of income in the family.

In a more recent study by the Department of Social Development, SASSA and UNICEF (2012), it is again confirmed by participants that the CSG formed an important source of income for the broader family. This was reflected in the discussions in the North West Province, where younger recipients of the CSG indicated that they had applied for the grant because of unemployment in the home, and getting the grant was a way of 'helping in the house' or supporting the family.

### 3.3.2.2 Theme 2: Participants' understanding of malnutrition

In the context of this study it was also important to explore the participants' understanding of the concept malnutrition. None of the participants knew how to define the concept malnutrition. However, they stated their understanding of malnutrition according to what the doctors have said following the diagnosis of the child in hospital. In this regard the researcher found that caregivers were aware of the fact that in terms of malnutrition the child presented indicators of not being well, but associated the condition to childhood illnesses.

The following quotations were participants' responses on their understanding of malnutrition in relation to what the doctors said about the type of sickness the child was suffering from:

- "From what I learn here in hospital, malnutrition means you are neglecting the child, you don't give the child enough food to eat".
- "Malnutrition is a sickness".
- "Malnutrition is when a child does not get enough food".
- "Malnutrition is when the baby develops diarrhoea and vomiting".

In relation to what participants said, the concept malnutrition is described by the *Medical Dictionary* (2009) as "a condition that develops when the body does not get the right amount of vitamins, minerals and other nutrients; it needs to maintain healthy tissues and organ functioning".

The participants' vague understanding of the concept malnutrition however correlates more or less with the World Health Organisation's (2008) definition of malnutrition as:

Impaired health is caused by a dietary deficiency, excess, or imbalance support to human life. Energy from fat, carbohydrate and protein, water and more than 40 different food substances must be obtained from the diet in appropriate amounts. Chronic intake of any of these substances at levels above or below ranges result to malnutrition, but commonly the term refers only to deficient intake.

Based on the above descriptions of malnutrition it is apparent that the symptoms of malnutrition presented by the participants were in line with the described meaning of the concept malnutrition.

### **3.3.2.3 Theme 3: Participants' views on the contributing factors of malnutrition**

In the biographical profile of the participants it was indicated that all the caregivers interviewed were unemployed with no further education post-metric. Participants revealed a dire situation in their families in relation to access to food. From the participants comments it was clear that poverty and unemployment due to lack of education were the main contributing factors to the malnutrition of the children they care for. Emotional and social factors were viewed by a small number of participants as contributing factors to malnutrition. For instance, one participant mentioned that she enjoys her child, but to provide in the child' needs is stressful.

The following quotations illustrate the participants' views on poverty and unemployment as contributing factors to malnutrition:

- "I don't work; the grant is very little. When I get it (CSG) I buy nutritional food and nappies which is very expensive".
- "When you have no money to buy food the child will remain sick".
- "Lack of money contributes to malnutrition".
- "It is not possible to get a job....I have no qualification".
- "I enjoy my child, but lack of money makes me depressed".

The participants' views and experiences of contributing factors are confirmed in literature. In this regard Delange (2004:13) and Klugman (2002:18) summarised the contributing factors of malnutrition as poverty, environmental factors, childhood diseases, harmful child care practises, and lack of education. UNICEF (2008) adds interrelated contributing factors that cause malnutrition, such as poverty, inequality, and ineffective development policies. The Ethiopia's National Nutrition Program (2012), also refers to poverty stricken families' who's only reliable source of income is the CSG,

leaving children under five years more susceptible to malnutrition.

#### **3.3.2.4 Theme 4: Participants' views on the consequences of malnutrition**

Malnutrition was considered as deadly by all participants if not treated. Some of the caregivers mentioned specifically certain physical consequences of malnutrition, namely that the child becomes more exposed to infections and loses weight which makes them more vulnerable. The quotations below depict the caregivers' views on the consequences of malnutrition:

- “The child may get sicker.”
- “The child will keep losing weight and die.”
- “More infections.”
- “The child can die.”

Bhutta et al(2008:54) confirms what the participants said by reporting that iodine deficiency during infancy can cause mental retardation even after the deficiency has been treated. Depending on the severity of the condition, the consequences of malnutrition leads to reduced physical and mental development during childhood. UNICEF (2008) adds that iron deficiency impedes cognitive development, whereas lack of vitamin A weakens the immune system of the sufferer and makes the child susceptible to illnesses.

Paediatric Oncall (2009:21) mentions that malnutrition results in an impaired immune response and increased infections. Furthermore, malnutrition is considered to be a leading cause of child mortality in developing countries. The immune systems of affected children get weaker and they die of diseases which they could have survived if they were not malnourished (UNICEF, 2008:15). The World Bank (2006) confirms that malnutrition is a major contributor to higher mortality diseases in the developing world, such as pneumonia, malaria, diarrhoea and measles.

From the interviews it was clear that the caregivers fully understood that malnutrition could harm the child seriously. However the fact that the damage it causes has a lasting



effect even if the child has recovered remains critical information that mothers and caregivers need to be educated on.

### **3.3.2.5 Theme 5: Participants' views on the challenges experienced**

Poverty and its consequences evoked negative feelings, as it affects caregivers' ability to care and provide for the children regardless of the availability of the CSG. The participants revealed that they experiencing certain social, emotional and financial challenges.

Regarding social challenges, some participants reported that they experienced a lack of support by the child's father in the process of raising the child. The sense of poor support was extended to other members of the paternal family as well, especially the paternal mother. In this regard the caregivers felt alone and helpless especially when they are unable to meet the needs of the child. One participant voiced herself as follows:

“The feeling of being alone creates negative emotions which affects my ability to render effective care and protection to the child”.

In terms of financial challenges, all the participants expressed that they are struggling to meet the child's needs. They emphasised the fact that the CSG is not enough to meet the needs of the child.

- “I don't work the money is little.”
- “When you have no money to buy food the child remains sick.”
- “Lack of money is the biggest challenge”.

The financial challenges and the linkage thereof with malnutrition as expressed by the participants are confirmed in literature. According to Steyn (2008) poverty and lack of food security are the primary reasons why malnutrition occurs in developing nations. In these developing nations 10% of all members of low-income households do not always have enough healthy food available to eat. Steyn (2008) elaborates on how a low income results in an inability to buy store food, which leads to nutritional deficiencies.

### 3.3.2.6 Theme 6: Participants' recommendations on combating malnutrition

In spite of poor living conditions the majority of the participants viewed malnutrition as a condition that can be prevented. Some of the participants recommended a few practical strategies to combat malnutrition, e.g. the caregiver should take proper care of the child in terms of good hygiene practices and provide food which is age appropriate to the child, as well as prolonged breastfeeding. Furthermore they suggested extra food support for children as an extension of the CSG, as well as more educational information regarding malnutrition. The following listed quotations illustrate the participants' recommendations to combat malnutrition:

- "Keep the place clean where the baby live and sterilise the bottles".
- "The child has to be in a clean place, bottles need to be kept clean and food should be appropriate for the baby".
- "Support on getting food for the child from government".
- "Child must not be stopped from breastfeeding early".
- "Doctors should give right information about malnutrition".

In terms of combating malnutrition the Department of Health (2008) in South Africa initiated the INP to address and prevent malnutrition with the vision of optimal nutrition for all. The approach was comprehensive, aiming at addressing the underlying causes of malnutrition through direct services, such as education, providing of micronutrient supplements, food fortification, and counselling.

Some indirect services were more recently developed, such as the provision of health care services, improved access to food, and the provision of clean and safe water supply (Department of Social Development, 2012).

Bhutta et al. (2008) and Klugman (2002) both agree that the levels of malnutrition can only be reduced if socio-demographic parameters, such as household monthly income, weekly expenditure on food, and employment, are a priority to the government and other international bodies.

### **3.4 SUMMARY**

This chapter focused on a detailed description of the research methodology used in the study, as well as ethical aspects considered in the study. The empirical findings have been discussed by covering the biographical profile of the participants and the qualitative findings in the format of themes and sub-themes. The following chapter will focus on the key findings, conclusions and recommendations.

## CHAPTER 4

### CONCLUSIONS AND RECOMMENDATIONS

#### 4.1 INTRODUCTION

Diouf (2008:179) indicates that six million children under the age of five years die throughout the world due to treatable diseases such as diarrhoea, pneumonia, malaria and measles, which they would have survived if their bodies had not been weakened by malnutrition. The scourge of malnutrition in children under the age of five remains a worldwide problem resulting in deaths that could have been prevented with a proper paediatric diet, good hygiene practices, and comprehensive development of basic infrastructures (Bizouerne, 2005:19). Hunt (2009) says without concerted action, 140 million children under five years will be underweight in the year 2020. The World Health Organisation (2010:17) adds that more than 180 million children under the age of five, nearly one in three, are stunted and up to 40% are growing up with insufficient vitamin A which will impact negatively in their growth process and adult life.

This study was guided by the following research question:

What are the views of caregivers on the contributing factors of malnutrition among children under the age of five who are beneficiaries of the Child Support Grant?

**The objectives of the research study were the following:**

- To conceptualise malnutrition as a social phenomenon and explore strategies of alleviating malnutrition with specific emphasis on the Child Support Grant.
- To determine caregivers' understanding of malnutrition among children as a social phenomenon.
- To determine caregivers' views on contributing factors of malnutrition among children who are benefiting from the Child Support Grant.
- To explore the challenges experienced by caregivers who receive the Child Support Grant.
- To make recommendations for combating malnutrition among children

under the age of five who are beneficiaries of the Child Support Grant.

## 4.2 KEY FINDINGS AND CONCLUSIONS

The key findings and conclusions will be discussed in terms of each of the objectives.

### 4.2.1 Objective 1

Objective 1 was to conceptualise malnutrition as a social phenomenon and explore strategies of alleviating malnutrition with specific emphasis on the CSG.

The first objective of the study (literature review) revealed that:

- Malnutrition is a worldwide social phenomenon. In the South African context progress has been made to combat malnutrition through the introduction of social assistance grants like the CSG, directed at families with limited income, although there are still challenges.
- The accepted concept of malnutrition is defined by the World Health Organisation (2008) as:

Impaired health caused by a dietary deficiency, excess, or imbalance support to human life. Energy (from fat, carbohydrate and protein), water, and more than 40 different food substances must be obtained from the diet in appropriate amounts.
- Literature refers to different causes of malnutrition. Considering the interrelatedness of each of these causes the key contributing factors seem to be poverty and inequality, poor childcare practises, insufficient resources, and lack of education.
- Different literature resources present different effects of malnutrition according to socio-demographics (Burden of Disease Research Unit, 2012). However, the

researcher had identified mortality, iron deficiency and reduced growth as the most crucial effects of malnutrition.

- On an international and national level different strategies and programmes are implemented and still needed to combat malnutrition among young children. However, a comprehensive approach to address the underlying causes of malnutrition through direct services, such as nutrition education and promotion; micronutrient supplementation; food fortification; and disease-specific nutrition counselling and support should be implemented (Department of Health, 2008).

It can thus be concluded that the scourge of malnutrition remains a challenge which requires evaluating present developmental strategies, as well as ongoing research involving multidisciplinary teams.

#### **4.2.2 Objective 2**

Objective 2 was to determine caregivers' understanding of malnutrition among children as a social phenomenon.

The following key findings and conclusions regarding objective 2 are relevant:

- It was clear that none of the participants could define malnutrition clearly. Their knowledge of malnutrition was primarily based on what the doctors told them.
- It was revealed from the findings that participants could not conceptualise clearly malnutrition as a social phenomenon. This was also revealed in the literature. For instance Blakeman (2002:51) mentions lack of education is a major contributing factor to malnutrition, because most caregivers are illiterate and they lack knowledge about nutrition, breastfeeding and parenting. This was also confirmed in a study conducted by Ditebo (2010) in Botswana where it was found that mothers have a lack of knowledge and wrong perceptions of malnutrition.

### 4.2.3 Objective 3

Objective 3 was to determine caregivers' views on contributing factors of malnutrition among children who are benefiting from the CSG.

Regarding this objective, the findings of the study revealed the following:

- Caregivers viewed poverty as the main contributing factor to malnutrition. When the family is poverty stricken, the children are not cared for properly. The participants felt poverty and its consequences presented negative feelings which affect caregivers' ability to care and provide for the children, regardless of the availability of the CSG.
- Linked to poverty, the participants identified unemployment as another contributing factor to malnutrition.

It can thus be concluded that poverty and unemployment with all their consequences were revealed as the main contributing factors of malnutrition.

### 4.2.4 Objective 4

Objective 4 was to explore challenges experienced by caregivers who receive the CSG. In this regard the following conclusions were important:

- All participants (100%) consider the CSG as insufficient to meet the basic needs of the children that they care for which results in caregivers being unable to consistently provide the right diet for the child. Serious financial challenges were thus experienced.
- All participants (100%) experience unemployment or a lack of opportunities to generate their own income as important challenges. The CSG is used to buy some necessities for the whole family, and therefore the caregiver is unable to provide the required nutrition for the child.

- The most outstanding emotional challenges experienced by the participants were loneliness and feelings of depression..

It can thus be concluded that the named challenges indicated that caregivers' financial circumstances, mainly due to unemployment and lack of a reliable sources of income, were the main challenges that make the CSG less than effective in assisting low income earning caregivers to meet the basic needs of the child, as it is intended to do.

### **4.3 RECOMMENDATIONS**

Based on the empirical findings and conclusions, the following recommendations can be made.

- Enhancement of jobs and more small business opportunities should be created by the government and private sector to enable caregivers to have access to a reliable income.
- Baby food parcels should be given to caregivers, accompanied by information on preventing malnutrition among young children as an additional support to the CSG.
- A national programme aimed at monitoring and evaluating the administration of the CSG by caregivers has to be developed in order to give support where needed.
- National educational programmes should be designated and implemented to combat malnutrition among young children. These programmes should focus on giving information to young people to contribute to development by bearing children when they are able to provide for them resulting to well cared children who will be less vulnerable to malnutrition related illnesses.
- Furthermore, reinforcing of child care, from conception up to independent stage, through a multi-disciplinary approach.
- Enhancement of community outreach programs aimed at preventing malnutrition.
- Furthermore, it is recommended that further research should be done on the



challenges faced in eradicating malnutrition among children below the age of five years.

#### **4.4 ACCOMPLISHMENT OF THE GOAL AND OBJECTIVES OF THE STUDY**

The goal of the study was to explore and describe the views of caregivers regarding the contributing factors of malnutrition among children under the age of five who are benefiting from the CSG and admitted at Chris Hani Baragwanath Hospital.

Table 2 below focuses on how the above goal and objectives of the study were accomplished.

**Table 2: Accomplishment of the study objectives**

Number	Objective	Objective achievement
1	To conceptualise malnutrition as a social phenomenon and explore strategies of alleviating malnutrition with specific emphasis on the Child Support Grant.	The objective was achieved as reflected in the literature review presented in Chapter 2.
2	To determine caregivers' understanding of malnutrition among children as a social phenomenon.	The objective was achieved as reflected in the research findings presented in Chapter 3.
3	Objective 3 was to determine caregivers' views on contributing factors of malnutrition among children who are benefiting from the Child Support Grant.	The research findings in Chapter 3 reflected that the objective was achieved.
4	To explore the challenges experienced by caregivers who receive the Child Support Grant.	The outcome of challenges as viewed by caregivers was given in Chapter 3.

#### **4.5 CONCLUDING REMARKS**

This study aimed to explore and describe the views of caregivers regarding the contributing factors of malnutrition among children under the age of five who are benefiting from the CSG and admitted at Chris Hani Baragwanath Hospital. The study has revealed the caregivers' views on the concept malnutrition, contributing factors of malnutrition, and the challenges they are experiencing.

According to the research findings it is evident that the research question which guided the study was answered, as all the objectives were achieved. In conclusion, this research study has contributed to the body of knowledge regarding malnutrition among children under the age of five and who are beneficiaries of the CSG.

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## **APPENDIXES A: INTERVIEW SCHEDULE**

## INTERVIEW SCHEDULE

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### Personal information of participants

#### 1.1 Caregiver's relationship with the child

<b>Biological Mother</b>	
<b>Non- Biological mother</b>	

#### 1.2 Gender of participants

Male	
Female	

#### 1.3 Marital status of participants

<b>Married</b>	
<b>Single</b>	
<b>Divorced</b>	

#### 1.3 Educational qualification

Matric	
Post- Matric	

#### 1.4 Figure 3.5: Main source of income

Employed	
Unemployed	
Self employed	

#### 1.3 Type of housing of the participants

Rapid development houses	
Shack	

## Interview guideline

1. Caregivers' knowledge of the Child Support Grant
  - Caregivers' understanding of the purpose of the Child Support Grant
  - Caregivers' views about the benefits of the Child Support Grant.
  - Information given by the Department of Social Development during the process of application on how to administer the Child Support Grant.
  
2. Caregivers' understanding of malnutrition as a social phenomenon
  - Caregivers' understanding of the concept malnutrition
  - Caregivers' views of possible causes of malnutrition
  - Caregivers' views if possible consequences of malnutrition
  
3. Caregivers views on contributing factors of malnutrition in their own situations
  - Financial factors
  - Physical factors
  - Emotional factors
  - Social factors
  
4. Challenges experienced by caregivers who receive the Child Support Grant
  
5. Recommendations of strategies to combat malnutrition

## **APPENDIX B: LETTER OF ETHICAL CLEARANCE**



UNIVERSITEIT VAN PRETORIA  
UNIVERSITY OF PRETORIA  
YUNIBESITHI YA PRETORIA

Faculty of Humanities  
Research Ethics Committee

11 September 2014

Dear Prof Lombard

**Project:** Caregivers' views on the contributing factors of malnutrition among children benefiting from the Child Support Grant  
**Researcher:** DE Zwane  
**Supervisor:** Prof CSL Delport  
**Department:** Social Work and Criminology  
**Reference number:** 21179311

Thank you for your response to the Committee's correspondence of 6 June 2014.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 10 September 2014. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

**Prof. Karen Harris**  
**Acting Chair: Research Ethics Committee**  
**Faculty of Humanities**  
**UNIVERSITY OF PRETORIA**  
**e-mail: karen.harris@up.ac.za**

**Research Ethics Committee Members:** Dr L Blokland; Prof M-H Coetzee; Dr JEH Grobler; Prof KL Harris(Acting Chair); Ms H Klopper; Dr C Panebianco-Warrens; Dr C Puttergill; Prof GM Spies; Dr Y Spies; Prof E Taljard; Dr P Wood

## APPENDIX C: PERMISSION LETTER FROM CHRIS HANI BARAGWANATH HOSPITAL



## GAUTENG PROVINCE

HEALTH  
REPUBLIC OF SOUTH AFRICA

MEDICAL ADVISORY COMMITTEE  
CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

### PERMISSION TO CONDUCT RESEARCH

Date: 26 March 2014

TITLE OF PROJECT: Caregivers views on the causes of malnutrition among children benefiting from the Child Support Grant

UNIVERSITY: Pretoria

Principal Investigator: D Zwane

Department: Social Development and Policy

Supervisor (If relevant): Prof C Delport

Permission Head Department (where research conducted): Yes

Date of start of proposed study: March 2014

Date of completion of data collection: December 2015

The Medical Advisory Committee recommends that the said research be conducted at Chris Hani Baragwanath Hospital. The CEO /management of Chris Hani Baragwanath Hospital is accordingly informed and the study is subject to:-

- Permission having been granted by the Committee for Research on Human Subjects of the University of the Witwatersrand.
- the Hospital will not incur extra costs as a result of the research being conducted on its patients within the hospital
- the MAC will be informed of any serious adverse events as soon as they occur
- permission is granted for the duration of the Ethics Committee approval.

.....  
Recommended  
(On behalf of the MAC)  
Date: 26 March 2014

.....  
Approved/Not Approved  
Hospital Management

Date: 31/03/14



## APPENDIX D: CONSENT FORM

Researcher :Duduzile Elizabeth Zwane

Cell: 073 100 4574  
51 Quartz Close  
Ormonde  
Johannesburg  
2091

### **INFORMED CONSENT FORM**

**Title of study:** Caregivers' views on the contributing factors of malnutrition among children benefiting from the Child Support Grant.

**Purpose of the study:** To explore and describe the views of caregivers regarding the contributing factors of malnutrition among children under the age of five who are benefiting from the Child Support Grant admitted at Chris Hani Academic Hospital.

**Procedures:** I understand that I will undertake an individual interview that will take approximately an hour and will be scheduled on the time convenient to me.

**Risks and Discomforts:** I recognize that there are no known medical risks or discomforts associated with this study. I will not be judged or penalised for the diagnosis of the child. In a situation where certain information shared during data collection results in harmful feelings I will be referred to a local clinic where there are social workers for counselling if needed.

**Benefits:** I understand that there are no direct financial benefits to me for participating in this study. However, my participation in this study may help the researcher to gain a better understanding of the contributing factors of malnutrition from the perspective of caregivers.

**Participant's Rights:** I am aware of the fact that I may withdraw from participating in the study at any time without any negative consequences.

**Confidentiality:** I am aware that an audio recorder will be used in order to record exactly what I will say during the interview. The recorded data will be listened to only

by the researcher and her supervisor at the University of Pretoria. The information gathered will be treated confidentially and my identity will not be revealed. Should I withdraw from the study, my data will be destroyed. The results of this study may be published in the researcher's dissertation, professional journals or presented at professional conferences, but my identifying details will not be revealed unless required by law.

I have been informed that the data that is collected through this study will be stored for fifteen years at the Department of Social Work and Criminology at the University of Pretoria. If anyone wishes to use these data, it will only be allowed with my informed consent.

**Person to contact:** If there are any questions or concerns, I understand that I can contact Duduzile Zwane on 073 100 4574.

I understand my rights as a participant and I voluntarily consent to participate in this study. I understand what the study is about and how and why it is being done. I will receive a signed copy of this consent form.

Respondent signature

..... Date.....

Signature of Researcher

..... Date.....

## **APPENDIX E: LETTER FROM THE EDITOR**

## EDITOR'S STATEMENT

7 September 2015

I hereby declare that I have edited Chapters 1 to 4 of this document by Duduzile Zwane during August 2015. The chapters' titles are:

- Chapter 1: General Background Information on the Research Study
- Chapter 2: Literature Review: Malnutrition as a Social Phenomenon
- Chapter 3: Research Methodology and Empirical Research Findings
- Chapter 4: Conclusions and Recommendations

The edit entailed correcting spelling and grammar where necessary, and checking for consistencies in style and reference method used. I have not helped to write this document or altered the student's work in any significant way. I will not be held accountable for bad spelling or grammar where the student has rejected my editing.

*Please note:* I was not responsible for the final layout of the document or the initial pages / index. I also did not edit the List of References.

It was not my responsibility to check for any instances of plagiarism and I will not be held accountable should the student commit plagiarism. I did not check the validity of the student's statements/research/arguments.

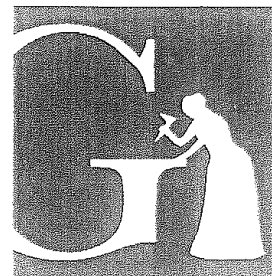


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