



**PERCEPTIONS OF YOUNG MOTHERS REGARDING CAUSES OF
MALNUTRITION IN CHILDREN ADMITTED AT SELECTED HOSPITALS IN
THE VHEMBE DISTRICT, OF THE LIMPOPO PROVINCE**

BY

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DECLARATION

I, Makhavhu Ndiambani Anastecious, hereby declare that the dissertation titled **“Perceptions of young mothers regarding causes of malnutrition in children admitted at selected hospitals in the Vhembe District, of the Limpopo Province”**, for the degree of Masters in Advanced Nursing Sciences at the University of Venda, has not been submitted to any other institution, nor will it be submitted to any other institution for consideration. I also declare that the work contained in this dissertation is my own original contribution, and that the materials consulted have been duly acknowledged.

Student signature.....

Date.....

DEDICATION

This study is dedicated to my late little son, Mulaudzi Lindelani, my two lovely sons, Murendeni and Khuthadzo Mulaudzi, my mother, Makhavhu Nditsheni Chrestinah, my uncle, Makhavhu Azwifaneli Fanie, and my entire siblings.

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ABSTRACT

Background: Globally, malnutrition among children is one of the most challenging and critical public health problem, and it remains one of the most common causes of morbidity and mortality among children under the age of 5 years. There is no exception for the Vhembe District.

Purpose: The study determined the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years in the Vhembe District, of the Limpopo Province.

Methodology: This study used qualitative, exploratory, descriptive and contextual design to collect data among young mothers regarding causes of malnutrition in children under 5 years. Twelve young mothers were sampled using probability, simple random sampling at selected hospitals population. In-depth individual interviews were used to collect data and analysed using Tesch's steps. Measures to ensure trustworthiness and ethical consideration were adhered to throughout the study.

Results: Three themes emerged from the analysed data, namely: Young mothers' perceived causes of malnutrition, young mother's beliefs about malnutrition, and health care seeking actions for a malnourished child.

Recommendations: This study recommend a strategies to integrate young mothers into the health promotion regarding their understanding and experiences about malnutrition. Policies on child nutrition should be reviewed regularly in the Vhembe District for prevention and management of malnutrition in children under 5.

Keywords: *perceptions, malnutrition, under 5 year's children, young mother.*

TABLE OF CONTENTS

DECLARATION	i
DEDICATION	ii
ACKNOWLEDGEMENTS	iii
ABSTRACT	v
TABLE OF CONTENT	vi
LIST OF ABBREVIATIONS AND ACRONYMS	ix
CHAPTER ONE: ORIENTATION TO THE STUDY	1
1.1 Introduction and background of the study.....	1
1.2 Malnutrition in children.....	1
1.2.1 Acute malnutrition.....	3
1.2.2 Moderate acute malnutrition.....	3
1.2.3 Severe acute malnutrition.....	6
1.2.4 Causes of malnutrition.....	8
1.2.5 Young mothers cultural views regarding causes of malnutrition.....	14
1.2.6 The effects of malnutrition.....	15
1.2.7 Nutritional status assessment.....	18
1.3 Problem statement.....	20
1.4 Purpose of the study.....	21
1.5 Research questions.....	21
1.6 Objectives of the study.....	22
1.7 Significance of the study.....	22
1.8 Definition of concepts (conceptual and operational).....	23
1.9 Theoretical framework.....	24

1.10 Research methodology	26
1.11 Study settings.....	28
1.12 Population.....	28
1.13 Sampling method	28
1.14 Data collection.....	29
1.15 Data analysis.....	29
1.16 Literature control.....	29
1.17 Measures to ensure trustworthiness.....	30
1.18 Ethical considerations.....	31
1.19 Outline of the dissertation	31
1.20 Summary.....	32
CHAPTER : TWO RESEARCH METHODOLOGY.....	33
2.1 Introduction	33
2.2 Research design.....	33
2.3 Study setting.....	35
2.4 Population.....	37
2.5 Sampling method.....	37
2.6 Data collection methods.....	39
2.7 The role of the researcher.....	42
2.8 Data analysis.....	45
2.9 Literature control.....	47
2.10 Measures to ensures trustworthiness.....	47
2.11 Ethical consideration.....	49
2.11.1 Permission to conduct the study.....	49
2.11.2 Principle of respect for persons.....	50
2.11.3 Principle of beneficence.....	52

2.11.4 Principle of justice.....	53
2.12 Summary.....	54
CHAPTER THREE: DISCUSSION OF THE RESEARCH FINDINGS.....	55
3.1 Introduction.....	55
3.2 Sample description.....	55
3.3 Discussions of the findings.....	56
3.4 Summary.....	69
CHAPTER FOUR: CONCLUSION, LIMITATIONS AND RECOMMENDATIONS.....	70
4.1 Introduction.....	70
4.2 Evaluation of the study.....	70
4.3 Conclusion.....	71
4.4 Limitation of the study.....	72
4.5 Recommendations.....	72
4.6 Summary.....	73
REFERENCES.....	74
ANNEXURE A: LANGUAGE EDITING.....	81
ANNEXURE B: APPROVAL FROM UHDC	82
ANNEXURE C: APPROVAL FROM REC.....	83

ANNEXURE D: APPROVAL FROM DOH.....	84
ANNEXURE E: APPROVAL FROM VHEMBE DISTRICT.....	85
ANNEXURE F: APPROVAL FROM SELECTED HOSPITALS.....	86
ANNEXURE I: PARTICIPANTS INFORMATION SHEET.....	87
ANNEXURE K: CONSENT FORM.....	94
ANNEXURE L: TRANSCRIPTS.....	95

LIST OF ABBREVIATIONS AND ACRONYMS

CIDA	: Canadian International Development Agency
CHWs	: Community Health Workers
EBF	: Exclusive Breastfeeding
ICF	: Improved Complementary Food
MCI	: Integrated Management of Child Illness
MAM	: Moderate Acute Malnutrition
MUAC	: Mid Upper Arm Circumference
NDoH	: National Department of Health
PEM	: Protein Energy Malnutrition
PHC	: Primary Health Care
RHC	: Rural Healed Centre
SAM	: Severe Acute Malnutrition
SDs	: Standard Deviations
SDGs	: Sustainable Development Goals
STD	: Sexual Transmitted Disease
SMART	: Standardized Monitoring and Assessment of Relief and Transition
UNICEF	: United Nation International Children Emergency Fund
WHO	: World Health Organization

CHAPTER ONE

1. ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Malnutrition among children is one of the most challenging and critical public health problems globally, and it remains one of the most common causes of morbidity and mortality among children under the age of 5 years. Malnutrition affects physical growth, morbidity, mortality, cognitive development, reproduction and physical work capacity, and it consequently impacts on human performance, health and survival (Berra, 2013).

1.2 MALNUTRITION IN CHILDREN

Malnutrition is a disease that emerges when the body does not get the required food nutrients in the right amount. Such food nutrients comprise minerals, vitamins, protein, carbohydrates, fat and lipids in order to maintain organ function and healthy tissues. De Lange, (2010) describes malnutrition to be a disease of hunger, a very common condition affecting mainly children under 5 years particularly at the time of weaning. Furthermore, it is used to describe Protein Energy Malnutrition (PEM), and PEM refers to a form of malnutrition where there is inadequate calorie or protein intake, and it applies to a group of related disorders that include marasmus and kwashiorkor. Malnutrition is another word for under nutrition and over nutrition (Ismail & Suffla, 2013).

Ogunrinade, (2014) on the other hand defines malnutrition as a general term used to refer to poor or inadequate nutrition. Whereas, Boatbill, Guure, and

Ayoung, (2014) refer PEM as the main type where there is inadequate intake of protein, carbohydrates and fats in the form of marasmus, kwashiorkor, underweight, stunting and wasting. Oruamabo, (2017) refers malnutrition to the failure of the body to get the adequate amounts of nutrients to maintain healthy tissues and organ function. Several South African researchers Khunga, Okop and Puoane, (2014) and Mweemba, (2017) revealed that malnutrition is problematic globally and is still one of the top causes of death in children under the age of 5 years. Nearly half of all death in children under the age of 5 years is due to under nutrition.

Breastfeeding is one of the most effective ways of preventing malnutrition and infectious diseases; this is achieved by boosting the child's immunity level. World Health Organization (WHO, 2011b) and United Nation International Children Emergency Fund (UNICEF, 2015) recommend breastfeeding is started immediately following delivery of the baby to get colostrum (Petit, 2010). Awogobenja and Ugwuona, (2010) found that amongst the effective measures for decreasing death rates in children younger than 5 years of age, promotion of exclusive breastfeeding (EBF) and improved complementary food (ICF) at the proper age have been ranked first by WHO and UNICEF.

A study done by Dube, (2014) report that growth improved significantly after nutritional adequate and hygiene complementary food were linked to the infants' diet. Furthermore, children who do not received colostrum (first milk) were more likely to have malnutrition, because it is rich in vitamin A and prevents infections as it contains natural antibiotics. The study further indicates that colostrum was different from breast milk and mothers threw away it because of its colour and its creamy nature.

A study conducted by Rollet, Gray, Previ and Forrester, (2014) revealed that malnutrition among children in Haiti is mostly caused by inappropriate infant

and young child feeding practices, and being initiated to complementary food (CF) before the recommended six months. Similarly, Abeshu, Adish, Haki, Lelisa and Geleta, (2016) indicate that malnutrition starts when the infants change from exclusive breastfeeding to weaning or solids from the age of 6 to 23 months. As the Millennium Development Goal (MDG) No 4 is to decrease the death rate of children, it should be supported by standard practices of nutrition which is important in child survival, growth and development (NDoH, 2015).

1.2.1 ACUTE MALNUTRITION

Acute malnutrition is caused by a decrease in food consumption and/or illness resulting in bilateral pitting pedal oedema and/or a sudden weight loss. Poor appetite and medical complications are clinical signs indicating or aggravating the severity of acute malnutrition (NDoH, 2015). Acute malnutrition is classified as moderate malnutrition (MAM), or severe acute malnutrition (SAM). These are discussed below.

1.2.2 MODERATE ACUTE MALNUTRITION (MAM)

MAM is defined as a weight-for-height between -3 and -2 SD (standard deviation) below the median of the WHO,2011b) child growth standards, Mid-upper arm circumference (MUAC) from 11.5-12.5cm (WHO, 2011b). No oedema of both feet. The types of SAM are discussed below:

Wasting

Wasting (weight loss) is the term used to describe severe fast fat loss due to severe food restriction or illness (NDoH, 2015). Inadequate food intake leads to weight loss and growth retardation, and when it is prolonged, it leads to body wasting and emaciation. Furthermore, wasting is low weight for height, and is used as an indicator for identifying severe acute malnutrition (SAM),

and occurs at any age. Wasting can be either moderate or severe, and we call it marasmus when it is severe (Mensah, 2015). A child is wasted when the weight for height is less than 70% of the median and is equal to a standard deviation score of $-3SD$.

Stunting

Stunting (low height for age) is a greater problem than wasting and underweight. It usually occurs in infants and children younger than 5 years during times of growth and development, and in the developing world it affects about 195 million children less than 5 years, and one in three children in Africa (De Lange, 2010). The first clinical sign of malnutrition is stunting, and is also an indicator of long term inappropriate diet and chronic malnutrition due to chronic energy deficiency (WHO, 2011b). A study conducted by Black, Victora, Walker, Bhutta, Christian, de Onis, Ezzati, Grantham-McGregor, Katz, Martorell, Uauy and the Maternal and Child Nutrition Study Group, (2013) found that stunting in south-central Asia has the largest number of 36%, whereas in east Africa, it is 42% and in Ghana is at 32.5% (Saaka, 2014).

The study done in Zambia by Khunga *et al.*, (2014) revealed a high rate of stunting at 45%, and three years down the line in the same country Mweemba, (2017) indicates that stunting is at 40%, and in tribal Melghat in India high rate of stunting is at 66.1% (Dani, Satav, Pendharkar, Satav, Ughande, Adhav & Thakane, 2016). In South Africa, stunting is at 27 % and was highest common in children with poorly illiterate mothers living in informal or tradition housing. Furthermore, child is stunted when the height for age is less than 70% of the median and is equal to a standard deviation score of $-2SD$. On the other hand, Semba, Shardell, Fayrouz, Ashour, Moaddel, Trehan, Maleta, Ordiz, Kraemer, Khadeer, Ferrucci and Manary, (2016) suggest that stunting is at 60%. Both thinness and shortness indicated by Growth failure. Children are at greater risk of becoming stunted living in rural communities than in urban areas. Giving supplementary foods too late

could increase probabilities of nutritional stunting. Stunting can also referred to as growth faltering or failure to thrive, which refers to inadequate growth or slow weight gain in the infant and young child.

Mweemba, (2017) revealed that stunting is a leading type of malnutrition. Stunting attacks about one-quarter of children under 5 years of age worldwide, and develops during the first two years of life, and is due to infectious diseases and inappropriate nutrition. The study further report that poor nutrition in the first 1000 days of child life can also lead to stunted growth, which is irreversible and associated with impaired cognitive ability and reduced school and work performance.

Underweight

Underweight (low weight for age) is a common condition in children and an important form of PEM, which is missed many times. According to WHO, (2011b) underweight children can also be stunted, wasted or both. Children who are underweight identified early through regular growth monitoring of weight and height, and can be missed easily when both height and weight are not indicated on the road (RtHC). When a diet is insufficient in protein and or energy, there will be a slowing down of linear height and failure to gain weight or weight loss (De Lange, 2010). The study further indicate that children who are underweight are prone to infections, such as, respiratory diseases, gastro enteritis, TB and measles.

The study done in Ghana by Abubakar, Hlding, Mwangome and Maitland, (2011) found that in a rural Africa setting underweight is at 30-50% so as Matsunyana, Karama, Tanaka and Kaneko, (2013) revealed that in Kenya underweight is at 20.3%. Saaka, (2014) indicates that in Ghana underweight is at 12.9%, and so as Sreeegiri, Nayak, Naidu and Madhavi, (2015) found that underweight among under 5 children in Visakhapatnam is at 49.2%.

When growth monitoring is done, the child must be suspected of being malnourished, if a child presents with a weight for age below the third percentile (less than 80% expected weight or less than 90% expected height). The child is underweight when the weight for age is less than 70% of the median and is equal to a standard deviation score $-2SD$ (IMCI, 2014).

1.2.3 SEVERE ACUTE MALNUTRITION (SAM)

SAM is defined as weight-for-height or length below -3 (SD), and (MUAC) of less than 11.5cm in children aged 6-60 months, the presence of bilateral pitting pedal oedema, or visible severe wasting. SAM is a form of malnutrition that occurs when there is not enough protein in the diet (NDoH, 2015). Two types of SAM are discussed below.

Kwashiorkor

Kwashiorkor is found in children of one to three years of age and usually after 18 months, and is one of the type of SAM. The body of the child requires nutrients such as protein to function properly, and if the child is not eating sufficient nutrients these leads to malnutrition. It is more common in villages where there is a small gap between successive pregnancies of mothers. In the Gold Coast of Africa kwashiorkor refers to an evil spirit that transmits the first child when the second child is born (De Lange, 2010). Furthermore, after the birth of the second born, the first is weaned from breastfeeding so that the second born can be breastfed, this will lead the first child to receive low protein food.

A study done by Ogunrinade, (2014) revealed that kwashiorkor develops when the child is suddenly deprived by the mother or the mother has become pregnant. Considering how kwashiorkor occurs, it is easy to see how the Ghanaians came to use the word kwashiorkor.

De Lange, (2010); Mensah, (2015) indicate that the child with kwashiorkor has a well-nourished appearance, with some body fat retention because the body swells due to oedema. Even though some tissue wastage and weight loss are present, they may be over shadowed by oedema. Furthermore, Kwashiorkor occurs within few weeks and present fast, with swelling of the feet and legs, which spreads to the face, hands and body. A child suffering with kwashiorkor has a failure of growth, their skin looks flaky and discouraged, there is hair loss, they look unhappy and lack interest, and suffer from diarrhoea, and loss of appetite and weight (Ogunrinade, 2014).

It is difficult to determine which factors are major contributors and which are responses. In combination with weight loss, oedema has been accepted as the main criteria for identifying kwashiorkor. Kwashiorkor is more common in stunted or wasted children, and also occur in normal size children. There is signs of infections and hypovolemic, low blood pressure and sodium retention in kwashiorkor children. Patients with nutritional oedema are metabolically different from those with marasmus. The mortality rate in children with kwashiorkor is much higher than in marasmic children (De Lange, 2010).

Marasmus

De Lange, (2010) referred marasmus as wasting, and is more common in towns and cities due to early cessation of breastfeeding, and is also linked to severe deprivation or impaired absorption of protein, energy, vitamins and minerals. Similarly, a study done by Macabela, (2015) found that marasmus develop in urban areas where factors such as cessation of breastfeeding and incorrect use of formula milk are practiced. This means that marasmus can be preventable if exclusive breastfeeding is practiced for the period of 6 months. Marasmus is defined as another form of severe malnutrition which occurs in children below the age of 1 year and are underfed (Ogunrinade, 2014).

It is characterised by energy deficiency (namely carbohydrates and fats) in the diet, failure of linear growth (stunting) and loss of weight (wasting). It develops when the body of the child doesn't get enough calories, protein, carbohydrates which include other essential nutrients such as vitamins, minerals and iron (Butler, 2016). Contrary, Biggers and Mehta, (2016) indicate that nutrients deficiency is not the only source of marasmus but inability to process nutrients appropriately due to inappropriate feeding such as feeding the child one type of food like carbohydrates and infections such as tuberculosis, congenital diseases and syphilis.

De Lange, (2010) found that marasmus emerge within months and a child looks emaciated and present with fluffy hair, failure of linear growth, loss of weight and appetite, and skin does not change colour and or break. Similarly, the child suffering with marasmus appears with growth retardation, resemble little old man, muscle and weight loss, and angular stomatitis (Ogunrinade, 2014). The child with marasmus looks emaciated apart from other signs such as sunken eyes, thin face, and wasting of muscles (Biggers and Mehta, 2016). Mortality rate in children with marasmus is relatively low, unless there are underlying illnesses or infections.

1.2.4 CAUSES OF MALNUTRITION

There are so many causes of malnutrition. In this section a few will be discussed as the key factors contributing to malnutrition; these include lack of knowledge, access to health services, poor maternal and child care, poverty, food insecurity and diseases.

Lack of knowledge

At an exosystem level, the education of the mothers also plays a role in whether the child develops malnutrition. In terms of the mother's

characteristics, maternal education is one of the most important elements in addressing child malnutrition and those who are illiterate are more at risk of having children who develop malnutrition. Several researchers in the Democratic Republic of Congo, indicate that they noticed a high gap of stunting prevalence between the children from illiterate mothers or those whose mothers have a primary school level of education, and those from mothers with a secondary or high level of education (Kandala, Madungu, Emina, Nzita & Cappuccio, 2011). Furthermore, Kandala, *et al.*, (2011) report that educated mothers believed that it is important to attend prenatal care so that they get an opportunity to get information which is more important to the mother and the child about health nutrition.

A study done by Paul, Khalfan, Humphrey and Caffarella and Stoltzfus, (2011) revealed that inappropriate knowledge of nutrition by mothers can worsen child feeding practices and inadequate cooking methods for preparing food suitable for children. Berra, (2013) indicates that some mothers accept that colostrum is nutritious for infants, while some have no idea what colostrum could supply to their children at all. The study further report that about 72% of educated mothers have a positive perception of colostrum, compared with less-educated or uneducated mothers. Both indirect and direct maternal education acts as preventative measure for child malnutrition (Berra, 2013 and Macabela, 2015).

A study done by Nousiainen, (2014) found that mothers in Southern Benin lack knowledge about child feeding and about how to prepare complementary foods using local ingredients. Malnutrition is worsened by lack of nutritional information and knowledge, especially maternal nutrition education, which leads to unhealthy dietary habits, poor nutrition-related practices and attitude, perception and socio-cultural influences (NDoH, 2015). The above authors found that the higher the level of the mother's education, the better

knowledge they have on how to prepare a balanced diet for their children, and this will lower the likelihood of the child developing malnutrition.

Hackkett, Mukta, Jalal and Sellen, (2015) report that mothers in Bangladesh had very little knowledge of the benefits of breast milk such as that it is nutritious, it contains vitamins, keeps the baby healthy or provides energy. While Mensah, (2015) found that in Ghana, malnutrition is caused when the child is in contact with other malnourished child by using the same weighing bag at the clinic, which discourage mothers from attending the well-baby clinic. A study done by Cumber, Ankrleh and Monju, (2016) revealed that mothers with appropriate knowledge of disease had children with better nutritional status than mothers with inappropriate knowledge. Furthermore, in Cameroon, most mothers indicate that malnutrition is when the child started having large head and swollen stomach, loss of weight and proper body nutritional requirements.

Access to health services

Malnutrition rates are still high because of the lack of access to health services. A study done in Zambia, by Khunga *et al.*, (2014) report that distance to the health facilities and bad roads were reported as challenges that prevent mothers from taking children to hospitals for follow-up activities and growth monitoring, because it is a very helpful tool for measuring infant and child health, and they end up refusing to take their children for treatment or even after referral advice.

The study by Khunga *et al.*, (2014) further indicate poor access to PHCs and relevant institutions, the stigma of taking care of a thin child in hospital, and fear of hospital admission are identified as some reasons for the poor management of severe malnourishment in children under 5 years. Similarly, a study conducted by Macabela, (2015) revealed that poor roads and lack of

a public transport system make it impossible for the community to access the health facilities.

Poor maternal and child care

The results of a study conducted in the Northern Cape by De Lange, (2010) indicate that malnutrition can occur in children due to mothers who wean their babies too early because of another birth leading the mother to stop breastfeeding the first baby, and end up feeding the older baby formula milk or introducing non-nutritious complementary food. This will cause the older child to become sick when the new baby arrives.

Ngwu *et al.*, (2014) found that some mothers in Nigeria are against exclusive breastfeeding because they do not want their breasts to be floppy, and would rather retain their breast shape. Breastfeeding should continue together with weaning food up to and beyond second year of life. However, infant feeding and weaning practices have cultural, social, and economical influences, making malnutrition more prevalent than medical problems. Children should be put to their mother's breast immediately after birth so that they can get colostrum, because it protects children from certain infections and helps to clear out meconium (Ogunrinade, 2014).

A study done by Hackkett, *et al.*, (2015) revealed that most young mothers in Bangladesh considered colostrum (the local term is *Gaja Dhud*) as the yellowish milk that comes out first and was full of vitamins and healthy to their babies, whereas a few mothers insisted that colostrum must never be fed to babies because it regarded as bad milk. The findings of a study done by Sreegiri, Nayak, Naidu and Madhavi, (2015) is in contrast with several studies in that it revealed that the majority of tribal children under 5 years in Paderu Division, Visakhapatnat, received exclusive breast milk. Contrary, in Pakistan exclusive breastfeeding is not practiced by the majority of mothers, (Zulfigar,

Ghazanfar, Shahzadi, & Mehmood, 2016). Children who are exclusively breastfed are less likely to be malnourished.

Poverty

A study done by Kandala, *et al.*, (2011) found that poverty is associated with malnutrition in the DRC, because children from poorer households have a high risk of suffering with kwashiorkor because their parents cannot afford to buy proteins, such as groundnuts, beans, meat, milk and fish for their children, unlike the richer households. Similarly, a study conducted in Nigeria by Ngwu, *et al.*, (2014) also revealed that few mothers are aware of nutritious food which is rich in protein, such as meat and eggs that is needed for their children, but they cannot afford them regularly. People who are rich end up buying fruits such as paw-paw, orange, carrots, banana to protect their children. Whereas, Berihu, Abera, Berhe & Kidana, (2013) indicate that MDG No 1 focusing on elimination of extreme poverty on child nutrition.

According to Nousiainen, (2014) poverty in Southern Benin is the biggest obstacle to optimal complementary feeding practices that limit the access to high quality and nutritious foods and it affects care of the child. While, a study done in the Eastern Cape of South Africa by Macabela, (2015) associated poverty with lack of basic services, such as poor sanitation and lack of safe drinking water which increase the risk of diarrhoea and childhood malnutrition. Furthermore, poverty referred to the death of the mother or when she is working far from home and children are taken care of by the father or next of kin.

A study conducted in the Limpopo Province by Mushaphi, Dannhauser, Waish, Mbhenyane and Rooyen, (2015) report that the majority of caregivers were unemployed and relying on child support grants for income, leading to a negative effect on the nutritional status of the children. Some researchers,

such as Mensah, (2015) and Zulfigar *et al.*, (2016) found that poverty does not look to be the principal cause of malnutrition. Only 23% in Pakistan believe that it is the cause of malnutrition, whereas 77% people in Ghana believe is something else.

Food insecurity

According to De Lange, (2010) malnutrition in the Northern Cape can occur in children due to neglect, inappropriate mealtimes, insufficient quantities of food and food taboos, by a care giver or parent. This leads to reduction of child food intake, because when there is not enough food in the house, it will be difficult to decide who will receive what is available, and they end up feeding the child junk food, and this will lead to weight loss. Contrary, Kandala, *et al.*, (2011) report that in the DRC, food is lacking due to insecurity rather than their inability to produce food because they do not want to work in agriculture, they rather work in the traditional extraction of diamonds and this leads to the high rate of malnutrition. Mweemba, (2017) found that some mothers in Lusaka believed that poor feeding, not giving enough food, lack of variety in the diet, number of feeding times and giving food with little nutrients caused malnutrition in children.

Diseases

Some researchers in South Africa, De Lange, (2010); Magadi, (2011), ; Kimani-Murages, (2013), ; Khunga, *et al.*, (2014), ; Macabela, (2015), ; Matara, *et al.*, (2015) and Mweemba, (2017) found that diseases such as HIV/AIDS have a great effect in child growth and also associated HIV/AIDS as a significant risk factor in malnutrition. Those HIV infected children with malnutrition are three times more likely to die compared with uninfected children as their immune system is compromised. Their findings further indicate that mothers who are infected become too sick to take care of themselves and their children's nutritional needs. Similarly, in Zambia mothers and caregivers associated HIV/AIDS with a child suffering with marasmus and this increased the stigma

for both the mother and the child. Apart from HIV/AIDS, diarrhoea is also another disease which causes malnutrition three times more than in children who have no diarrhoea (Mensah, 2015).

1.2.5 YOUNG MOTHERS CULTURAL VIEWS REGARDING CAUSES OF MALNUTRITION

Some researchers had different cultural beliefs about causes of malnutrition. A study done in Kenya by Matsunyana, *et al.*, (2013) report that infants may be snatched by an evil eye when they or their mothers are seen by outsiders during meals or breast feeding. Matsunyana, *et al* further indicate that mothers believed that diarrhoea happens if an eagle sees a baby as it flies over the village, and may lead to more sickness namely, *nyumi*, which is distinguished by rolling eyes and fits. Similarly, Khunga, *et al.*, (2014) revealed that mothers, care givers and communities believed that malnutrition in children is caused by ‘bad air.

Furthermore, Khunga, *et al.*, (2014) added that women in Zambia did not say that feeding a child junk food, left-overs or contaminated foods and complementary feeding is associated with malnutrition, but they relate malnutrition to poverty, diarrhoea, and breastfeeding the child during pregnancy. According to Boatbil, *et al.*, (2014) residents in Kenya believed that sexual transgressions caused malnutrition in children which attract the wrath of gods and also witchcraft. Furthermore, they also believed that when a child sucks the breast whilst mothers are pregnant, the foetuses pass ‘ekhiria’ (marasmus) to older ones due to jealousy.

Whereas, Hackkett, *et al.*, (2015) report that many young mothers described child sickness as repeatedly the results of “problems in the breast milk”, and they stopped breastfeeding completely when the babies are sick. Their findings further report that young mothers perceived breast milk as

inadequate in quantity and this lead them to introduce complementary foods early to keep the child happy and quiet, fulfil the hunger of the baby, balance nutrition, ensure proper body weight, reduce disease to meet the growing child's energy requirements so that the child becomes intelligent. In the communities in Biraul, under nutrition is seen not as a sickness itself, but as a consequence of various diseases, and witchcraft or spirits (Burtscher & Burza, 2015). Furthermore, the majority of participants related child health with proper hygiene, safe complementary food preparation and cleanliness by washing all cooking utensils, cooking thoroughly, feeding only freshly prepared food, covering children food to prevent contact with flies and gems.

According to Matara, *et al.*, (2015) most people in Zimbabwe believed that breastfeeding alone is not adequate enough for the babies and they end up commencing solids food early for the child to grow more. Mweemba, (2017) indicates that mothers mentioned common childhood diseases, such as diarrhoea and worms, as factors which cause malnutrition to children, but also believed that children with HIV are suffering from malnutrition. The study further explains that mothers had strong beliefs that malnutrition in children is caused by poor feeding and care practices, but mentioned hunger, lack of food, inadequate intake of food due to lack of appetite and diseases as causes of malnutrition.

1.2.6 THE EFFECTS OF MALNUTRITION

The medical and physical effects, social effects, psychological effects, the effects on the malnourished children and the effects on the health care system will be discussed below.

Medical and physical effects on the child

According to Matara, *et al.*, (2015) about 35% of all child mortality can be due to under nutrition. HIV/AIDS continue to take a terrible number of deaths of children under 5 years, regardless of some progress being made towards HIV/AIDS and malnutrition. Macabela, (2015) found that the effects of malnutrition in early childhood can be short term, and affects brain development, body composition, muscle growth and the metabolic programming of glucose and lipids, whereas long term affects the child's cognitive and educational performance. Due to being immune compromised, the child is at risk for developing conditions such as obesity, diabetes, heart disease, high blood pressure, and cancer.

The study done by Macabela, (2015) further explains that poverty and serious physical disabilities can impact other child development stages and occur in low birth weight children due to malnutrition, such as learning delays often discovered when a child wants to perform writing and reading. These children are characterised with lower levels of intelligence, and result in grade retention and drop out of school as they cannot cope with the difficult situation because of being affected physically and psychologically in the adulthood stage (Macabela, 2015).

Social and psychological effects on the child

The brain is the organ that grows most rapidly during the first months of life, and is slower, with some wasting during malnutrition. Children suffering with marasmus have a smaller brain and those who are malnourished, and have a smaller head circumference than normal children of the same age (De Lange, 2010). Furthermore, the study report that poor growth is related to delayed mental development, and there is a relationship between impaired growth status, poor school performance and reduced environmental achievements. Malnourished children may develop depression, anxiety, feelings of

inadequacy and isolation, and sometimes may develop aggression and impulsive behaviour because of the environment in which they are raised (Macabela, 2015).

Effects on the mother of the malnourished children

A study in Malawi by Bunn, Kauye, Tomenson, Vokhiwa and Steward, (2010) revealed maternal distress when children are too hospitalised with malnutrition. Factors that are closely associated with higher levels of maternal distress include, no close relationship with a spouse, a sick older child, having a previous death of a child and when the ill child is having diarrhoea.

The results of the study conducted in Durban by Buthelezi, (2011) found that mothers of children admitted to hospitals with malnutrition are generally poor, and depend on others for financial support. Furthermore, mothers who are taking the child support grant use the grant to support the whole family, rather than a specific child, and this will cause them to feed their children insufficient food and lead to malnutrition.

Effects on the health care system

Treating children suffering with malnutrition needs special attention and the majority of children need treatment, which puts a burden on hospitals. The results of high turnover of staff, errors in management and lack of supervision may be due to poor management of malnutrition cases (Hendrick & Bourne, 2010). Whereas, Buthelezi, (2011) report that malnutrition is a main public health problem, and is an underlying cause in the mortality of children who die from preventable diseases. NDoH, (2015) found that the death rate for children with malnutrition is three times higher than the overall death rate.

1.2.7 NUTRITIONAL STATUS ASSESSMENT

Nutritional assessment is used to determine whether a person or group is well nourished or malnourished (over-nourished or under-nourished). Assessment is used to measure an indirect quality of life of a population or community, and also give information on the nutritional and health status of subcutaneous fat tissue with chronic PEM, show growth retardation in terms of both height and weight (NDoH, 2015).

Anthropometry

Anthropometrics are set of non-invasive, qualitative body measurements used to assess growth, development, and health parameters. Ogunrinade, (2014) found that malnutrition in children can also be assessed by means of anthropometry, and the advantage of anthropometry is that body measurements are sensitive over the full spectrum of malnutrition, Anthropometric measurements can be used to measure nutritional status, even in less advanced cases of malnutrition. Anthropometric measurements are the following: mid-upper arm circumference (MUAC), weight, height and its disadvantage is that it lacks specificity because of the body changes (NDoH, 2015).

Weight

Loss of weight due to muscle wasting and loss of subcutaneous tissue is an immediate effect of malnutrition. A very low weight for height is seen as < -3 . A z-score of the median define severe acute malnutrition. Weight measurements must always be interpreted carefully for two important reasons: the presence of oedema can cause the child's true body weight to be overestimated, and the absence of oedema with a low weight is due to chronic energy deficiency ('stunting') rather than recent weight loss ('wasting') (De Lange, 2010).

Weight for age is most frequently used as a sign of children nutritional status. Weight must be interpreted together with a measurement of length or if over two years with height. The total weight is used as a sign even though skeletal and essential organ weight has a slow tissue turnover. Body weight of children may be done using baby scale (WHO, 2011b). According to NDoH, (2015) weight is also categorised by the manifestation of visible severe wasting, or the presence of nutritional oedema.

Mid upper arm circumference (MUAC)

MUAC is used for the assessment of nutritional assessment and is the circumference of the left upper arm, measured at the mi-point between the tip of the shoulder and the tip of the elbow. Weight only is inadequate to differentiate between an underweight and short child with an adequate weight, when age is unavailable. Where no scale is available in field conditions, MUAC doing well (De Lange, 2010) but it can distinguish between moderately and severely malnourished children and is not sensitive. MUAC is more appropriate sign of death rate, and perfect for assessing children that will need more care than weight for height.

According to WHO, (2011b) children aged 6 to 59 months, with an arm circumference less than 110mm are severely malnourished. The use of MUAC as an anthropometric indicator for screening and admitting children into community based therapeutic care, gives the community a chance to help and take responsibility for their children. MUAC is regarded as a best sign in underprivileged communities for identifying children at high risk of death from malnutrition (Integrated Management of Childhood Illness, 2014).

Height / Length

According to IMCI, (2014) all children should be measured for height at least every three months in order to determine if the child is growing properly and indicate when the child's health and well-being are at risk. Height measurements can be used with weight to measure overall growth for comparison to growth standards. In infants and young children less than 24 months, height is measured by taking supine length when the child is lying down, stand or not. Height measurement is done in a standing position in order to get the accurate length measurements, in children two to five years (NDoH, 2015). When the measuring board is used, the child must be held firmly, to make sure that the head and feet touch the head and foot panels respectively, and the knees are kept down

1.3 PROBLEM STATEMENT

Brink, (2016) describes the problem statement as a problem to be studied, which should be short and to the point and also contain three important aspects, namely, topic, target group and settings where the study will be conducted.

In the Vhembe district hospitals (Tshilidzini, Elim, Donald Frazer, Musina, Louis Trichardt, Siloam and Malamulele), there was a high admissions rate of children under 5 years with malnutrition. According to the Vhembe District Health service statistics, in 2016 alone, there were 6326 admissions of children under the age of 5 years. Out of these 6326 admissions, 1810 (29.1%) were admitted with malnutrition.

The researcher has been employed as a registered professional nurse in the paediatric medical ward in one of the hospitals of the Vhembe District in the Limpopo Province, for 8 years. The researcher observed that most children

admitted were due to malnutrition, and that most of these children were of young mothers. The researcher did a thorough literature review on perceptions of young mothers regarding causes of malnutrition in children less than 5 years in the Vhembe district, and none was found conducted at the Vhembe district. Several studies were done in South Africa by Berra, (2013); Khunga, *et al.*, (2014), Ngwu, *et al.*, (2014), Macabela, (2015) and Mweemba, (2017) focus on perceptions of mothers, caregivers and families regarding malnutrition, but little focus has been done on perceptions of young mothers regarding malnutrition.

Therefore, the researcher sought to explore the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years in the Vhembe District of the Limpopo Province.

1.4 PURPOSE OF THE STUDY

Brink, (2016) defines the purpose of the study as showing the direction for the research project, but it also delimits it. It indicates what the researcher plans to do and it should therefore be clear, understandable and acceptable.

The purpose of the study was to determine the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years in the Vhembe District, Limpopo Province.

1.5 RESEARCH QUESTION

The research question is a question usually asked after the problem has been formulated (Brink, 2016).

The research questions were:

- What are the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years?
- What are the health seeking behaviours/actions of participants for their malnourished child?

1.6 OBJECTIVES OF THE STUDY

According to Polit and Hungler, (2015) objectives are the steps that will lead to the fulfilment of the aim, and are specific and measurable. In this study, the objectives were to:

- explore the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years.
- describe the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years.
- determine the health seeking actions/behaviour of participants for the malnourished child.

1.7 SIGNIFICANCE OF THE STUDY

The research study should have the potential to increase the body of science knowledge from the study, health practice and policies should improve, implemented and cost effective (Brink, 2016). The beneficiaries of this study envisaged are:

Policy makers

The findings of the study may help the policy makers to design appropriate nutrition education programme, and it may also influence the further development of policies, protocols and guidelines regarding malnutrition.

Body of knowledge

The study findings may share more light about perception of young mothers regarding causes of malnutrition that led their children to be admitted, and add to the existing body of knowledge regarding young mother's attitudes and cultural beliefs regarding child nutrition.

1.8 DEFINITION OF CONCEPTS (CONCEPTUAL AND OPERATIONAL)

Perception

According to Steinberg, (2013) a perception is a process whereby people gather information about the environment through the five senses. The interaction of these senses assists people to get meaning within themselves as well as the environment.

In this study, a perception is the way young mothers view, understand and interpret causes of malnutrition.

Child under five years

Children who are less than five years old, especially those who are not in full time education, are in need of more care (WHO, 2011b).

In this study, a child under the age of 5 years is referred to a young female or male human being whose age ranges from 0 to 36 months.

Malnutrition

(Oosthuizen, 2010) defines malnutrition as the inadequate, excessive or imbalance consumption of nutrients.

In this study, malnutrition refers to lack of adequate nutrition which leads to micronutrients deficiency (wasting, underweight, stunting) or macronutrients deficiency (kwashiorkor or marasmus).

Young mother

A young mother is any woman under the age of 30 years, who is actively involved in parenting a child (<http://www.youngmommies.com>). Accessed 12 January 2016.

In this study, a young mother refers to a biological mother of the age of 30 years take care of an under five child.

1.9 THEORETICAL FRAMEWORK

This study was guided by the Ecological System Theory. Berk, (2001) says, Urie Bronfenbrenner's ecological framework for human development applies socio-ecological models to human development, and views the person as developing within a complex system of relationships affected by multiple levels of the surrounding environment. Environmental factors such as social, economic and psychological can influence how children are raised and have an effect on whether a child becomes malnourished.

Beliefs, norms, socio-culture and social factors affects the whole system or family when the child gets ill. Economic factor can both cause the problem

and impact the intervention and solution to the problem. Psychological factors such as stress and confusion of mothers when taking care of the malnourished child must be taken into consideration. The main affected person is the child but also the mother is affected. Four systems that are used in this research study are described by Ecological system theory in (Macabela, 2015):

Microsystems level

This system is concerned about the relationship between the affected person and the environment. The family, especially the mother, who is the primary caregiver, plays an important role in the development of the child and how to protect the children from malnutrition. Basic needs in child life, such as hygienic food, education, love, compassion and home as a place of belonging should be provided by those family members.

Exosystems level

This system looks at the wider community system, such as educational systems, welfare, health, justice and employment can provide positive support to the individual or hamper the development and well-being of the individual.

Macrosystems level

This system consists of the laws, customs, value and resources of a given culture. The policy context in which child malnutrition can be understandable should be provided by the macro system. Government policies can provide resources to support families which can influence on the immediate environment making it more useful to good care of the child.

Mesosystems level

This system focuses on connections among immediate settings, like a neighbourhood which is the social environment in which the family carries out its daily life. The neighbourhood can play a major role in the care and well-being of children. It can provide resources that support positive child care or contribute to problems such as malnutrition.

1.10 RESEARCH METHODOLOGY

This study was conducted using situational analysis where only qualitative design was used. The study methodology and design will be discussed in detail in chapter 2.

Research design

According to Van de Walt and Van Rensburg, (2016) research design is a procedure which the research has to follow throughout the study, from sampling, data collection and the approaches that the researcher will use when analysing data. Since the study is focusing on the perceptions of young mothers regarding causes of malnutrition in children under 5 years, in this study, the following approaches were applied, namely qualitative, explorative, descriptive and contextual. The designs will be discussed in chapter 2 of the study.

Qualitative

Qualitative research refers to openness, relevance, epistemological and methodological congruence, thoroughness in data collection and the analysis process, and researcher's self-understanding (Brink, 2016). In this study, the researcher used the qualitative design to allow young mothers to narrate the depth, richness and complexity inherent in their perceptions regarding causes

of malnutrition in children and secondly because little was known about the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years.

Exploratory

The exploratory qualitative research component seeks to explore and give answers in different ways about how a phenomena and process occur (Polit & Beck, 2012). In this study, perceptions of young mothers regarding causes of malnutrition in children under 5 years were explored.

Descriptive

Descriptive design is concerned with gathering information from a represented sample of the population (Brink, 2016). In this study, the researcher gave young mothers an opportunity to describe their perceptions regarding causes of malnutrition on less than 5 year old children.

Contextual

According to Polit and Beck, (2012); Brink, (2016) contextual design seeks to explore and give answers into different ways about how the phenomena and processes take place. Furthermore, contextual design aims to describe and understand events within a concrete and natural context as they take place. This study is contextual in nature, because individual interviews were conducted with young mothers in Tshilidzini, Siloam and Donald Frazer hospitals in the Vhembe District of the Limpopo province, where children suffering with malnutrition are admitted.

1.11 STUDY SETTING

The study setting is a specific place or places where the data will be collected, a real life situation or environment (Brink, 2016).

This study was conducted in three selected hospitals with high rate of malnutrition namely: Tshilidzini, Siloam and Donald Frazer hospitals in the Vhembe District of the Limpopo province. Study setting will be discussed in detail in chapter 2.

1.12 POPULATION

According to Burns and Groves, (2012) and Brink, (2016) population is the entire group or object that is of interest to the researcher or that meets the criteria the researcher is studying about. In this study, the population were young mothers between 18-26 years whose children under 5 years of age were admitted and recorded in the admission register with malnutrition in Tshilidzini, Siloam and Donald Frazer hospitals in the Vhembe District of the Limpopo Province.

1.13 SAMPLING METHOD

Sampling

According to Wood and Haber, (2014) sampling is a process of selecting a portion or subset of the designated population to represent the entire population. A non-probability and probability sampling were used in this study. The purposive sampling method is based on the judgement of the researcher regarding participants that are typical or representative of the study or who are especially knowledgeable about the question at issue (Brink, 2016). The sampling method will be discussed in detail in chapter 2.

1.14 DATA COLLECTION

According to Polit and Beck, (2012) data collection is the gathering of information to address a research problem. In this study, data collection will include preparation, data collection, instrument and a role of the researcher, and these will be discussed in detail in Chapter 2.

The researcher, as a data collection instrument, used effective communication skills to facilitate interviews (Brink, 2016). Details of all effective communication skills will also be discussed in Chapter 2.

1.15 DATA ANALYSIS

Data analysis entails categorizing, ordering, manipulating and summarizing the data and describing them in meaningful terms with the aim of highlighting useful information, suggesting conclusions and supporting decision making (Brink, 2016).

In this study, the researcher analysed data following a step-wise format as defined in Tesch's eight steps of data analysis (Creswell, 2014). Details of the steps will be discussed in Chapter 2.

1.16 LITERATURE CONTROL

After data analysis, perceptions of young mothers regarding causes of malnutrition in children under 5 years were identified and a literature control was conducted.

1.17 MEASURES TO ENSURE TRUSTWORTHINESS

Polit and Beck, (2012) describe trustworthiness to a degree of confidence qualitative researchers have in their data, assessed using the criteria of credibility, transferability, dependability and conformability. These were described below and details will be discussed in Chapter 2.

Credibility (Truth value)

Credibility refers to the confidence in truth of the data and the interpretation thereof (Brink, 2016).

Transferability (Applicability)

According to Brink, (2016) transferability refers to the extent to which the findings will be applied in other contexts or with other respondents.

Conformability (Neutrality)

Polit and Beck, (2012) describe conformability as the state that the results could be verified by others to the objective and the findings are reflective of the participants and the study itself.

Dependability (Consistency)

According to Brink, (2016) dependability refers to the provision of evidence such that if the study will be repeated with similar participants in similar context, its findings will be similar.

1.18 ETHICAL CONSIDERATIONS

According to De Vos, *et al.*, (2011) and Burns and Grove, (2012) ethics are a set of moral principles which are suggested by an individual or group, and a branch of philosophy that deals with morality. Permission obtained by the researcher from the University of Venda's ethics committee, the Department of Health of the Limpopo Province, Vhembe District, and from the selected hospitals where data was collected.

The researcher in this study ensured the following ethical principles to protect the rights of the participants, which will be explained in full in Chapter 2.

- Permission to conduct the study
- Principle of respect for persons
- Principles of beneficence
- Principle of justice

1.19 OUTLINE OF THE DISSERTATION

The chapters in this dissertation are organised as follows:

Chapter 1: Orientation to the study

Chapter 2: Research Methodology

Chapter 3: Discussion of the results

Chapter 4: Conclusion, Limitations and Recommendations

1.20 SUMMARY

This chapter gave an orientation of the study, which comprised, introduction and background of the study, problem statement. Purpose, research question, objectives, and the significance of the study were described in this chapter. A full description of design and methodology will be given in the next chapter.

CHAPTER TWO

2. RESEARCH METHODOLOGY

2.1 INTRODUCTION

The previous chapter described the orientation to the study to enable an expose of the research topic. This chapter describes the research design and methodology. It also comprises the study setting, population, sampling, data collection, and data analysis, measures to ensure trustworthiness as well as ethical consideration and ethical consideration.

2.2 RESEARCH DESIGN

This study used qualitative, exploratory, descriptive and contextual design to collect data

Qualitative design

A qualitative design was used to allow young mothers to express themselves fully, without being limited by the researcher or research questions, due to its nature of asking open-ended question. The design was suitable for this research study, since the purpose of the study was to determine the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years. Making use of a qualitative research design gave the young mothers an opportunity to narrate the depth, richness and complexity in their perceptions regarding causes of malnutrition in children. Young mothers were awarded enough time to respond to questions which were posed to them, without any limitations. It was also used because little was known about the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years. The design was relevant for this study due

to its nature of reporting detailed views of the young mothers in their natural setting.

Exploratory design

Perceptions of young mothers regarding causes of malnutrition in children under 5 years were explored. This yielded new understandings and new ideas about the perceptions of young mothers regarding causes of malnutrition in children under 5 years.

Descriptive design

Data about the study was gained through in-depth individual interviews where the young mothers were given an opportunity to describe their perceptions regarding causes of malnutrition on under 5 year's children.

Contextual design

This study is contextual in nature, because individual interviews were conducted with young mothers at the Tshilidzini, Siloam and Donald Frazer hospitals in Vhembe District, of the Limpopo province, where children suffering with malnutrition were admitted. Furthermore, the researcher focused only on those young mothers whose children are under 5 years and are admitted with malnutrition only. Young mothers who were below 18 or above 26 years of age were not entertained. Mothers whose children were admitted in paediatric medical wards in three selected hospitals with other diseases were also not entertained. The language used during interviews was Tshivenda.

2.3 STUDY SETTING

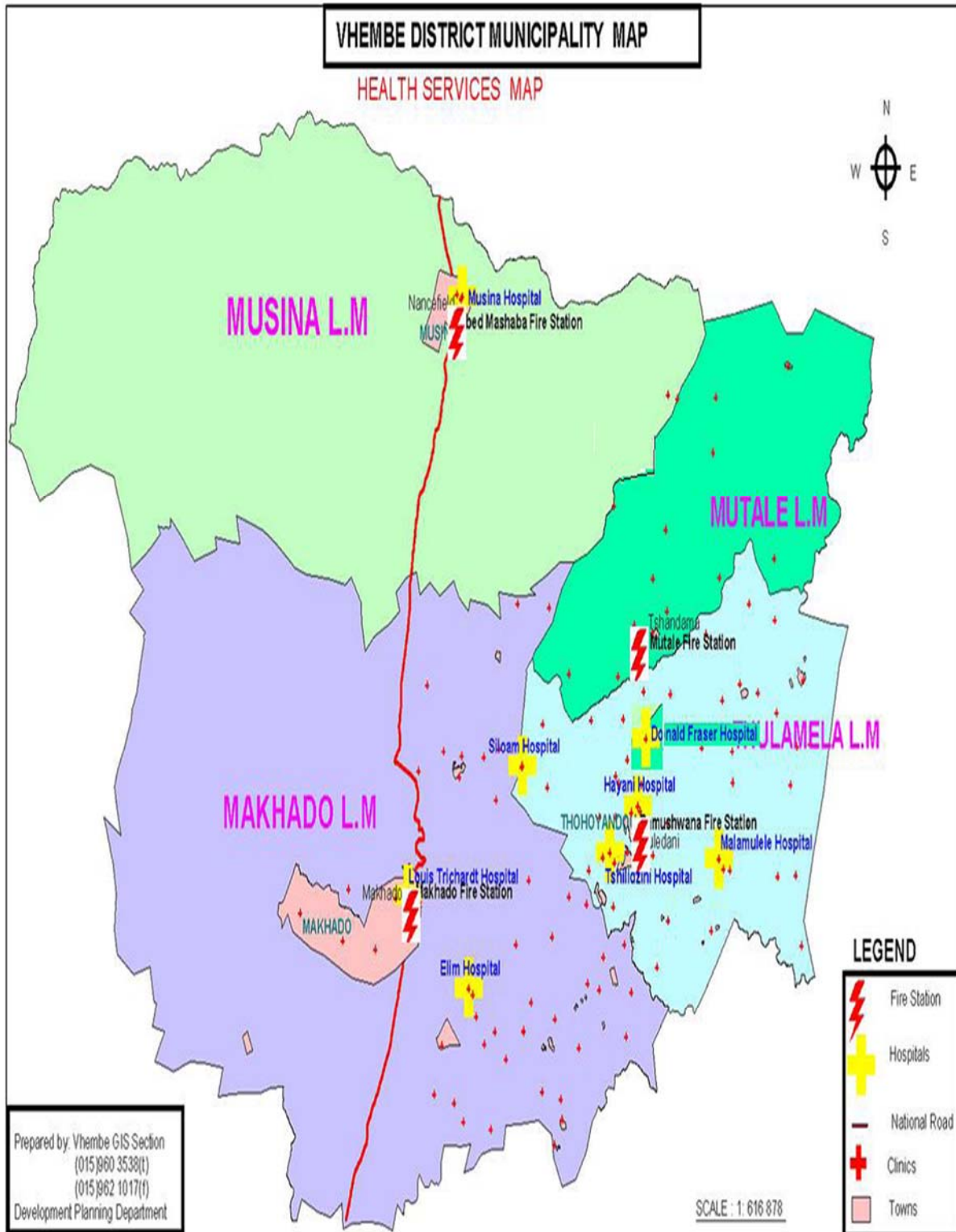


Figure 2.1 shows Vhembe District Map, Municipalities and Hospitals.

This study was conducted in three selected hospitals with high rate of malnutrition namely: Tshilidzini, Siloam and Donald Frazer hospitals in the Vhembe District of the Limpopo province. The Vhembe District lies in the Northern part of the Limpopo Province, which is one of the nine provinces in South Africa. Vhembe covers 18,569 square kilometres and a population of 1.3 million people. It is one of 5 districts in the Limpopo Province.

Limpopo is the poorest of all provinces in South Africa; the Vhembe District comprises of four local municipalities: Makhado (Louis Trichardt), Musina (Messina), Thulamela (Thohoyandou) and Mutale. There are 7 district hospitals, in Vhembe; the Tshilidzini Hospital, Siloam Hospital, Donald Frazer Hospital, Musina Hospital, Malamulele Hospital, Louis Trichardt Hospital, and Elim Hospital. Most people in the population are unemployed and also their educational level is low and these lead to low socio-economic status. People in Limpopo province have strong beliefs on their culture. Concerning health system beliefs, most people prefer to consult traditional healers' first than western doctors. These delay them to visit their nearest clinics or hospitals and they end up coming to hospital on a critical condition. Some people during hospitalisation, they request to fill and sign refusal of hospital treatment (RHT) so that they can visit their traditional healers.

2.4 POPULATION

Population

The study population were young mothers between 18-26 years whose children under 5 years of age were admitted and recorded in the admission register with malnutrition in Tshilidzini, Siloam and Donald Frazer hospitals in the Vhembe District, of the Limpopo Province.

2.5 SAMPLING METHOD

In this qualitative study, non-probability and probability sampling method were used. There are two methods of sampling namely non-probability and probability sampling. Non-probability sampling includes purposive, convenience, quota, and snowball sampling. Probability sampling involves simple random, systematic, cluster random, stratified random sampling (Brink, 2016).

Non-probability purposive sampling was used in this qualitative study to select the hospitals. And the probability, simple random sampling was also used to sample the young mothers. Sampling was done in two phase, namely, sampling of hospitals and sampling of participants. All young mothers under 18-26 years of age, who speak Tshivenda, were found in the selected hospitals in paediatric medical wards, were sampled to become participants in this study. Sampling was done in two phases, namely, sampling of hospitals and sampling of participants. Each is described below:

Sampling of the hospitals

The top three hospitals, namely: Tshilidzini, Siloam and Donald Frazer, with a high rate of admissions in children under the age of 5 years due to malnutrition were purposefully sampled. This was supported by the Vhembe district statistics.

Sampling of Participants

In this study, twelve young mothers were randomly sampled. Young mothers who met the criteria of inclusion were approached and informed about the study. The names of those who agreed to form part of the study were written on identical small pieces of papers and put in a container. The researcher then randomly picked young mothers at selected hospitals, six at Tshilidzini, three at Siloam and three at Donald Frazer.

Inclusion criteria

Inclusion criteria refers to the eligibility criteria which form the basis for the researcher's decision to include the subject (Brink, 2016).

The inclusion criteria were the following:

- Biological young mother, aged between 18 to 26 years.
- Who gave consent to participate at the time of the study.
- Young mothers who speak Tshivenda, and of children under 5 years admitted with malnutrition.

2.6 DATA COLLECTION METHODS

Data collection involved preparation, data collection instrument, and the role of the researcher. These are discussed below:

Preparation for data collection

Permission was sought from the University of Venda Higher Degree and Research Ethics Committee, the Limpopo provincial Department of Health, Vhembe District Department of Health, and the selected hospitals. After permission was granted the researcher visited the paediatric medical wards of Tshilidzini, Siloam and Donald Frazer hospitals and asked permission from the ward manager, and also asked for the admission register book in order to check all children under 5 who were admitted with malnutrition only. After getting all the information, all young mothers of those admissions were recruited to participate in the study. Young mothers were clearly explained that they are relevant sources of information for the study.

Young mothers were informed that their participation is voluntary, and there will be no payments for participation in the study. Consent forms were given to read and sign before they could be interviewed. They were informed that if they do not want to sign they can only give verbal consent. They were informed that they are allowed to withdraw their participation from the study, even if they have already signed the inform consent. And they were not questioned for their reason to stop participating in the study.

The researcher prepared a venue which was a relaxed vacant office, conducive, quiet and arranged, with two chairs next to each other before commencement of the interviews. Furthermore, to avoid distractions, a noticed was placed on the door where the interview took place indicating that

the office was occupied by people busy with an interview. The researcher built rapport and trust with the participant by dressing appropriately and not in uniform, introduced herself to the participants and other small talk were done to break the ice. Interviews were done at a suitable time to avoid interruptions of routines or visiting time. A note book was prepared to record biographical data.

During the interview, participants were allowed to bring their children and also to switch their cell phones on for access of their relatives. The tape recorder was tested beforehand. Young mothers were informed that the interview will be recorded, only if they allow the researcher to do so. And if there is something that they do not want to talk about which they do not want to be recorded, they could press the red stop button at any time.

Data collection instrument

A research instrument is the device used to collect data in research studies (Brink, 2016).

In this study, data were collected through in-depth individual interviews with young mothers as participants, in a manner which allowed young mothers to narrate their perceptions regarding causes of malnutrition in children less than 5 years. This was a one-to-one talk between the researcher and the participants. Young mothers of children under 5 years admitted with malnutrition were interviewed using this method and each interview ranged between 30-45 minutes. The instrument included open-ended questions in Tshivenda and one central question used as a point of departure, followed by probing:

“What do you think is the cause of kwashiorkor in your child?”

Data was transcribed verbatim by the researcher. The interview was free-flowing with its structure limited to the focus of the research. An audio recorder was used during the interview to record the conversation.

Pretesting

Pretesting is about verifying the ability of the research instrument to collect data and ensuring that the instructions on the instrument are clear (Brink, 2016).

Prior the actual data collection process, two young mothers of children less than 5 years admitted with malnutrition were selected in one of the selected hospitals and interviewed them, to check if the question was phrased in a manner which they understood.

The participant was asked *“What do you think is the cause of your child’s poor health?”*

The researcher realized after interviewing the first young mother, that the question was not clear, because her responses were not relevant to the research topic and she asked again and again what the question was all about. Then research supervisors were consulted and they helped phrase the question in a different way: *“What do you think is the cause of kwashiorkor in your child?”* The second participant was interviewed, and after the interview the researcher could see that there were some improvements from the young mother’s responses because the question was clear. Probing was done in order to get more information from the young mothers. Those two participants who were interviewed were not included in the main study.

2.7 THE ROLE OF THE RESEARCHER

The principal research instrument of data collection was the researcher (De Vos, *et al.*, 2011).

The role of me as researcher was that of being a human tape recorder. The researcher was the main research instrument for data collection and observed, interviewed, recorded, analysed and interpreted as faithfully as possible what the participants said as was interacting with them during data collection. The researchers started by establishing rapport and trust where she displayed an attitude of unconditional acceptance, respect, empathy, honesty, openness and modesty, and appeared as relaxed and natural as possible.

She explains that they should feel free to describe their perceptions and that their names would be hidden in the report. There is no right or wrong answer, but differing points of view. Participants were thanked for their participation at the end of the interview. According to Babbie, (2011), De Vos, (2011); Brink, (2016), the researcher as a data collection instrument used the effective communication skills to facilitate the interview:

Listening

The researcher applied listening skills, and paid attention throughout the interview process.

Probing

Probing questions were asked, emanating from the participants answers, to allow participants to give more clarity.

Clarifying

The researcher always sought clarification on statements that I did not understand, in order to avoid assumptions.

Minimal verbal response

Minimal verbal responding by nodding head, saying “mmhh”, “Yes”, “Ohk ” to allow free flow of information and to encourage participants to talk. This made participants feel more relaxed and more willing to talk about their perceptions.

Validating

The researcher observed the participants and interpreted their non-verbal communication such as vocalization, facial expression and body gestures, and transcribed them for analysis.

Focusing

Participants were given full attention as they described their perceptions regarding causes of malnutrition in children under 5 years. This was demonstrated by the way of a sitting arrangement, where the researcher ensured that, when interview was conducted, chairs were the same, with no table between us. A non-threatening environment was maintained throughout the interview to enable participants to relate their stories without fear.

All interviews were conducted at a time that was convenient to participants. The interviews were conducted in a private, comfortable place accessible to the participants in their homes as agreed. The researcher was respectful towards the participants; all of these kept participants focused on the Interview.

Paraphrasing

The participant's words were rephrased in another form but with the same meaning. This encouraged the participants to give more information. Furthermore, the researcher paraphrased the responses from the participants before asking the next question.

Reflecting

Reflection was demonstrated by repeating the statements as mentioned by the participant in a question form in order for the participant to expand more on the specified points. She then reflected back to the participant in her own words to understand what was being said when need might arise.

Using Silence

The researcher used silence by keeping quiet and observed all deliberations to allow the participants to think and continue to talk at own pace without interference. The researcher demonstrated awareness and hearing, listened actively and attentively to what the participants were saying both verbally and non-verbally. The researcher maintained eye contact, remained silence while demonstrating to the participants that was there listening to them.

Establishing a trust relationship

The researcher immersed herself in the participant's life world in order to better understand perceptions of young mothers regarding causes of malnutrition in children. Mutual trust was ensured to gain cooperation of the participant and also improve the quality of collected data. A pleasant interpersonal relationship was maintained throughout the interviews. The researcher responded in a manner that showed that the participants were worthy of their disclosure and did not condemn or oppose the participants.

2.8 DATA ANALYSIS

Data was analysed following a step-wise format as defined in Tesch's eight steps of data analysis (Creswell, 2014).

Step 1- Getting a sense of the whole

After data collection was done from the participants, the researcher sat down and listened attentively to the voice recorder. Where the researcher did not get or understand the information well, she paused and played the tape recorder repeatedly so that she understood it clearly without missing any information. She then started transcribing exactly what the participants said word by word, and avoided using my own words. Data was arranged into different themes and sub-themes depending on the participant's responses.

Step 2- Reading through the transcript

One transcript at a time was picked by the researcher and transcript red through. Then transcripts re-red and all similar points were written down in the margins.

Step 3- List the topics

After completing step two for several participants, a list of all topics was put together, then topics were divided into columns of major topics, special topics and left overs cannot be grouped. Pens with various colours were used to make the task easy.

Step 4- Taking the list back to data

From the list of topics, the researcher went back to the data and allocated each topic an abbreviated and identifiable code. Then from the abbreviated list of topics, data segments were written next to that code.

Step 5- Describe the topics

From the topics, the researcher found the most descriptive words and turned them into themes or categories in a table form. Topics that related together were grouped together thus reducing the list of themes.

Step 6- Abbreviate Categories

The researcher then finalized the abbreviations for each theme and alphabetize the codes. This was done after checking by the codes thoroughly for several times to make sure that all codes were noted.

Step 7- Assemble data

Data material assembled according to each theme in one place, and a preliminary analysis was performed using a cut and paste method.

Step 8- Recording

The researcher recorded the existing data into columns as categories and sub-categories to ensure that no data is missing.

2.9 LITERATURE CONTROL

A literature control was applied to confirm the results of perceptions of young mothers regarding causes of malnutrition in children less than 5 years. After all the participants had been interviewed, a computerised data base like internet, books, scientific journals, theses, dissertations and other document were consulted as they contain the most recent information on the subject. Information from these sources served to enrich knowledge.

2.10 MESUARES TO ENSURE TRUSTWORTHINESS

Measures to ensure trustworthiness were considered through credibility, transferability, dependability and conformability, and were discussed below.

Credibility (Truth value)

Credibility was used as a strategy to ensure truth value. The credibility of this study was further be enhanced by consensus discussion with experts in qualitative research as promoters of this study are qualitative researcher themselves. They played an active role of acting as “devil’s advocate” while challenging the researchers question in relation to objectives, data sets, analysis, and interpretation as a way of making her to be more focused and in direct engagement with her study. The Credibility was ensured through prolonged engagement and member checking.

This was achieved through:

- Prolonged engagement

According to Polit and Beck, (2012) prolonged engagement refers to the investment of sufficient time during data collection to have in-depth understanding of the phenomenon under study.

Young mothers of children under 5 years admitted with malnutrition were visited in the hospitals for interview, in order to build rapport and trust (dressing appropriately, not in uniform, introducing herself and running small talk to break the ice), so that they can feel free to share their perceptions with the researcher during the interviews. The researcher also made the participants understand the questions by reframing the question whenever the respondents show a misunderstanding and showed interest in what they were saying by actively listening. Participants were given sufficient time to respond to question and this ensured prolonged engagement.

- Member checking

Member checking means that the researcher provides feedback to the study participants about emerging interpretations and obtains their realities (Polit & Beck, 2012).

The audio recording was played back after each interview for young mothers to verify if what is in the recorder is actually what they said. Probing was done during the interviews in order to have clear and deep understanding of what the young mothers were saying. After data was fully analysed, the researcher went back to the young mothers for final member checking to determine if what was transcribed is what they meant during the interviews.

Transferability (Applicability)

Transferability was ensured by appropriately describing the background information of participants. The research context and setting were described, so as to permit others to evaluate how transferable the findings were.

Conformability (Neutrality)

Conformability was ensured in this study by playing back the tape-recorded interview to the participants to verify what they had said is what they meant. Furthermore, the researcher tried to be non-judgemental and strived to report what was found in a balanced way.

Dependability (Consistency)

The researcher coded the data and waited for a certain time, then retained to the recorded tape of the same data to ensure accuracy.

2.11 ETHICAL CONSIDERATIONS

Ethical issues were discussed as follows: permission to conduct the study, the principle of respect for persons (informed consent, respect for human dignity, the right to self-determination, privacy), the principle of justice (confidentiality and anonymity), the principle of beneficence (the right to freedom from harm, the right to protection from exploitation and withdrawal of participants from the study). These are described below:

2.11.1 PERMISSION TO CONDUCT THE STUDY

In this study, the following ethics were identified and applied. Permission to conduct this study from the following was requested:

- The University of Venda Research Ethics Committee. A proposal was presented to the Higher Degree Committee of the School of Health Sciences (UHDC). (See Annexure B)

- An ethical clearance certificate and permission to conduct the study was given by the University of Venda through the Higher Degree Committee. (See Annexure C).
- The Limpopo Province Department of Health Research Ethics Committee. - (See Annexure D).
- The Department of Health Vhembe District. (See Annexure E).
- The Chief executive officer of three selected Hospitals in Vhembe District. (See Annexure F)
- Participant information sheet. (See Annexure I)

The rights of the participants was protected by the following principles namely: principles of respect for person, principle of justice and principle of beneficence and are discussed below:

2.11.2 PRINCIPLE OF RESPECT FOR PERSONS

Participants have the right to decide whether to participate in a study without any risk of penalty or harmful treatment.

- **Informed consent**

Burns and Grove, (2012) describe consent as the prospective participant's agreement to participate in a study which is reached after assimilation of essential information.

Participants were given information regarding the purpose of the study, benefits of the study and how data was collected. (See Annexure J).

The participants were asked to give a written consent. (See Annexure K).

- **The right of self determination**

The right to self-determination is based on the ethical principle of respect for persons and it indicates that humans are capable of controlling their own destiny (Burns & Grove, 2012).

This was ensured by allowing participants to decide whether or not to participate in this study, and they have a right to withdraw from the study if they do not wish to continue to participate. Young mothers who were able to read were allowed to do so on their own and then made a choice about participating in this study.

- **Respect for human dignity**

The researcher informed the participants of their right to decide whether or not to participate in the research. The researcher respected the values, norms and personal beliefs of the participants. The setting for collecting data was also respected and not changed in any way just because of the study.

- **Privacy**

Participant's rights to privacy were respected by interviewing them individually in a quiet room. No participants were forced to talk about issues

they are not be willing to share. Furthermore, participants were assured that information obtained was not linked to them and that no untested data were published.

2.11.3 PRINCIPLE OF BENEFICENCE

Brink, (2016) beneficence means that the researcher is required to do well and above all to do no harm.

- **The right to freedom from harm and exploitation**

The well-being of the participants were secured and protected from discomfort and harm. Young mothers were informed that participation is voluntary and that they could withdraw at any moment should they wish to do so, without punishment used against them.

- **Withdrawal of participants from the study**

Participants were given every assurance that they are free to discontinue their participation at any time without an explanation. They were also be informed that stopping participation not prejudiced their receiving services. The participants were also cautioned that the researcher utilized a tape recorder for the purpose of saving information, and ensure the participants that the information was used only for the purpose of the study.

2.11.4 PRINCIPLE OF JUSTICE

The right to fair treatment is based on the ethical principle of justice, which holds that each participant should be treated fairly and receive what he or she is due (Burns & Grove, 2012).

Participants were selected and treated fairly. Furthermore their Participation was voluntary and were chosen for reasons directly related to the research problem and not because they were readily available.

Confidentiality

Confidentiality indicates the handling of information in a private and trusted manner (De Vos *et al.*, 2011).

The researcher shared no information which was assembled with anyone outside the research team, such as family members, close friends or any other unauthorised persons. Information which was provided by the young mothers during the interviews was kept in a safe place, where other people who were not part of the study could not access it. It would only be published for the benefit of the researcher and the Department of Health.

Anonymity

Anonymity prohibits the researcher from making available any information which can lead to the identification of the researcher participants (De Vos *et al.*, 2011).

The names of the participants were not recorded, and only codes were used in this study. The information which was provided by the young mothers was

not changed during data analysis or when reporting the findings, to suit the objectives of the study.

2.12 SUMMARY

A qualitative research which was, explorative, descriptive and contextual was used to gather “Perceptions of young mother’s regarding causes of malnutrition in children under 5 years admitted at selected hospitals in the Vhembe district, of the Limpopo Province”. Detailed descriptions of research design, population, sampling method, data collection, measures to ensure trustworthiness and ethical considerations were also outlined. Discussion of research findings are described in full in Chapter 3.

CHAPTER THREE

3. DISCUSSION OF THE FINDINGS

3.1 INTRODUCTION

The chapter gives detailed information of the findings obtained from collected and analysed data on the perceptions of young mothers regarding causes of malnutrition in children under 5 years in the Vhembe District, of the Limpopo Province. The researcher comments on how the findings relate to the theory and previous research. The sample description, identified themes, categories and sub-categories which emerged during the interviews are presented in this chapter in detail. Data saturation occurred after interviewing twelve participants. A literature control was done to validate the findings of the study.

3.2 SAMPLE DESCRIPTION

The sample comprised twelve young mothers of children under 5 years, who were admitted with malnutrition at three selected hospitals in the Vhembe District. The twelve young mothers ranged in age from 18-26 years. The saturation of data was researched after twelve interviews were conducted.

Table 3.1 presents age and number of young mothers per hospital who were interviewed in this study.

Table: 3.1 Age and number of young mothers interviewed per hospital

Hospital	Ages	No of young mothers
Tshilidzini	18-20	6
Siloam	21-23	3
Donald Frazer	24-26	3
Total		12

3.3 DISCUSSION OF THE FINDINGS

Data was analysed using Tesch's eight steps of data analysis (Creswell, 2014). Three themes were emerged from the analysed data, namely: Young mothers perceived causes of malnutrition, young mother's beliefs about malnutrition, and health care seeking actions for a malnourished child.

3.3.1 Theme 1: Perceived causes of malnutrition

Table 3.2 presents the themes, category and sub-category of perceived causes of malnutrition.

Table 3.2 Theme 1

THEME	CATEGORY	SUB-CATEGORY
1. Young mother perceived causes of malnutrition	Feeding practices	<ul style="list-style-type: none"> • Stopped breastfeeding early at 8 months • Stopped breastfeeding early at 1 year 1month. • Eating unbalanced diet. • Fed him soft porridge mixed with Rama, Mageu, Formula milk, Danone, water and Juice for children. • Gave him soft porridge mixed with sugar only, Vita juice, matabela, movite, soup and Rooibos tea for children. • Doesn't want to play nor eat. • Refuse eating food nor drinking anything

	<p>Knowledge deficit about signs and symptoms of malnutrition</p>	<ul style="list-style-type: none"> • Child develops swelling on arms, feet and cheeks. • May be he is getting fat. • He is getting fat or gaining weight. • Develop sores inside the mouth. • Started by passing loose stools and vomiting. • He started losing weight and appetite. • He is lacking nutritious food in his body. • Started having peeling of the skin. • This child doesn't have appetite. • His brother is thin like him
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3.3.1 DISCUSSION: THEME 1: PERCEIVED CAUSES OF MALNUTRITION

This theme emerged from the data that reflected that young mothers perceived feeding practices and knowledge deficit about signs and symptoms of malnutrition as causes of malnutrition. The following are the categories identified from the theme and each is discussed below.

- Feeding practices.
- Knowledge deficit on signs and of malnutrition.

Feeding practices

During the interviews, the majority of young mothers indicated feeding practices as the main cause of malnutrition in their children. The following were sub-categories that emerged from this category:

Stopped breastfeeding early at 8 months, Stopped breast feeding at 11 months, Stopped breastfeeding early at 1 year 1month, Eating unbalanced diet, Fed him soft porridge mixed with Rama and Peanut butter, Mageu, Formula milk, Danone and Juice for children, Gave him soft porridge mixed with sugar or Rama only, Vita juice, Maltabela, Movite and Rooibos tea for children, Doesn't want to play nor eat. Following quotes narrate how participants perceive feeding practices.

One participant advanced argument as follows; *"...I think what made him sick is because this child doesn't have appetite that is why he doesn't want to eat food nor drink anything. I decided to stop breastfeeding him early at the age of 8 months thinking that maybe he will eat but the problem remains the same. After that I started feeding him mageu, soft porridge mixed with rama and peanut butter, formula milk, vita juice for children and rooi boss tea for children, and these even don't work."*

Another participant said experience as follow; *"...I think that may be is because this child doesn't want to eat, I have tried giving him so many things but still doesn't want to eat, And I chose to stop breast feeding him early thinking that if I stopped giving him breast milk may be he will eat. After stopping him breast milk, I introduced him to formula milk, rooi boos tea for children, mageu and glucose and still continue to refuse eating."*

Data indicates that young mothers stopped breastfeeding their children early and fed them an unbalanced diet, such as soft porridge mixed with Rama or peanut butter, Rooi boos tea, Mageu, formula milk, Danone, water and juice.

The above quotes show that early cessation of breastfeeding and not breastfeeding children on demand, lead young mothers to practice mixed feeding and introduce complementary food early, either due to having to go to school or work. Petit, (2010) indicates that the infant should be exclusively breastfed for the first 4 to 6 months of life on the child's demands, with no other fluids, including water. A study done by Kyei, *et al.*, (2014) report that mothers reduced the period of breastfeeding to twenty four months and above fifteen months or less. Mothers should breastfeed their babies for more than 2 years to boost their babies' health.

Furthermore, Kyei, *et al.*, (2014) indicate that young mothers perceived breast milk inadequately as a major obstacle to infant feeding, because they stop breastfeeding early and introduce supplementation of food frequently give their babies pre-lacteal feeds, with water, tinned milk, honey and fruit juice, rather than breast milk as the first substance to feed their babies after birth. Adolescent mothers in rural Bangladesh perceived rice as a good complementary food because of its energy content, vegetables as best because they contain most vitamins and fruits as healthy because of their ability to make children smarter (Hackett, 2015)

One participant elaborated *"I breastfed my child only in the afternoon or at night because I don't have enough time to spend with this child or Maybe is because of food he eat at crèche. He attends our local Crèche daily, because I am student who is doing grade 12. But what I know at crèches they give children a well-balanced diet. They draw the diet list for the whole week. Sometimes they feed them beans, pumpkin, mashed potatoes and different soft porridges."*

Another participant said “...I stopped breastfeeding my child at the age of 1 year 1 month because I was pregnant... I thought that may be my pregnancy will make him sick then I started feeding him formula milk, mageu, glucose and Rooibos tea for children.”

Berra, (2013) found that mothers in Ethiopia have a negative perception towards exclusive breastfeeding, because a few mothers declare that job and insufficient breast milk are their main reason for not following EBF practices during the early life of the baby, and this will cause malnutrition. The study findings further added that mothers sometimes wean their babies too early because of another birth, leading to stopping breastfeeding the first baby, and they end up feeding the older baby formula milk or introducing complementary food. Hackkett, *et al.*, (2015) relate that complications after birth prevent early commencement of breastfeeding because mothers are in too much pain to breastfeed. A study conducted by Zulfigar, *et al.*, (2016) revealed that there is a low rate of breastfeeding because these days’ mothers are career directed.

One young mother advanced argument as follows“... my child doesn’t want to eat nor play, I have tried giving him many things but still refuse to eat. I started feeding him mageu, danone, vita juice for children and, matabela and movite soft porridge. This thing stressed me so much because my child is losing weight. I end up feeding him using force (u nusa) and still he continue to refuse eating”.

Khunga, *et al.*, (2014) found that some children are considered as choosy eaters by preferring certain food than others.

The same content is expressed in this “except” Another participant said“... Eish, I really don’t know because I heard it here that my child is suffering with Kwashiorkor by doctors and nurses... I thought I correctly fed my child a

nutritious food because I gave her soft porridge mixed with Rama only, formula milk, danone, soup, glucose, water and mageu”.

In this study, data revealed that few participants were unaware of nutritious food suitable for children under 5 years. The results of a study conducted in the Northern Cape by De Lange, (2010) indicate that malnutrition can occur in children due to neglect, inappropriate mealtimes, insufficient quantities of food and food taboos, by a care giver or parent. Similarly, several researchers, (Khunga, *et al.*, (2014) and Mweemba, (2017) confirmed that poor infant feeding practices, such as long storage of food, inadequate dietary intake and feeding children with an unbalance diet are causes of malnutrition. In Bangladesh, mothers fed their babies with cow’s milk, formula milk as well as fruit juice because they had caesarean sections and were too weak to breastfeed (Hackkett, *et al.*, 2015).

Knowledge deficit on signs and symptoms of malnutrition

From the data that was collected it was found that young mothers lack knowledge on signs and symptoms of malnutrition. The following were sub-categories that emerged from this category:

Child develop swelling on both arms, feet and cheeks, Maybe he is getting fat, He is getting fat or gaining weight, Develop sores inside the mouth, Started by passing loose stools and vomiting, He started losing weight and appetite, He is lacking nutritious food in his body, Started having peeling of the skin, This child doesn’t have appetite. The following quotes are what participant said regarding this category.

One participant elaborated“... *I don’t know, this thing started when my child develop swelling on both arms, feet and cheeks for the past 2 weeks...I thought*

maybe he is getting fat or gaining weight, but my worry is that he is not happy and he doesn't want to play nor eat anything”.

May be the other thing is because she was passing loose stools and vomiting, and sores on her the mouth, they seems to be painful that is why she refuses eating food”. This as the expression's from a frustrated mother

In addition one mother shared information as follows; “...*because my first born (his brother) is thin like him. He is not the only one in the family who is thin, even his father is also thin (a vha na muvhili, ndi vhasekene). Like father like son. I was so surprised when I heard that he is suffering with Kwashiorkor because this is not new in our family. And food is available in our family”.*

Data revealed that young mothers were unable to identify the signs and symptoms of malnutrition in their children. They think that they are healthy, but have other conditions such as goni or diarrhoea. Young mothers referred to their children as fat or gaining weight because they developed swelling on arms, feet and cheeks.

De Lange, (2010) conducted a study in Northern Cape reports that oedema begins in the feet and legs, and then spreads to the hands, face and body. A study conducted in Lusaka by Mweemba, (2017) confirmed that early symptoms of malnutrition were confused with other conditions such as diarrhoea. One participant declared that malnutrition is difficult to know because the child looks healthy and fat.

Ngwu, *et a.l*, (2014) indicate that malnutrition is usually due to lack of education and knowledge about healthy nutritional behaviours and feeding practices. Whereas, Berra, (2013) and Macabela, (2015) found that maternal

education is one of the most important elements in addressing child malnutrition.

CONCLUSION

Feeding practices was one of the main causes of malnutrition in children under 5 year's old, even though young mothers breastfed their children for the first six months of age. Young mothers fed their children inappropriate diets, and innutritious food, and they also lack knowledge about signs and symptoms of malnutrition.

3.3.2 Theme 2: Young mothers' beliefs about malnutrition

Table 3.3 indicates the category and sub-category of young mothers' beliefs about malnutrition.

Table 3.3: Theme 2:

THEMES	CATEGORY	SUB-GATEGORY
2. Young mothers' beliefs about malnutrition	Cultural beliefs	<ul style="list-style-type: none"> • Refused going for removal of goni. • Not following vhavenda culture

3.3.2 DISCUSSION: THEME 2: YOUNG MOTHERS' BELIEFS ABOUT MALNUTRITION

This theme emerged from the analysed data that indicate young mothers' perceived different beliefs as the cause of malnutrition to their children. One category emerged from this theme and is discussed below.

Cultural beliefs

Few young mothers' perceived cultural beliefs as another cause of malnutrition to their children. They perceived that their children are sick because of refusing to go for removal of goni or not following their culture. The following quotes are what participants said regarding cultural beliefs.

One participant said *"... I think what made my child sick is that, last week we were fighting with my mother because I refuse to go for removal of goni."* in our cultural (VHAVENDA) beliefs "goni" is the sickness which affects the woman and the child some few weeks or months after child birth. You know musi in our culture we do have some beliefs".

Another participant shared experience as follows *"...my grandmother phoned and told me to ask discharge for the baby because she wants to accompany me for removal of goni...she verbalized that if I am not going there my child will become worse and die because doctors don't know how to treat this sickness. She has a belief that this sickness is treated only by the traditional healer"*.

Matsunyama, *et al.*, (2013) indicate that extramarital relationships by the father during *arobani* are believed to be an additional source of sick health in new-borns. Similarly, a study conducted by Khunga, *et al.*, (2014) added that

mothers and caregivers believed that only traditional healers can treat some of the problems, such as the father's immoral behaviour or promiscuity. Their findings further explain that mothers in Zambia relate malnutrition as a form of bewitchment or 'bad air' in the environment where the child is raised. Similarly, Mweemba, (2017) reports that mothers believed in witchcraft, violation of sexual taboos and breastfeeding while pregnant.

CONCLUSION

Cultural beliefs also caused malnutrition because young mothers believed that there were other conditions that cannot be treated by doctors, but only by traditional doctors.

3.3.3 Theme 3: Health-care seeking actions for a malnourished child

Table 3.3. Indicates the category and sub-category for health-care seeking actions for a malnourished child.

3.4: Theme 3:

THEMES	CATEGORY	SUB-GATEGORY
3. Health care seeking actions.	Health care facilities	<ul style="list-style-type: none"> • I visited the special doctor. • Took her to the traditional healer. • Took him to the nearest local clinic. • Bought multivitamin from the chemist

3.3.3 DISCUSSION: THEME 3: HEALTH CARE SEEKING ACTIONS FOR A MALNOURISHED CHILD.

Data reveals that participants perceived seeking actions from various health care facilities as the cause of malnutrition. One category emerged from the data, namely, health care facilities and is discussed below.

Health care facilities

During interviews, most of young mothers indicated that they depend on self-measures and also seek health-care if they suspect that the child is getting malnourished, they visited the special doctor, took her to the traditional healer, bought multivitamins from the chemist, or took their child to the nearest local clinic. The following quotes narrate what young mothers said regarding this category:

But my worry is that he is not happy, he doesn't want to play nor eat. I visited my nearest clinic the special doctor and he told me that my child is sick. He gave me the referral letter to come here. He told me that my child is suffering with Kwashi because of eating unbalanced diet" So said the worried participant

Another participant accounted that by saying "...I tried him different type of food but he refused, my mother told me that my child doesn't have appetite that is why she is refusing food, she gave me the money to go to our nearest chemist to buy multivitamin medication for boosting her appetite."

A study conducted by Matsunyana, *et al.*, (2013) revealed that caregivers in Kenya give homemade herbal remedies, or over-the-counter medicines for the common sicknesses of small babies. Similarly, Khunga, *et al.*, (2014) and Mweemba, (2017) found that most of the mothers buy medicine from the local chemist or medicine store to treat conditions like diarrhoea, worms, and to improve appetite, and that some parents take a child suffering with malnutrition to the clinic.

Furthermore, their study indicate that the traditional healers, known as *Mganga wa nyumi*, declared that the care givers of the babies sought

treatment and consultation from them for various forms of health issues, such as stomach-ache, sue to evil eye, fever, fits and bad coughs. Macabela, (2015) found that mothers in Bizana, in the Eastern Cape, used traditional medication for the child because they were suspecting traditional sickness called ‘inyoni’ before bringing the child to the hospital.

CONCLUSION

Care seeking actions from heath facilities by young mothers still cause malnutrition in children, and these caused delays in them being hospitalized.

3.4 SUMMARY

This chapter presented, analysed and discussed the data. Themes that emerged from the data were analysed and discussed. The findings were supported by transcribed data and literature control.

CHAPTER FOUR

4. CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

This is the final chapter of the study about “Perceptions of young mothers regarding causes of malnutrition in children admitted at selected hospitals in the Vhembe District, of the Limpopo Province”. It comprises the evaluation of the study, conclusion, limitations, as well as recommendations.

4.2 EVALUATION OF THE STUDY

The study is evaluated against its purpose and objectives as set out in Chapter one.

The purpose of the study was:

To determine the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years in the Vhembe District, of the Limpopo Province. The purpose of this study was achieved through in-depth individual interviews.

The objectives of the study were as follows:

- To explore the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years.
- To describe the perceptions of young mothers regarding causes of malnutrition in children under the age of 5 years.

The objectives of the study were reached as causes of malnutrition were explored and described.

4.3 CONCLUSION

In this study, three themes emerged, namely, young mothers' perceived causes of malnutrition, young mother's beliefs about malnutrition, and health care seeking actions for a malnourished child. These are discussed below.

4.3.1 Young mothers perceived causes of malnutrition

Feeding practices

This study revealed that the majority of young mothers who participated in this study have negative perceptions toward child feeding practices, because they fed their children inappropriate nutrition due to lack of knowledge. Furthermore, some young mothers associated early cessation of breastfeeding as a cause of malnutrition.

Knowledge deficit on signs and symptoms of malnutrition

The findings of this study found that the young mothers had a knowledge deficit about signs and symptoms of malnutrition in their children. Some think that their children are healthy or getting fat, not knowing that they are sick.

4.3.2 Young mother's beliefs about malnutrition

This study revealed that some young mothers had beliefs from their vhavenda culture, and they believed that a child who is suffering with malnutrition had goni. Furthermore, they believed that goni is only treated by traditional healers, not by doctors. The study has also found that young mothers perceived the reality of cultural beliefs as risky, but a few end up choosing it as their care seeking method.

4.3.3 Health care seeking actions for a malnourished child

The findings of this study indicate that young mothers rely on special doctors, rather than visiting the hospital when their children were suffering with malnutrition. In addition, they depend on self-measures by buying medication from the chemist to boost the appetite of their children.

4.4 LIMITATIONS OF THE STUDY

The participants tended to get tired in a short time of period, and sometimes, during the interview, their relatives or Health care workers, such as a doctor, dietician or nurses would call them, or their children started crying, and they stopped the interview and attend to them.

4.5 RECOMMENDATIONS

Recommendations are based on the findings of the current study and are directed to the policy makers and to the hospital management:

Recommendation to the policy makers

The researcher recommends the following at the national and provincial level:

- Policies on child nutrition should be reviewed regularly in the Vhembe District to eradicate malnutrition in children under 5 years.

Recommendations to the nursing practice

- Hospitals should reinforce the implementation of guidelines regarding prevention and management of malnutrition in children under 5.
- Health education should be done through the media, pamphlets and posters regarding child nutrition.

Further research

- This study recommend strategies to integrate young mothers into the health promotion regarding their understanding and experiences about malnutrition.
- A research study should also be conducted regarding attitudes and cultural beliefs among young mother's regarding child nutrition.

4.6 SUMMARY

In this final chapter of the study, the following were outlined: conclusion, recommendations, as well as limitations of the study.

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ANNEXURE A

Dr Catherine Hutchings Freelance Editorial Services

51 Bathurst Road
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Cape Town
Western Cape
South Africa

Telephone/Fax: + 27 21 7618522
Mobile: + 27 82 9702219
E-mail: catherinehutchings@gmail.com

To whom it may concern.

**I hereby confirm that I edited
MAKHAVHU NDIAMBANI ANASTECIOUS's**

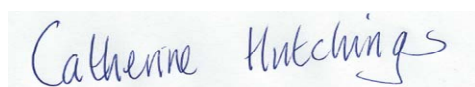
MCur thesis,

Title:

**PERCEPTIONS OF YOUNG MOTHERS REGARDING CAUSES OF
MALNUTRITION IN CHILDREN ADMITTED AT SELECTED
HOSPITALS IN THE VHEMBE DISTRICT, OF THE LIMPOPO
PROVINCE**

in February 2018.

I wish this student well in their endeavours.



Catherine Hutchings

ANNEXURE B

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MRMS NA MAKHAVHU
SCHOOL OF HEALTH SCIENCES

FROM: PROF J.E. CRAFFORD
DEPUTY VICE-CHANCELLOR, ACADEMIC

DATE : 05 DECEMBER 2016

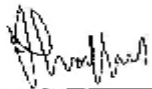
DECISIONS TAKEN BY UHDC OF 29 NOVEMBER 2016

Application for approval of Master's research proposal in Health Sciences:
N.A Makhavhu (11503396)

Topic: "Perceptions of young mothers regarding malnutrition on children admitted at Selected Hospitals in Vhembe District."

Supervisor	UNIVEN	Dr. M. Malulake
Co-supervisor	UNIVEN	Mrs. A.R. Tshilo

UHDC approved Master's proposal



Prof J.E. CRAFFORD
DEPUTY VICE-CHANCELLOR: ACADEMIC

ANNEXURE C

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms NA Makhavhu

Student No:
11503396

PROJECT TITLE: Perceptions of young mothers regarding malnutrition on children admitted at selected hospitals in Vhembe District, Limpopo Province.

PROJECT NO: SHS/17/PDC/09/3105

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr M Maluleke	University of Venda	Supervisor
Mrs AR Tshillo	University of Venda	Co- Supervisor
Ms NA Makhavhu	University of Venda	Investigator – Student

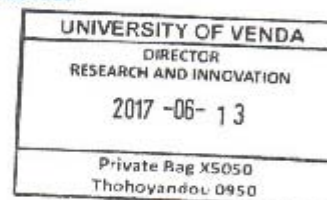
ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: June 2017

Decision by Ethical Clearance Committee Granted

Signature of Chairperson of the Committee: 

Name of the Chairperson of the Committee: Prof. G.E. Ekosse



University of Venda

PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9050

"A quality driven financially sustainable, rural-based Comprehensive University"

ANNEXURE D



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Stols M.L. (015 293 6189)

Ref:4/2/2

Makhavhu NA
PO Box 8024
Shayandima
0945


Greetings,

RE: Perceptions of young mothers regarding causes of malnutrition in children under 5 years at selected hospitals in Vhembe District, Limpopo Province

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that-
 - Research must be loaded on the NHRD site (<http://nhrd.hst.org.za>) by the researcher.
 - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
 - In the course of your study there should be no action that disrupts the services.
 - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - The above approval is valid for a 3 year period.
 - If the proposal has been amended, a new approval should be sought from the Department of Health.
 - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.


Head of Department

2017/07/13
Date

ANNEXURE E



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF HEALTH
VHEMBE DISTRICT**


Ref: SS/6
Baq: Mivvuri MME
Date: 02. August 2017

Dear Makhawhu N.A

PERMISSION TO CONDUCT RESEARCH : " Perceptions of young mothers regarding causes of malnutrition in children under 5 years"

1. The above matter bears reference
2. Your letter received on the 02/08/2017 requesting for permission to conduct a research on " Perceptions of young mothers regarding causes of malnutrition in children under 5 years at selected hospitals in Vhembe District, Limpopo Province" is hereby acknowledged.
3. The District has no objection to your request .
4. Permission is therefore granted for the study to be conducted within Vhembe District.
5. You are however advised to make the necessary arrangements with the facility concerned.

Wishing you success in your studies


.....
DISTRICT CHIEF DIRECTOR

2017/08/07
.....
DATE

Private Bag 2008 TROMPSBURG 0359
OLD Parliamentary Building Tel (015) 962 9000 (Health) (015) 962 4098 (Social Dev) Fax (015) 962 7774/4623
Old Parliamentary Building Tel (015) 962 1848, (015) 962 1842, (015) 962 1754, (015) 962 18017/34,516 Fax (015) 962 2373, (015) 962 777



ANNEXURE F

TSHILIDZINI HOSPITAL ETHICS COMMITTEE

Memorandum of understanding

Tshilidzini Hospital Ethics Committee with M. M. M. M. M. at their meeting resolved to sign a Memorandum of Understanding after the two parties have agreed on the following information:


1. Reasons for making a research at Tshilidzini hospital.
Research on the prevalence of HIV/AIDS in the community.
2. What will be the benefit of the entire hospital community out of your findings?
It will help the community to know the prevalence of HIV/AIDS and how to prevent it.
3. Who to meet in conducting your research
1. Hospital management, 2. Community members.
4. What do you do with your findings?
Present the findings to the hospital management and the community.
5. We will require the hard copy of your research
Yes
6. We do not anticipate any information to be divulged in all types of media without the knowledge of the Ethics Committee and Hospital Board.
7. Memorandum of understanding should be signed by both parties.

Signed by: [Signature]

25/08/2017
Date:

[Signature]
Researcher

ANNEXURE G

 **LIMPOPO**
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF HEALTH
SILDAM HOSPITAL**


Confidential

Ref : Sd/21/173
Eng : Moshuphi N.T
Date : 21 August 2017

To: Malhavu, N.A

RE: PERMISSION TO CONDUCT RESEARCH YOURSELF.

1. The above matter ref. rs.
2. The Hospital highly acknowledges the receipt of your letter dated 08 August 2017 regarding the above matter.
3. Kindly note that the institution is granting you permission to come and conduct your research.
4. You are kindly requested to adhere to the conditions as set out in your approval from the Provincial Office.
5. Hoping you will find the above in order.



Acting Chief Executive Officer

22 - 08 - 2017
Date

Private Bag X2437, Makhadu, 0920
Tel (015) 973 0104/5/6, 015 973 1147/8, 015 973 1977, 015 973 1892/4/9 Fax (015) 973 0407.

~~Development is about people~~

ANNEXURE H

**LIMPOPO**
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

**DEPARTMENT OF HEALTH
DONALD FRASER HOSPITAL**

Ref: 47/2
Enquiries: Mphahlele VF
Tel no. 015 963 436
Ext. 9306
14/09/2017

TO: MRS Makhavhu MA
University of Venda
Private Bag x505
Tlokoeng
0950

RE: Permission to conduct Research study at Donald Fraser Hospital on perception of young mothers regarding causes of malnutrition in children admitted at selected hospitals in Vhembe District, Limpopo Province, South Africa.

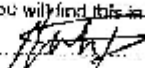
The above matter refers

1. Permission to conduct the above mentioned study is hereby granted.
 - Kindly be informed that - In the course of your study there should be no action that disrupts the services.
 - You are to give report to quality assurance manager of Donald Fraser Hospital after completion of research study at Donald Fraser Hospital.
 - After completion of the study, a copy should be submitted to our institution to serve as a resource.
 - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
 - You are therefore requested to contact nursing administration office number 7, OPD basement for logistic arrangements.

4. Please bring along the following documents:

- Permission letter granted from department of health.
- Permission letter granted from educational institution.
- This letter.

Hoping you will find this in order

SIGNED:  Date: 14/09/2017

CHIEF EXECUTIVE OFFICER

DEPARTMENT OF HEALTH
PRIVATE BAG X1172, YHUTANI
71-09-17
DONALD FRASER HOSPITAL
LIMPOPO PROVINCE

Private bag X1172, Yhutani 0971
Tel: 015 963 1778/9, 015 1783 1791/2 • Fax: 015 963 1773, 015 963 1796
Cell: 083 248 0184

ANNEXURE I

PARTICIPANT'S INFORMATION SHEET

Title:

“Perceptions of young mothers regarding causes of malnutrition in children admitted at Selected Hospitals in Vhembe District, Limpopo Province”.

The purpose of the study:

The purpose of the study was to determine perceptions of young mothers regarding malnutrition in children admitted at Selected Hospitals in Vhembe District, Limpopo province.

The objectives of this study were to:

- Explore perceptions of young mothers regarding causes malnutrition on children under the age of 5 years.
- Describe perception of young mothers regarding causes malnutrition on children under the age of 5 years.

Significance of the study:

The beneficiaries of this study were:

Body of knowledge:

The study findings might share more light on how mothers who their children suffer from malnutrition, perceive causes of malnutrition, and add to the existing body of knowledge about perception of young mother's regarding causes of malnutrition on children under 5 years of age.

Policy makers:

The findings of the study might help the policy makers to design appropriate nutrition education programme, and it might also influence the development of policies, protocols and guidelines regarding malnutrition.

Harm:

There was no harm or threats expected to young mothers through participating in the study.

Benefits:

Your participation in this study contributed much in generating information that were reduce child mortality and morbidity rate.

Rights as a participant in this study:

Your participation in this study was entirely voluntary and you can decline to participate, or stop at any time, without stating the reason.

Withdrawal:

You can withdraw from the study if you consider it not to be in your best interest. If you do not follow the regulations of the study facility and guidelines of the study, you can be withdrawn from the study at any time.

Ethical approval:

This study was submitted to the University of Venda and written approval was granted, Permission to conduct the study was granted by the provincial, district and hospital managers (CEOs) of Department of Health.

Confidentiality:

All information that were obtained during the course of this study, including personal and research data, were kept strictly confidential. Only codes was used so that anonymity can be maintained.

Source of information:

If you want any information regarding your rights as a research participant, or have complaints regarding this research study, you can contact the following individuals:

Supervisor: Dr Mary Maluleke 076 394 9752

Co-supervisor: Dr Azwidihwi Tshililo 072 615 5399

Student: Miss Ndiambani A Makhavhu..... 076 178 8933

ANNEXURE J

INFORMATION RELATING TO INFORMED CONSENT

Dear participant

REQUEST FOR CONSENT FROM PARTICIPANTS

I, Makhavhu Ndiambani A, a post-graduate student doing the Master's degree in nursing science at the University of Venda, School of Health sciences, am conducting a research titled **“Perceptions of young mothers regarding causes of malnutrition in children admitted at Selected Hospitals in Vhembe District, Limpopo Province”**.

The study is conducted under the supervision of Dr Maluleke M, Dr N.J Ramakuela and Dr Tshililo A.R of the Department of Advanced Nursing Science in the School of Health Science. The Ethics Committee of the University of Venda approved the study. You have the right to withdraw at any stage of the research if you wish to do so. There was no harm or threats expected to you through participating in the study, all the information given by you were confidential.

The interview was audio recorded, transcribed and verified with you and an independent person. I would like you to participate voluntarily in this study. The recorded information was erased on completion of transcribing the records to ensure confidentiality. Your anonymity was safeguarded by not

using names. The information related to the interview were only accessible to the researcher and independent coder. No data were linked to your name.

For any information on your participation, contact researcher on the following number (015)9644345 (Work), 0761788933 or 0723802096 (Cell)

Researcher's signature

Date

.....

.....

ANNEXURE K

Sample of consent form for participating in the research:

I,.....voluntarily participate in the study on **“Perceptions of young mothers regarding causes of malnutrition in children admitted at Selected Hospitals in Vhembe District, Limpopo Province”**.

I read and understood through the content of concern form that I understood that my participation was voluntary and that I might withdraw at any time.

.....

Signature of participant

Date

.....

Researcher 'signature

Date

ANNEXURE L (1)

OLD TRANSCRIPT

The purpose of this study is to determine perceptions of young mothers regarding causes of malnutrition in children under 5 years.

KEY: Researcher: R

Participants: P

Thank you for being my participant in this interview. I need to conduct interview with you regarding your understanding on causes of your child's poor health. This is a tape recorder to audio tape the interview. During transcribing your name will be omitted and the information related to the interview will only be accessible to me and the promoters. The taped information will be erased on the completion of transcribing the tapes. I will request you to sign the consent form. Remember you can withdraw anytime you feel like without any penalty.

R: Any question?

Silence

P: No, questions.

We can start.

R: Ok. Good morning.

P: Good morning.

R: How are you today?

P: I am fine, and how are you?

R: I am good, thanks for asking.

R: My name is Makhavhu Ndiambani Anastecious, a registered nurse at Tshilidzini Hospital working in Paediatric Ward and also a Masters student at University of Venda. What is your name and where do you stay?

P: I am Ndou Mulalo. I stay at Maungani village next to Sidogi Restaurant.

R: How old are you?

P: I'm 23 years old.

R: Are you married?

P: No. I'm not married.

Silence

R: Are you working?

P: No, I'm self-employed. I passed grade 12.

R: Ok, How many children do you have?

mmmhhh

P: Two, this is my second born son.

R: Ok. How old is your son?

P: 13 months old.

R: When was your child admitted in this ward?

P: My child admitted a day before yesterday. On the 6 June 2017

R: I understand. What is the main cause of your child admission in this ward?

Pause

P: Because he is sick.

R: What do you think is the cause of your child poor health?

Pause

P: I don't know, but my child started sick two weeks back and I visited my local clinic (Tshisahulu clinic and tell the nurse that my child doesn't want to eat anything and his weight is down. The clinic nurse gave me medications. I used that medications with no improvement. I went back again to the local clinic and explained to the nurse that my child's condition is not improving. The clinic nurse gave me the referral letter to come to here.

R: mmmhhh, what was the problem with your child?

P: He doesn't want to eat and losses weight.

R: Ok. I understand. What do you think is the cause of your child loss of weight and loss of appetite?

P: I don't know because I used to feed my child mageu, danone, simba and soft porridge mixed with rama, and sometimes rooibos tea for children. I don't understand why nurses said that these things are not good to my children because I once fed my first born with this diet. My child is bewitched by my grandmother because she doesn't love me at all and I don't know what her problem is.

Silence

R: Do you stay with her on the same house?

P: No. She stays with my sister in law at Muledane village. My child is crying I'm going. We will continue next time.

R: Thank you very much for your participation.

P: Thank you.

END

END

END

END

ANNEXURE L (2)

NEW TRANSCRIPT

The purpose of this study is to determine Perceptions of young mothers regarding causes of malnutrition in children under 5 years.

KEY: Researcher: R

Participant: P

R: Good morning.

P: Good morning.

R: How are doing this morning?

P: I am good and how are you?

R: I am also good, thanks for asking. Today is a sunny day.

P: Yes, it's summer time. I heard vho Mugeru today in the morning weather show saying that it will rain tonight.

R: Ohk. It will be better. Do you remember me?

P: Yes, I do. I saw you yesterday musi.

R: If you do remember me what is my name?

P: Your name is Ndiambani but I forgot your surname.

Researcher and participant smiling

R: Yes, I am Ndiambani. My surname as I said yesterday is Makhavhu. I am a student at University of Venda doing research on what young mothers think may be the cause of kwashiorkor in their children.

Participant nodding her head smiling

P: That is good. You mean Kwashu on my child?

R: Yes, I mean Kwashu.

P: Ok, don't be surprised, we call it Kwashu or vhulwadze ha ndala in our ward.

R: Ok. Thank you for being my participant in this interview, this interview is for learning purpose. Your information will remain confidential and your name will be omitted during transcribing and this information will only be accessible to me and my promoters. I will request you to sign the consent form. Remember you can withdraw anytime if you feel like without any penalty.

P: Ok. I understand.

R: Any question?

P: No question.

R: Can we start with our interview?

P: Yes.

Participant smiling

R: This is a tape recorder to audio tape the interview but you can press this red stop button whenever you like if you feel that you are no longer interested. The taped information will be erased on the completion of transcribing the tapes.

R: When was your child admitted in this ward?

P: My child admitted in this ward on Saturday.

R: You mean this Saturday or last Saturday?

P: I mean last Saturday. This is our 10th day being admitted in this ward, Doctors, and Nurses told me that we are going to stay longer here because my child is suffering with Kwashu.

Silence

R: Ok. What do you think may be the cause of this Kwashiorkor to your child?

P: I think is because I stopped breastfeeding him early.

R: You stopped breastfeeding him early, what do you mean?

P: Yes, because I stopped breastfeeding him when he is 1 year 1 month.

R: Ok, Why do you stopped breastfeeding him so early?

P: I stopped him because he doesn't want to eat.

R: What do you mean when you said he doesn't want to eat?

Participant Silence

P: This child doesn't have appetite that is why he doesn't want to eat food nor drink anything. I decided to stop breastfeeding him early thinking that maybe he will eat. After stopping him breast milk, I introduced him to formula milk, Rooi boos tea for children, Mageu and Glucose and still continue to refuse eating.

R: Ok, I understand.

P: Yes, after some few weeks he started losing weight because all he want to eat is soft porridge mixed with sugar only.

R: You said he likes soft porridge mixed with sugar only.

Participant nodding her head

P: Yes, this thing stressed me so much because my child is not growing well. I end up feeding him using force (u nusa) and still continues to refuse eating.

R: I know, this thing is so frustrating when a child doesn't want to eat. My elder son was also the same with your son.

P: What do think may be also the cause of Kwashu in your child?

Silence

P: I think may be is because I refuse to go to the traditional healer for removal of GONI.

R: mmmhhh, GONI? What is GONI?

P: Participant smiling, don't you know GONI?

R: No.

P: You are lying. If you are a pure mvenda I know you know it very well.

Researcher and participant smiling

P: GONI is the disease which in our cultural beliefs (vhavenda) that affects the woman and the child some few weeks or months after child birth. You know musi in our culture we do have some beliefs. We have a belief that if this disease is not treated by the traditional healer, the child will become sick and after some few days the child may die.

R: mmmhhhh. Why do you refuse to go there?

P: I refused because I am scared and don't believe on that things. My mother in law forced me several times and I continued refusing to go there, and she said to me if I am not going there my child is going to die. I told her that it will never happen to my child because doctors and nurses are taking good care to my child.

R: Ok, I understand. Is there anything you want to discuss with me about Kwashiorkor?

P: No.

R: If I heard you correctly you said that the causes of kwashiorkor to your child is because you stopped breastfeeding him early at the age of 1 year 1 month because he doesn't want to eat, and the other thing you said you refuse to go to the traditional healer for removal of GONI.

P: Yes, that's what I said.

R: I am going to play back the audio recorder so that you can hear everything you said during our interview.

P: Ok, that's true.

R: I will come back to you to determine if what I transcribed is what you meant during our interview.

P: Ok. No problem.

R: Thank you very much for your participation and information you provided to me.

P: Thank you.

END

END

END

