

# **An Investigation on the Knowledge, Attitudes and Practices of Caregivers Nursing Children with Malnutrition towards the Health Education Given on the Condition at Public Health Institutions in Zimbabwe**

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**Abstract:** Zimbabwe faced its worst malnutrition rates in the past 15 years where more than 33 000 children urgently needed treatment for severe acute malnutrition every year hence the reason to conduct an investigation on knowledge, attitudes and practices of caregivers nursing children with malnutrition towards the health education given on the condition at Public Health Institutions in Zimbabwe. The study determined the level of knowledge on malnutrition caregivers nursing children with the condition have, assessed the attitudes regarding the health education given on malnutrition caregivers nursing children have and determined child feeding practices commonly used by caregivers nursing children have. 110 questionnaires were administered to the participants and 100 of them were returned giving a return rate of 90.9%. The study found that the majority of participants (66.3%) had inadequate knowledge on the proper types of food to give children to avoid malnutrition. Though weaning the children was not influenced by employment status, however, the majority of participants (68.4%) had no idea on the appropriate age to wean their children but other reasons known to them. It was further established that the participants (31.6%) acquired information on health education in their suitable environment. The results also indicated that the majority of the participants (59.0%) got unclear information on malnutrition. The study further found that the participants provided their children with the food that lacked balanced diet, which negatively affect their health. Therefore, the study recommended that sensitising parents on the importance of proper child feeding practices and proper type of foods to consume should be an on-going activity, sensitising parents on the importance of proper child feeding practices and proper type of foods to consume should be an on-going activity, appropriate actions and strategies should be made to reverse the high rate of malnutrition of children recorded in government hospitals and a follow up study with a large sample size should be conducted to investigate the knowledge, attitudes and practices of caregivers nursing children with malnutrition in both private and public health institutions across the country.

**Key Words:** Knowledge, Caregivers, Attitude, Malnutrition, Children, Practices And Nursing.

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## 1. INTRODUCTION AND BACKGROUND TO THE STUDY

WHO (2008) reports that nearly 55 million children under five years old worldwide are estimated to be suffering from acute malnutrition at any given time. Malnutrition has been associated with increased risk of mortality among the most common causes of mortality in children (Boois, 2010). Anderson (2010) says that mortality risk is directly related to the severity of illness. In Sub Saharan Africa, more than one third of child deaths are attributable to maternal malnutrition, which can lead to anaemia in pregnancy (Powell, 2011). The condition predisposes to serious maternal and foetal complications, intra and postnatally. Severe acute malnutrition occurs often in families with limited access to nutritious food and are living in unhygienic conditions which increases the risk of repeated infections.

In a study conducted by UNICEF (2016), indicates that the Fifty-Fifth World Health Assembly endorsed the Global Strategy for Infant and Young Child Feeding, which recommended actively searching for malnourished infants and young children in order to commence treatment early. This approach, along with preventive action are cost-effective interventions to reduce child mortality. UNICEF (2016) further reports that Zimbabwe faces its worst malnutrition rates in 15 years, as nearly to 33 000 children in the country are in urgent need of treatment for severe acute malnutrition every year. Over the years, the El Nino-induced drought has taken its toll across large parts of the country resulting in large numbers of hungry families (WHO, 2016). Children endured the greatest force of this crisis due to two consecutive seasons of failed rains, which have resulted in diminished food harvests and reserves. This has caused some dried up water sources and decimated livestock, increasing hunger and malnutrition in children (Mudondo, 2016). The Ministry of Health and Child Care, together with its partners from the non-governmental organizations are working tirelessly to ensure that routine medicines, therapeutic feeds and supplements are always available for children during admission and upon discharge (UNICEF, 2016).

On admission of a child at the hospital who is malnourished, caregivers received health education from health personnel on important aspects of child care such as breastfeeding, infant and child feeding practices, nutrition, timely health seeking behaviour when child is ill, family planning and hygiene (WHO, 2016). WHO further reports that the caregiver training is meant to equip them with knowledge that is required to look after their children during hospitalization and on discharge to prevent readmissions and reduce the prevalence of the illness. According to Zimbabwe Vulnerability Assessment Survey (ZVAS) (2016), Zimbabwe has since adopted the Integrated Management of Malnutrition (IMAM), which gives direction on handling of patients with malnutrition during admission and upon discharge from in-patient facilities. This survey also finds that nearly 2.8 million people in rural Zimbabwe (approximately 30% of the rural population) require food assistance of which half of them are children below the age of 18 years. The impact of the drought on households, according to the survey was adverse. ZVAS (2016) further reveals that the proportion of hungry households had almost doubled from 16 to 27% from May 2015 to January 2016 and 2% of these children with severe malnutrition were aged between 1 to 2 years old. In Zimbabwe, the Integrated Management of Acute Malnutrition (IMAM) was put in place by the World Health Organization (WHO) in 2014 and was adopted. It is aimed at mobilization of the community and providing in and out patient therapeutic care by managing acute malnutrition utilizing a ready-to use-therapeutic-food commonly known as plump nut. It is very effective for treatment of malnutrition.

WHO (2017) reports that plump nut has improved the status of people living with HIV and AIDS in the Sub Saharan countries as they can now recover to normal nutritional status. The Ministry of Health and Child Welfare (MOHCW) has been rolling out integrated facility based and Community based Management of Acute Malnutrition (CMAM) with support from the United Nations Children's Fund (UNICEF) and this program is now spread across the country. This support includes commodity support such as F-75 Therapeutic Milk, F-100 Therapeutic milk and plump nut to implementing sites in the country (WHO, 2017). To date over 451 health facilities are implementing IMAM. The program enables children with severe acute malnutrition to be treated at home if they have no medical complications. This enables families, to continue with their normal routine responsibilities, without fear of stigmatization due to hospitalization (WHO, 2018).

## 2. LITERATURE REVIEW

### **Nutrition Concept**

Musoke (2011) posit that adequate nutrition is essential for normal child's growth and development. Globally, under nutrition affects more than 50% of the children especially those under 5 years of age. Malnutrition remains one of the most common causes of morbidity and mortality and it is an underlying cause of about 3.5 million children deaths each year. Under nutrition is not simply as a result of food insecurity. Many under-fives in food secure environments and from fair socio-economic backgrounds, are undernourished probably as a result of inadequate knowledge of breast feeding and complementary foods, poor feeding practices and food restrictions due to cultural beliefs (Powell, 2011). These factors are often greater determinants of malnutrition than even the availability of food itself (Reinbott, 2016). WHO (2008) further highlights that in addition to predisposing under-fives to death, under nutrition affects their immune system predisposing them to infections and if the under nutrition is not addressed early and corrected these children could suffer irreversible physical and cognitive damage thereby impacting their future health, welfare and economic well-being. Prevention of under nutrition would prevent at least one third of childhood mortality and morbidity (Reinbott, 2016). The mother is the main caregiver and she is the one who is the key person in the prevention of under nutrition. Unable to look after themselves, the children completely depend on their mothers for their nourishment which is limited to what their mothers provide. Mother's chances of preventing under nutrition are likely to be increased if she has the right knowledge or information on how to feed her children. Successful implementation of nutritional interventions is also an important contributor to the achievement of the Fourth Millennium Goal which is reduction of mortality by two-thirds among children under five (Masibo, 2016).

WHO (2016) defines malnutrition as the cellular imbalance between the supply of nutrients, energy and the body's demand for them to ensure growth and maintenance. Malnutrition generally implies under nutrition and refers to all deviations from adequate and optimal nutritional status in infants, children and adults. Nutrition is essential for child's normal growth and development. It is well recognized that the period from birth to two years of age is a "critical window" opportunity for the promotion of optimal growth, health and behavioural development. After a child reaches 2 years of age, under nutrition can lead to irreversible physical and cognitive damage. Masibo (2016) argues that every time an innocent child suffers the scourge of malnutrition the responsibility goes to the mother, the family and to the community due to their lack of knowledge regarding the benefits of exclusive breast feeding, timely initiation of complementary feeding and dietary practices.

### **Knowledge on Malnutrition**

According to Saito (2012), mothers are the foremost providers of primary care for children. Their understanding of basic nutrition and health measures strongly influence the care they provide. The aspects of nutrition knowledge include duration of exclusive breastfeeding, appropriate age for introducing solid foods into a child's diet and the type of nutritional solid foods to introduce, frequency of child feeding, diet during illnesses and the mother's perceptions of her own child's nutritional status. Mother's practical nutrition knowledge is important for the child's nutritional outcome. Saito (2012) further finds that 96% of the mothers had enough knowledge that exclusive breastfeeding should be practiced for six months and 91% knew that colostrum was good for the baby. Despite having the correct knowledge only 69% practiced it. Greiner (2014) views exclusive breastfeeding as feeding the infant only breast milk, with no supplemental liquids or solids except for liquid medicine and vitamin/mineral supplements. A similar study conducted by Matanda (2014) in Kenya, shows that only 1.8% of the mothers exclusively breastfeeding their children for six months. The low percentages was attributed to lack of correct knowledge that exclusive breast milk is sufficient for the first six months of life, and lack of which contribute to a high prevalence of malnutrition. WHO (2016) and United Nations Children's Fund (UNICEF) (2014) recommend mothers to exclusively breastfed their infants for the first six months in order to prevent childhood illnesses such as acute respiratory infections and diarrhoea, which are reported to have caused infant mortality worldwide. As much as 84% of infants were already receiving complementary feeds as early as the first month of life, unfortunately, these low in energy supplements cause

reduction in breast milk consumption, which lead to loss of protective immunity predisposing the child to infections (ZVAS, 2016). Subsequently, nutritious foods are considered to be expensive by some mothers, while traditional locally available foods can provide just as much nutritional value at an affordable price. There is need for knowledge of locally available foods.

### **Malnutrition and its Causes**

WHO (2016) defines malnutrition as the deficiencies, excesses or imbalances in a person's intake of energy and /or nutrients. In malnutrition, the deficiency of certain vital nutrients in the diet causes reduced growth and poor health. Several nutrition disorders may develop depending on which nutrients are lacking. Conversely, Klugman (2012) outlines the causes of malnutrition as poverty, ignorance, faulty feeding practices, food scarcity and consumption of food with low availability of food nutrients. De Lange (2014) points out that stressed caregivers, trauma and poor psycho-social care can also be considered as immediate causes of childhood malnutrition. Torun and Chew (2014) also add that the basic causes of malnutrition include poor availability and control of resources, environmental degradation, poor agriculture, war, political instability, urbanization, population growth and size, distribution, conflicts, poor trade agreements, natural disasters and religious and cultural factors. A study conducted by Ditebo (2010) in Botswana, finds that lack of knowledge about malnutrition, wrong perception of malnutrition by mothers, illiteracy and unemployment as well as cultural factors like taking a child to a traditional healer instead of a medical health facility for treatment may cause malnutrition. According to WHO (2016), malnutrition symptoms include fatigue, dizziness and weight loss while in children; other symptoms include poor weight gain, slowing of growth, irritability, apathy and anxiety. The condition of malnutrition can be mild and cause no symptoms. It can also be so severe that the damage done to the body is permanent, even if one survives. The effects of malnutrition can be life threatening (Greiner, 2014). Iodine and iron deficiency during infancy have been reported as causing mental retardation even after the deficiencies had been managed. The severity of these deficiencies can predispose to growth stunting, kwashiorkor, marasmus and failure to thrive (Bhutta et al, 2014).

### **Marasmus and Kwashiorkor**

Marasmus and Kwashiorkor are particular kinds of malnutrition. In kwashiorkor, children experience acute protein-calorie malnutrition. They do not get enough protein in their diet to build and restore body tissues. UNICEF and WHO (2014) report that kwashiorkor usually occurs when there is a sudden change in both quality and quantity of the child's diet, especially during the weaning period. It is characterized by underweight with oedema, weakness, skin lesions and a change in hair colour, which cause a general appearance of chubby features and a blotted body (Greiner, 2014), resulting in hypo albuminaemia. At the time, parents may think the child is gaining weight. They may not be convinced that the child will be malnourished. Failure in growth is remarkable and weight is reduced in spite of the presence of the chubby features. And varying degrees of muscle wasting are present (Matanda, 2014). The discoloration of hair and skin give the child a characteristic of "red baby" look. Marasmus is also a form of severe malnutrition that develops over a long period of time and is characterized by extreme underweight, wasting (loss of muscle and fat under skin so that the bone structure becomes visible), irritability and nervousness (Reinbott, 2016). This is as a result of negative energy balance. The condition usually occurs in younger children accompanied by failure to thrive. Affected children are thinner and smaller for their age with shrunken and wrinkled skin due to lack of body fat (Masibo, 2016). WHO (2016) reports that both conditions are caused by a lack of protein but kwashiorkor will seldom appear before six months as the baby is being breastfed. Marasmus leads to a more extensive impairment of biological functions compared to kwashiorkor (Rainbott, 2016). According to Masibo (2016), a marasmus child will look emaciated, while a child with kwashiorkor will look bloated and seemingly of normal weight. However marasmus is more common than kwashiorkor and most commonly occur in third world countries because of poverty (ZVAS, 2016). In the case of any protein calorie malnutrition, the body will lack amino acids, which are the carbon compounds that uses to rebuild the tissues. Chronic (stunting) and acute (wasting) malnutrition are other forms of growth failure. Chronic malnutrition occurs overtime unlike acute malnutrition (Reinbott,

2016). A child who is stunted often appears to be normally proportioned but is actually shorter than normal for his/her age (Masibo, 2016). Stunting starts before birth and is caused by poor maternal feeding practices, poor food quality as well as frequent infections which, can slow down growth (ZVAS, 2016).

### **Attitude**

In most communities, there are foods, which are thought to be forbidden for children due to cultural or social taboos (Klugman, 2012). Certain foods like meat, eggs and nuts are thought to be too hard for the children to digest and therefore associated with illnesses. There are different beliefs on causes of malnutrition. According to a study done in Somalia by Paulos (2010), colostrum was not fed to children by majority of mothers as it was considered dirty, toxic, and harmful to children's health. They also regard feeding bananas and curd to an infant in the rainy and winter seasons as causing cold and cough. Mijikenda (2014) says that in Kenya, maternal perceptions of factors contributing to severe under nutrition among children, where mothers claimed that long term breast feeding causes under nutrition and early weaning was an appropriate intervention. Maternal gravidity during breastfeeding was also raised as a cause of severe malnutrition (UNICEF, 2014). Breastfeeding while pregnant was thought to emit 'heat' from the unborn child which cause burns on the toddler being breastfed predisposing to severe under-nutrition. The mothers were advised to stop breastfeeding forthwith as soon as pregnancy was confirmed (Mijikenda, (2014). Saka (2014) notes that most mothers believe that symptoms of kwashiorkor and marasmus were not associated with inadequate feeding but with transgression of sexual taboos by the parents. These inappropriate beliefs led to inadequate diet, thus predisposing the children to under nutrition.

### **Feeding Practices**

WHO (2013) reports that globally, the rates of practicing exclusive breastfeeding are still low. Lack of exclusive breastfeeding for the first six months of life can contribute to a high prevalence of malnutrition. Timely introduction of complementary foods promotes good nutritional status and growth in infants and young children. Too early or too late introduction of complementary foods carries the risk of development of malnutrition (Delange, 2014). In Kenya, complementary foods are introduced as early as the first month of life (Matanda, 2014). Different studies queries the reasons as to why mothers introduced feeds before the age of six months. However, and according to Greiner (2014), reasons given for stopping breastfeeding include: inadequate milk secretion, perception that that breast feeding should stop during illness, perception that the feeds should be reduced during illness, and work commitments. Cultural factors and taboos have powerful influence on feeding practices and eating patterns with young mothers often finding it impossible to ignore their ill-informed elders and peer groups on when to introduce feeds (UNICEF, 2013). WHO (2013) provides reasons for delayed introduction of complementary foods as vomiting on introduction of complementary foods, lack of knowledge of when to start complementary foods, advice of the mothers-in-law that milk was sufficient for the child till the age of one year. Early introduction of complementary feeds is coupled with unhygienic preparation and storage conditions, which predispose many infants to diarrhoea and inadequate diets causing a negative impact on growth and development (UNICEF, 2014). Larrette (2011) establishes that the majority of mothers, 71.1%, were not boiling drinking water and 86% used bottles for feeding. Lack of food fortification, inappropriate quality, inadequate quantity, thin consistency and wrong frequency of meals also affect the nutritional status of the child (Lima, 2010). In a study conducted in Addis Ababa by Percy (2012), finds that the frequency of feeding in a well-nourished households was four times higher than the frequency in the malnourished households in which the children were also fed on enriched porridge.

## **3. RESEARCH METHODOLOGY**

The research study used the descriptive survey design of the quantitative method. Khorthari (2004) describes descriptive survey design as a study which is concerned with describing the characteristics of a particular individual or of a group. A structured questionnaire was self-administered to the participants. The study population comprised of caregivers nursing under-fives who were readmitted in the children's ward with

malnutrition at public health institutions in Harare. These children’s ages ranged from 6 months to 2 years. As a result, a sample of 110 participants was drawn from a subset of caregivers of all age groups who were taking care of the children aged 6 months to 2 years who had been admitted for more than once at these public health institutions in Harare for malnutrition from 2019 to current readmissions of 2021. The study did not include children that were admitted for other ailments, which had nothing to do with malnutrition despite fitting into the age range. All the children who were admitted prior to the zoned area of before 2019, were not included in the study as well as the participants that did not sign the consent form.

#### 4. RESEARCH FINDINGS

##### Demographic Characteristics of the Participants

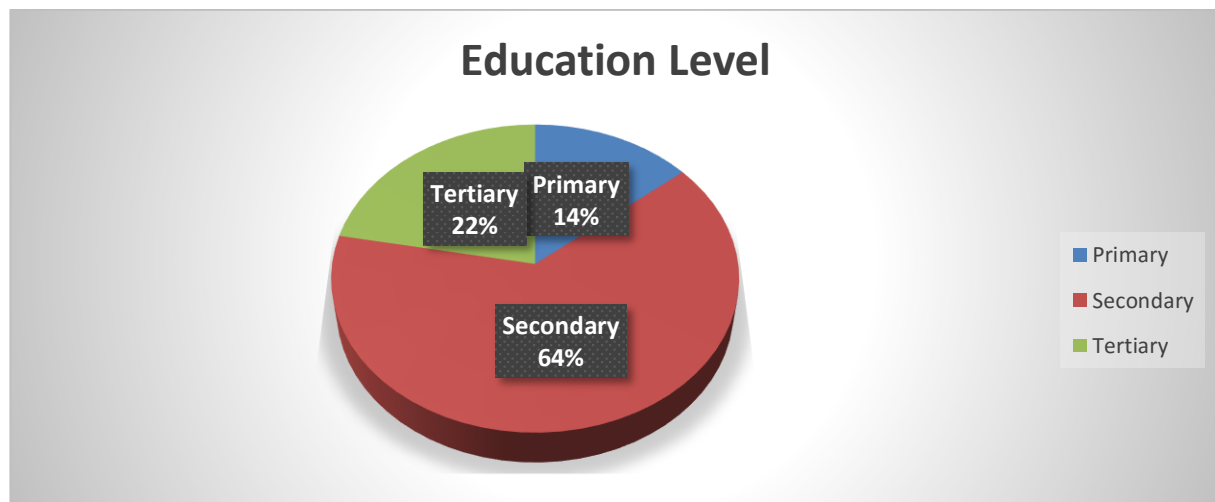
**Table 1:** Distribution of Participants According to Age

**N = 100**

Age in Years	Frequency	Percentage
Below 30	24	24
31- 40	35	35
41-50	41	41
<b>TOTAL</b>	<b>100</b>	<b>100</b>

Table 1 showed that the most represented age group ranged from 41 -50 years old, which had participants (41%). On the other side, participants (35%) had their ages ranged from 31 - 40 years old and participants (24%) had their ages below 30 years old.

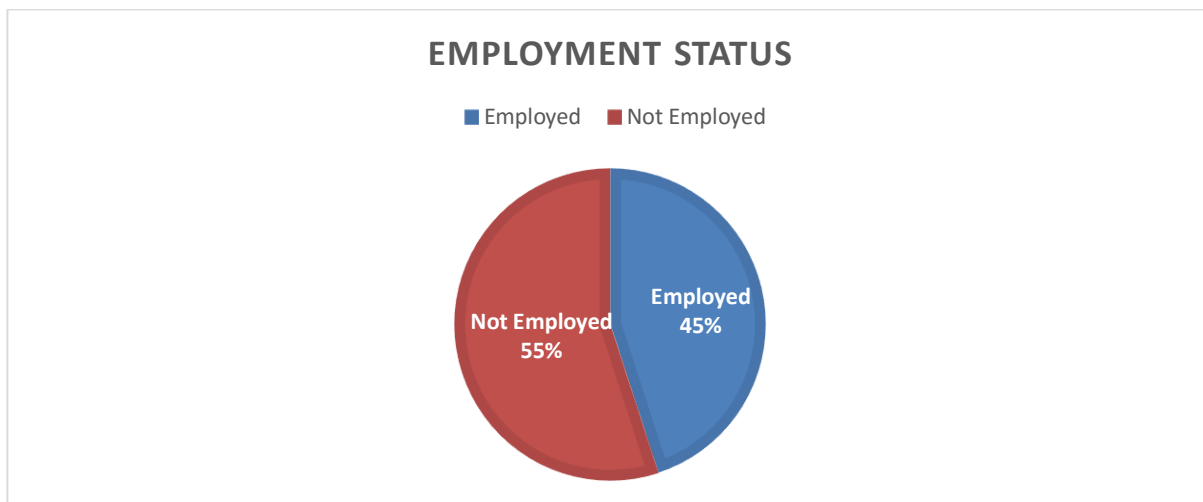
**N = 100**



**Figure 1: Educational Level of Participants**

Figure 1 showed that the majority of participants (64%) had gone up to secondary level followed by participants (22%) that had gone up to tertiary level and only participants (14%) had gone up to primary level. According to CIA World Fact book (2018), Zimbabwe has a literacy rate of 88.5% in males, 84.6% in females. Saito et al (2012) highlight the aspects of nutrition knowledge such as; the duration of exclusive breastfeeding, appropriate age for introducing solid foods into a child’s diet and the type of nutritional solid foods to introduce, frequency of child feeding, diet during illnesses and the mother’s perceptions of her own child’s nutritional status. Mother’s practical nutrition knowledge is important for the child’s nutritional outcome hence: the need to be knowledgeable on what should be consumed.

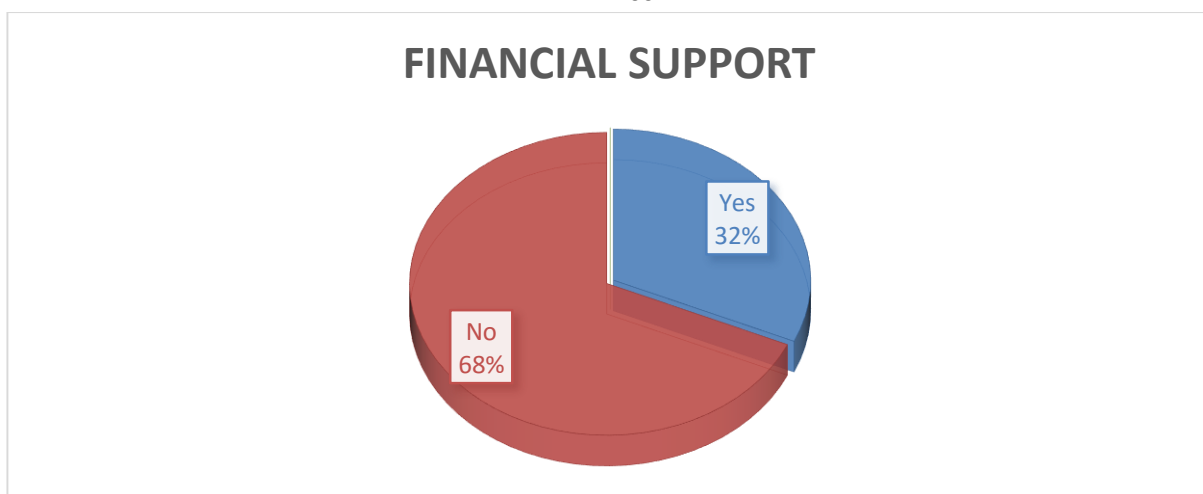
**N=100**



**Figure 2: Employment Status of Participants**

Figure 2 showed that among the participants, more than half 55 (55%) were not employed while participants 45 (45%) were employed. In line with the research findings, the distribution of wealth has been found to be associated with malnutrition in those groups who have limited access. According to Saito et al (2012), the marginalized groups have limited income that is not enough to purchase food. Another research conducted by Save the Children (2012) finds that Bangladesh, Ethiopia, Myanmar and Tanzania have shown that those people with inadequate financial support (unemployed) for a nutritious diet, were likely to be malnourished. Saito et al. (2012) further argue that children whose fathers are not employed are twice more likely to develop malnutrition as opposed to those employed.

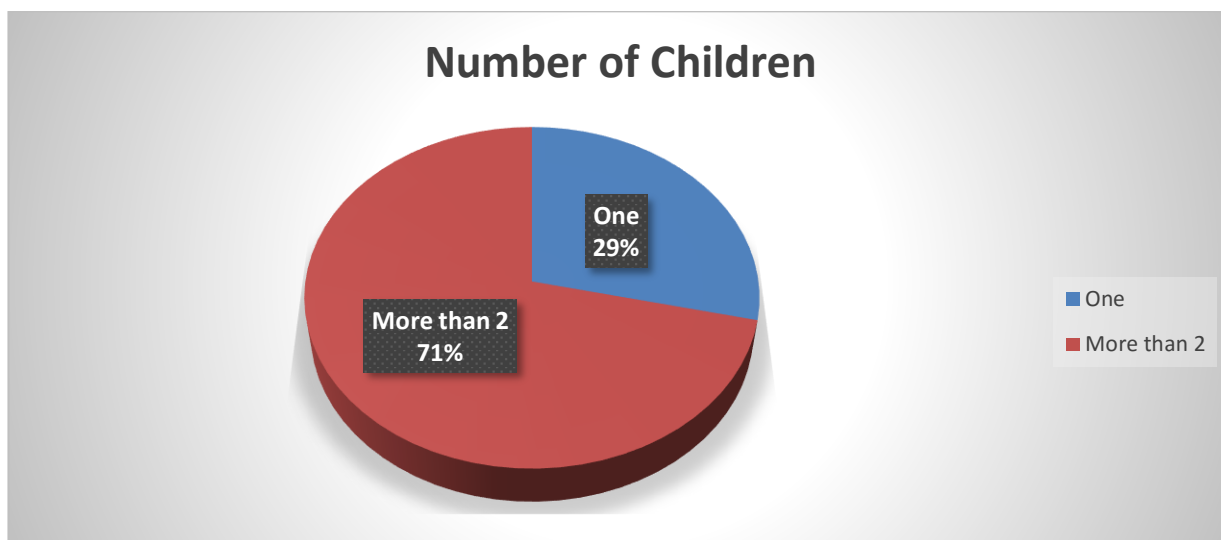
**N=100**



**Figure 3: Adequate Financial Support**

Figure 3 showed that the majority of the participants (68%) had no adequate financial support to take care of their children while participants (32%) confirmed that they were barely managing. However, Greiner (2014) argues that inadequate financial support hinders progress in the family and national economy. Lack of financial support forces people to consume type of foods that are unbalanced. Delange (2014) concurs with Greiner (2014) that survival of the fittest will negatively affect those that are not getting adequate financial support.

**N=100**



**Figure 4: Distribution of Participants According to Number of Children**

Figure 4 showed that the majority of the participants (71%) were taking care of more than two children while, participants (29%) were taking care of only one child at home. The information provided by the participants indicated that families had huge responsibility of taking care of their children. Matanda (2014) says that a large family sometimes encounter challenges in the distribution of food especially if the parents or guardians are not employed.

**Table 2: Number of Times that Child under Care of the Participant was admitted for Malnutrition.**

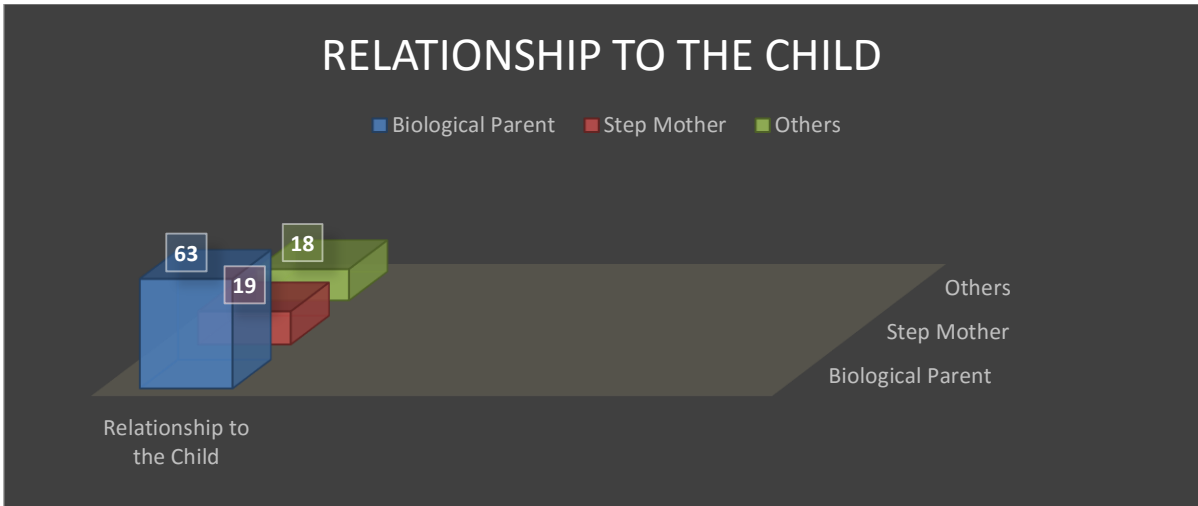
**N=100**

Attribute	Number	Percentage (%)
Twice	28	28
Thrice	27	27
More than thrice	45	45
<b>TOTAL</b>	<b>100</b>	<b>100</b>

Table 2 exhibited that the majority of children (45%) were admitted more than thrice, followed by those that were admitted twice (28%) and those that were admitted thrice (27%). These results signified the challenges faced by the participants in taking care of their children. Saito et al (2012) say that the mother's practical nutrition knowledge is important for the child's nutritional outcome. Matanda (2014) blames mothers with lack of knowledge to initiate complimentary foods to their children before or long after six months of age. However, Klugman (2012) notes not all mothers can afford to buy nutritious foods as a result of their expensiveness, while traditional foods are locally available.

**N=100**



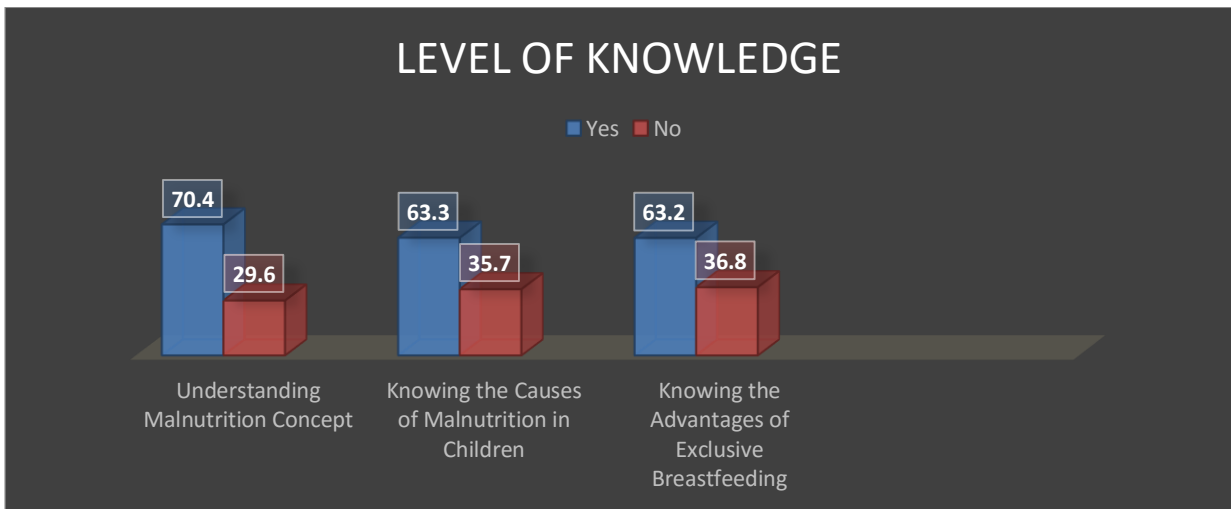


**Figure 5: Relationship of Participant to the Child**

Figure 5 showed that the participants (63%) were biological parents to the children while, participants (19%) were step mothers whereas, participants (18%) were other relatives staying with the child. The results depicted that the majority of the participants (63%) stayed with their biological children. This means that the biological parents have more care to their children as compared to any other relatives. According to Ditebo (2010), biological parents have their children at heart and can take all necessary measures to ensure that maximum support and care are given and considered.

**Knowledge Level on Malnutrition and Child Feeding Practices Commonly used by Caregivers Nursing under Fives**

**N=100**

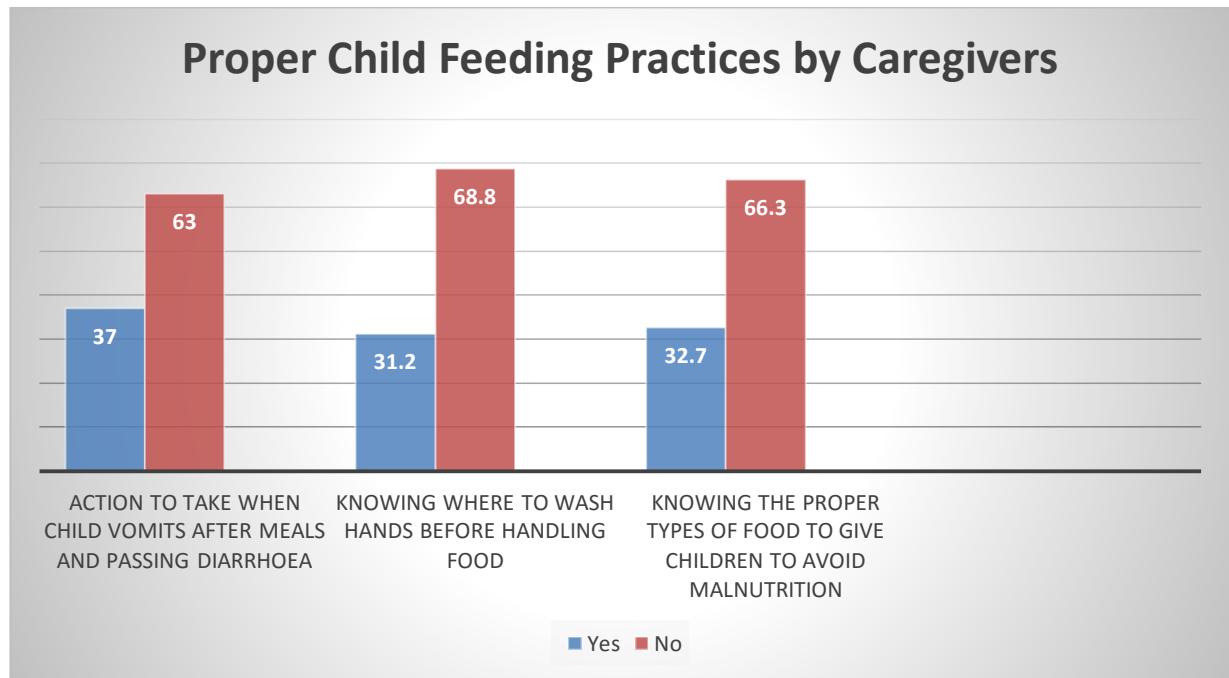


**Figure 6: Distribution of Participants According to Knowledge on Malnutrition**

Figure 6 showed that the majority of participants (70.4%) had knowledge on malnutrition while, participants (29.6%) had no idea. It was further established that participants (63.3%) knew the causes of malnutrition in children while, participants (35.7%) were not even aware. More so, it was further noted that participants (63.2%) had knowledge on the advantages of exclusive breastfeeding while, participants (36.8%) were not even sure. Of note, the results showed that most of the participants had knowledge in most areas as indicated. According to Matanda (2014), mother's practical nutrition knowledge is important for the child's nutritional outcome. A study conducted by Saito et al (2012) in Nigeria found that 96% of the mothers had adequate knowledge on exclusive breastfeeding, which should be practiced for six months and 91% had knowledge on the benefits of colostrum for the baby. Greiner (2014) describes exclusive breastfeeding as feeding the infant

only breast milk, with no supplemental liquids or solids except for liquid medicine and vitamin or mineral supplements.

**N=100**

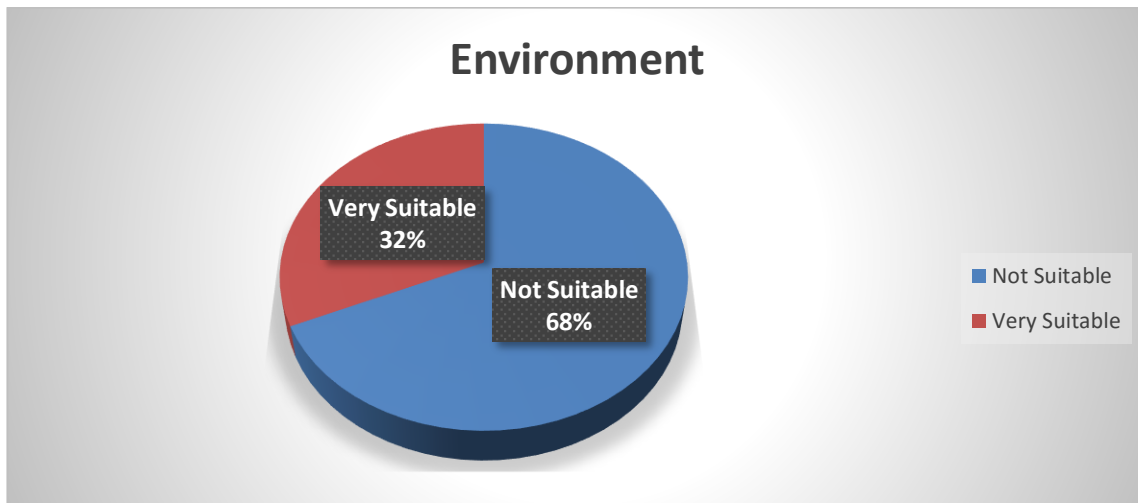


**Figure 7: Level of Knowledge on Proper Child Feeding Practices by Caregivers**

Figure 7 exhibited that the majority of participants (63%) had little knowledge on the action to take when their children vomit after taking some meals and passing diarrhoea, while participants (37%) had adequate knowledge about it. It was further established that the majority of participants (68.8%) had also little knowledge on where to wash their hands before handling food while, participants (31.2%) had adequate knowledge about it. More so, the majority of participants (66.3%) had little knowledge on the proper types of food to give to their children in order to avoid malnutrition while, participants (32.7%) had adequate knowledge about it. Based on these findings, it showed that the majority of participants had little knowledge on the action to take when their children vomit after taking some meals and passing diarrhoea, where to wash hands before handling food and the proper types of food to give children to avoid malnutrition. In line with these findings and according to Torun and Chew (1994) cited in Anderson (2010), basic causes of malnutrition include; poor availability and control of resources, environmental degradation, poor agriculture, war, political instability, urbanization, population growth and size, distribution, conflicts, poor trade agreements, natural disasters and religious and cultural factors. Ditebo (2010) also mentions lack of knowledge about malnutrition, wrong perception of malnutrition by mothers, illiteracy and unemployment as well as cultural factors like taking a child to a traditional healer instead of a medical health facility for treatment as the most disturbing factors contributing to malnutrition especially to third world countries.

**Attitude Regarding the Health Education Given on Malnutrition**

**N=100**



**Figure 8: Suitability of Environment where Health Education was conducted**

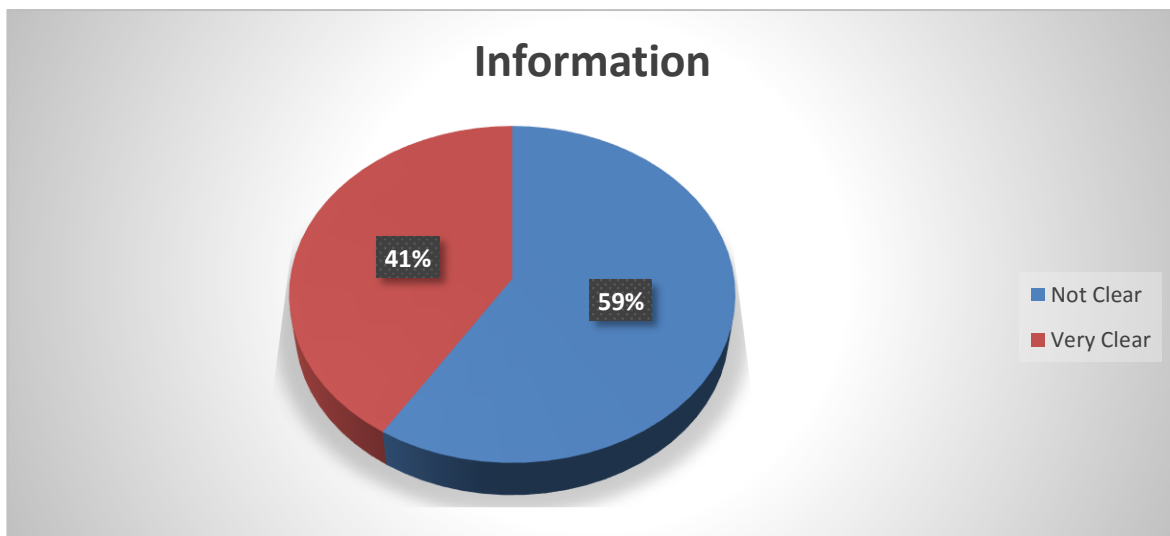
Figure 8 showed that the majority of participants (68%) indicated that the environment was not suitable for health education while, participants (32%) confirmed the suitability of the environment. The environmental factors are important to consider when conducting health education. Delange (2014) suggests that conducive and supportive environment are key to success in conducting health education. Mijikunda (2014) believes that conducive and supportive environment allow the community to develop the interest and zeal to participate and learn more.

**Table 3: Health Professional Attitude**

Attribute	Number	Percentage (%)
Desirable	57	57%
Undesirable	43	43%
<b>TOTAL</b>	<b>100</b>	<b>100%</b>

Table 3 showed that the majority of participants (57%) perceived the attitude of health professionals as desirable while, participants (43%) perceived it as undesirable. It is therefore, important for the health professional to improve on their attitude towards their clients.

**N=100**



**Figure 9: Clarity of Information Given During Health Education**

Figure 9 showed that the majority of participants (59%) indicated that the information given during health education was not clear while, participants (41%) confirmed that the information provided was clear. In light of this, communication becomes important and effective in providing clear information during health education. According to Fiske (2012), communication is the process of passing the information and understanding from one person to another. Vikram and Prya (2009) suggest that all persons engaged in both oral and written communication should remember the use of seven Cs (clear, concise, complete, correct, concrete, courtesy and consideration). Rajendra and Korlahalli (2009) discourage the use of jargon or unfamiliar words. Vikram and Prya (2009) in support of Rajendra and Korlahalli (2009) advise individuals to use simple words and sentences that are clear to understand.

**Table 4: Language used During Health Education**

**N=100**

Attribute	Number	Percentage (%)
Understandable	96	96%
Not under stable	4	4%
<b>Total</b>	<b>100</b>	<b>100%</b>

Table 4 showed that almost all the participants (96%) understood the languages used during health education while, participants (4%) did not understand the languages used. The results were satisfying as the majority of participants (96%) confirmed their understanding on the languages used during health education.

**Table 5: Opportunity to Ask Questions**

**N=100**

Attribute	Number	Percentage (%)
Given	100	100
Not Given	0	0
<b>Total</b>	<b>100</b>	<b>100</b>

Table 5 showed that all the participants (100%) were allowed to ask questions during health promotion thus, showing the significance of oral communication. The results showed that the participants were accorded ample time to ask questions and were much involved in the activities conducted during health education. Mijikunda (2014) states that participants feel happy and respected when they are allowed to participate and ask questions thus, enabling the participants to have a sense of ownership in all their endeavours.

## 5. RECOMMENDATIONS

Based on the research findings, the following recommendations were made to address the problem:

- Government should come up with effective policies and strategies to address the challenges associated with caregivers nursing children with malnutrition and reverse the high rate of malnutrition of children recorded in government hospitals.
- Government should also address the unemployment issue so that people are involved in different income generating projects to get disposable income to purchase appropriate and proper foods.
- Awareness campaign on health related issues such malnutrition, water bone diseases etc. should be regularly conducted across the country.
- Sensitising parents on the importance of proper child feeding practices and proper type of foods to consume should be an on-going activity.
- Public health practitioners should continuously educate people on health related matters especially on child feeding practices.

- A follow up study with a large sample size should be conducted to investigate the knowledge, attitudes and practices of caregivers nursing children with malnutrition in both private and public health institutions across the country.

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