

**CULTURAL ISSUES IN THE TREATMENT OF
HOSPITALISED, MALNOURISHED CHILDREN: AN
EXPLORATORY-DESCRIPTIVE STUDY OF THE
ATTITUDES OF HEALTH PROFESSIONALS AND
MOTHERS IN A RURAL HOSPITAL SETTING**

BY

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ABSTRACT

Culture plays a significant role in the treatment of certain illnesses and in the maintenance of good health in communities. In hospitals, professionals are constantly faced with medication non-compliance and other defaulting behaviour by health consumers or patients due to lack of their sensitivity towards cultural issues.

It is true that most Africans are faced with a dilemma of choosing between Western treatment approaches and their own traditional healing. Therefore some may need still to adopt both Western and African approaches.

The study examines the attitudes of both the professionals and mothers with malnourished children towards the cultural values linked to the treatment modalities. An exploratory - descriptive method is used as a focus for the study. Because of the illiteracy of the mothers, an interview schedule was used to collect data and get impressions about certain issues. A questionnaire was used to collect data from the professionals; which included nurses, an occupational therapist, a physiotherapist, and people working for the Kwashiorkor Centre.

Both the literature review and other studies showed that there is a difference in attitudes regarding cultural issues in the treatment of malnourished children between the health consumers and the health professionals.

Findings of this study revealed negative attitude towards mothers who used traditional medicine before coming to hospital. Mothers felt that they were reprimanded regarding their cultural value systems.

This study includes recommendations that health professionals need to be sensitive to the cultural belief system of the health consumers for better compliance and service delivery.

It is recommended that health care providers be aware of their value systems and above all respect those of the consumers. To facilitate better participation in health education programmes it is important that these programmes are culturally sensitive.

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CHAPTER ONE

INTRODUCTION TO THE TOPIC AND STUDY

1.1 INTRODUCTION

Malnutrition is one of the most common diseases in rural areas which kills children within the age range of one to three years. Reid (1991), undertook a study of malnutrition in Sekhukhuniland where the results indicated that there was not only stunting of growth but a high mortality rate (50%) in infants between birth and the first five years. He states "At least 50% of all children born alive fail to reach their fifth birthday and the majority of those who die do not reach their third birthday". In 1982 Dr Mphahlele (in De Beer 1984) who worked for the Lebowa Government, quoted a survey done in 400 schools in the territory to conclude that 100,000 children in the area were malnourished. A survey conducted by doctors for the then Ciskei government in 1978 found that half of all two and three year olds were malnourished.

All available evidence shows that malnutrition is a direct result of poverty. Dasen et al (1988) state that it has now been widely recognised that malnutrition is always part and parcel of an eco-socio-cultural system that includes other adverse environmental conditions, such as poverty, poor housing, poor sanitation, repeated exposure to infectious and parasitic diseases, inadequate health care, poor feeding and child practices. Dasen et al (1988:123) add that malnutrition never occurs alone, it occurs in conjunction with low income, poor housing, family disorganisation, a climate of apathy, ignorance and despair, in other words in the context of poverty.

Malnutrition has been a major social and health problem which social workers and welfare department services have not adequately addressed. The new African National Congress (ANC), government of the day, elected in 1994, has declared that the primary focus for health is Primary Health Care (ANC, 1994).

The lack of involvement of social work in this area motivated the researcher to embark on this study, and of particular concern was the treatment of malnourished

children in the hospital setting and how cultural issues were perceived and experienced to impact on that treatment.

The particular focus of the study is to explore the attitudes of both mothers and professionals regarding cultural issues that influence both the treatment, and specifically the health education provided for mothers / parents of malnourished children.

The second aspect which the study explores is the role of the clinical social worker in the treatment process of the malnourished children. In South Africa in particular malnutrition is treated at the secondary and tertiary levels by medical professionals who deal mainly with the symptomatic features and hence the repeated re-admission children for hospitalisation. It should be noted that social workers are not involved in dealing with the causative factors. Dasen and Super (in Dasen et al, 1988) stated that much of the research efforts in the early 1970s had been concerned with attempting to establish a direct link between malnutrition per se and different aspects of psychological development, especially intellectual functioning.

Literature reviewed also indicates very little concerning the role of the clinical social worker and cultural issues.

Two different groups of respondents are involved in the study. The reason for choosing them is that both groups are from the same cultural background, viz. "Pedi" or "Northern Sotho"; but their treatment approach to malnutrition is grossly affected by their different cultural values and belief systems in which they operate. Despite the fact that the health professionals share the same cultural value systems with the mothers, they are so dominated and overshadowed by Western cultural influences that they disregard the mothers' value systems in health care.

In addition, a questionnaire using a sample of professionals was used in order to explore their attitudes towards mothers' responses regarding treatment of their malnourished children.

Chapter two deals with the characteristics of malnutrition; the highlights of cultural belief systems and how they might influence treatment of malnourished children. This chapter will look at the influence of the family in the use of traditional healers with regard to the treatment of malnourished children.

Chapter three discusses the role and effects of cultural research. Chapter four discusses research design and methodology, while Chapter five discusses the attitudes of health professionals. Chapter six deals with the perceptions of the mothers. Chapter seven discusses the findings and finally, Chapter eight, summarises these findings and gives conclusions and recommendations.

1.2 RESEARCHER'S PERSONAL INTEREST IN THE STUDY

The author is both researcher and clinical social worker in the hospital where the study was conducted. During the years she has worked there she has become more and more concerned about the lack of involvement of social workers in the treatment programme of malnourished children.

The researcher observed that in the medical paediatric ward most children were dying of Kwashiorkor. The majority of children tend to be readmitted with the same condition or else the mother will often bring the siblings in with malnutrition. The majority of children who died came with a severe marasmic condition after they had been treated by traditional healers for a long time. Usually the poor mother would try to explain to the hospital staff that she had visited a traditional healer for treatment of 'hlogoana' or 'thema' according to custom. It is a Northern Sotho cultural belief that children should be treated for ailments by the traditional healer and only as a last resort would the very ill child be brought to the hospital. The professional staff at the hospital would scold and reprimand the mother, stating that her child might die because of Kwashiorkor or 'phepo mpe' which means poor nutrition in Northern Sotho.

Traditional healers are still the health care choice for a large number of South Africans. This is confirmed by Staugard (1985), Freeman and Motsei (1991), Pretorius (1991), Freeman (1992), and in Tabane (1995).

It is the potentially conflicting attitudes and differences between African traditional medicine and Western medical belief systems that motivated the researcher to carry out research to find out to what extent Northern Sotho cultural beliefs influenced the attitudes of both mothers and professionals regarding the treatment of malnourished children brought to hospital when all else had failed.

While studying for the Clinical Masters Course the researcher became interested in the attitudes of the health professionals towards the cultural beliefs of the mothers when they arrived at the hospital because these attitudes interfered with the treatment of the malnourished children. In the course of her work as a health care worker attached to a hospital the author observed with dismay that the mothers' cultural sensitivities and belief systems were not taken into consideration by the hospital staff.

This led the researcher to question whether this lack of sensitivity for the cultural aspects and belief systems affected the mothers' understanding of the importance of health education which formed part of the hospital treatment package.

1.3 PURPOSES OF THE STUDY

Firstly, the study explores the attitudes of the hospital staff with regard to the mothers with malnourished children who bring with them cultural beliefs about the treatment of malnutrition. How the hospital staff handle the possibility of including cultural beliefs is explored as part of the treatment of malnourished children.

Secondly, the study explores the mothers' attitudes towards the hospital staff regarding treatment of their children, and their degree of compliance with the health education given to them.

Thirdly, the study explores the need to include psycho-affective stimulation in the treatment of malnourished children.

Fourthly, the study examines whether variables such as culture, belief systems and religion could play an influential role in the treatment of malnourished children in the Northern Sotho rural setting.

Finally, the study explores the role of the Clinical Social Worker in the treatment of malnourished children and recommendations for their treatment are highlighted where there is a need.

1.4 SIGNIFICANCE OF THE STUDY FOR SOCIAL WORK

According to Kreps and Kunimoto (1994) the modern health care system is a cultural melting pot, comprised of individuals from different combinations of national, regional, ethnic, racial, socio-economic, occupational, and health-status cultural orientations. It has become increasingly common to encounter foreign-born and foreign-educated health care providers in South African hospitals. Recently appointed Cubans, Zairians and Germans in our hospitals bear testimony to this. As the South African population becomes more multicultural there will be an increasing number of culturally diverse individuals both seeking health care and administering health care.

This challenges social workers in particular, to be culturally and holistically sensitive to the needs of their patients in health care. Pincus and Minahan (1978) believe that social work is concerned with interactions between people and their social environment. These interactions affect their ability to accomplish life tasks which help them alleviate distress and realise their aspirations and values. Tabane (1995) states that if social workers have an understanding of African traditional healing, they will be able to discern when to refer clients to traditional healers and where these traditional healers can be found.

1.5 RATIONALE FOR THE STUDY

The purpose of this study is to explore the impact of the cultural belief systems of both the professionals and that of mothers with malnourished children, who present their children for hospital treatment.

Galanti (1991) purports that, to treat patients successfully, it is extremely important to take their beliefs into account, whether these beliefs be about the causes of disease, how it should be treated, what behaviour is appropriate or how the body is viewed. This study attempts to explore some of the dimensions such as poverty, values, communication and families which may be bearers of these cultural belief systems.

If the assertion is made that the consumers' cultural background may impinge on the Western type of treatment then many of the stereotypes that prevail about culture may unconsciously be transmitted in hospital treatment. Galanti (1991) states that even in cases where treatment offered by Western scientific medicine are clearly superior, if the patient believes such treatment is insufficient for treating the problem, it probably will be for that patient.

The mothers of the malnourished children who are the health consumers often feel that they need to hide their cultural values and beliefs as they do not want to transgress the rules of the hospital. The researcher asserts that in the process of training health professionals, the need to train them to be culturally sensitive and to be aware and know the values and beliefs of the consumers will be helpful for them in helping them not impose their values on their patients.

1.6 DEFINITION OF TERMS

- The term 'malnutrition' will refer to Kwashiorkor, marasmic and under-weight conditions.
- The term 'professional' will refer to doctors, nurses, social workers, occupational therapists, physiotherapists.

- Psycho-affective stimulation refers to basic, natural bonding activities which any mother should display toward her child. For example, giving or showing love, caring, nurturance, and play.
- Culture in this study will refer to values, beliefs and customs of the members of an ethnic group who define themselves as belonging to such a group.
- "Pedi" --- this study also focuses on thirty Northern Sotho mothers who belong to the Pedi culture in a rural setting.
- 'Hlogoana' is an African condition similar to malnutrition or Kwashiorkor with regard to clinical presentation.
- 'Thema' is a red spot at the back of the head, which is regarded as most dangerous, because the baby or child dies without any fever or running temperature.
- 'Phepo mpe' means poor nutrition.
- Black means black African person.

CHAPTER TWO

CHARACTERISTICS, CAUSATION AND THE SIGNIFICANCE OF MALNUTRITION AS A HEALTH PROBLEM

2.1 INTRODUCTION

This chapter will provide an overview of malnutrition. It will also discuss the aetiology, causation as well as the types of malnutrition.

2.2 DEFINITION OF MALNUTRITION

Malnutrition may be broadly defined as a disease with a deficient intake or lack of proper food. van Rensburg and Mans (1982 : 167) state in their definition that malnutrition may include any deficiency with regard to food intake or diet; thus for this reason, malnutrition is a problem of the developed as well as the developing world, Greene (1977 : 1). The World Health Organisation (WHO) (1981 : 83) states that malnutrition is a chronic condition and when a child has been malnourished for a long time the growth failure can be seen in several ways such as poor motor sensory and physical development. Williams et al (1978 : 5) further state that malnutrition in many parts of the world probably depends less on the shortage of foodstuffs than on the failure of individuals to select, to prepare and to give available foods to children at the right ages and in the right way.

2.3 THE EXTENT OR PREVALENCE OF MALNUTRITION IN THE RURAL AREAS WHERE THE STUDY WAS CONDUCTED

Malnutrition is still one of the commonest diseases in rural areas that kills children between the range of one-to-three years. In 1982 Dr Mphahlele (Minister of Health in the then Lebowa Homeland) quoted a survey done in 400 schools in the territory to conclude that 100,000 children in the area were malnourished, De Beer (1984 : 5). In the current admission for 1994 in the

hospital where the researcher is employed there were twenty-seven children with malnutrition and nine were severely malnourished with severe complications. Some of the symptoms were not seen for a long time and nurses and doctors were worried and shocked to see such conditions.

2.4 TYPES OF MALNUTRITION (Protein-Calorie Malnutrition)

It is necessary for the researcher to provide the reader with details about the two types of malnutrition and have a full overview of the conditions and their differences. There are for the purpose of this study, two types of protein-calorie malnutrition which will be discussed in detail as they form the major part of the study. These two types of malnutrition will be referred to interchangeably by the researcher. The two severe forms of malnutrition are kwashiorkor and nutritional marasmus.

2.4.1 Kwashiorkor

The World Health Organisation (1981 : 83) defines Kwashiorkor as the more serious form of protein-calorie malnutrition (PCM); while van Rensburg and Mans (1982 : 170) define Kwashiorkor as a nutritional disorder arising in babies and young children whose diet is constantly deficient in essential proteins and is particularly prevalent in less-privileged communities where maize is a staple diet.

Trowell, cited in Inter-African Conference (1954 : 46) states that the reason why infants do not thrive appears to be that they are given a diet which contains too low a proportion of protein though it is adequate in amount to satisfy hunger. This then, is the firmly established cause of all cases of severe Kwashiorkor and is the reason why so many children in the tropics do not thrive and have signs of mild Kwashiorkor.

Clinical Features of Kwashiorkor

Trowell (1954 : 351) states that in making the diagnosis of severe Kwashiorkor, attention should be paid to the history of the disorder, preceding diet, the age of the patient, the result of the clinical changes and the responses to treatment. The relevant signs and considerations are :

- (i) Kwashiorkor children are mostly unhappy and often irritable :
 - Many of them cry for long periods.
 - They sit and take no interest in anything - not even food.
 - Many of them have no appetite (WHO, 1981 : 185).
- (ii) The child is always seriously ill and there is a high mortality rate in untreated cases.
- (iii) Most cases occur from the ninth to the thirty-sixth month, the most severe ones develop after complete cessation of breast feeding. The disease does not occur during the first few months of life if breast feeding has been adequate in amount. It is rare during childhood after four years of age.
- (iv) The weight is always markedly subnormal especially when allowance is made for the presence of oedema.
- (v) Oedema (swelling in the body tissue) is always present. It may be variable in amount and it may be lost during dehydration. A few cases, typical in all other respects, display no clinically demonstrable oedema, although they are seriously ill.
- (vi) Muscles are always wasted.
- (vii) The hair always shows some change in its texture and there is usually some loss of pigment, if this has previously been dark in colour (hair is thin and breaks easily).
- (viii) Mental apathy is always present and in many cases children often display peevishness when they are disturbed.
- (ix) Moderate anaemia (deficiency in number of red blood cells) almost always occurs. It is usually normocytic but may be macrycytic as regard means of corpuscular volume.
- (x) The appetite is variable at the beginning of the illness, it is markedly impaired in advance cases.

2.4.2 Marasmus

Greene (1977 : 3) states that children develop Marasmus secondary to severe deprivation of both protein and calories with resultant growth retardation, weight loss, muscular atrophy (emaciation) and severe decrease of subcutaneous tissue.

Clinical Features of Marasmus

According to WHO (1981 : 82):

- (i) Children with Marasmus are very thin and wasted.
- (ii) They have been called 'skin and bone' children.
- (iii) The fat under the skin has been used up, and there are loose folds of skin over the arms, legs and buttocks.
- (iv) The muscles are wasted and as a result the arms and legs are thin and all the bones stand out.
- (v) The abdomen is distended partly because the abdominal muscles are weak.
- (vi) The face is also wrinkled and the bones stand out.
- (vii) The child looks like a 'worried old man'.
- (viii) The hair is usually normal in colour, but may be rather sparse (not thick).
- (ix) Marasmic children are usually hungry.
- (x) They are also grossly underweight.

The above features show that Marasmus is on the other side of the continuum and is more severe than Kwashiorkor and results from poor nutrition.

Evans (1969) states that Marasmus is the childhood equivalent of starvation and is characterised by an onset often in the first year of life when breast

feeding provides a qualitatively insufficient calorie intake and where supplementary feeding is not provided.

2.5 CAUSES OF PROTEIN-CALORIE MALNUTRITION

Malnutrition is caused by a number of complex and closely related factors which relate to the social and economic condition of the family. It is stated by the World Health Organisation (WHO) that malnutrition refers to a broad clinical spectrum of nutritional diseases referred to as protein-calorie Malnutrition (PCM). The two nutritional diseases are represented by Kwashiorkor and Marasmus respectively, the calorie deficiency in Kwashiorkor being not as severe as the protein deficiency.

Further, the majority of cases of protein-calorie malnutrition (PCM) do not show either the pure syndromes of Kwashiorkor or Marasmus, they present a mixed picture and occupy an intermediate position on the PCM spectrum, the typical diagnosis being that of Marasmic-Kwashiorkor.

Malnutrition renders the child more susceptible to a variety of infections and there is again a vicious cycle which accentuates his already precarious nutritional state.

Some of the major causes of malnutrition are the following :

(a) **Poverty**

Poverty is one of the socio-economic factors that contribute towards the causes of malnutrition. van Rensburg and Mans (1982 : 193) state that poverty is associated with the paucity of funds to provide food and other essentials, as well as a so-called 'culture of poverty' which in many ways contributes to the creation of a specific socio-psychic situation frequently resulting in substandard living circumstances. From the researcher's point of

view, poverty plays an important role in the development of malnutrition. According to the researcher's own knowledge of the area; children treated for malnourishment mostly come from poverty-stricken families, whereby the only source of income is an old age pension of the grandmother/grandfather which maintains often over eight people in the household. Also the majority of the families survive with hand-outs from welfare or Operation Hunger.

Williams et al (1985 : 105) state that innumerable studies have pointed to social environmental factors associated with poor nutritional status in children such as poverty (especially with maldistribution of wealth and with inflation), family size, mother's literacy level, single-parent households, maternal deprivation and many other factors including child neglect or abuse. Dasen et al (1988) concur and state that 'malnutrition never occurs alone but in conjunction with low income, poor housing, family disorganisation, a climate of apathy, ignorance and despair', in other words in the context of poverty.

(b) Ignorance

Ignorance on the part of mothers is a potent cause of malnutrition and this is sometimes related to the poor education of both the mothers and care-givers. van Rensburg and Mans (1982 : 173) state that ignorance manifests itself as a lack of knowledge concerning suitable hygiene and nutrition, coupled with an unwillingness to accept new ideas and practices - a resistance frequently encountered among the less privileged.

According to Reid (1991) ignorance contributes to malnutrition in various ways. It affects what is grown in the field, how best to produce food and how food is prepared and cooked. Over-cooking destroys some of the basic food elements. Ignorance is not necessarily a function of formal education.

The researcher agrees with Reid. In the area where the research was undertaken most people were very ignorant about the preparation of nutritious food and how best to spend what little money there was on food which supplied the best nutrition. It is common in the hospital to see mothers of

malnourished children buying their hospitalised children cold-drinks and biscuits which are very expensive instead of bananas and milk which are readily available.

(c) Parental Neglect

Parental neglect in the area where the research is undertaken is illustrated by an instance of a mother running away from home or being employed elsewhere, leaving the baby in care of the granny or other members of the family. Maternal deprivation also plays a very important role, as parents are also so stressed themselves that they cannot afford to care properly for their own babies.

(d) Disrupted Family Life

van Rensburg and Mans (1982 : 178) regard disrupted family life as most frequently encountered among migrant labourers, and which gives rise to extra-marital relationships, resulting in poor child care or child neglect in an environment without proper marital, familial and domestic ties or adequate financial provision.

(e) Cultural Factors

Williams et al (1985 : 107) state that cultural practices may restrict the use of locally available nutritious foods. For example, eggs in some areas are not eaten lest they make females infertile. It is a cultural belief among the rural Pedi's in the Northern Transvaal that a pregnant woman should not eat eggs towards the last stages of pregnancy because it could cause some complications during delivery.

Greene (1977 : 12) agrees with van Rensburg and Mans by stating that cultural influences are among the most important environmental factors that determine food consumption. For example, in the rural areas of the Northern Transvaal, babies are started off on solids, that is, soft porridge even while the mothers are breast-feeding. Greene (1977) also confirms this by stating that Northern Thai children are started on supplemental rice and bananas

very early in life. These are often given prior to breast-feeding and lead to a decreased consumption of breast milk.

2.6 MANAGEMENT OF PROTEIN-CALORIE MALNUTRITION

We have seen that one of the causes of malnutrition is poverty, therefore, to treat malnutrition, poverty should be eliminated first. As this is obviously extremely difficult to do, this is why many children who have been treated for malnutrition repeatedly come back for re-admission.

Fernando (1991 : 342) states that a treatment programme would lack meaning if aimed only at the child's recovery. He further states that since the malnourished child is the product of poverty and misery, a return to such an environment could cause a relapse.

Further he stated that an important factor that has not received enough consideration to date in the treatment of severely malnourished children is the effect of psycho-affective stimulation. He states that recent observations make it clear that adverse emotional factors delay the recovery of severely malnourished children. He further says that in their experience when a carefully planned programme of psychomotor and affective stimulation is implemented in addition to nutritional support, recovery is significantly accelerated.

In South Africa, most treatment programmes are based only on nutrition and improvement of the standard of living. Small scale gardening is encouraged in order to provide proper nutrition for these children, as well as providing a source of income for the mothers. These infants are often left in the care of their grandmothers when mothers go back to school or are away in urban areas looking for employment. Grandmothers are mostly too frail or too weak to provide the stimulation the children need. Their role is mainly to supervise and help with the basic care of the children.

2.7. CONCLUSION

This chapter has discussed an overview of malnutrition and special emphasis was given to the two types of malnutrition viz. Kwashiorkor and Marasmus. The prevalence as well as the causes and management has been discussed.

CHAPTER THREE

THE ROLE AND EFFECT OF CULTURAL FACTORS IN THE HEALTH SETTING

3.1 INTRODUCTION

This chapter discusses and explores the role and effects of cultural value systems in health settings, particularly with the treatment of malnourished children. The purpose of this chapter is to show the importance of culture to both health consumers and personnel and how its neglect or ignorance can affect hospital treatment and communication.

The "folk remedies" as well as traditional medicines are explored and how this has an impact on health education.

3.2 CULTURE

As all human species are bound by their culture, we have to acknowledge and understand what role culture plays in the lives of people. The researcher believes that for health professionals to be relevant in their approach to treatment they need to understand and respect the culture of the community they serve. Galanti (1991) concurs by stating that ideally, if medical professionals everywhere will recognise the value of what other systems have to offer, they can then take the best of each and reach the ultimate goal of providing effective health for all. Taylor in Helman (1994 : 2) provides a definition of culture : 'That complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society'.

Usually In health care settings there are two cultures which interact and are often in conflict with each other viz. the patient's and professional's culture. Kreps and Kunimoto (1994) further state that health care consumers and providers approach health care situations with their own unique communication, characteristics, health beliefs and customs, based on their personal background which dramatically influences their health care needs, and the health behaviour they choose to engage in.

In the area where the researcher is doing the study, management of the diseases should be holistic and there should be less distance between these two 'cultures' because the hospital staff is from the same cultural community as the consumers. The patients know the hospital staff, the professionals know the case background of their patients and can weigh psycho-social as well as clinical factors in diagnosis and management. However, in the researcher's experience, this is not the case. Why is this?

Spector (1985 : xvii) confirms the above statement by stating that he believes there is a fundamental difference between the health beliefs of health care providers and the consumers. It is the assumption of the researcher that culture plays a vital role in the management of malnutrition.

In the Pedi culture the newly born baby and mother together with an older woman, are confined in a house until the umbilical cord has fallen off. During this period the woman performs the protective rituals for the baby. This ritual functions as "protection" and "immunisation" from evil forces for the baby. Also there is a saying that 'a baby belongs to the grannies'. Traditionally it is also a period when major conditions such as 'thema' (red spot at the back of the head; which is regarded as dangerous, because according to African belief it causes infant death) or 'hlogoana' (which has the same clinical pictures as Kwashiorkor) are being treated or attended to.

Spector (1985 : 5) states that each of us enters the health care community with our own culturally based concept of health. During the educational and

socialisation process in our profession, nursing, medicine or social work, we are expected to shed these beliefs and adopt the standard definitions. This difference in culture usually causes the misunderstanding of the 'disease' or diagnosis. Helman (1994 : 92) states that as well as searching for 'disease', the clinician should try to discover how the patient and those around him view the origin, significance and prognosis of the condition and how it affects other aspects of their lives.

In treating malnutrition like any other 'disease', professionals should not only deal with physical abnormalities or malfunctions. The many dimensions of 'illness' - emotional, social, behavioural, and religious, should be treated by adequate explanation and reassurance in terms which make sense to the patient. Where necessary, treatment may have to be shared with a psychotherapist, counsellor or priest or in some non-western communities with a culturally-sanctioned "folk healer" (Helman, 1994 : 93).

3.3 CULTURE AND MALNUTRITION

Culture on its own does not have a strong bearing on causes of malnutrition. Cultural influences alone do not account for most cases of malnutrition - though they may contribute towards them Helman (1994 : 34). According to Dasen et al (1988) it has been widely recognised that malnutrition is always part and parcel of an eco-socio-cultural system that includes other adverse environmental conditions such as poverty, poor housing, sanitation, repeated exposure to infectious and parasitic diseases, inadequate health care, poor feeding and child practices. In the area where this study is conducted most black rural people, even learned ones, believe that the newly born baby should be given very 'thin' soft porridge to relieve the crying baby from hunger pangs. In cases of a home delivery, usually immediately after birth, the person in charge of the delivery will prepare soft porridge for both the mother and the baby. Monnig (1967 : 102) confirms this by stating that 'soon after birth the child is forcibly fed with a very thin porridge. This is done by

midwives by stroking the porridge into the mouth of the child with the finger'. In the "Pedi" culture the baby is introduced to solids at a very early stage. A few years ago it was a common sight in hospital to see newly admitted babies with extended tummies due to over-feeding. The researcher is of the opinion that this habit contributes towards the manifestation of malnutrition; because babies are given soft porridge, usually with no milk formula or little breast milk.

Spector (1985 : 67) states that the providers of health care, such as physicians, nurses, social workers and others, are socialised into the 'culture' of their profession. Professional socialisation teaches the student a set of beliefs, practices, norms and rituals. This newly learned information regarding health and illness differs in varying degrees from that of the individual's background. As students become more and more knowledgeable they usually move farther and farther from their past belief systems, and indeed farther from the population at large in terms of its understanding and beliefs regarding health and illness. Kreps and Kunimoto (1994) concur by stating that health care consumers and providers approach health care situations with their own unique communication characteristics, health beliefs, customs, based on their personal background that dramatically influences their health needs and the health behaviour they choose to engage in. According to the researcher, one can speculate that this problem of moving away from the population's culture and belief system poses major problems in the delivery of health care in the hospitals, because the community expects the professionals to understand them as they fully believe that they share the same beliefs and value systems.

Williams et al (1985 : 19) state that the lack of cultural awareness of health workers has been related to the fact that social anthropology and other behavioural sciences have until recently been unappreciated, even unrecognised as aspects of medical training. Also too many health workers in the past have concentrated on teaching their own ideas, rather than on

understanding those of other people. Success in the management and prevention of disease depends on :

- (i) Recognition of the causes of disease.
- (ii) The resources of the patient.
- (iii) The cultural patterning and outlook of patients, both as groups and as individuals.

A quote by Dr Caleb Parry (in Williams et al : 1985) confirms the above statements 'I would rather know something about the man who has the disease, than about the disease the man has'. It is the researcher's knowledge that if the professionals can change their attitudes and try to understand the patients they serve, then health delivery and education will be easier as the latter would feel that they are also human beings and their views are valued and they are respected rather than being treated as objects.

3.4 CULTURAL VARIATIONS AND MOTHER-AND-CHILD HEALTH WORK

Williams et al (1978 : 14) state that the local cultural pattern is of great importance to the mother-child health worker anywhere in the world for the following reasons :

- (i) It leads to an understanding of cultural factors underlying disease patterns in the community.
- (ii) It gives insight into a people's values, knowledge of and attitude to health and disease.
- (iii) It suggests how to ensure from a population the best co-operation with, participation in, and appreciation of, health work carried out by personnel trained in a foreign that is scientific medicine.

Most mother-child health work in developing countries presents cross-cultural problems to a greater or lesser extent, whether the work is

carried out by foreigners or by scientifically trained local people who have themselves frequently become cut off from village-level customs and behaviour. Probably the most significant field in which this is likely, is in health education, when, unless careful thought is given to cultural concepts, the ideas of the scientific health educators may find no common ground at all with those of the local people. Health education which aims at the modification of harmful behaviour is most likely to be successful if it is planned within the local cultural framework.

- (iv) It enables scientific medicine to become enriched by new ideas, methods and techniques.

In the field of child-rearing, cross-cultural studies of the numerous different methods employed in other cultures can be expected to give information of value much needed in the current confusion abounding in the world as a whole.

Generalisations are dangerous. In every region, there will be some who are sophisticated and receptive, while others cling to ancient practices. The problems are intensified when urbanised health workers with no sensitisation or cultural preparedness, are sent to work in rural areas.

In the same breath, hospital management poses problems when they send junior nurses who lack the basic knowledge about the community and approach in general, to give health education to the mothers with malnourished children. For example, some nurses are very young and do not deal with issues such as malnutrition sensitively, as a result the mothers are not going to listen to what has been said.

3.5 EMPOWERING WOMEN

If women remain helpless during the health education programmes, there will be no change as far as their attitudes and behaviours are concerned. The World Health Organisation (1973 : 25) states that information is a first step

and a necessary one for education. However, the purpose of education is to bring about change and change will only take place when people have been through a process of applying information to their own situation in a way that creates understanding and motivates action.

Nor is education enough in itself. During the process of education, women need to be empowered so that they not only want to take action, but have the means and feel enabled and supported to do so.

The researcher feels that women can also be educated at home by a community health nurse, e.g. a volunteer woman can organise a party with other women at home and a health nurse can come and give them a health talk about health issues. Since the environment will be familiar, women will feel free to listen and to ask questions where they do not understand. According to the researcher's own experience, this kind of exchange does not occur in hospitals. Participation is limited because the atmosphere is not conducive to asking questions.

3.6 FAMILIAL FOLK REMEDIES

Spector (1985 : 24) states 'As modern medicine becomes more impersonal, people are recalling with some wistfulness old country cures administered by parents and grandparents over the generations'. If this practice occurs within the general population, should it not also occur among those who deliver health care?

The researcher agrees with Spector since the participants in her study (mothers), still depend a great deal on the familial folk remedies.

Monnig , in his book , "The Pedi", states that 'soon after birth the mother is given medicines which clean out the womb', Monnig (1967 : 101).

In the "Pedi" culture, folk remedies are still the most preferred type of medicine for the following reasons:

- To protect members against evil spirits and witchcraft.
- To treat and prevent diseases such as "Hlogoana" or "Thema".
- Accessibility due to poor infrastructure in the rural areas.
- Lack of resources and poor financial status makes it a preferable means of treatment.

Health professionals should attempt to bring to consciousness their knowledge of familial folk remedies so that they are able to understand the people that they are trying to help. Spector (1985 : 25) says there are two reasons for exploring one's familial past. First, it draws your attention to your ethnic heritage and belief system. Many of one's daily habits relate to early socialisation practices that are passed on by parents or additional significant others.

A second reason for this examination of familial health practices is to sensitise one's self to the role one's ethnic heritage has played.

Spector (1985 : 33) in a conscious-raising exercise states the following : 'A classroom tactic. She used to break the ice to reveal an experience she had upon the birth of her first child. Her mother-in-law, a woman from Eastern Europe, drew a circle around the child's crib with her fingers and spat on the baby three times to prevent the evil spirits from harming him. Once such an anecdote is shared, other participants have less difficulty in remembering similar events that may have taken place in their own homes'.

Spector (1996 : 46) states that natural folk medicine has been and is widely practised in the United States and throughout the world. However, the researcher has noted that some of these cultural practices may also prove harmful to the children. Thus, it is easy to understand the resistance of the health care professionals.

The poor administration by family members and traditional healers gives validity to the frustrations of the health professionals. Since most malnourished children and adults with different serious illnesses present at the hospital only after traditional medicine has failed. At this point they are seriously ill and sometimes nothing can be done for them. This annoys and frustrates the health professionals.

While the researcher partly agrees with the health professionals and shares their frustrations, one still believes that good communication can help in bringing about the right changes for the good in the rural areas.

Most of the professionals in health settings act as if they do not have or know about self-care practices. They often feel ashamed to talk about such practices.

The researcher believes that if the health professionals could share their knowledge with the mothers during health education, then the mothers themselves would feel free to talk about how other people and traditional healers have tried to help them before they came to the hospital.

Waxler-Morrison et al (1990 : 251) state that the extended family plays an important part in the decision-making about help-seeking and illness management. Usually, there is deep respect for elders and their advice about matters relating to health does not go unheeded. For example, it is not uncommon for grandparents, usually the grandmother, to introduce traditional remedies at the same time that western medicines are being used. Family members may feel obliged to use them.

This is quite true with the population where the study was conducted.

Most mothers with malnourished children were young and depended on the advice and care of grandparents. Dasen et al (1988) state the caretaker's characteristics (usually the mother) of the malnourished child as :

- Age below 19 years or above 35 years.

- Mother's poor nutritional history.
- Mother's problematic childhood history.
- Poor prenatal health care.
- Early weaning and bottle-feeding in unfavourable circumstances.
- Immature personality.
- Unwanted pregnancy.
- Anxiety, stress, depression and apathy.

These characteristics confirm the reason why members of the extended family, in particular grandmothers, are taking care and become influential with regard to the treatment of the malnourished child. Galanti (1991) concurs by stating that health professionals should see patients as members of an extended family unit, and not just individually.

Waxler-Morrison et al (1990 : 251) state that health professionals also need to keep in mind that although a patient may agree to treatment, he or she may not adhere to the treatment if the family does not approve, or treatment may be adjusted to include the use of traditional remedies. In some instances the dosage may be reduced out of concern that the medication is too strong for the patient. Turk and Kerns (1985) state that family attitudes have been shown to be a major concern in patient compliance.

Associated with an extended family is ethnicity. How are ethnic and cultural factors associated with ethnic group membership? These culturally linked diseases are often unusual and not a central part of Western medical training, and the knowledge about them is obviously useful to professionals. Kreps and Kunimoto (1994) state that developing effective multicultural relations between culturally unique participants in the modern health care system is a prerequisite to effective health care delivery.

Secondly, ethnic membership often means family structure, religion, medical beliefs and practices which are incongruent with Western society or its health

beliefs, thus leading to unfulfilled expectations and dissatisfied doctors and patients.

Thirdly, these incongruencies often result in ineffective health care, to patient non-compliance, from the point of view of the practitioner and to continued illness, alienation and feelings of being discriminated against, from the point of view of the ethnic patient.

van Rensburg et al (1992) agree by stating that all indications are that traditional medicine will remain acceptable to its clientele because as an open system it is particularly flexible and continually able to incorporate new elements.

It is the researcher's contention that health care is a social process in which both parties, the professional and the patient, each bring a set of beliefs, expectations and practices to the encounter. Their common task is to negotiate an understanding of the problem or diagnosis and decide what to do about it.

3.7 MODERN HEALTH CARE AND THE POSITION OF TRADITIONAL MEDICINE/HEALING IN SOUTH AFRICA

From the researcher's view point, traditional medicine is widely used by the majority of African people. Tabane (1995) supports the above statement by stating that most Africans use both traditional and Western medicine. van Rensburg et al (1992) state that 'despite this, traditional care survived in South Africa and has up to the present continued to exist as a well-established health care system in both rural and urban areas where Western culture and medicine are so much more intensively in vogue'.

As the 'New South Africa' is moving towards a Primary Health Care Model in accordance with the overall Reconstruction and Development plan for health,

thorough assessment of the utilisation of both traditional and Western approaches need to be taken into consideration if health by the people and for the people is to be successful (African National Congress' Health Plan : 1994).

van Rensburg et al (1992) state that a recent development which could significantly influence both the demand for and utilisation of traditional health care is the world wide emphasis currently being placed on primary health care, especially since the 1978 'Alma Ata' Conference. The World Health Organisation, which for several decades advocated the implementation of a Western medical model in Africa, South-East Asia and the Western Pacific Ocean area, have, however, reviewed this policy since 1975 in terms of a new dispensation which promises to be a radically new health plan.

In South Africa, as elsewhere in the world, traditional medicine is one such explorable alternative, and its utilisation is worth considering, not only by virtue of its approval by WHO, but also by virtue of the high degree of acceptance or general demand for, and consumption by, a large portion of the black population in South Africa; and also as a result of successful experimentation in other parts of the world.

The researcher shares the same viewpoint as van Rensburg et al (1992) that it is of the utmost importance that we regard these traditional care systems as being part of the total South African health care system.

3.8 CULTURAL ISSUES AND PSYCHO-AFFECTIVE STIMULATION

It appears that, in general, Northern Sotho women do know how to bond, nurture, and play with their children appropriately. However, the issue is not so much a cultural one as a socio-economic one. To explain this, Northern Sotho women, coming from a poor background, are forced to leave their children in the care of grandparents who are unaware of the correct dietary

needs of the children. These children therefore suffer from malnourishment, and at the same time lack bonding with their own mothers which contributes to their failure to thrive.

3.9 CLINICAL SOCIAL WORKERS AND CULTURAL ISSUES

Much is known about the cultural issues in health care settings and how they affect treatment. Nash et al (1990) state that in health care settings diagnosis and treatment should be viewed within the context of cultural beliefs.

While clinical social workers are not directly involved with treatment in most health care settings, they can still play a major role in advising patients within their cultural value systems. Clinical social workers can also teach the health professionals about the cultural diversity of local communities and this will encourage health professionals to be culturally sensitive to the needs of their patients.

Nash et al (1990 : 562) further state that Western scientific medicine has done much to bring relief from suffering and disease prevention to Africa, yet illness and disease persist, and it is becoming increasingly apparent that technical evaluation without anthropological understanding will lead to inappropriate care, and thus much wasted effort. Klokke (1961) maintains that "It is the failure to establish an intimate relationship between the patient and the doctor which makes people return to or stick to traditional medicine".

The social worker, as a multi-disciplinary team member in the hospital could play an invaluable role during ward rounds where she could mediate and provide information about her client's cultural context.

3.10 CONCLUSION

The cultural beliefs of a person have a strong influence on how one perceives and interacts with others and on how one forms relationships.

It is suggested that professionals need to be aware of their own cultural beliefs as people and feel proud of their heritage. They need to integrate their own personal, cultural values with that of their professional values. The researcher assumes that this will make them more culturally sensitive, accommodative and responsive to the cultural needs of their patients.

CHAPTER FOUR

RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION

This chapter discusses the research methodology and design utilised in this study. The broad aim of this study is to explore the possible effects and impact of cultural issues on the treatment of the hospitalised malnourished children. It also aims to establish the extent to which recognition of patients' usage of traditional medicine is incorporated into hospital treatment.

This study explores the attitudes of both the professionals and mothers with malnourished children regarding cultural value systems as they impact on the treatment: It further establishes if professionals are aware and accommodative of the mothers' value systems. This issue of incorporating traditional healers in hospital treatment is still under debate and there is little research, especially in South Africa on the subject.

The use of an exploratory-descriptive study is the preferred method, since this is an initial attempt to accurately describe the professionals and mothers' attitudes and general experiences with cultural belief systems and how they impact on treatment.

It is exploratory in that it attempts to identify what may be important questions for future research in the area of cultural belief systems and practices in conjunction with the Western type of treatment.

4.2 SPECIAL OBJECTIVES

The specific objectives to be explored are described below :

- To explore the role of the clinical social worker in the treatment of malnourished children.
- To explore the attitudes of mothers towards the hospital staff regarding treatment of their malnourished children, and their compliance with health education given to them.
- To explore the attitudes of the hospital staff with regard to the mothers with malnourished children who brought with them cultural beliefs towards the treatment of malnutrition.
- To explore the need to include psycho-affective stimulation in the treatment programme of malnourished children.

4.3 ETHICAL CONSIDERATIONS IN THE STUDY

It is evident that some respondents are likely to find certain questions to be of a sensitive nature and some might feel their privacy to be invaded. The researcher has attempted to minimise the invasion of privacy by explaining the purpose of the study to the respondents. As Bailey (1987 : 44) has pointed out that if the respondents thought that the information to be gathered was important enough, he or she might be willing to participate and have his/her privacy invaded; but he/she would not co-operate if the study seemed to be a trivial matter with no good purpose but to harass the respondents.

The other ethical consideration in the study is the violation of voluntary participation. Most mothers admitted with their children to hospital, experienced a loss of parental power associated with hospitalisation and this was also a personal observation of the researcher as she worked closely with them. Because the mothers did not know their rights and what was expected of them, some felt fearful and refused participation in this research. This was minimised by the researcher's thorough explanation and the highlighting of

some important questions in the schedule and addressing their concerns before involving them in the research.

4.4 RESEARCH TOOLS

4.4.1 Interview Schedule

An interview schedule (Appendix B) was chosen as the most appropriate tool for gathering data from the mothers because of their illiteracy and relative ignorance about health care issues. This tool allowed the researcher to probe and explore their reactions, experiences and attitudes towards the hospital treatment of their children. It was an appropriate technique for revealing facts about sensitive and emotionally laden topics as well as for a thorough investigation of emotions which underlie responses.

4.4.2 Questionnaire

A questionnaire was a tool appropriate for data collection from the health professionals because of their level of education and also they were able to complete the questionnaire at their own pace and in their own time.

To guarantee co-operation the researcher mailed questionnaires accompanied by a covering letter explaining the nature and purpose of the study, and also an address where the questionnaire could be returned to, as well as a contact telephone number if further clarification was needed.

There were many advantages in using this tool, as respondents were able to secure information both through consultation of hospital records and from their colleagues. Because of the rotation of the staff, most respondents were recently allocated a paediatric ward and they were able to consult with others for more details.

There was also no interview bias; the respondents completed the questionnaire independently without the researcher's interference (as the researcher also worked in the hospital).

The questionnaire gave the respondents an opportunity to answer sensitive questions anonymously.

The disadvantage of this tool was that there was a fairly moderate response rate, that is, out of twenty questionnaires only thirteen respondents returned them.

4.5 PRE-TESTING OF THE RESEARCH TOOLS

A questionnaire was tested on four health professionals, viz., two hospital nursing sisters, one medical doctor and one staff member from the Community Centre who were not included in the study. This helped a great deal as few questions were altered.

Another pre-test on an administered interview schedule was used on five mothers, who were also not part of the study. This helped the researcher to reframe the questions on psycho-affective stimulation in more understandable terms.

Lodger mothers were requested permission to be involved in the pilot study, and were reassured about their confidentiality and anonymity. All five mothers were interviewed individually in the Social Worker's office.

4.6 ADMINISTRATION OF THE RESEARCH TOOLS

4.6.1 Administration of an interview schedule

This was time consuming and seen as a catharsis by the respondents. Respondents were readily available in the ward and were allowed to bring along their children during the interview which the researcher believed led to the reduction of resistance.

An interview schedule was administered by the researcher herself to the sample of thirty mothers. Accidental or convenience sampling was used, thus only mothers whose children were admitted to the hospital with malnutrition were selected in the sample. The researcher visited the ward frequently to find out about the new admissions and recruited them for participation and conducted individual interviews to complete the sample target. Sometimes there were no lodger mothers with Kwashiorkor children for a week or two which delayed the administration process. The malnourished condition evoked emotional issues related to the abject poverty of the mothers. An administered schedule was best suited to obtain data from the mothers. The researcher was able to establish rapport which ensured confidentiality. This tool evoked close intimacy which allowed free probing into the most intimate aspects of the respondents' lives (Goode & Hatt : 1952). Lastly, it was an advantage to record sensitive questions and non-verbal behaviour regarding attitudes which are difficult to state verbally.

The researcher introduced herself in detail and the purpose of the study was explained to the mothers so as to make them feel comfortable. They were then asked for permission to be interviewed and were informed about their rights to refuse if they were not comfortable with the idea.

4.6.2 Administration of the questionnaire

The sample size of twenty health professionals was drawn from a population of two hundred professionals. A purposive sampling procedure was used as only those who were involved in the treatment of malnourished children or working in the medical paediatric ward were involved; e.g. medical officers professional nurses, a physiotherapist, an occupational therapist, a social worker, a dietician and assistant nurses. Out of twenty questionnaires only thirteen (65%) were returned. This percentage is considered a good response rate (Grinnel, 1985). The literature states that members of special groups are generally good respondents because they tend to be interested, are loyal to the group, and feel guilty if they do not respond. They are also usually familiar with the subject and so are able to answer more comprehensively and with a minimum of instruction (Bailey, 1987).

Within the response rate of thirteen, a majority (69%) were nurses. Other health professionals were in the minority. In the hospital of \pm 500 beds there is a maximum of one or two para-medicals, two social workers, two occupational therapists, one physiotherapist, one dietician and one speech therapist. Some of these health professionals were unable to complete the questionnaire due to work pressure and the limited time spent in the children's ward. During the data collection phase there were no speech therapists or dieticians in the hospital.

The questionnaires were given to the various heads of sections within the hospital and were returned to those sections. Only those for the general practitioners were handed to them by the researcher herself. Each questionnaire was personally addressed and enclosed in a self-addressed envelope. After completion they were informed to return them to the head of the paediatric ward who would put them in the sealed box in the duty room. In addition the questionnaire had a covering letter which assured confidentiality and anonymity and indicated a return date.

4.7 LIMITATIONS OF THE STUDY

- One hospital is not representative of the whole population for the study and generalisation will be confined only to the institution in which the study was carried out. The geographical area is very wide with six regions, each region having five to six hospitals - excluding clinics. Pietersburg Provincial Hospital is the only tertiary (teaching) hospital in the Province.
- Consultation with traditional healers is often done secretly, therefore, the honesty and reliability of the answers will be difficult to substantiate. This is partly according to African culture. van Rensburg et al (1992 : 333) concur by stating that in fact a client often prefers to consult a traditional healer in another area, on the one hand because he expects the traditional healer to identify the problem without someone informing him about it; and on the other hand because the person, e.g. a neighbour, who has harmed the client, may also consult the same healer.
- The researcher being part of the hospital staff may have affected the findings as the respondents might have answered to satisfy her.
- The interview schedule was too long and time consuming, so mothers were tired towards the last questions.
- The lack of the doctors' participation had an impact on the generalisation as their view points are unknown.
- The discussion of findings has its own limitations, i.e. it depended on the researcher's limited expertise.
- The research tool was problematic. It was carried out in Northern Sotho despite the English text. This could have led to misinterpretation on the part of the researcher.
- The researcher's lack of research experience in this field is evident. (This was her first research study undertaken).

- The research design carries its own inherent limitations in that it was only an exploratory study.

4.8 RELIABILITY AND VALIDITY

4.8.1 Reliability

Internal reliability may have been compromised by faulty research tools.

4.8.2 Validity

There was an attempt at seeking validity through the research tools which were able to fairly directly address the central questions of the study.

While some of the more abstract questions may have compromised this to some extent, the generally concrete and specific nature of the questions helped ensure that valid answers were being given. However ambiguity may have negatively impacted on the validity of this study.

CONCLUSIONS

The research design, tools and methodology have been discussed. Advantages and disadvantages of the research techniques have been outlined in this chapter. Limitations which might have affected the generalisations of the findings were also discussed.

CHAPTER FIVE

ATTITUDES OF HEALTH PROFESSIONALS REGARDING THE CULTURAL ISSUES IN THE TREATMENT OF HOSPITALISED MALNOURISHED CHILDREN

5.1 INTRODUCTION

The findings of this study are presented in tabular form, followed by a descriptive analysis, and supplemented in many instances by additional impressions gained by way of responses to the open-ended questionnaire.

In view of the amount of data obtained, only the central data will be dealt with in the discussion. An attempt will be made to offer trends and themes, and where possible significant data will be highlighted.

5.2 IDENTIFYING INFORMATION

5.2.1 Age Distribution of the Respondents

Eight of the thirteen respondents were in the age group of 30 - 39 and three were in the age group of 20 - 29 years. One of the respondents was in the age group of 40 - 49 and one was in the age range of 50 - 59 years.

Discussion: These findings have implications for the results in this study in that, firstly, a representative spread does not exist across all age groups. Secondly, the majority of the respondents fell in the middle age group of 30 - 39 years which has a very great influence on the study regarding professionals' values and belief systems and one speculates that this will have a great influence on how they view the patients' belief systems.

5.2.2 Gender of respondents

All thirteen respondents in this study were females.

5.2.3 Religions of respondents

While there was a wide variation in membership of the different churches; only two respondents indicated that they did not attend any denomination.

Of the sample three were Lutheran, two were Roman Catholic, two were Dutch Reformed, one was Christian, one was Apostolic, one was Anglican, and one was from "other denominations" not listed.

Discussion: These findings have implications for this study, since religion also has an influence on both culture and the healing process. The majority of the respondents represented the Western type of Christianity which has a tendency to look down upon the traditional way of healing. This is the researcher's viewpoint.

5.2.4 Educational qualification of respondents

While the questionnaire provided for the following qualifications, viz. doctor, matron, professional nurse, staff nurse, enrolled nurse, social worker, physiotherapist and occupational therapist and others, the respondents were from the following professions: professional nurses, enrolled nurses, physiotherapists, occupational therapists and other.

Of the sample, seven were professional nurses, two were enrolled nurses, one was a physiotherapist, one was an occupational therapist and two were from the "other" category and were health workers at the Malnourished Centre. They had special knowledge as they were educating mothers on the subject of malnutrition. The researcher felt that participation of the health workers would be crucial to this study as their perspectives, approaches and management differed from the hospital outlook. They studied the communities from which the mothers came, visited them at home, and made them feel accepted. In dealing with the mothers these health workers from the Malnourished Centre always stressed the importance of culture.

Three groups were well represented, viz., professional nurses, enrolled nurses and health workers from the Malnourished Centre. It is important to note that neither

doctors nor social workers took part in this study. This might affect the results as the doctors are the main people with regard to management. The view point of the social workers regarding their role in management would also have been useful.

5.2.5 Years in the professional field

Four of the respondents had experience of less than five years; four had experience of more than five years, and four had experience of more than ten years. Only one member had more than fifteen years experience.

5.3 PROFESSIONALS WHO FELT THAT HEALTH EDUCATION FOR MOTHERS WITH MALNOURISHED CHILDREN WAS A WASTE OF TIME

Table 5.1

Professional respondents	Numbers
1. Strongly agree	1
2. Agree	3
3. Unsure	3
4. Disagree	3
5. Strongly disagree	3
TOTAL	13

Of the respondents nearly a third (4) agreed that health education for mothers is a waste of time, nearly a quarter (3) were unsure, and about half (6) disagreed with the statement.

Discussion: As nearly half of the respondents disagreed with the statement and a further three were unsure, there seemed to be a fairly negative attitude regarding the effectiveness of health education. Health education is considered by many to be a viable tool for preventative measures in all types of diseases; for example, the World Health Organisation (1973 : 25) regards information as a first step and a necessary one for education; it further states that the purpose of education is to bring about change and change will only take place when people have been through a process of applying information to their own situations in a way which creates understanding

and motivates action. It is interesting to note that six of the professionals in this sample, i.e. less than 50% fully supported health education for mothers.

5.4 WHETHER PROFESSIONALS THOUGHT THAT MOTHERS OF MALNOURISHED CHILDREN CAME TO THE HOSPITAL WITH THEIR OWN DIAGNOSIS OF 'HLOGOANÔ' OR 'THEMA'

Table 5.2

Mothers bringing their own diagnosis	Numbers	%
1. Strongly agree	3	23
2. Agree	10	77
3. Unsure	-	-
4. Disagree	-	-
5. Strongly disagree	-	-
TOTAL	13	100

All the respondents agreed that mothers came to hospital with their own diagnosis. Most comments indicated that most African mothers consult with the traditional healers before coming to the hospital to sort out witchcraft problems, or diseases that are caused by the evil spirits of ancestors.

This finding is significant as it is evidence of the strong African cultural perspective regarding the treatment and diagnosis of illnesses by the mothers.

5.5 PROFESSIONALS ESTIMATION OF MOTHERS COMING IN WITH THEIR OWN DIAGNOSIS

Table 5.3

Experience of mother's own diagnosis	Numbers	%
1. 0% - 20%	1	8
2. 20% - 40%	3	23
3. 40% - 60%	9	69
4. 60% - 80%	-	-
5. 80% - 100%	-	-
TOTAL	13	100

The majority of the respondents (9) gave a high percentage of between (40% - 60%) of mothers coming with their own diagnosis; 3 agreed to a rate of (20%- 40%); and 1 stated that mothers who came with their diagnosis were in the lowest percentage (0% - 20%) in their experience.

Discussion: As the majority of the respondents (9) reported a high proportion of mothers coming to the hospital with their own traditional or folk diagnosis, it is evident that at least about half of the mothers must be consulting traditional healers or using family folk medicine before coming to the hospital.

Other studies and reports in the literature have found that a high proportion of Africans consult traditional healers. In a recent study done by Tabane (1995) at the Red Cross Hospital, the respondents mentioned that they knew that both healers were important to them and they did not want to lose either, as they play different roles.

5.6 PROFESSIONALS KNOWLEDGE OF THE FACT THAT A DIAGNOSIS HAS BEEN MADE BY A LAY OR TRADITIONAL HEALER

Table 5.4

Diagnosis from lay and traditional healer	Numbers	%
Yes	13	100
No	-	-
TOTAL	13	100

All the respondents 13 (100%) were aware of the diagnosis made by the lay or traditional healer.

Discussion: This finding reveals the fact that traditional medicine plays an important role in the lives of the African people. It is also true that the majority of health consumers prefer to consult the traditional healer first to find out if the illness

is related to witchcraft; because there is a strong belief that if it is the latter the doctors will not be able to affect a cure. Tabane (1995) concurs by stating that most Africans use both traditional and Western medicine, while Van Rensburg et al (1992) state that traditional care survived in South Africa. Traditional healing has continued to exist as a well-established health care system not only in rural but also in urban areas where Western culture and medicine are much more intensively practised.

5.7 HEALTH EDUCATION SHOULD INCLUDE THE CULTURAL BELIEFS AND VALUES OF THE MOTHERS TO MAKE IT MORE COMPREHENSIVE

Table 5.5

Health Education should be more comprehensive	Numbers	%
1. Strongly agree	7	54
2. Agree	5	38
3. Unsure	-	-
4. Disagree	-	-
5. Strongly disagree	1	8
TOTAL	13	100

Although the majority of the respondents (92%) agree that health education should include the cultural beliefs and values of the mothers; it should be noted that more than half the respondents (54%) felt very strongly about the statement.

Of the total of twelve respondents who agreed and strongly agreed that health education should include cultural beliefs, five substantiated their answers by giving the following reasons:

- 'While considering cultural beliefs and values of mothers, the scientific method of handling such problems should be emphasised to minimise the complications.'
- 'Because healing occurs if you believe that a particular thing will take all the suffering from you. Whatever you believe in makes you feel better.'
- Yes because people don't believe that malnutrition is a disease but witchcraft.'

- 'Yes because mothers will know when not to take their children to the traditional doctor, and be aware of other methods useful to the treatment of malnourished children.'
- 'Mothers always say they understand but when asked questions they keep quiet because they believe more in their culture, as long as their culture does not endanger their lives.'

"They are used to the fact that mothers do not tell the truth about their situation" that is, the respondent felt that they often hide behind illiteracy and ignorance to avoid conflict with the hospital staff.

Comments given by the respondents highlight the uncertainty and uneasiness of the health professionals regarding the traditional medicine/ healing. Education regarding cultural healing practices appear to be necessary for the health professionals.

Only one respondent (8%) said she disagreed and gave the reason that she doesn't believe nor practice cultural beliefs, as the two beliefs (science and culture) differ a lot, and she said she asked mothers to give science a chance.

5.8 MOST HEALTH PROFESSIONALS ARE NOT CULTURALLY SENSITIVE TO THE VALUES AND BELIEF SYSTEMS OF MOTHERS WITH MALNOURISHED CHILDREN

Table 5.6

Professionals culturally insensitive to the values of mothers	Numbers	%
1. Strongly agree	3	23
2. Agree	5	38
3. Unsure	-	-
4. Disagree	-	-
5. Strongly disagree	3	23
6. No response	2	15
TOTAL	13	100

In response to the question eight respondents agreed that professionals are not sensitive to the cultural beliefs of the mothers. The reasons given were as follows:

- 'They are used to mothers scape-goating.'
- 'Because of what they learned from their profession, it is very difficult for them to change and adapt.'
- 'Transcultural nursing skills are not known.'

Of the sample two never responded to the question; whereas only three disagreed and stated they felt that mothers needed to be taught the right things in order to prevent future occurrences and complications.

5.9 THERE IS A TENDENCY OF HEALTH PROVIDERS TO IMPOSE THEIR PROFESSIONAL VALUES ON MOTHERS WITH MALNOURISHED CHILDREN

Table 5.7

Imposition of professional values on mothers	Numbers	%
1. Strongly agree	6	46
2. Agree	2	15
3. Unsure	-	-
4. Disagree	2	15
5. Strongly disagree	3	23
TOTAL	13	100

Of the sample a majority of respondents (8) agreed that they imposed their professional values on the mothers. It should be noted that health professionals, in general, strongly agreed with the statement; meaning that health professionals are aware of imposing their values on the health consumers.

A minority (5) of the respondents disagreed. However, this does not alter the fact that professionals have a tendency to impose their values.

Those who agreed gave the following reasons:

- 'Mothers don't understand food supplements because of their poor level of education.' Meaning that this is sometimes misunderstood as imposing one's value system.
- 'Lack of transcultural skills from professionals.'
- 'Because professionals feel that whatever they know and have learned is important.'

These comments are substantiated by Kreps & Kunimoto (1994) who argue that health care consumers and providers approach health care situations with their own unique communication characteristics, health beliefs and customs, based on their personal backgrounds which dramatically influence their health care needs, and the kinds of health behaviour they choose to engage in.

5.10 **PROFESSIONALS VIEW REGARDING THE APPROPRIATE TIME TO GIVE HEALTH EDUCATION TO THE MOTHER WITH A MALNOURISHED CHILD**

Table 5.8

Appropriate time for Health Education	Numbers	%
1. On admission	8	64
2. When child if fully hydrated	1	7
3. On discharge	3	23
4. No response	1	7
TOTAL	13	100

The majority of the respondents (8) agreed that health education should be given on admission. Only three professionals said mothers should be given health education on discharge. Only one respondent considered the relevant time to be when the child was fully hydrated. One respondent didn't respond to this question.

Discussion: Two of the respondents who regarded the right time for health education to be given on admission gave the following responses:

- 'That mothers can acquaint themselves with the right procedures, how they should feed, and measure the correct amount, while in the meantime being involved through practice.'
- 'From admission until discharge it gives both professionals and mothers time to evaluate and if possible to re-educate and give further advice.'

Those who preferred health education on discharge stated that during admission mothers are very confused, and anxious about the condition of the child, so they do not concentrate or listen to what is being taught.

5.11 MOTHERS ARE OFTEN REPRIMANDED BY HEALTH PROFESSIONALS FOR HAVING CONSULTED OR USED TRADITIONAL HEALERS/ MEDICINE

Table 5.9

Attitudes of professionals towards traditional healers	Numbers	%
1. Strongly agree	6	46
2. Agree	3	23
3. Unsure	-	-
4. Disagree	-	-
5. Strongly disagree	4	31
TOTAL	13	100

The majority of the respondents (9) agreed that mothers are being reprimanded by health professionals; while (4) disagreed that mothers are reprimanded.

Discussion: It should be noted that six respondents strongly agreed to the statement that affirms the poor communication and to an extent negative attitudes of professionals towards the mothers or patients in general. Those who affirmed the statement gave the following responses:

- 'Professionals are frustrated by the complications arising from the medicine/ treatment of the traditional healers because most of the time these children are brought to the hospital when they are critically ill.'
- 'Most patients come to the hospital with many complications and are very sick, so professionals feel frustrated to handle patients who have a poor prognosis.'

The researcher also observed that most of the relatives bring patients to the hospital when nothing more, clinically, can be done for them. Besides being frustrating and annoying for the health professionals, it is potentially life threatening for the children.

5.12 TRADITIONAL HEALERS SHOULD BE INCLUDED IN THE TREATMENT OF MALNOURISHED CHILDREN

Table 5.10

Inclusion of traditional healers	Numbers	%
1. Strongly agree	6	46
2. Agree	2	15
3. Unsure	2	15
4. Disagree	2	15
5. Strongly disagree	1	8
TOTAL	13	100

A majority (8) agreed that traditional healers should be included in the treatment, whereas only three respondents disagreed that the treatment of malnourished children should include traditional healers / medicine.

Discussion: Of the respondent sample nearly a half (6) strongly agreed, and these respondents tended to favour what could be called an integrated approach. Their reasons for supporting the system were as follows:

- 'They form part of the multidisciplinary health team.'

- 'For the purpose of teaching the traditional healers about the type of diseases, causes and treatment.'
- 'Yes, because they will also help in the diagnosis and proper treatment and giving mothers proper advice and education'.
- 'Traditional healers should also be educated about balanced diet, and taught about signs and symptoms of malnourished children and the importance of sending these children to hospital as soon as possible.'

5.13 **WHETHER THE PSYCHO-SOCIAL NEEDS OF A MALNOURISHED CHILD ARE THE SAME AS ANY OTHER CHILD**

Table 5.11

Importance of psycho-social needs of a malnourished child	Numbers	%
1. Strongly agree	9	69
2. Agree	1	8
3. Unsure	1	8
4. Disagree	2	15
5. Strongly disagree	-	-
TOTAL	13	100

The majority of the respondents (10) agreed that the psycho-social needs of the malnourished child are the same as those of any other child; only two disagreed; and only one was unsure.

Discussion: The one respondent who was unsure did not give a reason; the two respondents who strongly disagreed gave the following reasons / comments:

- 'Because their psycho-social needs are to a large extent the needs of their mothers.'
- They lack proper care and stimulation only, and their home environment is not conducive.'

5.14

**WHETHER LACK OF PSYCHO-AFFECTIVE STIMULATION OF
MALNOURISHED CHILDREN BY THEIR MOTHERS
PROLONGS HOSPITAL TREATMENT**

Table 5.12

Lack of psycho-affective stimulation prolongs hospital treatment	Numbers	%
1. Strongly agree	5	38
2. Agree	3	24
3. Unsure	-	-
4. Disagree	-	-
5. Strongly disagree	5	38
TOTAL	13	100

A majority of the respondents (9) agreed to the statement; while just over a third (5) disagreed with the statement.

Discussion: The majority (8) who felt that lack of stimulation for malnourished children prolonged treatment, gave the following reasons:

- 'Yes, because for a child to develop effectively he/she needs multi-stimulation from the parents and the environment.'
- 'If the mental aspect is not stable, it is obvious that the body too will be affected and it would really take a long time for the child to recover.'
- 'Because the child is depressed and sad, he might recover physically but the lack of stimulation will take him a long time to treat his appetite and play which is good for children to express their emotions.'

5.15 WHETHER PROFESSIONALS BELIEVE THAT MEDICAL TREATMENT SHOULD BE COMBINED WITH PSYCHO-AFFECTIVE STIMULATION TO FACILITATE A SPEEDY RECOVERY OF A MALNOURISHED CHILD

Table 5.13

Combination of psycho-affective stimulation and treatment will speed up recovery	Numbers	%
1. Strongly agree	6	46
2. Agree	5	38
3. Unsure	1	8
4. Disagree	1	8
5. Strongly disagree	-	-
TOTAL	13	100

The majority (11) of the respondents agreed that psycho-affective stimulation be coupled with medical treatment; and (6) of these strongly agreed to this statement.

Discussion: The integration of medical treatment and psycho-affective stimulation was supported by the majority of (11) respondents. They gave the following statements to support this system.

- 'Company and play relieves sad emotions of a child, improves his appetite and developmental milestones.'
- 'Speedy recovery.'
- 'Children to be treated in totality, meaning socially, psychologically, physically and mentally.'
- 'Yes, because the cognitive developmental skill needs stimulation both from physical and social facets.'
- 'If the child is generally unhappy - dull and apathetic, then the process of the recovery will be slow.'
- 'Because the holistic approach facilitates speedy recovery.'
- 'The mother will feel accepted in the treatment of her own child and will participate actively, and even at home she will continue.'

5.16 PROFESSIONALS' OPINIONS ABOUT WHO SHOULD EDUCATE/TRAIN MOTHERS IN PSYCHO-AFFECTIVE STIMULATION AT HOME

Three of the respondents didn't answer this question. The majority (10) gave the following persons as good trainers for educating mothers about psycho-affective stimulation:

- Nurses, mainly occupational therapists, and their assistants and voluntary community workers.'
- 'Occupational therapist.'
- 'Health providers, nurses.'
- 'Care groups and community nurses.'
- 'Medical professionals - nurses, dieticians, social workers, clinical psychologists and community workers.'
- 'Community health workers and care group mothers.'
- 'Community health nurses during home visits.'
- 'The health professionals should do that as they are having more knowledge.'
- 'The community health nurse at the clinic because she is offering primary health care, and she is the first contact with the mothers, she is able to do home visits to further guide them.'

It should be noted that from all the respondents, they seemed not to see the role of the social worker in the stimulation of the children or educating the mothers.

5.17 WHAT PROFESSIONALS THINK WILL FACILITATE MOTHERS' INVOLVEMENT IN HEALTH EDUCATION PROGRAMMES

Two of the respondents did not complete this question. However, the majority (11) who responded to this question gave the following statements to support their answers:

- Friendly attitude of the nurse, use of relevant teaching aids and not giving radical examples with the particular malnourished child.'

- 'If the community nurses could take part and get to know the mothers they would become aware of the fact that they too are mothers and not only professional people.'
- 'Education, if mothers are well-educated and well trained they will feel free to participate.'
- 'By coming down to their level and not seeing health professionals as people who always impose orders to them, but by working together with them in trying to solve this problem.'
- 'Let them be fully involved and respect their norms, values, language and culture.'
- 'Community participation and positive attitudes.'
- 'If they can have confidence in professionals, good approach with positive criticism and give them an opportunity to take part.'
- 'If they are not harassed by health givers, if they are shown harmoniously what they should do, how to start their own health programmes on their own.'
- 'The use of pictures to educate mothers will make them feel free to participate.'
- 'Unconditional acceptance of the mother, and baby, treat her as a unique human-being with her own needs and beliefs.'

Discussion: The reasons reveal that professionals are aware of the poor communication, lack of community participation and lack of cultural components in health care.

While professionals were able to provide several reasons of how mothers can be helped to participate freely in health education programmes, the need to take into account the mother's culture, has been underscored. Professionals tend to overlook the fact that mothers already have knowledge which they have learned and practised over a long period from their elders, folk healers and community at large. Therefore, professionals should note that new information should be built on what is already known, that is, they should start at the level where the mothers are. Werper and Bower (1982 : 7-1) concur by stating that helping people rediscover the value of many of their traditional ways, increases their confidence in their own knowledge, experience and ability to meet their needs themselves.

CHAPTER SIX

PERCEPTIONS AND EXPERIENCES OF MOTHERS REGARDING HOSPITAL TREATMENT OF THEIR MALNOURISHED CHILDREN

6.1 INTRODUCTION

Presentation of findings from the mothers

The findings of this study are presented in tabular form, followed by a descriptive analysis. Additional impressions gained by way of further questioning as well as observations of non-verbal responses are also presented.

Where the respondents gave more than one answer, the total percentage exceeds 100 and therefore the relative frequency was calculated for purposes of analysis. The researcher rounded off all figures calculated to the nearest whole number.

6.2 IDENTIFYING INFORMATION

6.2.1 Age distribution of the mothers

TABLE 6.1

Age Categories	Numbers	%
1. N/A	1	3
2. 10 - 20	6	20
3. 20 - 30	10	33
4. 30 - 40	11	37
5. 40 - 50	2	7
6. 50 - 60	-	-
TOTAL	30	100

NB: Only one respondent did not know her age.

Respondents ranged in age from 17 - 47 years. The majority of the respondents were thus represented by the younger age group in this study viz. 10 - 30 years, i.e. 16 (53%), 13 (43%) of the respondents fell in the age group of 30 - 50 years. One respondent (3%) did not know her age.

6.2.2 Cultural background of the respondent mothers

All of the 30 mothers were of the Northern Sotho origins (Pedi culture). Attitudes to Kwashiorkor and Marasmus have been referred to in Chapter 3 : 20-21.

6.2.3 Number of children and the position of the malnourished child

TABLE 6.2

Number of children	1	2	3	4	5	6	7+
Number of mothers	11	3	4	5	2	1	4+

There was a wide spread of number of children in the families of the respondents; with range of one to nine children (median : 1 child).

The majority of the respondents 11 (37%) had one child; 5 (17%) had four children; 4 (13%) had three; 2 (7%) had five; 1 (3%) had nine and 3 (10%) had two.

It is interesting to note that the majority of the respondents 23 (77%) had between 1-4, whereas a smaller percentage 7(23%) had more than 4 children (5 to 9). By black cultural standards 1-4 children constitutes a reasonably small family whereas in a white culture 1-2 children may be deemed a small family. This is because the majority of the respondents in this sample are still very young. This confirms the literature that malnourished children are born to young mothers who may be ignorant about health issues.

6.2.4

Marital status of respondentsTABLE 6.3

Marital Status	Numbers	%
1. Married in civil law	3	10
2. Divorced	3	10
3. Separated	1	3
4. Single	13	43
5. Customary Marriage	2	7
6. Cohabiting	7	24
7. Married by family	1	3
8. Other	-	-
TOTAL	30	100%

For the sake of clarity the author wishes to explain the category “married by family” as being different to “customary marriage”.

In a customary marriage, a lobola is paid and a man marries a woman within traditional customs.

In a “marriage by family” the grandparents could “marry” one of the women in the sense that she/he pays lobola for the woman provided she agrees to mother as many children as possible to continue the family name.

The majority of the respondents 13 (43%) were single; 7 (23%) cohabited; 3 (10%) were divorced,, and 3(10%) were married in civil law; 1 (3%) was separated; 1 (3%) was married by the family.

The findings confirm the literary review (Dasen et al : 1988) that malnutrition is also related to poverty and poor social circumstances. The marital status of the mothers puts them in a vulnerable situation financially and emotionally because they affect both the nutritional status of the mothers and poor prenatal health care.

6.2.5

Religion

TABLE 6.4

Religious affiliation	Numbers	%
1. Roman Catholic	4	13,3
2. Lutheran Church	2	6,7
3. Zion Christian Church	8	26,7
4. Apostolic Church	8	26,7
5. Presbyterian Church	2	6,6
6. Not attending	6	20
TOTAL	30	100

While the questionnaire provided for the following religious groups viz. Roman Catholic, Anglican, Lutheran, Dutch Reformed, Zion Christian, Christian, Apostolic, Presbyterian, Not Attending and Others, for convenient analysis. They were tabled into the six religions according to the respondents as indicated by the table above.

Of the sample 8 (26%) were Zion Christians; 8 (26,7%) were Apostolic; 6 (20%) did not attend any church; 4 (13,3%) were Roman Catholic; 2 (6,7%) were Lutherans and 2 (6,7%) were Presbyterians.

It is important to note that the majority 22 (73%) belonged to the non-western type of religion viz. Zion Christian Church and the Apostolic Church, while a significant

group (20%) did not attend church. Those attending the African Apostolic Church and those "Not Attending" use cultural practices and water as a means of treatment. The Zion Christian Church uses water to relieve pain and to protect themselves against the demonic forces.

6.2.6 Educational distribution of respondents

Although there was a wide representative of respondents on all levels of education; of the sample, which is the majority of the respondents 19 (63%) had either lower primary education or never attended school; 9 (30%) had higher primary and secondary education; and only 2 (7%) had high school education.

This finding confirms the literary review, Williams et al (1995), that mothers / caregivers of malnourished children are ill-informed and this is mostly related to poor education. This finding also supports previous studies done in this area that poor education results in poverty and ignorance which contributes towards malnutrition. The researcher observed that the majority of the respondents are very apathetic and ignorant about the general hygiene of their children, and the family in general. Reid (1991), on the other hand, states that ignorance is not necessarily a function of poor formal education.

6.2.7 Occupation of respondents

The majority of the respondents 12 (40%) were housewives; 7 (23,3%) were labourers; 4 (13,3%) were employed as domestic workers; 4 (13,3%) doing other viz. shebeen, subsistence farmers etc.; 2 (6,7%) were attending school and only 1 (3%) was a hawker.

6.2.8

Sources of income of mothersTABLE 6.5

Financial provider	Numbers	%
1. Husband	8	26,7
2. Grandfather	7	23,3
3. Grandmother	4	13,3
4. Brother	3	10,0
5. Sister	1	3,3
6. Self	6	20,0
7. Other	1	3,3
TOTAL	30	100

11 (37%) source of income was from grandparent; 8 (26,7%) was from husbands; 6(20%) was from self; 3 (10%) was from the brother; 1 (3,3%) was from the sister and 1 (3,3%) was from other sources. The findings depict that the majority of the respondents (11) depend on the income of R470 from pension funds which is below the poverty-datum line. This is also affected by the size of the family. Reid (1991) concurs with this study by stating that the size of the family is related to the income of the family. He further states that in a study in in Bonteheuwel in Cape Town, families with an income of R21 per week or less had signs of malnutrition.

Amount of income

TABLE 6.6

Income in Rands	Numbers	%
1. 0 - 100	4	13,3
2. 100 - 200	6	20,0
3. 200 - 300	2	6,7
4. 300 - 400	6	20,0
5. 400 - 500	3	10,0
6. 500 - 600	1	3,3
7. 600 - 700	2	6,7
8. 700 - 800	3	10,0
9. 800 - 900	1	3,3
10. 900 - 1000	1	3,3
TOTAL	30	100

Of the sample, the majority 22 (73%) had an income of less than R500 per month; 6 (20%) had an income of R500 - R800 per month; only 2 (7%) had a higher income of R800 - R1000. This finding concurs with previous studies done in the same field that poverty is one of the socio-economic factors which contributes towards the causes of malnutrition. van Rensburg and Man (1982) further state that poverty is associated with the paucity of funds to provide food and other essentials, as well as a so-called "culture of poverty" which in many ways contributes to the creation of a specific socio-psychic situation frequently resulting in sub-standard living circumstances.

TABLE 6.7

Area category	Numbers	%
1. Urban	5	16,6
2. Semi-urban	3	10,0
3. Rural	10	33,3
4. Semi-rural	3	10,0
5. Remote rural	7	23,3
6. Farms	2	7,0
TOTAL	30	100

Of the sample, 8 (26,6%) were from urban and semi-urban areas; while the majority 20 (67%) were from semi, remote and rural areas; and a small percentage 2 (7%) were from the farms.

Discussion: With regard to the respondents' home areas, majority 20 (67%) were from rural, semi-rural and remote rural areas. This is significant as most rural areas are poverty-stricken and lack resources; only 8 (26.6%) were either from urban or semi-urban areas and only 2 (7%) were from the farms.

Wilson and Ramphela (1989 : 101) state that homeland areas appear to be the worst environments in which to raise children; they further state that community surveys of ambulant pre-school children in the Elim Hospital area of Gazankulu and the Driefontein Tribal Trust area near Piet Retief showed one-third to be underweight. These authors refer to the work of Buch, Nyathi and Ntlemo, who emphasise the high incidence of malnutrition in Mhala area of Gazankulu (formerly "Tsonga" Homeland).

6.3 HEALTH EDUCATION

6.3.1 Help seeking behaviour of mothers when they discovered their children were ill

TABLE 6.8

Help seeking behaviour	Numbers	%
1. Tried traditional medicine	9	30,0
2. Seek local advice	2	7,0
3. Consulted traditional healer	4	13,3
4. Clinic	5	16,6
5. Hospital	5	16,6
6. General practitioner	5	16,6
7. Other specify	-	-
TOTAL	30	100

Of the sample 9 (30%) of the respondents tried traditional medicine; only a small percentage 2 (7%) sought local advice; 4 (13,3%) consulted traditional healers; 15 respondents (16,6%) consulted the Western type of service viz. clinic, hospital and general practitioner.

From the sample it is interesting to note that an equal percentage (50%) reported that they consulted either traditional or Western type of treatment/services. This reported frequency has a bearing on the actual practice as the majority of African still prefer to consult the traditional healer before coming to the hospital.

6.3.2

The person who diagnosed the malnourished childTABLE 6.9

The person who diagnosed	Numbers	%
1. Neighbour	2	7,0
2. Traditional healer	1	3,3
3. Staff nurse	3	10,0
4. Nursing sister	14	47,0
5. Hospital doctor	2	7,0
6. General practitioner	4	13,3
7. Family member	4	13,3
TOTAL	30	100

The majority of the respondents 14 (47%) were given the diagnosis by the nursing sister; 4 (13,3%) were given by the general practitioner; 4 (13,3%) were given by the family; 2 (7%) by a neighbour; 2 (7%) by a hospital doctor and only 1 (3,3%) was given by a traditional healer. The findings show that professionals plays an important role in giving the diagnosis, as almost three-quarters were informed by professionals.

6.3.3 Whether the language used in a Western, clinical setting was appropriate, and whether it was understood

TABLE 6.10

Clarity of Diagnosis	Numbers	%
1. Yes	11	37
2. No	7	23
3. Unsure	12	40
TOTAL	30	100

The majority of the respondents (12) were unsure if the diagnosis was interpreted to them; (7) were not interpreted; and a significant percentage (11) agreed that the diagnosis was interpreted in the language they could understand.

Respondents who answered 'no' and 'unsure' gave the following reasons:

'Child very sick during admission/consultation and all the attention was given to the child.'

'Sister and doctor not talking to the mother during the ward rounds.'

'Nurses very rude and unsympathetic to the mother.'

As over half of the respondents felt that the diagnosis was not interpreted to them in simple language, this result confirms a picture of poor communication and relationship between health professionals and health consumers.

6.3.4 The context in which the diagnosis was given

TABLE 6.11

How diagnosis was given	Numbers	%
1. You were told alone	8	26,7
2. You were told in a group	2	6,7
3. You were told with or without sympathy and support	17	56,7
4. You were told with simple terminology	2	6,7
5. You were told with confusing terminology	1	3,3
6. Other - specify	-	-
TOTAL	30	100

Of the sample 10 (33%) were told with sympathy and support; 7(23%) were told without sympathy and support; 8(27%) were told alone; 2(7%) were told in a group;

2(7%) were told with simple terminology; and 1(3%) with difficult confusing terminology.

Mothers had difficulty in answering this question as it has several answers but after explanation they were able to give answers. The majority of mothers felt that they were told with sympathy and support about the malnourished condition of their children; whereas 23% of the respondents felt they were told without support. 27% of the respondents were told alone; and this has the serious implication on information giving because sometimes mothers may have left the hospital without knowing what was wrong with their children or they were informed casually during discharge.

6.3.5 Whether or not mothers were made to feel comfortable/at ease by the nursing staff

TABLE 6.12

Whether nursing staff made respondents comfortable	Numbers	%
1. Yes	14	47
2. No	8	27
3. A little	4	13
4. Very much	2	7
5. Not at all	2	7
TOTAL	30	100

The majority of the respondents 14 (47%) felt they were made comfortable; 8 (27%) were not comfortable; 3 (10%) were made a little comfortable; 2 (7%) were made very comfortable; and 2 (7%) never made to feel at ease.

Some answers that were given by the respondents who were not made to feel at ease were:

'Most of the nurses are very harsh and do not talk to us well, but others are very good and understanding, it is difficult to say that I was made comfortable.'

'Nurses are always harsh. I was told that I cared for myself but I'm neglecting my child. I need to be arrested.'

'Nursing staff are rude, but Occupational Therapist is taking care of me.'

'I only knew that the child is lacking feed and needs proper food.'

'Nurses are very rude to us, there are some that are good but most are not talking to us nicely.'

'Didn't talk to me well, they were negative and arrogant, because they also suspected sexual abuse.'

6.3.6 Whether mothers at hospital/clinic were able to find out all they wanted to know about their child's condition

TABLE 6.13

Response	Numbers	%
1. Yes	13	40,0
2. No	13	43,3
3. Unsure	5	16,7
TOTAL	30	100

Of the sample 12 (40%) of the respondents got everything they wanted to know about their children; the majority 13 (43,3%) did not get all the necessary information they wanted to know about their children; only 5 (16,7%) were unsure.

Those who answered 'no' or 'unsure' motivated their answer by giving the following reasons:

'Doctors and nurses were busy among themselves, they never gave me a hearing.'

'Even now, I don't know what is wrong with my child.'

'When the doctor comes he only talks to the sister and I was asked how was the child and I told them that she is improving.'

'Now my child is having a lot of diarrhoea and is losing weight, I heard the other sister saying, my child is marasmic, at this stage I'm confused, I don't know what is wrong, blood was also drawn from both of us, I don't know what for.'

These comments from the respondents reveal a poor relationship between the health professionals and a significant number of the health consumers. From my observation working in a hospital, during ward-rounds most of the time doctors and sisters will tend to talk about the patient rather than with the patient, the latter being often consulted for clarity only.

6.3.7 Whether mothers were satisfied with the way in which they were told about the diagnosis

TABLE 6.14

Respondents satisfied	Numbers	%
1. Yes	17	56,6
2. No	5	16,7
3. Unsure	8	26,7
TOTAL	30	100

The majority 17 (56,6%) were satisfied with the way they were told; 5 (16,7%) of the respondents were not satisfied; and 8 (26,7%) of the respondents were unsure.

Those who were not satisfied or 'unsure' gave the following reasons as motivation to their answers:

Shrugged, 'they never told me.'

'I don't know.'

I was told only once, and I was afraid to ask questions because the child was improving.'

'I needed thorough explanation, because this child was never done 'Hlogoana'. I believe that is the cause of the illness, they used Zion Christian Church water which is not powerful. 'I'm not sure what is this Kwashiorkor.'

'The first sister told me with understanding, but others confused me and they don't talk to me but among themselves, it is difficult to ask them because the child is very sick.'

'In the beginning wasn't clear, but after the social worker explained to me about the condition I fully understood.'

'They should have explained to me what is wrong, now the child is OK. I don't even know what is wrong with her.'

All these comments indicate that a significant number of patients were not informed about their conditions / diagnosis and the majority (over 50%) were satisfied with the way they were told. One could speculate that this is the reason why many African patients prefer to consult with the traditional healers because from these healers they tend to get an explanation about their condition and are treated with a better attitude that enhances their self-worth.

6.4 ATTITUDES

6.4.1 How mothers describe the attitude of health professionals who gave them the health education/diagnosis of their child's condition

TABLE 6.15

Professionals' attitudes	Numbers	%
1. Friendly	12	40,0
2. Unfriendly	7	23,3
3. Helpful	1	3,3
4. Encouraging	4	13,3
5. Cold	1	1,3
6. Authoritarian	1	3,3
7. Empathetic	4	13,3
8. Other - specify	-	-
TOTAL	30	100

Of the sample, the majority of the respondents 12 (40%) had a friendly attitude from the health professional; 7 (23,3%) had unfriendly attitude; 4 (13,3%) had an encouraging attitude; 4 (13,3%) had an empathetic attitude; a small group had equal percentage 1 (3,3%) with two negative attitudes which were cold and authoritarian and another one which was helpful.

Results indicate that most mothers experienced a positive attitude from health professionals; and only nine out of thirty experienced a negative attitude.

The findings concur with other previous researches for dual consultation, that is despite the positive attitude from health professionals, the majority of the health consumers will consult with the traditional healer because as already stated they

tend to get an explanation about their condition and are treated with a better attitude that enhances their self-worth.

6.4.2 **Mothers' reactions when they were told about the diagnosis**

TABLE 6.16

Respondents' attitudes	Numbers	%
1. Shocked	4	13
2. Bewildered	3	10
3. Confused	2	7
4. Disappointed	6	20
5. Hopeless	5	17
6. Resentful	-	-
7. Numb	1	3
8. Depressed	1	3
9. Worried	8	27
10. Upset	-	-
11. Other	-	-
TOTAL	30	100

The majority of the respondents 24 (87%) had motivated their reactions regarding the diagnosis, this means that they were able to delineate why they felt the way they reacted, while 4 (13%) have not motivated their reactions. The analysis of the data in Table 16 above, reveals that mothers experienced four principal reactions to their children's diagnosis, viz. shock, disappointment, hopelessness; and worry.

It seems therefore, that the diagnosis of malnutrition is a painful experience for the mothers. Mothers stated several reasons related to their reactions:

'Didn't know what is wrong.'

'Worried because the child nearly died.'

'Disappointed because I thought I'm giving my child the best food and care.'

'Disappointed because I'm giving my child right food and treatment.'

"I'm always very depressed about my circumstances so my child's diagnosis made me more depressed.

6.4.3 Whether mothers had received treatment from a traditional healer for themselves or for their children

TABLE 6.17

Traditional treatment	Numbers	%
1. Yes	18	60
2. No	7	23
3. Unsure	5	17
TOTAL	30	100

The majority of the respondents 18 (60%) had received treatment from a traditional healer; while 7 (23%) had no treatment from traditional healers; and only 5 (17%) were unsure.

This means that the majority of the respondents still prefer to consult the traditional healing as well as Western medical practice and this is confirmed by the literary review (Freeman and Motsei : 1990). In this study the respondents stated that families take the children to the traditional healers, and further, children are taken to the healers for treatment of "Hlogoana". In actual practice patients prefer to consult with the traditional healer first and when the treatment is unsuccessful or the condition is very serious they then go to the clinic, hospital or general practice. According to my observation this is what causes conflict between the health

professionals and patients. The latter came to the hospital when there was already serious damage and very little could be done to save the patient.

6.4.4 Responses received

The following are the answers given by the respondents:

'For "Hlogoana".'

'Its a cultural belief to take the child to a traditional healer.'

'We often go to consult the traditional healer for everything although we use the clinic quite a lot.'

'We took all our children for "thema" but only when there are symptoms.'

'My grandmother took me for treatment to the traditional healer.'

'For "Hlogoana", it is traditional; we often take every baby to the traditional healer to be treated.'

'Epilepsy, I think the traditional healer helped her because she never had the attack again. If she can relapse I take her again.'

'For Hlogoana. It is very important for the child to be treated for it otherwise she will die.'

'For diarrhoea. People advised me to go to the traditional healer, because his neck was very weak falling toward the back.'

'For abscess and Hlogoana. After hospital treatment has failed, I took her to the traditional healer who said we need to "phasa" that is to talk to the ancestors.'

'Child was crying during the night and the traditional healer said he needs a name for the ancestors.'

'All my children are treated for "Hlogoana", and I was treated for "sefulane".'

'Thema because the neck was not firm and was very weak and we knew that it was thema.'

The answers reveal the importance of traditional healers to the Africans. This means that African people do not consult traditional healers only because of accessibility

but also for cultural influence. One speculates that even in future when both services are accessible they would prefer to use both.

6.4.5 Whether their family influenced them to consult the traditional healers

TABLE 6.18

Family influence	Numbers	%
1. Yes	19	63
2. No	4	13
3. Unsure	7	23
TOTAL	30	100

The majority of the respondents 19 (63%) were influenced by their families; 7 (23%) were not sure and 4 (13%) were not influenced by the family.

The findings reveal that families play an important role in the type of treatment members will receive and adhere to. Thus the family is the source of social, economic and emotional support for its members, that is why it has power to influence or pressurise its members.

This finding also concurs with Waxler-Morrison et al (1990) who state that the extended family plays an important part in the decision-making about help seeking and illness management. Usually there is a deep respect for elders and their advice about matters relating to health does not go unheeded. They further stated that it is not uncommon for grandparents, usually the grandmother, to introduce traditional remedies at the same time as Western medicines are being used.

Respondents who were influenced by the family gave the following reasons:

'Parent belief in traditional medicine.'

'Grew up in the community where every newly born baby needs to be treated for "Hlogoana".'

'Family consult traditional healer for everything.'

'Mother was an "inyanga".'

'One of the family members is the traditional healer and usually helps the family.'

6.4.6 Whether mothers felt that health professionals also considered traditional medicine

TABLE 6.19

Perceptions	Numbers	%
1. Yes	11	37
2. No	14	47
3. Unsure	5	16
TOTAL	30	100

Of the sample 11 (37%) of the respondents felt that their belief system were considered by the health professionals; while the majority 14 (47%) felt their belief systems were not considered and 5 (16%) answered 'unsure'.

The majority of the respondents 19 (63%) felt their belief system and practice of traditional medicine were not taken into consideration.

6.5 PSYCHO-SOCIAL NEEDS

6.5.1 Problems mothers experienced with malnourished children

The respondents did not have an isolated problem; but the majority had multi-problems. Respondents had problems in the following areas viz. food, finance and transport. Thus, the majority 18 (60%) had both financial and food problems; 4 (13%) had transport problems; 3 (10%) had support, education and resource problems; 5 (17%) had hospital and other unspecified problems.

This finding depicts the most common problems experienced by mothers with malnourished children which are food, finance and transport. The literary review (Dasen et al : 1988) indicates some of these problems / needs as the characteristics found in families with a malnourished child both at the macro and micro environmental level, that is, the community / society and family levels.

6.5.2 Problem behaviour of malnourished children

Respondents experienced three problems associated with malnourishment, namely withdrawal behaviour, irritability and an unfriendly attitude. It should be noted that most problems are related to social adjustment.

The majority of the respondents 16 (53%) experienced irritability in their children; 8 (27%) experienced withdrawal behaviour. Only an insignificant number 6 (20%) had experienced unfriendly attitudes in their children.

6.5.3

**Whether mothers knew that a social worker was
available in the hospital**

TABLE 6.21

Knowledge of social worker	Numbers	%
1. Yes	3	10
2. No	27	90
3. Unsure	-	-
TOTAL	30	100

The majority 17 (90%) of the respondents did not know about the presence of a hospital social worker where their children were admitted; only an insignificant percentage 3 (10%) knew about the hospital social worker. The findings in the above table depicts a lack of knowledge of services rendered by a social worker for families with malnourished children. This is because of the fact that most health care services are still run on a biomedical model. Furthermore, in rural areas where this research is done most social workers are not directly involved with the patient's care. They provide welfare services that are not related to treatment. Those who are attached to hospitals only deal with financial discharge problems and destitute patients.

It is important to note that social workers mostly attend to referrals during discharge which pertains to material and transport assistance.

6.5.4 How mothers got to know about the social worker

Three said 'yes' (10%) and responded that they knew about the social worker through other people, who had social problems and social workers helped them in the hospital.

6.5.5 Mothers' perceptions of the role of the social worker

Although respondents were advised regarding the services of most professionals in the hospital and in particular the social worker as they have encountered her during the administering of the schedule they did not know the role of the social worker in the hospital. 14 (47%) never attempted to give an answer, and 16 (53%) although they attempted to answer they saw her role as not related to their children or clinical treatment, thus, they saw the hospital social worker's role as the following:

'Helping with family problems.'

'Helping with maintenance / support grants.'

'Providing material needs and poor relief.'

'Help to find a job.'

'Social worker should assist all the needy people with everything.'

6.5.6 Mothers' opinions concerning the role the social worker could play in the treatment of the malnourished child

The majority of the respondents 17 (57%) had no idea of how the hospital social worker can assist them with the problems of their children; while 13 (43%) gave their opinions. It should be noted that a significant percentage of 7 (23%) out of (43%) still view the social worker's role as providing material assistance; and 6 (20%) see her role as dealing with emotional needs.

This finding shows that respondents had no idea about the role of the social worker with malnourished children and also in general about her role in the hospital.

Furthermore the findings show lack of education and information given by hospital staff regarding the role of the social worker in the hospital and also lack of promotion by social workers of their own services.

6.5.7 Whether mothers were told or advised about psycho-affective stimulation “Bo hlokwa bja go hlaletša ngwana”

TABLE 6.22

Knowledge of psycho-affective stimulation	Numbers	%
1. Yes	10	33
2. No	18	60
3. Unsure	2	7
TOTAL	30	100

Of the sample, the majority 18 (60%) were not advised; 2 (7%) were unsure, and 10 (33%) were advised.

The table above depicts a lack of education around the importance of psycho-affective stimulation for mothers with malnourished children. In this question the researcher tried to explain psycho-affective-stimulation - “Hlaletšo ya ngwana” but still mothers stated that they are sometimes tired or they don’t have the time to do so.

6.5.8 Whether mothers believed that stimulation could help towards the speedy recovery of their children

All the respondents who were advised 10 (33%), gave the following reasons as to how stimulation can help the speedy recovery of their children:

'Yes, because my child will feel loved and happy and will be able to play.'

'Happiness in the family also helps a child to be happy who will be willing to play with others.'

'My child will no longer be irritated and will eat properly and will be healthy.'

6.5.9 The kinds of services mothers believe will help them in their care of malnourished children

Initially, respondents could not suggest any preferred service for their malnourished children and themselves, but after thorough explanation, the majority 15 (50%) recommended the following services: parent-child relationship, health education, mothers support group; and positive attitude of professionals towards the mothers with malnourished children; 9 (30%) recommended services regarding material assistance; and 6 (20%) did not have any recommendations regarding services to be established.

CHAPTER SEVEN

DISCUSSION OF THE FINDINGS

7.1 INTRODUCTION

In this chapter an attempt will be made to link and discuss both the findings from the professionals as well as those from the mothers. In this study an attempt was made to investigate the attitudes of both health professionals and mothers regarding the cultural issues and value systems around the treatment of hospitalized malnourished children. Further, it attempted to explore the role of health education for mothers and also if there is a need to incorporate the traditional together with the Western treatments.

Finally, the study explores the need to include psycho-affective stimulation in the treatment of malnourished children, if there is a need, and who should provide it.

Although there were some limitations in the research, the results appear to be remarkably similar to the findings of the previous and similar research in the same field (Freeman and Motsei: 1990; and Tabane: 1995).

This study also highlighted certain important issues.

7.2 HEALTH EDUCATION:

7.2.1 It is significant to note that most of the respondents felt that health education is a pivotal issue for the mothers with malnourished children. Although a proportion of the professional respondents had mixed feelings regarding this statement, this was an insignificant percentage.

The World Health Organization (1981) states that information is a first step and a necessary one for education. It further states that the purpose of education is to bring about change and changes will only take place when people have been through a process of applying information to their own situation in a way that creates understanding and motivates action.

It is the researcher's contention that the respondents' mixed feelings regarding health education were related to their low morale due to unhealthy working conditions which left professionals apathetic and irritable. Webb (1994) concurs by stating that barriers to patient education include the fact that many doctors, nurses, and others are traditionally ill-prepared to teach or what they do teach is poorly understood and no checks or evaluations are built into the patient education programs. The professionals rather just assume that all is well. Webb (1994) further states that professionals need an assessment of the existing knowledge, attitudes and motivation of the health consumers/mothers to be able to change behaviour. This assessment must be undertaken before teaching can begin.

Werner and Bower (1982:5-1) concur with Webb (1994) by stating that in planning health education professionals should use an open-ended approach in which the experience of the students have value. They said that importance should be given not only to the subject but also to the less clearly defined learning that happens along the way, which includes:

- experimenting with new teaching methods
- showing quick learners ways to assist those who learn more slowly.
- observing and respecting each other's traditions and beliefs, strengths and uncertainties.

The majority of the mother respondents (21) show a positive attitude towards health education. These results indicate that generally speaking, mothers felt comfortable about the health education.

7.2.2 Diagnosis and its interpretation

It is significant to note that professionals, especially nurses, played an important role in giving a diagnosis to the mothers. Mothers felt that they also received diagnoses from family members, neighbours and from traditional healers.

The findings concur with previous studies that family members also play an important role in the diagnosis of their members. Waxler-Morrison et al (1990) state that the extended family plays an important part in decision-making about help-seeking and illness management. Among Africans there is usually a deep respect for elders and their advice about matters relating to health that does not go unheeded.

The researcher observed that most mothers depend upon either a neighbour or relative to advise them about coming to the hospital.

Although the majority of the mother respondents received their diagnosis from health professionals it is interesting to note that a significant percentage (63%) responded that they were either unsure or never had an interpretation about the diagnosis. Only 11 (37%) of the respondents felt that the diagnosis was interpreted in a language they could understand.

The researcher's findings confirm that there is poor communication between health professionals and the mothers at the hospital. On the one hand both health professionals and mothers more or less share the same culture but the health professionals are unable to speak simply and in a culturally sensitive manner. The researcher postulates that this might be a contributory reason for non-compliance for the health consumers. Webb (1994) concurs by stating that the inability to speak the same language inevitably leads to much greater difficulties. Health beliefs and reasons for health action are even more difficult to explore across a linguistic divide. She further states that health personnel should ensure that information is language, culture

and age appropriate. While collecting data the researcher asked the mothers about their children to find out if they knew what was wrong with them and the majority responded that they did not know. This is evidence of poor communication between the professionals and patients in general.

The majority of the mothers responded that the diagnosis was given to them without sympathy, support and with confusing terminology, and a significant number were told alone. The researcher believes that this dogmatic approach by health workers created a lot of resistance to change and that mothers felt relatively powerless. Werner and Bower (1982) concur by stating that this kind of education is called authoritarian, because its purpose is to strengthen the authority of those in control. It is education designed to keep things as they are - education that resists change.

7.2.3 Mother's own diagnosis of "Hlogoana" or "Thema" and diagnosis from a traditional healer

All professional respondents stated that they were aware of the diagnosis from a traditional healer. This corresponds with the recent study done by Ledwaba (1994), at Ga-Rankuwa hospital, whereby out of 40 mothers interviewed in the paediatric ward, 55% of them were found to have taken their children to traditional healers before bringing them to hospital.

The researcher, in her hospital practice, learned from patients that they strongly believed that there were other illnesses related to witchcraft which health professionals would be unable to treat, e.g. complicated diabetes, cancer and epilepsy. This is due to the sudden onset of symptoms and sometimes fast deterioration of the condition and above all, lack of a cure for an advanced state of these conditions. The researcher postulates that this is the reason why health consumers prefer to combine traditional and Western treatment.

Professionals all commented that most Africans consult with the traditional healers before coming to the hospital to sort out witchcraft problems or disease that is caused by the evil spirits of ancestors.

Pretorius (1991) confirms the above by stating that liaison between traditional healers and modern doctors could improve health care knowledge and benefit everyone, particularly with regard to the inherent possibility of extended and more efficient population coverage.

Galanti (1991) concurs by stating that, ideally, if medical professionals everywhere would recognize the value of what other systems have to offer, they can then take the best of each and reach the ultimate goal of providing effective health for all.

Regarding the percentage of the mothers who came to hospital with their own diagnosis, the majority of the health respondents (9) had the highest percentage of between (40-60) of the mothers who brought their own diagnosis. The findings confirm previous studies that traditional healers were still consulted by a large number of South Africans (Freeman and Motsei, 1990).

The majority of health professionals (69%) acknowledged that they also experienced mothers bringing their own diagnosis of "Hlogoana" or "Thema" to the hospital. These findings confirm earlier research by Kreps and Kunimoto (1994) that health care consumers and providers could approach health care situations with their own unique communication characteristics, health beliefs, and customs based on their personal background which could dramatically influence their health needs and the health behaviour they chose to engage in.

Spector (1985) also supports the finding by stating that each of us enters the health care community with our own culturally based concept of health and during the

educational and socialisation process in our profession, nursing, medicine or social work, we are expected to shed these beliefs and adopt the standard definitions.

The researcher who shared the same cultural value systems with the mothers, knew that it was common practice among Africans to treat newly born babies for "Hlogoana" using traditional medicine and usually with the consultation and prescription of the traditional healer. According to the researcher's observation most mothers/patients attend hospital after they have consulted with traditional healer who advises them on whether to attend hospital or not. The professionals' responses support Tabane's (1995) study who found that in the hospital where she worked it was common practice for patients not to follow-up on their treatment because they had gone to visit traditional healers in a rural area.

The purpose of this finding was that there was a conflict of diagnosis between health professionals and health consumers and that this was most likely due to lack of cultural sensitivity by the professionals. Helman (1994) reflects this conflict by stating that in health care settings there are usually two cultures that interact and are most often in conflict with each other.

7.3 ATTITUDES

7.3.1 Attitudes of the professionals regarding mothers' consultations with traditional healers and the inclusion of traditional healers in the treatment of malnourished children

While professionals were aware of the fact that mothers came to the hospital with their own diagnosis, a substantial percentage of the health respondents (9) agreed with the statement that health professionals often reprimanded the mothers for having consulted traditional healers or for using traditional medicine. These findings reveal a negative attitude on the part of health professionals towards the cultural belief systems of the

mothers with malnourished children. The researcher concludes that the authoritarian attitude of the health care workers creates conflict and poor compliance by the health consumers.

In the hospital where the researcher was doing this study, mothers were strongly reprimanded to an extent that they never wanted to tell the truth about their consultation with traditional healers. For example, a mother might bring a child to the hospital with severe herbal intoxication which sometimes warranted intensive care nursing and when asked about what the patient was given most of the time mothers refused to tell the truth. Unless professionals become receptive to their patients' cultural belief systems and values, there will always be a poor practitioner-patient relationship and ineffective treatment. Gaines (1992) states that a healthy, communicative relationship with a patient was sought by psycho-therapists as well as spiritualists. Both recognize the vital importance of a good relationship as a basis upon which rests trust, and subsequently effective treatment.

Inclusion of the traditional healers in the treatment process of malnourished children was strongly supported by a high percentage (61%) of the professionals. Respondents argued their points by stating that the inclusion would help to strengthen or build the multidisciplinary health team, and that traditional healers would be taught about disease and treatment of the malnourished condition.

This corresponds to the study carried out by De Villiers (1991), who investigated beliefs and behaviours in transcultural health amongst Xhosa-speaking patients in the Eastern Cape. He found that modern doctors were only consulted for symptomatic relief, before going to a traditional healer. Tabane (1995) in her Red Cross War Memorial Children's Hospital research in the dehydration ward, revealed that a number of children had been referred to the hospital by the traditional healer.

The researcher also found that in the hospital where she worked and where the study was being conducted, mothers of malnourished children stated that they had been using traditional medicine, and that they had consulted with the traditional healer before coming to the hospital. Pretorius (1991) says that liaison between traditional healers and modern doctors could improve health care knowledge and benefit everyone.

van Rensburg, et al (1992) agreed by stating that all indications were that traditional medicine would remain acceptable to its clientele because as an open system it was particularly flexible and continually able to incorporate new elements. A minority of respondents (23%) did not support the inclusion of the traditional healers in treatment of malnourished children, and only 15% of the respondents were unsure. Those who disagreed felt that traditional medicine was very dangerous to the physical health of the patients. Furthermore because there was no scientific proof of the effectiveness of their medicine, there was no way that they could be incorporated into Western health care services.

Pretorius (1991) says that the linking of Western medicine with African beliefs could also be plagued by issues such as the different views held by traditional healers and doctors regarding the aetiology of illness, treatment methods, religious principles, morbidity and mortality.

7.3.2 Attitudes of mothers towards health professionals regarding treatment of their malnourished children

It is significant that the majority of mothers have a positive attitude towards the health professional who gave the health education or diagnosis. Only (9) of the respondents had a negative attitude. Although mothers experienced a positive attitude towards the health professional who gave the diagnosis, they nevertheless reacted with shock, worry, disappointment and helplessness to the diagnosis. (Section 6.4 : 75).

It seems therefore that with regard to treatment from a traditional healer, the majority of the mothers (8) had consulted a healer for the following reasons.

- "Hlogoana" and "Thema".
- child crying during the night
- family often consult the traditional healer for everything.

The majority of the mothers (63%) felt that health professionals were not happy about their belief systems and their consultation with the traditional healer.

These findings reveal the discomfort of both professionals and mothers regarding the African cultural belief system. The researcher concludes that this may be a major reason for poor compliance on the part of health consumers.

Drower in McKendrick (1991) says that health care in South Africa is characterized by a professional scientific approach to disease and service provision. She further says that, existing alongside this approach, is a system of traditional medicine which enjoys support both in rural and urban areas.

Williams et al (1985) state that the lack of cultural awareness of health workers has been related to the fact that social anthropology and other behavioural sciences have until recently been unappreciated, even unrecognized as aspects of medical training.

7.4 PSYCHO-SOCIAL NEEDS OF THE MALNOURISHED CHILD

There was consensus between the health professionals and mothers with regard to the psycho-social needs. Mothers state that they do not only experience feeding problems with their children, but also experience other problems such as lack of finance, transport, resources, and poor support. Their malnourished children present with behaviour problems such as irritation and withdrawal.

These findings concur with the literary review which showed that malnutrition is the end result of poverty, ignorance, maternal deprivation and other related problems. Dasen et al (1988) concur by stating that it had been widely recognized that malnutrition was always part and parcel of an eco-socio-cultural system that included other adverse environmental conditions such as poverty, poor housing, poor sanitation, repeated exposure to infectious and parasitic diseases, inadequate health care, poor feeding and inadequate child practices.

van Rensburg and Mans (1982) regard disrupted family life as most frequently encountered among migrant labourers, which gives rise to extra-marital relationships. This results in poor child care or child neglect in an environment without proper marital, familial and domestic ties or adequate financial provision.

It seems therefore that services for malnourished children and mothers will require a comprehensive and intersectoral approach.

7.5 PSYCHO-AFFECTIVE STIMULATION AND ITS EFFECT ON TREATMENT

While the majority of the professionals regard psycho-affective stimulation as an important aspect of treatment, mothers did not appear to be aware of it. They also did not understand the concept, but after this was explained to them (33%) agreed that stimulation could help towards the speedy recovery of their children because it would also make them happy, lovable and able to play. King and Burgess (1993 : 241) concur by stating that when a child begins to recover, he/she needs mental stimulation with games, toys, and stories appropriate to his/her age and home background. Health workers should help families to find ways to play with and talk to their children to stimulate them.

Fernando (1991) concurs with these findings by stating that a treatment program would lack meaning if aimed only at the child's physical recovery. He further states that an

important factor which has not received enough consideration to date in the treatment of severely malnourished children was the effect of psycho-affective stimulation, Fernando (1991 : 342). He further states that recent observations made it clear that adverse emotional factors delay the recovery of severely malnourished children (p. 342).

The researcher also observed that most children who were admitted to hospital took longer periods to be healed even if they received good nutrition and most often re-admissions with the same condition were very common. It was also observed that caregivers were suffering from bouts of lethargy and depression and as a result, they could not stimulate their children.

According to the researcher's anecdotal observation, psycho-affective stimulation is pivotal to the treatment of malnourished children and this is also backed up by research. Fernando (1991) concurs by stating that in their experience, when a carefully planned programme of psychomotor and affective stimulation was implemented in addition to nutritional support, recovery was significantly accelerated.

Most professional respondents regarded the need to include psycho-affective stimulation in the treatment plan as very significant as they agreed that stimulation played an important role in the speedy recovery of infants.

Respondents supported their argument by giving the following statements that:-

"...stimulation will facilitate a speedy recovery"

"holistic approach facilitates a speedy recovery"

"the mother will feel accepted in the treatment of her own child and will participate actively. She will continue with this programme at home".

This corresponds with the research of Fernando (1991), who investigated the effects of psycho-affective stimulation on malnourished children in Canada and observed that adverse emotional factors delay the recovery of severely malnourished children. The researcher observed that often mothers or caregivers who were very lethargic, depressed and neglected could to an extent be mistaken as patients. It was further observed that even if they are relaxing or breast-feeding they cannot smile or keep eye-contact with their children. Instead these mothers prefer to leave the children in their beds and roam about the hospital premises to satisfy their own needs.

Of the sample only one of the respondents strongly disagreed that psycho-affective stimulation had an effect on treatment, and one was unsure.

The results concur with the previous studies that psycho-social stimulation is not only necessary but very important in the treatment of malnourished children. Bowlby (1953) states that human attachment is seen as an instinctive response to the need for protection against predators and one as important for survival as nutrition and reproduction. Thus, for proper emotional and physical nourishment, the child needs cuddling and playing, the intimacies of suckling by which he learns the comfort of his mother's body, the rituals of washing and dressing by which through her pride and tenderness towards his little limbs he learns the value of his own.

The professional respondents ten considered nurses in general; occupational therapists and community health workers as the main people to provide training to the mothers. It is interesting to note that in this study the clinical social worker was not regarded by most of the respondents as the person to provide training for psycho-affective stimulation. The findings reveal the lack of involvement by the social worker in the treatment of malnourished children.

With regard to mothers, (27) had no idea about the role of the social worker in the hospital, and they also did not know how she could help in the treatment process of

their malnourished children. The majority of the respondents (16) saw the role of the social worker as that of providing material needs, finding a job, helping with family problems. This finding depicts the lack of involvement by the social worker in primary health care in general as a preventative method for service delivery.

7.6 **SUGGESTED SERVICES FOR MOTHERS WITH MALNOURISHED CHILDREN**

Respondents (Mothers) could not suggest any preferred service for their malnourished children because of lack of knowledge and poor services but after the researcher had explained, the majority (15) recommended parent-child relationships, health education, Mother's support groups and a positive attitude of the professionals towards the Mothers. Whereas (9) recommended material assistance; and (6) of the respondents never gave any comment.

This finding supports other studies done in the same field that ignorance and poverty play an important part in the manifestation of malnutrition.

This researcher postulates that, while education in health care settings is being offered it is not carefully planned to meet the different needs of health care consumers. Northouse and Northouse (1985) concur by stating that health professionals should explore the patient's perspective about the nature of help and need.

7.7 **WHAT PROFESSIONALS SHOULD DO TO IMPROVE THE PARTICIPATION OF MOTHERS IN THE HEALTH EDUCATION PROGRAMME**

The majority of the health professionals (11) responded to this question by giving the following reasons to their answers:

- "Friendly attitude of Nurses".
- "Community participation and positive attitude of the professionals".

- “Unconditional acceptance of mother and baby, treat her as a unique human being with her own needs”.

The findings show that there is indeed a lack of mothers participating in health education programmes due to negative attitudes and unfriendliness of health professionals. This finding is supported by Spector (1985) who stated that as students (professionals) become more and more knowledgeable they usually move farther and farther from the population at large in terms of its understanding and beliefs regarding health and illness and this discourages the mothers from feeling understood and reassured.

CHAPTER EIGHT

SUMMARY OF THE FINDINGS; CONCLUSIONS AND RECOMMENDATIONS

8.1 This study investigates the impact of socio-cultural issues on the treatment of hospitalised malnourished children.

The research indicates that most of the African health consumers still prefer to consult their traditional healers and folk remedies before coming to the hospital. It also reveals the influence of the family on consultation with the traditional healers in particular with the illnesses that are amenable to diagnosis within the traditional healers frame of reference. It further indicates that both health professionals and mothers realise the importance of including cultural belief systems in health care programmes to encourage optimum participation and full understanding of the mothers with malnourished children.

Most of the respondents in the interview schedule feel that professionals have a negative attitude towards their cultural belief systems and that their value systems are not respected.

The study also indicates that although professionals have negative attitudes, they also support the need to include traditional healers in the treatment programme and this finding concurs with previous studies which suggest that traditional healers should be linked to modern health settings (Odebiyi, 1990; Freeman and Motsei, 1991; and Tabane, 1995).

The literature reviewed widely acknowledges the impact of the cultural value systems in treatment of illnesses and the need to include traditional healers in the treatment model in hospital. The study itself indicates that there is a negative attitude from professionals regarding traditional healing and its value system and

that professionals are acutely aware of the consultation of consumers with traditional healers. The study itself illustrates further that there is a lack of psycho-affective stimulation for malnourished children, and a lack of social services assisting these children. The respondents are not aware of the potential role of the social workers and what their services can provide for malnourished children.

The health professionals interviewed regard stimulation as important and see the health workers as the main people to offer the programme to the mothers. It is interesting to note that the social worker is not considered as having a role to play in this regard.

8.2 CONCLUSIONS

- The findings of the study indicate the need to view the malnourished condition from a much more holistic point of view than merely that of the protein deficiency of the child. Malnutrition has physical, emotional, psycho-social, functional and environmental concomitants, not only for the child, but for his parents and family as well.
- The study also indicates a need for Health Services to include/and consider the role of traditional healers in the treatment plan of malnourished children.
- While it seems that nutritional food is the basis for treatment, it is important to include the psycho-affective stimulation as part of the treatment for malnourished children. It has been found in this study that cultural influences and belief systems play an important role in the treatment of the children.
- Health professionals should learn to accommodate the patient's viewpoint regarding treatment to enhance appropriate and mutual care.
- Health professionals need to acknowledge and take cognisance of the values and cultural value systems of the health consumers to facilitate co-operation and participation in health education programmes.
- Health professionals require training in a culturally sensitive application of their treatment model.
- Ward rounds could benefit from the presence of a Sangoma or an anthropologist.

- The role of the social worker in the treatment of malnourished children needs to be strengthened, to assist in counselling, provide information and in the training of mothers for psycho-affective stimulation. Mothers of malnourished children require knowledge about poverty and its consequences. They also need guidance and support to adjust to their children not only for their own social and emotional well-being but also for the healthy development and adjustment of the child.
- Mothers seem to require more information in the areas of the nature of the malnourished condition, types of food, psycho-affective stimulation and the role of the social worker who will deal with their emotional problems.

8.3 RECOMMENDATIONS

Having come to the above conclusions based on the findings, the researcher makes the following recommendations:

- Health professionals need to take responsibility to learn and acquaint themselves with the cultural value system of the patients through in-service training and workshops with the traditional healers and the community leaders.
- Culturally sensitive curricula should be established to develop resources and educational programmes which will assist the hospital staff in meeting the needs of its culturally diverse communities.
- The use of traditional healers in the treatment of hospitalised malnourished children be considered by the health officials.
- Primary health care within a multi-disciplinary approach needs serious attention in addressing the causes of malnutrition.

- Social workers in health care need consultative meetings and good working relationships with community developers at the grass-roots level in order that the problem of poverty can be fully addressed and alleviated.
- Health education programmes for malnourished children should accommodate the needs of the mothers and the communities at large which they serve.
- Social work training and orientation in a health care setting should include cultural issues which are essential in equipping clinical social workers with the knowledge to meet the cultural needs of both health professionals and patients.
- Psycho-affective stimulation programmes should be given a priority in the treatment plan of malnourished children so that they can have a speedy recovery.
- In conclusion, it is recommended that a larger study of this nature be carried out in order to yield findings which could be generalised to the wider South African situation.

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CONFIDENTIAL QUESTIONNAIRE

Dear Colleague

Enclosed please find a confidential questionnaire.

I am a registered Social Worker completing my post-graduate specialized training in Clinical social Work (M Soc Sc) at the University of Cape Town. Part of the requirement for academic studies is the completion of a dissertation.

The enclosed questionnaire forms part of an empirical study which I am undertaking under the supervision of the clinical staff of the School of Social Work. The aim of my research is to explore the effects of cultural issues on the treatment of the hospitalized malnourished children. It is also aimed to establish the need to include traditional medicine to the hospital treatment.

The questionnaire is directed at all health professionals working with malnourished children.

Your response will be completely confidential and the manner in which the information will be integrated into the thesis will be greatly valued and appreciated. Kindly return the questionnaire to the head of the paediatric (medical) ward.

If there should be any queries feel free to contact me at (015) 297-3163 ext 305 during office hours or (015) 296-3133 after hours.

Yours sincerely

.....
Mmabotsha Motswaledi

QUESTIONNAIRE FOR PROFESSIONALS

SECTION ONE :

Please tick the appropriate square

- | | | | |
|----|-----------------------|--------------------------|--------------------------|
| 1. | <u>Age in years</u> : | 20 - 29 | <input type="checkbox"/> |
| | | 30 - 39 | <input type="checkbox"/> |
| | | 40 - 49 | <input type="checkbox"/> |
| | | 50 - 59 | <input type="checkbox"/> |
| | | 60 - over | <input type="checkbox"/> |
| | | | |
| 2. | <u>Gender</u> : | Male | <input type="checkbox"/> |
| | | Female | <input type="checkbox"/> |
| | | | |
| 3. | <u>Religion</u> : | Zion Christian Church | <input type="checkbox"/> |
| | | Roman Catholic | <input type="checkbox"/> |
| | | Lutheran Church | <input type="checkbox"/> |
| | | Dutch Reformed | <input type="checkbox"/> |
| | | Christian Church | <input type="checkbox"/> |
| | | Apostolic Church | <input type="checkbox"/> |
| | | Anglican Church | <input type="checkbox"/> |
| | | Not attending any church | <input type="checkbox"/> |
| | | Other | <input type="checkbox"/> |

4. Educational Qualifications :

- | | |
|------------------------|--------------------------|
| Doctor | <input type="checkbox"/> |
| Matron | <input type="checkbox"/> |
| Professional Nurse | <input type="checkbox"/> |
| Staff Nurse | <input type="checkbox"/> |
| Enrolled Nurse | <input type="checkbox"/> |
| Social Worker | <input type="checkbox"/> |
| Physiotherapist | <input type="checkbox"/> |
| Occupational Therapist | <input type="checkbox"/> |
| Other | <input type="checkbox"/> |

5. Years in the professional field :

- | | |
|---------------|--------------------------|
| 0 - 4 years | <input type="checkbox"/> |
| 5 - 9 years | <input type="checkbox"/> |
| 10 - 14 years | <input type="checkbox"/> |
| 15 - 19 years | <input type="checkbox"/> |
| 20 - 24 years | <input type="checkbox"/> |
| 25 - 29 years | <input type="checkbox"/> |
| 30 and over | <input type="checkbox"/> |

SECTION TWO :

Please indicate your response by ticking the appropriate square. In addition please comment on your response.

6. Health education to mothers with malnourished children sometimes is a waste of time because mothers never listen.

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

7. Mothers with malnourished children often come to the hospital with their own diagnosis of 'Hlogwana' or Thema'.

Strongly agree

Agree

Unsure

Strongly disagree

Disagree

Please comment on your response :

.....

.....

8. If you had the experience of mothers coming with their own diagnosis, what percentage applies in your malnourished cases?

0 - 19%

20 - 39%

40% - 59%

60% - 79%

80% - 100%

9. Are you aware in your situation of any diagnosis made by a lay or traditional healer?

Yes

No

10. Health education should include the cultural beliefs and values of the mothers to make it more comprehensive.

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

11. Most health professionals are not culturally sensitive to the values and belief systems of the mothers with malnourished children.

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

12. There is a tendency of health providers to impose their professional values on the mothers with malnourished children.

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

13. What do you consider to be the appropriate time to give health education to the mother with a malnourished child?

On admission

When child is fully hydrated

On discharge

Please comment on your response :

.....

.....

14. Mothers are often reprimanded by health professionals for having consulted or used traditional healers/medicine.

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

15. Traditional healers should be included in the treatment of malnourished children.

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

SECTION THREE :

16. The psycho-social needs of a malnourished child are the same as any other child.

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

17. Lack of psycho-affective stimulation of malnourished children by their mothers prolongs hospital treatment.

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

18. In your opinion can medical treatment be combined with psycho-affective stimulation to facilitate a speedy recovery of a malnourished child?

Strongly agree

Agree

Unsure

Disagree

Strongly disagree

Please comment on your response :

.....

.....

19. Who should educate and train caregivers/mothers as to how to provide for their malnourished children with psycho-affective stimulation at home?

Please comment on your response :

.....

.....

20. In your opinion what do you think will help mothers with malnourished children to feel free to participate in health education programmes?

Please comment on your response :

.....

.....

STRUCTURED INTERVIEW SCHEDULE FOR MOTHERS WITH MALNOURISHED CHILDREN

1. IDENTIFYING DATA

1.1 Name of Respondent :

1.2 Age :

1.3 Gender :

1.4 Number of children in the family, in chronological order in the space provided below (Please circle the malnourished child).

	SIBLINGS	AGE	SEX
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
Total			

1.5 Marital status (Please mark with an X) :

1	Married in civil law	
2	Divorced	
3	Separated	
4	Single	
5	Customary marriage	
6	Cohabiting	
7	Never married	
8	Marriage by the family	
9	Other - specify	

1.6 Religious aspect (Please mark with an X) :

1	Roman Catholic	
2	Anglican Church	
3	Lutheran Church	
4	Dutch Reformed	
5	Zion Christian Church	
6	Christian Church	
7	Apostolic Church	
8	Presbyterian Church	
9	Not attending	
10	Other - specify	

1.7 What is your highest level of education (Please mark with an X) :

1	Never attended school	
2	Sub A	
3	Sub B	
4	Std 1 - 2	
5	Std 3	
6	Std 4	
7	Std 5	
8	Std 6	
9	Std 7	
10	Std 8	
11	Std 9	
12	Std 10	

1.8 Occupation (Please mark with an X) :

1	Housewife	
2	Scholar	
3	Domestic Worker	
4	Hawker	
5	Labourer	
6	Other	

1.9 Who is the source of income? (Please mark with an X) :

1	Husband	
2	Grandfather	
3	Grandmother	
4	Brother	
5	Sister	
6	Self	
7	Other - specify	

1.10 How much is the source of income? (Please mark with an X) :

1	R 0 - R 99	
2	R100 - R199	
3	R200 - R299	
4	R300 - R399	
5	R400 - R499	
6	R500 - R599	
7	R600 - R699	
8	R700 - R799	
9	R800 - R899	
10	R900 - R1000	
11	over	

1.11 What area do you live in? (Please mark with an X) :

1	Urban	
2	Semi-urban	
3	Rural	
4	Semi-rural	
5	Remote rural	
6	Farm	

2. HEALTH EDUCATION

2.1 When did you first realise that there was something wrong with your child, where did you first seek help?

1	Tried traditional medicine	
2	Seek local advice	
3	Consulted Traditional Leader	
4	Clinic	
5	Hospital	
6	General Practitioner	
7	Other - specify	

2.2 Who gave you the diagnosis that your child suffered from malnutrition? (Please mark with an X) :

1	Neighbour	
2	Traditional Healer	
3	Staff Nurse	
4	Nursing Sister	
5	Hospital Doctor	
6	General Practitioner	
7	Family Member	
8	Other - specify	

2.3 If the diagnosis was given in hospital, clinic or surgery, was it interpreted in the language that you understand? (Please mark with an X) :

- 1 Yes
- 2 No
- 3 Unsure

2.4 How were you told about the malnourished condition of your child? (Please mark with an X the one which is most applicable to you) :

1	You were told alone	
2	You were told in a group	
3	You were told with sympathy and support	
4	You were told without sympathy and support	
5	You were told with simple terminology	
6	You were told with difficult confusing terminology	
7	Other - specify	

2.5 Were you made to feel comfortable / at ease by the nursing staff? (Please mark with an X) :

1	Yes	
2	No	
3	A little	
4	Very much so	
5	Not at all	

Please motivate your answer :

.....

2.6 When in hospital / clinic were you able to find out all you wanted to know about your child's condition? (Please mark with an X) :

- 1 Yes
- 2 No
- 3 Unsure

2.7 If **NO** or **UNSURE** what could have been done differently? Motivate your answer.

.....

.....

3. **ATTITUDES OF THE HEALTH PROFESSIONAL DURING YOUR VISIT TO HOSPITAL / CLINIC**

3.1 How would you best describe the attitude of a health professional who gave you the health education/diagnosis of your child's condition? (Please mark with an X the one that is most applicable to you) :

1	Friendly	
2	Unfriendly	
3	Helpful	
4	Encouraging	
5	Cold	
6	Authoritarian	
7	Empathetic	
8	Other - specify	

3.2 What was your reaction when you were told about the diagnosis of your child? (Please mark with an X all that apply to you) :

1	Shocked	
2	Bewildered	
3	Confused	
4	Disappointed	
5	Hopeless	
6	Resentful	
7	Numb	
8	Depressed	
9	Worried	
10	Upset	
11	Other - specify	

Please motivate your answer :

.....

3.3 Most Africans like to go to the traditional healers for help as well as coming to see the doctor. Did you feel that your belief system and practice of traditional medicine were taken into consideration by the health professionals?

1	Yes	
2	No	
3	Unsure	
4	Other - specify	

Please motivate your answer :

.....

3.4 Sometimes the doctors and other health professionals seem to have a negative attitude towards a person who has visited the traditional healer before coming to the hospital. In your situation what was the attitude of the professionals regarding your visit to the traditional healer? (Please mark with an X) :

1	Accepting	
2	Empathetic	
3	Understanding	
4	Acknowledging	
5	Encouraging	
6	Harsh	
7	Not accepting	
8	Not Acknowledging	
9	Other - specify	

Please motivate your answer :

.....

3.5 Have you and your child received treatment from a traditional healer/faith healer at one stage? (Please mark with an X) :

1	Yes	
2	No	
3	Unsure	
4	Other - specify	

3.6 If YES what was the treatment for? Please motivate your answer :

.....

.....

3.7 Did your family influence you to consult the traditional healer/faith healer? (Please mark with an X) :

- 1 Yes
- 2 No
- 3 Unsure

Please motivate your answer :

.....

.....

4. **PSYCHO-SOCIAL NEEDS**

4.1. In what areas have you experienced problems with your malnourished child?
(Mark with an X that which applies to you) :

1	Transport	
2	Financial	
3	Support	
4	Education	
5	Resources	
6	Food	
7	Hospital/clinic	
8	Other - specify	

4.2 Has your malnourished child any other problems? (Please mark with an X all that apply to you) :

a. **emotional problems**

1	Withdrawn	
2	Apathetic	
3	Personal identity difficulties	
4	Bed Wetting	
5	Other - specify	

b **social adjustment**

1	Temper tantrums	
2	Insecurity	
3	Feeling of rejection	
4	Irritability	
5	Unfriendly	

4.3 Did you know there was a social worker in the hospital where your child was admitted? (Please mark with an X) :

- 1 Yes
- 2 No
- 3 Unsure

4.4 If YES how did you know about him/her?

1	Through referral	
2	Through other people	
3	By chance	

4.5 What do you think his/her role in the hospital is?

Please explain :
.....
.....

4.6 In your opinion what role do you think he/she can play in the treatment of/in helping you with the problem of your child?

Explain :
.....
.....

4.7 While in hospital/clinic were you told or advised about the psycho-affective stimulation of your child?

- 1 Yes
- 2 No
- 3 Unsure

4.8 If YES do you believe that stimulation can help towards the speedy recovery of your child?

Please comment on your answer :

4.9 What would be the most helpful thing that anyone, either in the hospital or clinic could do to help all mothers with malnourished children?

Explain :
.....
.....