

Delivery of the Nutrition Supplementation Programme in the Cape Town metropolitan area from the perspective of mothers of under-5s: A qualitative study

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Background. Child malnutrition is a major problem in South Africa despite implementation of various policies and programmes. Ideally these programmes should be delivered within a human rights paradigm, i.e. parents are responsible for their children's health, while the State authority is obliged to help parents meet their responsibility. The Nutrition Supplementation Programme (NSP) aims to help underweight children gain weight and empower parents to tackle malnutrition.

Objective. To study mothers' experience with the NSP, and assess this in relation to South Africa's emphasis on human rights.

Subjects and methods. Seven focus group discussions were conducted with a total of 28 mothers of under-5s included in the NSP. The methodology used is particularly suitable for disclosing unexplored and unexpected issues.

Results. Most mothers expressed satisfaction with receiving the supplements, which they perceived to be nutritious. However, they had received little or no education and lacked knowledge and skills regarding how to help their children gain weight. In addition, many mothers had experienced poor communication with staff members as well as unfavourable comments and lack of respect. These experiences and perceptions were real for mothers and indicate that the way the NSP was delivered resulted in inadequate compliance with certain principles of human rights, especially respect for human dignity, client participation and empowerment.

Conclusions. Even though small studies are relatively prone to bias, this qualitative study is informative. More focus on the education part of the NSP would enable mothers to manage their children's nutrition better. Measures to improve health workers' knowledge of how to work within a human rights paradigm are necessary in order to strengthen accountability of the health authorities and improve children's health.

Background and objective

Malnutrition among infants and young children is a major health problem in South Africa, as has been well documented over the past two decades.¹⁻⁷ Two nationwide surveys in 1994 and 1999 found the prevalences of stunting and underweight among young children to be 25% and 10%, respectively.^{4,5} A third survey in 2005 showed only a marginal improvement in the rate of stunting to 20% among the youngest children.⁷ This figure is still unacceptably high.

This situation exists despite the fact that in the post-apartheid years the South African government has attempted to improve

the health care system for all throughout the country, including nutritional health care. In this context the Department of Health has set up the Integrated Nutrition Programme (INP), which consists of various components aimed at addressing immediate and underlying causes of malnutrition.⁸ The INP is a broad national nutrition strategy focusing on infants and young children, at-risk pregnant and lactating women, and those affected by chronic diseases. Some programmes under the INP are delivered through primary health care facilities, and one such programme is the Nutrition Supplementation Programme (NSP). The NSP is a rehabilitation programme intended to last for a maximum of 6 months and aimed at

undernourished people from the abovementioned groups. The main components of the NSP are provision of nutrition supplements according to age-specific criteria, including breastmilk substitutes, infant porridge, energy drinks and maize meal porridge, together with nutrition education and consultation on long-term solutions for the clients.⁹

There have been few evaluations of the NSP, so there is uncertainty regarding the effectiveness and quality of the programme. Two recent assessments conducted in the same area as the present study found a number of problems with regard to implementation and compliance,^{10,11} but there were somewhat conflicting findings from questionnaire interviews with clinic staff members and clients, respectively. The clinic staff attributed most of the problems with the programme to the clients' behaviour,¹¹ whereas the clients reported inadequate programme delivery by the clinic.¹⁰ Clearly more insight is needed to provide policy-makers and managers with recommendations for adjusting current practice and help ensure effective, well-targeted and sustainable programmes.

The present study was undertaken to obtain a deeper understanding of these conflicting findings by assessing clients' perceptions and experiences of different components of the NSP. A human rights-based approach was chosen to solicit opinions of mothers with children included in the NSP. This was in part inspired by various policy statements by the South African government regarding application of a human rights paradigm and principles in addressing development issues pertaining to health and nutrition.¹²⁻¹⁴

Human rights-based approach

South Africa's Constitutional Bill of Human Rights has given rise to numerous policy statements of relevance to this study. The Infant and Young Child Feeding Policy of the Department of Health states: 'Infant and young child feeding interventions should be conducted within a human rights paradigm wherein the following principles are enshrined: (i) The child's best interest is of paramount importance; (ii) Children should enjoy the highest attainable standard of health; (iii) Children's survival, growth and development should be protected.'¹³ Furthermore, in its Integrated Food Security Strategy the Department of Agriculture points to the right of every citizen to have access to sufficient food and water.¹²

In *A Policy on Quality in Health Care for South Africa* a number of principles are embedded that aim to inform patients, involve them in decision-making and enable them to care for themselves or for their children¹⁴ (see Box 1).

These principles are in line with internationally accepted principles of human rights honouring, *inter alia*, human dignity of those holding the rights in question, and *empowerment* and *participation*, closely related and with empowerment meaning – among other things – to have the appropriate knowledge, skills, support and resources to act. Those responsible are, in a human rights paradigm, *accountable* for acting towards the realisation of the rights in question. The clinics must be accountable for how the NSP is run, while the health authorities are accountable for *empowering* the clinics to fulfil their duties as effectively as possible. It is therefore important that the NSP is delivered according to current policies and human rights principles.

Methods

The study was based on data from focus group discussions with mothers of children included in the NSP during March - June 2008.

Box 1. Excerpts from *A Policy on Quality in Health Care for South Africa*¹⁴

Informing patients and involving them in decision-making. The active participation of patients in their care can improve the effectiveness of care as well as their satisfaction with their care. Patients who are treated with dignity and are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans.

Enabling patients to care for themselves. Empowering individuals with the skills and tools to care for themselves is especially important for individuals with chronic illness or disability. Enabling users to assess their health, and practise preventive health care, and self-care, will improve their health and reduce unnecessary health care services and costs.

Sampling

Sampling was performed in two stages, first the clinics and then the mothers being selected. All primary health care clinics in Cape Town metropolitan area were randomised and contacted in successive numbers, and those providing the NSP for children were invited to participate. A purposeful, criterion-based sampling method was used to select the participants for the focus groups.¹⁵ All mothers of a child included in the NSP who were present at the included clinics at the day of the data collection were invited to participate, and all who were invited accepted the invitation. The participants were informed about the study and signed a written consent form. Clinic and participant recruitment and collection of data were performed in parallel until no new information emerged, i.e. until saturation of data was met. Six clinics with a total of 28 participants were included.

Focus group discussions

The focus group methodology complied with the principles of human dignity, participation and empowerment in allowing clients to perceive and experience the different components of the programme. It facilitated disclosure of unexplored and unexpected issues and therefore a better understanding of the problems in question.

Seven focus group discussions were conducted, each with 3 - 5 participants. The discussions were conducted by two hired moderators in the preferred language of the participants, either Xhosa or Afrikaans. The moderators had some experience with moderating focus groups beforehand, had been trained by the main researcher, and had been able to practise through a number of pilot focus group discussions. The discussions followed a structured interview guide and lasted for 1 - 2 hours. The two main topics were the mothers' perceptions regarding child health, weight and feeding practices, and the mothers' experiences with being clients in the NSP. The discussions were audio-taped, transcribed and translated into English by the moderators.

Analyses

The analyses were performed according to the Systematic Text Condensation method developed by Malterud,¹⁶ a modified version of Giorgi's method¹⁷ suited for the development of descriptions and notions related to human experience.¹⁶ It is based on a four-step process: (i) reading through the entire text

to get a first impression; (ii) identifying essential topics and meaning-bearing units (coding); (iii) abstracting the contents of individual meaning-bearing units; and (iv) summing up their importance. The analysis included a search for areas of both agreement and dissent. Quotations from the focus group discussions are used to illustrate the findings.

The study was approved by the Ethics Committee for Human Research at Stellenbosch University and by the research committee of the health authorities in the City of Cape Town.

Results

The results presented in this section are confined to descriptions of the mothers' own experiences and opinions as reported by them in the focus group discussions.

Participant characteristics

Of the 7 focus groups, 3 consisted of coloured women and 4 of black women. Owing to the limited sample size, ethnicity was not separately analysed. The mothers' ages ranged from 18 to 40 years, with an average of 29 years. The age distribution was similar in the coloured and black groups. Fourteen mothers had only one child, and more than 60% were single mothers. The socio-economic characteristics of the women are set out in Table I.

Nutrition supplementation products

All the mothers had received nutrition supplements on the day of inclusion in the NSP, and they all received the products according to schedule, which is once a month.

Most of the mothers expressed satisfaction with receiving the supplements, which they perceived to be nutritious. As stated below by one mother, they reported that their children had gained weight after eating the products:

'I think the cereal we get here is better than the one I used to buy for her, because I tried everything for her to gain weight but

nothing helped. So this food they give out here at the clinic is good because I can see the difference already.' (Focus group 3)

Furthermore, it was clear that the mothers were satisfied with receiving the products for economic reasons:

'I like the fact that I do not have to worry about the money to buy food for my child because I do not always have the money to buy food. I like the fact that my baby is getting healthy.' (Focus group 6)

Many mothers shared the products with other children in the household. These mothers seemed to understand that the products are special supplements meant for a specific child, but were in a dilemma about what to do with their other children who were also hungry:

'I think that is wrong but I'm doing it anyway. I mean, what am I to do if I do not have money to buy food for my other kids, should I let them go to school hungry when there is some sort of food in the house?' (Focus group 7)

Even those mothers who did not give the products to other children agreed that this was a difficult situation, and found it understandable that some mothers shared the products.

Nutrition education

It was clear from the discussions that mothers in all the groups felt that they had received very little if any nutrition education. Almost none of them reported being counselled on issues concerning the body's requirements for nutrients, the nutrient content of food, specific requirements of a child who needs to gain weight, specific requirements during illness, or diets for weight improvements:

'They do not give advice; they only ask what you give to your child. That's that, nothing else.' (Focus group 1)

Some mothers said they had been given practical advice. This was, however, almost exclusively related to the supplements.

Furthermore, the group discussions revealed poor knowledge among the mothers concerning what to feed their children

TABLE I. SOCIO-ECONOMIC CHARACTERISTICS OF THE PARTICIPANTS

	All participants (N (%)) 28 (100)	Participants in black groups (N (%)) 16 (57)	Participants in coloured groups (N (%)) 12 (43)
Education			
None	2 (8)	2 (12)	0
Primary	12 (42)	6 (38)	6 (50)
Secondary	14 (50)	8 (50)	6 (50)
Employment status			
Unemployed	18 (64)	11 (69)	7 (58)
Student	3 (11)	3 (19)	0
Economically active	7 (25)	2 (12)	5 (42)
Household income/month			
None	11 (39)	9 (56)	2 (17)
R1 - 500	6 (21.5)	3 (19)	3 (25)
R501 - 1 000	3 (11)	1 (6)	2 (17)
>R1 000	6 (21.5)	1 (6)	5 (41)
Do not know	2 (7)	2 (13)	0
Household food expenditure/week			
R0 - 100	14 (50)	9 (56)	5 (42)
R101 - 200	6 (21)	5 (31)	1 (8)
>R200	8 (28)	2 (13)	6 (50)

in order for them to gain weight, thus confirming the lack of emphasis on nutrition education in the programme. The mothers identified various healthy food products and acknowledged the need to eat healthily in order to gain weight. However, the foods the mothers emphasised and the meal frequency they reported were mostly low-energy foods given too few times a day, and hence not specifically suited for gaining weight.

Even though the South African health authorities have produced educational material related to the NSP, none of the mothers had seen any of this. Furthermore, none of them had been counselled on long-term dietary regimens, as explicitly stated in the guidelines for counselling in the NSP.

Communication with clinic staff

Expressions of dissatisfaction with communication were abundant among the mothers in this study. They felt that the clinic staff did not have enough time for the clients and rushed them through the consultations:

'No, they do not [have time]. They are always in a hurry to finish up.' (Focus group 7)

The attitudes of the clinic staff were also discussed, and the clients' need for support was repeatedly raised. Even though their experiences varied, all mothers appreciated clinic staff members who did understand their situation. Negative experiences from episodes of bad treatment were frequently reported in all groups:

'The sisters here they like to shout at us even if you haven't done anything wrong. At times they complain about the way we dress our kids. I mean we are the mothers, we care for our kids.' (Focus group 7)

More rarely, some individuals had good experiences:

'The sister told me that I mustn't feel bad because it's not that we are not looking after our babies. And she explained the whole programme to me and then I understood.' (Focus group 5)

The feeling of support seemed to influence the degree of confidence and openness in the client-staff interaction. Mothers who felt supported found it easier to ask the staff members if they had questions or problems. Other mothers said that they did not want to ask questions or disclose their problems because they feared the reactions from the staff. Their experiences were that staff members could be rude and shout at them, and also impose unfair consequences on them:

'I'm scared that they'll shout at me.' (Focus group 1)

'You as a mother do everything in your power to make sure that their weight improves, but when you come to the clinic the sister is on you about the baby's weight.' (Focus group 5)

'Yes, I do think that it is a problem if my child is not picking up weight because the sisters tell you that they are going to call a social worker in for you, but they don't know what your circumstances are at home.' (Focus group 4)

In one group all participants consistently expressed negative experiences of being a client, stating that they had received no information, education or instructions, while busy staff members had shown no consideration for them.

Another issue discussed in all the groups was the long waiting time for the consultations. The staff advised mothers to come with their children early in the morning, but then they were not attended to until hours later:

'They really do not know how to work with people. Sometimes we get to wait here for three hours without any assistance from them.' (Focus group 1)

'The only complaint I have is that the sister is working too slowly. We are working moms and sometimes we bring our children to the clinic before going to work. And then we arrive late for work. I am taking the taxi and the train, and by the time I get to work I could have stayed at home, because I lose a lot of money for the day.' (Focus group 2)

The issue of waiting time was obviously a particular problem for mothers who had to go back to work.

Discussion

The main findings in the current study were that the mothers had received little or no nutrition education in the NSP and therefore had little knowledge and skills with regard to how to help their children gain weight. Furthermore, many mothers experienced poor communication with staff members as well as rude comments and lack of respect. It appeared that the mothers currently do not have the capacity to act differently. Also, the way the NSP was delivered in the clinics studied resulted in inadequate compliance with certain principles of the human rights-based approach. The predominant focus on distribution of supplements and especially the undesirable attitudes on the part of staff members led to lack of respect for human dignity and limited client participation and empowerment.

Our study may have certain limitations. Importantly, we only focused on the mothers. The staff probably view the situation differently, as previously noted.¹¹ Moreover, the study included 7 focus groups with only 3 - 5 in each group. A larger number of groups could have enhanced the strengths of the findings, but the findings from the different groups did agree with regard to most topics, indicating saturation of information. The focus group discussions were conducted in the preferred language of the participants. Since the principal researcher does not speak these languages, two moderators were hired with the same mother tongue as the participants as well as similar backgrounds, which probably enhanced the quantity and quality of the information they shared. However, the use of moderators and languages foreign to the researcher might have resulted in problems in the interpretation of the findings. The moderators also did not have much knowledge of nutritional issues, and follow-up questions that could have been interesting were therefore missed.

Since the South African health authorities emphasised human rights in documents relevant to this study, the findings have been linked to principles of human rights. The following is a discussion of how human dignity, empowerment, participation and accountability are met in the implementation of the NSP, as perceived by the participants in this study and interpreted by the researcher.

Human dignity

The long waiting time and the bad treatment reported by the clients indicate lack of respect for this principle. Other studies from South Africa have found that staff members ascribed problems with the NSP to the mothers,¹¹ that clients complained about staff who were being rude, showing little respect and care for the clients, and who gave brief consultations,¹⁸ and that nurses commonly abused patients verbally and physically.¹⁹ Furthermore, long waiting times were commonly reported,

so that some mothers would get impatient and leave before having their consultation,¹¹ or the staff might take long breaks while there were still long queues so that by the end of the day some clients had not been attended to at all.¹⁸ It can be seen that these experiences are not unique to the clients participating in the present study.

Empowerment and participation

The poor nutrition education reported by the mothers does not contribute to their participation and empowerment. This is in line with other similar assessments from South Africa.^{10,20} One such study found that a combination of nutrition education and nutrition supplements is more effective in increasing people's knowledge of healthy diets and improving children's nutritional status than giving supplements alone.^{21,22} More nutrition education on weight-gain diets could therefore have been helpful for the mothers and children in the present study.

Mothers' confidence to engage themselves and participate fully is likely to be influenced by the respect and trust (of lack thereof) they experience in the clinics. The perceived accusations and resulting fear of clinic staff probably contributed to the mothers not feeling confident to ask questions or give feedback when they had problems. In such a situation mothers may respond according to their fears instead of the needs of the child.

The way delivery of the NSP focuses almost entirely on the distribution of products, as experienced by the mothers in the present study, may also have consequences for their confidence in handling children with malnutrition. Many mothers expressed gratitude for receiving products, both because the products are considered healthy and nutritious and because of economic reasons. But the children are eligible for the NSP for 6 months only, so if mothers become reliant on the programme this could diminish their confidence in handling their problems on their own after the 6 months are over.

Accountability

The problems revealed in this study, such as long waiting times and brief consultations, could be due to the clinic staff working inefficiently. A more likely reason is that there are not sufficient numbers of clinic staff working with the NSP and that the workload is therefore too big. South Africa has a lack of health personnel; an assessment by the World Health Organization in 2003 found that more than 60% of health care facilities struggled to fill existing posts, and that there were more than 32 000 vacancies for nurses.²³ The public health sector in South Africa is struggling with 'brain drain' both to other more developed countries and to the private health sector. In 1998 53% of general practitioners and 57% of nurses worked in the private sector, although this caters for less than 20% of the population.²³ Today the situation is almost certainly worse.

With regard to the inadequate nutrition education reported by the clients, it is of interest to note that the Policy and Implementation Guidelines for the NSP are very specific about how to hand out the food, but not very specific about how to give nutrition education.⁹ This indicates low emphasis on this component of the NSP on the part of the policy-makers. More



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attention to nutrition education in the guidelines could mobilise more attention to it in the clinics as well.

Since the end of apartheid and the start of the 'new democracy' in 1994, the state authorities of South Africa have emphasised human rights in their legislation and policies. These steps to make human rights principles visible in politics and policies have moved the country in the right direction, but measures to reach the 'people's consciousness' also need to be taken. Where health is concerned the principles of human rights therefore need to be honoured at the interface between health workers and clients.

Conclusion and recommendations

The experiences of the clients in the present study warrant a conclusion that the way the NSP was delivered in the clinics may point to inadequate compliance with certain principles of human rights. The predominant focus on distribution of supplements and especially the perceived undesirable attitudes of the staff members to the client mothers led to lack of respect for human dignity, and to limited client participation and empowerment.

The study therefore confirmed that there is still a need for improvements in delivery of the NSP. The problems identified are believed to be due to inadequacies both in the emphasis of the NSP policies and in the measures for their implementation, and - in part as a consequence - in staff members' performance. When improving delivery of the NSP the health authorities in South Africa should give particular attention to the nutrition education part of the NSP. Furthermore, in order to improve the quality of delivery of all health programmes the health authorities should strengthen the training of health personnel on issues relating to human rights. The authorities should also focus on good policies with corresponding realistic actions for the fulfilment of the policies. These steps will strengthen their accountability in the light of official statements that have already been made on the need to improve the quality of health care services.

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