Assessment of the Caring Practices in Two Motherless Babies’ Homes in Abia State, Nigeria and the Development and Delivery of a Nutrition Training Program to the Staff of These Homes to Improve Nutrition of Children in Their Care

by

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MASTER OF ARTS
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Faculty of Human and Social Development

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ABSTRACT

Reduction in under-five mortality rate was the challenge which WHO and UNICEF were responding to when they came up with “Family and Community Practices that Promote Child Survival, Growth and Development” (Hill et al., 2001). These practices are 12 in number. In a WHO publication “Improving Child Health in the Community,” four more practices were added to protect vulnerable children.(see Appendix II).

The Federal Government of Nigeria in collaboration with UNICEF has for the past two years integrated health, nutrition and psychosocial stimulation programs to produce synergy in addressing the holistic development of the child. The Family and Community Practices have formed a package for care, incorporating nutrition and health. Mothers and caregivers at home and in Early Child Centres are being trained on the above issues. The issue of children being orphaned by HIV/AIDS and the need for orphanage care is a fact we cannot afford to be silent about. Caregivers in orphanages have not been targeted in the trainings on care, therefore, this study seeks to assess the caring practices in two motherless babies homes in Abia State, develop a nutrition training program, and thereafter train the caregivers on nutrition.

The work was carried out in Compassionate Home Ahiaeke and Agape Motherless Babies’ Home Ubakala. A questionnaire was developed based on 14 of the caring practices. It was pre-tested and then administered to caregivers in the two homes. Thereafter, there were observation sessions in the homes, using a checklist.
A one-day nutrition training was organized for the caregivers in the homes, using the training program which was developed as part of the project.

Results show that more attention (though not adequate) was given to the health and nutritional aspects than to the cognitive and psychosocial aspects of care. The withdrawn looks of some of the children suggest inadequate stimulation.

It is intended that this study would have a ripple effect, as it is extended to other Motherless Babies’ Homes (Orphanages) in the State.

Project Advisory Committee:

Dr. Alan R. Pence, Supervisor (School of Child and Youth Care)

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DEDICATION

Dedicated

to the glory of God

and to the cherished memory of my

father, Solomon Nwache Okorocha

(Sine qua non).
CHAPTER 1: INTRODUCTION

The survival, growth and development of children are greatly affected by the care that they receive in their immediate environment. Children in orphanages (motherless babies’ homes) in Nigeria constitute a vulnerable group that needs better care. The aspects of care, which tend to receive attention at the moment, are feeding and disease treatment prevention. The psychosocial aspect of care is, however, inadequate.

One of the strategies for achieving the Nigerian Food and Nutrition Policy objectives is the enhancement of care giving capacity (National Planning Commission, 2001). “Care” refers to the behaviours and practices of caregivers (mothers, siblings, fathers, and childcare providers) to provide the food, health care, stimulation, and emotional support necessary for children’s healthy survival, growth and development (Engle, 1999).

WHO (see Appendix II), has a list of caring sixteen practices for the care of the child focusing on:

- Breastfeeding
- Quality of complementary foods
- Micronutrient supplementation and/or dietary diversification to ensure adequate micronutrient intake. (Vitamin A, Iron and Iodine)
- Faeces disposal and general hygiene
- Immunization schedule for the orphanage
- Protection against malaria
- Child stimulation vis a vis interaction with caregivers
- Nutritional care of the sick child
- Care for HIV/AIDS orphans and actions against further HIV infection
- Protection against injury
- Prevention of child abuse and neglect
- Fathers’ involvement in childcare (i.e., if the fathers of some of the children are alive)
- Treatments given to the children for infection
- Ability of caregivers to recognize when sick children need treatment outside the home
- Ability of caregivers to follow health workers advice on treatment and to follow up on the advice and referrals
- Ante and post natal care

Breastfeeding, ante and post natal care are not assessed because pregnant and nursing mothers are not resident in orphanages.

This project intends to support, encourage and strengthen good and appropriate practices while, amending or discouraging inappropriate ones. A nutrition training program with the clearly stated objectives and expected outcome(s) will be developed. During the delivery of the program, emphasis will be placed on observed areas of the nutritional deficiencies in the diet and general health of children being cared for in the orphanage.

Rationale

Under-5 mortality rates in developing countries (Nigeria inclusive) are still high. The figure for Nigeria is 183 per 1000 live births (UNICEF/FGN 2001). A great
percentage of these deaths is due to malaria, diarrhoea, acute respiratory tract
infection, vaccine preventable diseases, typhoid fever and malnutrition

Unless significant efforts are made to control these conditions, they will
continue to be major challenges both in Nigeria and internationally. In response to
this, the World Health Organization (WHO) and the United Nations Children’s Fund
(UNICEF) developed an Integrated Management of Childhood Illness (IMCI) within
which the “Improvement in family and community practices is a component.” (Hill,
et al., 2001).

WHO added four more practices that protect vulnerable children(see
Appendix II). When followed, these practices provide good home care for the child in
order to ensure survival, reduce illness and promote healthy growth and development.

The assurance of survival and reduction of morbidity require healthful
practices; healthy growth requires adequate nutrition, development (both
psychological and cognitive) requires proper stimulation.

The Nigerian government and international agencies have been making efforts
to face this challenge by initiating several programs including:

- The National Immunization Days (NIDs) program was instituted to boost
  routine immunization on which had been recording low levels. The
  immunization is against polio and other child killer diseases.

- Promotion of insecticide treated bed nets, and also of preventive drugs to
  prevent malaria.
- Public education on the home based management of diarrhea, and also the prevention and management of HIV/AIDS.
- Integrated management of childhood illness.
- Promotion of exclusive breastfeeding for the first six months of life and introduction of adequate complementary foods from six-month, and continue breastfeeding till two years.
- Control of micro nutrient deficiencies, particularly vitamin A, Iron and Iodine deficiencies.
- Addressing the developmental rights of children particularly the physical, cognitive and psychological development of preschool children aged 0-5 years. This includes an assessment of the care received by young children both within the family home and the community including daycare centers and pre primary institutions.

None of the above programs/initiatives, however, are targeted at orphans or the caregivers in orphanages. Moreover, the orphanages are in conditions that do not promote optimal child developments and these call for an immediate intervention.

After watching a video tape about an orphanage in Romania, shown during the ECDVU seminar in Johannesburg, the writer came to appreciate that the condition of children in orphanages is a problem not only in Nigeria, but globally. This created a strong passion to improve the care received by orphan children in institutions. The writer believes that the orphanage caregivers should have a proper orientation to understand what caring practices are because they are the people on ground to do the
job. The writer, having a passion for the holistic development of children, decided therefore to undertake this project, having the support of government.

The word “orphan” is derived from the Greek word *orphanos*, or Late Latin *orphanus* meaning *bereaved*. (Ruiz-Casares, n. d.) When a child was referred as being in a state of bereavement, it was assumed that both parents were dead. Today, there are a variety of definitions:

- A child who has lost both parents.
- Someone or something that lacks support or care or supervision.
- A young animal without a mother.
- A child deprived of parents by death or desertion.
- In general there are variations in the age up to which children are considered orphans (14, 15, 18 and 21 years old) and the patterns of parental death (both parents die, either parents die, or death of mother only).

Orphans in this study refers to infants who have (a) lost both parents (either by death, or as a result of child abandonment), (b) lost the mother (especially immediately after childbirth) and have no adult to care for them, and (c) mentally ill mothers and no adult is available to care for them. The age range for this project is 0-18 years. The absence of fathers who are alive and absent is a widespread contemporary issue that also needs to be taken into account.

With the number of HIV/AIDS cases growing exponentially in Nigeria, more children are likely to become orphans. Adoption is not very acceptable in some areas because of cultural reasons. For those who are more enlightened, economic pressures
may be a hindrance. Therefore the need arises for an improvement both in the quality and quantity (i.e., number) of orphanages.

Specific objectives for this project are:

a) To identify a list of all the caring practices in the motherless babies’ homes that enhance child development.

b) To build the capacity of the caregivers so that they would be able to offer adequate nutritional care to the orphans.
CHAPTER 2: LITERATURE REVIEW

Part of the Nigerian culture includes the extended family system. In this system, the upbringing of a child is not just the responsibility of the parents, but also of the extended family and the community at large. Before the establishment of orphanages, relatives and neighbours would always step in to help if a child needed motherly care. Stories have been told of where a mother dies post partum, and either breastfeeding mothers would contribute breast milk for the baby, or the baby’s grandmother would put the baby and induce re-lactation.

As a result of the worsening economic situation in the country, many women are working outside their homes and would not have time to take care of orphans. Moreover, the number of orphans is on the increase as result of unwanted pregnancies (mostly among) teenagers. These teenagers either abandon the babies on the streets, or take them to orphanages, where they would be cared for.

The situation of orphans as reported by Wolf and Fesseha (1995) and Ford and Kroll (1995, in McKenzie, n.d.) were among the factors that guided this review. Furthermore, the evidence provided by Pollak’s study and reported by Carlson (2003) on the adaptability of the brain in the right environment, is an indication that if the caring practices (including child stimulation) in the orphanages in Nigeria are improved, many aspects of their development could be supported and improved.
Caring Practices

Care is manifested in the ways a child is fed, nurtured, taught and guided. It is the expression by individuals and families of the domestic and cultural values that guide them (UNICEF, 1998).

During the 1990s, care came to be defined as the behavior and practices of caregivers (mothers, siblings, fathers and child care providers) who provide the food, health care, psychosocial stimulation and emotional support necessary for the healthy growth and development of children (Allen & Gillespie, 2001). These practices translate food security and health care resources into a child’s well being. Not only the practices themselves, but also the ways they are performed in terms of affection and responsiveness to the child are critical to a child’s survival, growth and development (Engle et al., 1997).

Food, health and care are all necessary for healthy survival, growth and development. According to Friedman and Amadeo (in press), one way of categorizing influences on children is to divide the environment into a continuum ranging from proximal (close) to distal (distant) Proximal aspects of the environment are directly experienced by the child and include both physical and social dimensions. Distal aspects of the environment are concerned with resources such as availability of a water source inside the house, amount of food available on a daily basis, or the energy and knowledge of a primary caregiver, and affect child nutrition indirectly. These could be compared to Bronfenbrenner’s micro, meso, and exosystem (Berk, 1999).
Care practices or behaviours, then, are proximal aspects of the environment that are primarily social and influence children’s growth and their development.

**Critical Caring Behaviours**

According to UNICEF (1998), feeding, protecting children’s health and support and cognitive stimulation for children are among the range of caring behaviours that are most critical.

**Feeding.**

According to Sanghvi (1999), the most cost-effective, widely applicable, and manageable nutrition interventions protect promote and support the achievement of the following priority nutrition outcomes: a) exclusive breastfeeding; b) appropriate complementary feeding with continued breastfeeding for two years; c) adequate nutritional care during illness and severe malnutrition; and d) adequate micronutrient intake (e.g., Vitamin A, Iron and Iodine).

**Exclusive breastfeeding.**

Breast milk provides the best nourishment for the child for the first six months of life (King, 1992). Exclusive breastfeeding is recommended for this period. The young infant requires no fluids other than breast milk. When infants are given solid foods, or even non-milk fluids, the prevalence of diarrhea is much higher due to the contamination of the bottles or food. However, in conditions where breast milk is either available or unsafe, infant formula may be given to the baby.
Appropriate complementary feeding.

Complementary feeding is the period during which foods or liquids are provided along with continued breast-feeding. This usually starts when the baby is six months old. Complementary feeding is poorly done in developing countries, due to lack of information about what foods are appropriate, how much should be given, how they should be given, and their inadequacy in quantity and quality among other problems (Allen & Gillespie, 2001). The nutrient content of the complementary foods can be improved by increasing the energy intake, increasing protein intake and improving the bioavailability of nutrients in plant-based complementary foods. The energy density can be increased by reducing the viscosity of cereals with amylases (Allen & Gillespie, 2001). This can be done by germinating local cereals. For example, the most common base for complementary food in Nigeria is maize. This is usually made into pap or gruel, which is viscous. Germination of the maize grains before processing of the maize into pap/gruel, helps to reduce the viscosity and increase the energy density. Infants’ protein intake can be increased by increasing the consumption of animal products or by careful combination of plant proteins.

Caregivers should be aware that the following principles (FADU) are key to feeding young children successfully (Sanghvi, 1999):

- Adequate **Frequency** of feeds
- Sufficient **Amounts** of food at each feed
- Use of foods to increase nutrient **Density** in the diet
- Ensuring that the food is **Utilized** after it is eaten (e.g., by reducing infections from contaminated foods).
Inasmuch as the quality and quantity of the child’s food is of importance, many practices related to how food is actually provided to the child and fed to him have also been found to influence nutrient intake (Engle, 1999). Four aspects of proximal behaviours that are part of complementary feeding and that affect intake are:

- Adapting the feeding method to the child’s psychomotor abilities (e.g., spoon handling)
- Feeding responsively, including encouraging a child to eat, attending to possible poor appetite, being warm or affectionate toward the child during feeding.
- Creating a satisfactory feeding situation by reducing distractions, developing a consistent feeding schedule and supervising and protecting children during eating
- Timing of feeding, including feeding frequently and feeding when the child is hungry.

Adequate nutritional care during illness.

Diseases such as pneumonia, diarrhea, measles, HIV/AIDS, malaria and fevers cause serious feeding problems and damage the nutritional status of children (Sanghvi, 1999). When children are ill, they lose their appetite, stop or reduce eating and experience nutritional losses. Caregivers need to recognize signs of illness and related feeding problems early and take active steps such as treating the illness and feeding enough fluids and foods.

However, some harmful traditional caring practices and outdated advice by health workers frequently lead to inappropriate nutritional care of sick and
malnourished children until it is too late. A common traditional practice in Nigerian communities is to withhold food from the child for some time because it is believed that the food would irritate the gut and aggravate the diarrhea. Without early detection of feeding problems and appropriate nutritional supplementation, many children with common diseases of childhood die or become disabled or severely malnourished. The child should be “actively fed” to prevent and manage common problems, and to help put the child on the way to recovery.

*Adequate micronutrient intake.*

Increasing the consumption of animal products is one strategy for improving the bioavailability of micronutrients (Allen & Gillespie, 2001). Animal products are high in most micronutrients, and many minerals and vitamins are better absorbed from foods of animal origin than they are from plant-derived foods. In developing countries, as a result of poverty and/or harmful cultural practices, children often receive small amounts of foods that contain animal products, if any. In some communities, it is believed that children who are fed eggs and meat would have the tendency to steal. Animal products usually contain more retinol, iron and zinc than plant products. When specific fruits rich in vitamin C (e.g., citrus) and vegetables are added to the complementary foods made with cereals and legumes, the bioavailability of micronutrients in the foods is improved; because vitamin C helps in the absorption of iron. A liberal intake of yellow, orange and dark green leafy fruits and vegetables provide good plant sources of vitamin A and Iron- the vitamin A is present in the form of beta-carotene. Beta carotene is converted to Vitamin A in the body. The use of iodized salt in cooking ensures an adequate intake of iodine in Nigeria.
Protecting children’s health.

Ensuring that children receive essential health care at the right time is another important caring behaviour. For example:

- Taking children as scheduled to complete a full course of immunizations (BCG, DPT and measles) before their first birthday. In 1999, 25 percent of children in South Eastern Nigeria were fully immunized and 18 percent had no immunization (UNICEF//FGN, 2001).
- Disposing of faeces, including children’s faeces safely; and washing hands after defecation, before preparing meals and before feeding children).
- Protecting children in malaria-endemic areas, by ensuring that they sleep under insecticide-treated nets.
- Adopting and sustaining appropriate behaviour regarding prevention and care for HIV/AIDS affected people, including orphans.

Sound health information needs to be made available to communities and families and those caring for children need to be supported in seeking appropriate and timely health care (UNICEF, 1998).

Cognitive stimulation for children.

A third set of care practices that influence survival, growth and development of children are social, emotional and cognitive interactions between caregivers and children. These practices include responsiveness of the caregiver to the child, the attention, affection and involvement that the caregiver shows, and encouragement of autonomy, exploration and learning (Engle, 1999).
A caregiver shows responsiveness when she is aware of the children’s signals and needs, interprets them accurately, and responds to them promptly, appropriately and consistently. The behaviours of the caregiver when a child cries or fusses is an illustration of responsiveness. The most appropriate response by a caregiver changes with the child’s developmental state. Caregivers who talk to their children in simple language, and respond to children’s verbal play, will help their children learn language earlier. Attention, affection, and involvement shown by caregivers also influence children’s survival, growth and development. According to Engle (1999), the most important factor in a child’s healthy development is to have at least one strong relationship or attachment with a caring adult who values the well-being of the child. Lack of a consistent caregiver can create risks for children. The child needs frequent positive interactions.

Young children are born with the ability to learn, but they need encouragement and freedom to develop that ability. Caregivers need to provide safe conditions for play, encourage exploration and provide learning opportunities in addition to good nutrition. Table 1 shows some caring practices and specific behaviours to demonstrate such practices:

Table 1: Caring Practices

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<thead>
<tr>
<th>Care Practice</th>
<th>Behaviours</th>
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<td>Complementary feeding</td>
<td>Timely introduction of complementary foods</td>
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<td>Frequent feeding</td>
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<td>Care Practice</td>
<td>Behaviours</td>
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<td>Feeding responsively</td>
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<td>Adequate feeding situation</td>
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<td>Ensuring adequate intra-household food distribution for children</td>
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<td>Appropriate response to poor appetite</td>
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<td>Food Preparation</td>
<td>Food preparation, cooking and processing</td>
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<td>Food storage</td>
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<td>Food Hygiene</td>
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<td>Hygiene Practices</td>
<td>Hand washing</td>
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<td>Bathing and cleaning child</td>
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<td>Cleaning house and children’s play area</td>
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<td>Adequate disposal of children’s wastes</td>
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<td>Use of sanitary facilities</td>
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<td>Making water safe, and choosing safe water.</td>
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<td>Home Health Practices</td>
<td>Prevention of illness</td>
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<td>Diagnosing illnesses</td>
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<td>Providing home, treatment, feeding during illnesses</td>
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<td>Care Practice</td>
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<td>Using preventive and promotive health services</td>
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<td>Timely seeking of curative health services</td>
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<td>Control of pests</td>
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<td>Avoidance of accidents</td>
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<td>Prevention of abuse/violence</td>
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<td>Psychosocial Care</td>
<td>Adapting behaviour to child’s developmental cues</td>
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<td>Attention to low activity levels and slow development of child</td>
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<tr>
<td></td>
<td>Frequent positive interactions (touching, holding, talking)</td>
</tr>
<tr>
<td></td>
<td>Maintenance of valuable traditional practices</td>
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<tr>
<td></td>
<td>Encouragement of playing, exploration, talking</td>
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<tr>
<td></td>
<td>Adoption of a teaching or guiding role</td>
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<tr>
<td></td>
<td>Prevention and protection from child abuse and violence</td>
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Source: Engle, 1999
Orphanage Care

Research indicates that care practices are associated with improved survival, growth and development (Engle, 1999). In an article, “Caring for Unaccompanied Children under Difficult Circumstances,” Long et al. (n.d.) propose that caring acts as a catalyst or effect modifier that increases the effectiveness of the intervention or allows an intervention to be delivered in a more sensitive manner. The authors observe that through caring practices, the majority of children, particularly, those who were traumatized made a complete recovery. Other indicators of recovery, apart from achieving the target weight for height, include children smiling; taking an interest in their surroundings; paying attention to their appearance; regaining their dignity; interacting and conversing with other children and the staff; playing; beginning to tell their story; starting to form friendships and to trust the adults providing care in the centre.

Wolf and Fesseha (1995) state, “There is a general agreement that unaccompanied children placed in institutional settings at a young age and for long periods are at greatly increased risk for psychopathology in late life.”

Wolf and Fesseha (1995) compared mental health and cognitive development of 9-12 year old Eritrean orphans living in two orphanages. Their results showed that the orphans who had personal interactions with staff members showed significantly fewer behavioural symptoms of emotional distress than those who did not have such interactions.

Medical research has shown that the most rapid period of brain development occurs in the first few years of life and that the experiences of early childhood have
an enduring effect on an individual’s future learning capacity. “The brain of a
ewborn is composed of trillions of neurons,” according to Begley (1996, in World
Bank, n.d.1):

all waiting to be woven into the intricate tapestry of the mind. Some of the
neurons have already been hard-wired but trillions upon trillions more are
pure and of almost infinite potential. The experiences of childhood determine
which means are used, that wires the circuits of the brain. Those neurons that
are not used may die. The experiences of childhood determine whether a child
grows up to be intelligent or dull, fearful or self-assured, articulate or tongue
tied.

The results of the work of Wolff and Fesseha (1995) are consistent with
research findings on brain development. The interaction of the children with the staff
is a form of stimulation. Brain stimulation by input from the surrounding environment
continues to establish new synapses (Berk, 1999)

In his paper “Orphanage Alumni: How They Have Done and How They
Evaluate Their Experience,” Richard B. McKenzie (n.d.) reports the findings of a
survey research on orphans who are now middle-aged or older. The paper seeks to
offer new evidence on what orphanages may or may not have accomplished by asking
the orphans how they have done in life and how they look back on their orphanage
experiences.

The findings of the research suggest that scholars of institutional care several
decades ago, who have been serious critics of orphanages, may have missed some
consequences of long-term institutional care that orphans themselves found
beneficial. For example, Ford and Kroll (1995, in McKenzie, n.d.) maintain that, “fifty years of research reconfirms the same findings: long-term institutionalization in childhoods lead to recurrent problems in interpersonal relationships, a higher rate of personality disorder, and severe parenting difficulties in life.”

McKenzie (n.d.) found out that:
o The respondents have a high school graduation rate of 88 percent, which is 17 percent higher than the 75 percent graduation rate for Whites in the general population 45 years of age and older.
o Assessing the emotional impact of orphanages on the children is difficult under the best of circumstances. Impact of separation from parents and family members can be substantial in the short term, given that the children must make major adjustments. Over the long term however, the impact need not be so great, given that children who are familiar with deprivation usually can find ways of coping. Only thirteen percent of the respondents reported that they had suffered from mental or emotional problem serious enough to seek the services of psychologist or psychiatrist (2.5 percent of the 13 percent reported problems for which they had sought counselling were related to their orphanage experience).
o In the overall assessments of their orphanage stays, 76 percent of the respondents gave their orphanages a very favourable rating.
o Length of stays in orphanages does not appear to have adversely affected all the measured outcomes, contrary to what may be conventional professional
positions on the issue; instead, length of stay appears to positively impact the respondents’ level of happiness’ and their overall assessments of their stays.

McKenzie however admits that not all orphans were helped by their orphanage experience. Some orphans (though in the great minority) were actually “damaged” in one way or another. This work is very interesting because the results are quite contrary to majority of the work and literature on orphanages.

Most of the published works on orphans raised in orphanages are written by people who observed/studied the effect of the orphanage environment on the development of the children in their formative years. McKenzie’s work, though focused on Orphanage Alumni, would have certain aspects of his report be of relevance—for example, taking into consideration, the length of time spent in the orphanage as different aspects of the caring practices are assessed.

Another research study carried out by Pollak, of the University of Wisconsin, Madison was reported by Carlson (2003) in the report *Orphanage Experience Alters Brain Development*. The study shows that children adopted from Eastern European orphanages into United States’ families suffer from a set of developmental problems that affect their growth, learning and social interactions. Pollak and other researchers studied children and the problems they face, and thereafter developed a better understanding of how early childhood experiences can alter the development of the brain and, as a result, also alter the development of particular skills or abilities.

Certain skills and abilities were studied among 5 and 6 year olds who have suffered a profound experience early in life. During their first 7 to 41 months of life, these children lived in Russian and Romanian orphanages.
The conditions of these orphanages ranged from ‘poor’ to ‘appalling.’ In many of them, the orphans spent the entire day in toy-less cribs, housed in quiet colorless rooms; they wore clothes that didn’t fit and they had little contact with caregivers. So few adults were caring for so many children that the environments were generally void of stimulation and human interaction.

After adoption, the children were set free from the most deprived environments. They now became part of well-educated, affluent, stable and loving families – in an environment optimal for children.

Despite the changes, as the children adjusted to their new surrounding, they continued to experience a number of physical and behavioural problems, such as ear and gastrointestinal infections, malnutrition and delayed growth. However, Pollak says that these problems vanish within a year of the children’s arrival in the United States. For some children, physical and behavioural problems persisted, for example, difficulties in learning and forming social bonds. As a result of this, the children were often diagnosed with intellectual delays, attachment disorders and/or Attention Deficit Hyperactivity Disorder (ADHD).

All the children studied performed well on tasks that required visual-perception skills such as arranging blocks in patterns. However, more than half of them showed extreme difficulties in paying attention to verbal information. When the children had to listen to words, remember a task and act quickly, many of them had a hard time.

All the children showed some delays in sensory-motor development. They had poor balance and difficulty integrating movement of the right and left sides of their
bodies, often making them clumsy. The researchers speculate that these motor delays may be caused by the lack of opportunities children in orphanages have to crawl or explore during infancy. The study also found that while a deprived environment appears to hinder some aspects of development among the adopted children, an enriched one enhances it. According to the results of Pollak and his fellow researchers, the longer children had been living with their adoptive families, the better they performed on many of the tests.

Among other things, these findings point to the significance of early experience on the development of the brain. Pollak speculates that it was the early orphanage experience (i.e., the lack of stimulation and interaction with others) that influenced the development of certain abilities and disabilities among the adopted children. The study also provides evidence that certain parts of the brain require stimulation for optimal development; the most amazing part is that it also shows just how adaptable the brain can be in the right environment.

Steele (2000), in an article titled “Study of Russian Orphanages May Impact Facilities There as Well as Childcare Centers Internationally” compared the way caregivers in a Russian orphanage were feeding children and the way a visiting mother was feeding her own child. The mother sat facing her baby talking to him, smiling, pausing to let him swallow before giving him another spoonful. Caregivers, in contrast, sat side by side with children. They quickly and silently fed them with a utensil that resembled a small shovel. There was no eye contact and much of the food ended up on the children’s bibs. The reason for the caregivers not wanting to get too attached to the children is that foreigners adopted the healthier ones or the children
may go back to their birth families. The caregivers do receive counselling about the importance of emotional attachments in the healthy development of children, but the skills and knowledge may not be put into practice as suggested by Steele’s (2000) study.

In another orphanage, some caregivers wondered aloud whether providing an emotionally supportive environment might actually harm children who move on to the next level of orphanages, because conditions in the latter are generally worse. The caregivers were informed that the preponderance of evidence is that older children are likely to fare better in a worse environment if they have experienced a healthy caring environment at a younger age.


- can be devastating and enduring. Whether or not children are well nourished during their first years of life can have a profound effect on their health status as well as their ability to learn, communicate, think analytically, socialize effectively and adapt to new environments and people. Good nutrition is the first line of defence against numerous childhood diseases, which can leave their mark on a child for life. In the area of cognitive development, when there isn’t enough food, the body has to make a decision about how to invest the limited foodstuffs available. Survival comes first; growth comes second. In this nutritional triage, the body seems obliged to rank learning last.

- Direct physiological crippling, such as retarded brain growth and low birth weight, causes some of the developmental problems experienced by malnourished
children whereas other conditions are the result of limited and abnormal interaction and stimulation vital to healthy development. Good nutrition and good health are very closely linked throughout the lifespan, but the connection is even more striking during infancy. More than 50 percent of child deaths in low-income countries can be attributed to malnutrition.

Martorell (1996) goes on to explain that poor nutrition during intrauterine life and early years leads to profound and varied effects including:

- Delayed physical growth and motor development
- General effects on cognitive development resulting in low IQ’s
- Greater degree of behavioural problems and deficit social skills at school age
- Decreased attention, deficit learning, and lower educational achievement

Strong evidence, according Martorell (1996), suggests that the earlier children begin benefiting from nutrition interventions the greater the improvement on behavioural development. In the case of physical growth, nutrition interventions may be effective only during pregnancy and the first 2-3 years of life. For behavioural development, nutrition interventions may have a benefit, although much reduced, at later ages.

Evidence indicates that substantial improvements can be achieved, even in severely malnourished children, if appropriate steps are taken at a young age to satisfy nutritional and psychological needs. The longer the developmental delays remain uncorrected, the greater the chance of permanent effects. Levinger (2000) reports of the Cali Preschool Study: According to him, this study examined the effects of a combined program of nutritional supplementation, cognitive stimulation and
health care on the development of lower class preschool children in Cali Colombia. The investigation involved 240 3-year-old subjects who were assigned to either a nutrition plus stimulation plus health care condition to a nutrition plus health care only treatment. Results obtained at the end of the study’s second year showed that subjects experiencing two years of the comprehensive intervention improved in verbal reasoning and general knowledge, whereas children in the nutrition plus health care only groups did not show comparable improvements. Furthermore, the performance of the nutrition plus health care only groups on the cognitive measures was not substantially different from that of low socio-economic status subjects in the control groups. In developing countries, where few children live to see their situation improve, once the effects of under-nutrition are established in early childhood, they typically become permanent. The intellectual potential of such children at school entry most likely is already damaged and irrevocable.

The importance of early nutrition interventions and their relationship to cognitive ability in the short and long term is very clear. Both nutrition and early stimulation programs work better when children benefit from them simultaneously.

The article by Martorell (1996) explains in detail the importance of two of the caring practices that will be assessed in this study:

- Quality of complementary foods
- Micronutrient supplementation and/or dietary diversification to ensure adequate micronutrient intake

It also stresses the importance of early interventions to minimize impact of the assault of malnutrition.
Bundy (1996, in World Bank, n.d. 3) states that of the most prevalent infections and diseases – acute diarrhea, malaria, measles and intestinal parasites – are said to have the tendency to achieve their highest incidence during this phase, and claim millions of young lives yearly. Prevention in early childhood is needed to avoid the constraints of these illnesses on physical and intellectual development and their long-term consequences for human capital development. For many of the most prevalent conditions, cheap and simple interventions have proved effective, for example, immunization against measles, ORT for diarrhoea, and anthelminthics for parasitic infestations (e.g., malaria). Other interventions, for example, the use of bed nets for controlling malaria have proven to be effective at operations research level.

A comprehensive program of care for young children, however, extends beyond disease control. Vitamin A supplementation enhances recovery from measles. This comprehensive package is a sure way of promoting early childhood development.

Children left without parental care at birth are often delayed in their growth and development in comparison to their peers growing in families. One of the reasons for this is the significant deficiency of care for their mental development on the critical period of early infancy, which they spend in government orphanages.

**Resources for Care**

Giving attention on caring practices without considering the resources for the care, may lead to a situation where the caregiver is blamed for inadequate care. Care practices cannot occur without resources to provide the care. According to Engle (1999), the distal aspects of the environment that provide resources for care can be
human, economic or organizational. Human resources at the family level include the caregivers’ knowledge, belief and education, and the physical and mental health and confidence that put that knowledge into practice. Economic resources include the caregivers’ autonomy and control of resources, economic support, and time (plus control of that time) in order to provide care.

In summary, caring practices have been presented as behaviours that promote child survival, growth and development. These include interventions in appropriate feeding, health protection/management, and mental stimulation. The focus is on the child (the child is at the centre) and not on the individual interventions. This strategy produces a synergistic effect that is required for the holistic development of the child, which occurs within a context – family or orphanage. Childcare is provided by someone (e.g., the caregiver), and the quality of the resources for care (human and material) should be taken into consideration.
CHAPTER 3: PROJECT DESCRIPTION

The Motherless Babies’ Homes

This study was carried out in two motherless babies’ homes in Abia State, Nigeria:

(i) Compassionate Home, Ahiaeke, Umuahia North Local Government Area
(ii) Agape Motherless Babies’ Home, Ubakala, Umuahia South Local Government Area

The Compassionate Home Ahiaeke was opened in 1992 by the Mercy Sisters of the Roman Catholic Church, with a mission of offering holistic care to the less privileged in society, especially orphans and abandoned children. The Mercy Sisters see to the day-to-day running of the home, with 10 women (caregivers) who come in daily to help. The caregivers work in shifts (three women per shift) of morning, afternoon and night, and they are paid.

Fifty-five children live in this orphanage:

- 20 children aged 0-7 months
- 15 children aged 7 months-3 years
- 20 children aged 3-18 years

Individuals, groups and organizations make voluntary donations both in cash and in kind to help the Mercy Sisters in the upkeep of the home.

The Agape Motherless Babies’ Home was founded in the year 2000 by pastors from a few Pentecostal churches and a young lady who is a graduate in linguistics and a diplomat in International Affairs. The young lady sees to the day-to-day running of
the home. The mission of Agape Home is to give care to destitute children. At present (December 2003), it houses six children aged 0-3 years. Three caregivers take care of the children and they live in the home. Unlike the Compassionate Home, this home depends solely on charity for its upkeep.

A letter was written giving information on the aim of the study and its objectives, which would be achieved at the end of the study. A copy of the project proposal was submitted with the letter.

Letter of Introduction from Government and Preliminary Visit

This letter was written by the Executive Secretary of the State Planning Commission, who is also the Chairman of the State Committee on Food and Nutrition. The letter solicited for maximum cooperation from the homes (see Appendix I). The letter was given to the homes by the researcher during a preliminary visit.

The purpose as well as modality of data collection was explained to them and their cooperation sought. Confidentiality of the information given was also emphasized.

Data Collection

For this work, two data collection methods were used: observation and use of questionnaires.

Questionnaire.

A questionnaire designed to collect information on different aspects of care was constructed. The questionnaire sought information complementary feeding,
micronutrient supplementation, faeces disposal, immunization and protection from malaria. Other important information sought were on child stimulation, nutritional care of the sick child, care of HIV/AIDS orphans and actions against further infections, protection against injury and prevention of abuse and neglect. Information was also sought on fathers’ involvement in childcare, ability of the caregiver to recognize when the children need treatment outside the homes, ability of caregivers to follow health workers’ advice on treatment, follow ups and referrals. The questionnaire was pre-tested and necessary amendments made before it was administered in the final form.

Observation.

Permission was sought from authorities of the homes to visit the homes at my convenience and to visit any part of the homes for observations. An observation guide/checklist with already set behaviours was prepared (Appendix V). The behaviours to be observed centered on:

- Interactions between caregivers and children to see if there were child stimulation activities (both psychosocial and physical stimulation).
- Child to child interactions.
- Food preparation techniques.
- Sanitary conditions of the kitchen and toilet areas.
- The sleeping areas especially with regard to mosquito prevention.

The observation checklist in Appendix V was used. The checklist was written to assess the aforementioned behaviours.
Administration of questionnaire.

The questionnaire (included in Appendix IV) was pre-tested in the Compassionate Home, Ahiake. Although the questions were written in English, I had to ask the caregivers in Igbo, the local language, because of their low literacy level. The pre-testing exercise afforded me the opportunity to reframe the questions and, in some cases, make further explanations so that the questions would be clearer and easier to understand.

The questionnaires were administered to six (out of the 10) caregivers in Compassionate Home, Ahiake and to the three caregivers in Agape Motherless Babies’ Home, Ubakala.

Data analysis.

Data was analysed, using descriptive statistics. The statistical tools in the analysis is percentages, expressed in the form of charts.

Development of Training Program and Training of Caregivers

The program in Appendix III was developed and a training session was arranged with the homes. During the training, emphasis was placed on areas of deficiencies as observed during the observation sessions. A copy of the training program is located in Appendix III.

The training program was carried out separately at each of the two homes, Compassionate Home Ahiake and Agape Motherless Babies’ Home Ubakala. In each case, the findings of the questionnaire were reviewed and then the program was conducted. The training took approximately one day to deliver at each of the two
homes. Six caregivers participated in Ahiaeke and three participated in Ubakala. At
the end of the training, there was a question and answer session, followed by a
general discussion on all the caring practices.

Recommendations regarding the need for training are included in Chapter 7.
CHAPTER 4: RESULTS/FINDINGS

The results/findings of the study obtained are as follows and will be discussed in the next chapter:

1. Complementary Feeding

*Figure 1.1 Age at which foods other than infant milk formula was given*

Many (56%) mothers gave other foods at 6-9 months. Some (22%) had even done so at 0-3 Months.

*Figure 1.2 Age at which infant milk formula was stopped*
Figure 1.3 Who feeds the children?

Most of the infants fed themselves.

Figure 1.4 Do you feed maize porridge to children 6-12 months?

All (100%) of the children were fed maize porridge at 6-12 months (Fig 1.4). Most (89.9%) fed thick porridges and the rest (11%) fed thin porridges (Fig. 1.5).
1.5 If answer to 1.4 is yes, what kind of porridge is it?

*Figure 1.5 Consistency of maize porridge*

![Figure 1.5 Consistency of maize porridge]

*Figure 1.6 Percentage having additions to maize porridge*

![Figure 1.6 Percentage having additions to maize porridge]

All respondents added something to the porridge (Fig.1.6). Most (67%) claimed that they added milk, some (22%) added soybean powder and 11% added sugar (Fig.1.7)
Figure 1.7 Additions to maize porridge
2. Micronutrient Intake/Supplementation

Figure 2.1 Brand of salt used for cooking

Many (55%) identified the salt they use for cooking as Dangote salt, 22% used Cassava brand and the rest (22%) did not know the brand of salt used for cooking in the homes.

Figure 2.2 Iron supplementation for children

Seven out of the nine caregivers said that the children received an iron supplement, one said that they did not, while one person did not know if the children received the supplement or not.
3. Faeces Disposal and General Hygiene

Figure 3.1 Handling/disposal of children’s faeces

Most (77.8%) dispose of faeces by throwing them into the latrine and the rest (22.2%) said that the children always used their toilets or gave other responses.

Figure 3.2 Hand washing with soap

Over a half (55.6%) washed their hands after using the toilet and 22% did so after attending to a child who had defaecated.
Figure 3.3 Source of water used in the homes

The homes obtained the water which they used, from water bore holes.
4. Immunization Schedule

Figure 4.1 Frequency of immunization.

Many (55%) responded that the opportunity of National Immunization Days (NIDs) was seized to immunize the children and the rest (44%) responded that the children were immunized regularly.
A check on the individual immunization cards of the children showed that 67% of them had none of the vaccines/supplements and 22% had all the vaccines/supplements (Fig. 4.2).
Most (78%) claimed that they weighed the children whenever there was a good weighing scale, 11% weighed them when they are brought into the homes while the remaining 11% never weighed the children because they did not think it necessary to weigh them (Fig 4.4)

4.4 If answer to (4.3) is NEVER, why not?

Figure 4.4 Reasons for not weighing children
4.5 If the children are weighed in (4.3), what do you do with the weights you get?

*Figure 4.5 Use of weights of children when taken*

Many (67%) plot the weights of children on individual health growth charts and 22% show them to the doctor. 11% do not know what to do with the information on the growth of the children.
4.6 What are your sources of advice on feeding the children?

*Figure 4.6 Sources of advice on feeding the children*

The major (67%) source of advice on child feeding was the doctor. In no instance was the advice from a nutritionist.
5. Protection Against Malaria

5.1. In your opinion, what causes malaria?

*Figure 5.1 Respondents opinion on causes of malaria*

44.4% of the respondents did not know the cause of malaria, 11% attributed it to eating too much (excessive) palm oil, while 44.4% attributed it to other causes (mainly mosquitoes)-Fig. 5.1. Many (44.4%) screen doors and windows to prevent malaria. A few 33.3% do so by keeping their environment clean (Fig. 5.2). A few (11%) use insecticide treated nets while majority use ordinary nets. (Fig. 5.3),. Only one respondent said nets were treated with a mosquito killing agent (Fig. 5.4) and this was usually done after 7 months (Fig. 5.5).
5.2 What methods do you use to prevent malaria?

*Figure 5.2 Methods of malaria prevention*
5.3 What type of nets do you use?

![Diagram](image1.png)

*Figure 5.3 Type of net used to prevent mosquitoes*

**Figure 5.4 Are the nets ever treated with a product that kills mosquitoes?**

![Diagram](image2.png)
5.5 If the answer to 5.4 is Yes, at what intervals are the nets treated with a product that kills mosquitoes?

*Figure 5.5 Intervals of treatment of mosquito net*
6. **Child Stimulation**

6.1 How do you communicate with the children?

*Figure 6.1 Means of communication with the children*

Many (44%) did not communicate with the children. A few (11.1%) did so by talking to them and 45% did so through songs. (Fig. 6.1). Many (%6%) of those who communicated with children reported doing so more than 10 times per week. Some did so for 6-10 times and 11.1%, less than once a week.
6.2 If you do communicate with them, how often?

*Figure 6.2 Frequency of communication with children*

6.4 What type of recreational activities do the children engage in?

*Figure 6.4 Types of recreational activities for children.*
7. Nutritional Care of the Sick Child

7.1 During which children’s illness do you withhold fluids?

*Figure 7.1 Withholding of fluid during illness*

Foods are withheld during malaria (33.3%) and diarrhea (22%). Some caregivers however (45%), will give more food during diarrhea.

7.2 During which children’s illness do you offer more food?

*Figure 7.2 Offering of food during illness*
7.3 After the child gets well, how much food do you offer?

*Figure 7.3 Quantity of food given to a child on recovery from illness.*

Many (88%) will give more food to a recuperating child. Some (11%) would give same as before illness.
8. Care for HIV/AIDS Orphans and Actions Against Further HIV Infection

8.1 Have you ever heard of HIV/AIDS before?

*Figure 8.1 Knowledge of HIV/AIDS*

All (100%) respondents had heard of HIV/AIDS (Fig. 8.1). 88% knew that it could be prevented through pre-screening of blood before transfusion and 12% by safe sex (Fig. 8.2)

8.2 How can HIV/AIDS be prevented?

*Figure 8.2 HIV/AIDS prevention*
8.3 How many of the children in this home have been screened for the virus?

*Figure 8.3 HIV/AIDS screening*

All the children in the homes have been screened for HIV/AIDS (Fig. 8.3) and one of the respondents reported that some children tested positive in Ahiaeke (Fig 8.4). Most of the caregivers said that unaffected children should be protected from the virus by avoiding the sharing of injection needles (Fig. 8.5).

*Figure 8.4. Responses to number of children who are HIV positive.*
8.5. If any have been found to be HIV positive, how are other children being protected?

*Figure 8.5 Methods of protection against HIV/AIDS*
9. Protection Against Injury

9.1 Which of the following precautions do you take against child injury

*Figure 9.1 Precautions taken against child injury*

Measures to prevent child injury (Fig. 9.1) included keeping sharp instruments out of their reach (56%) and fencing of ponds (22%) and all the caregivers said children’s play activities were supervised. (Fig. 9.2)
9.2. Does any caregiver attend to / supervise the children when they are playing?

*Figure 9.2 Supervision of children’s play activities.*
10. Prevention of Abuse and Neglect

10.1 How do you discipline the children?

*Figure 10.1 Methods of child discipline*

Discipline consisted mainly of scolding the children.

10.2 What type of work do the children help with in the home?

*Figure 10.2 Children’s work in the homes*

44% of the respondents said that the children did not do any work. However, 22% in each case said the children helped with fetching water and sweeping (Fig. 10.2). All the caregivers said that female orphans are not circumcised (Fig. 10.3)
Figure 10.3 Age at which female orphans are circumcised
11. Fathers’ Involvement in Childcare (For Children Whose Fathers Are Alive)

11.1 How often do the fathers visit?

*Figure 11.1 Frequency of fathers’ visit.*

Many (44%) of the caregivers say that the fathers visit once a month. A few reported that fathers visit twice yearly while in a very few cases, the fathers had never visited. (Fig. 11.1) The fathers’ interest is mainly in the overall well being of the children. (Fig. 11.2).
Figure 11.2 Fathers’ interest when they visit the homes

- 7 fathers want to see if they are ready to be taken home.
- 2 fathers want to see if they are getting fat.
- They want to see if there’s some sort of contribution they’ll make.
- All in all, well being of the child.
12. Home Treatment of Infections

12.1 What infections are children in this home prone to?

Figure 12.1 Common infections in the homes
12.2 What do you do for the children in the home during an infection/illness before seeking advice or treatment outside the home?

*Figure 12.2 Action taken during illness/ infection prior to seeking advice or treatment outside the homes*
13. Ability of the Caregivers to Recognize When Sick Children Need Treatment

Outside the Home

13.1 After how many days of illness do you normally go to seek care from outside?

Figure 13.1 Duration of illness before outside care is sought

![Chart showing percentage of caregivers seeking care within different time frames.](chart.png)
13.2 What are the indicators that prompt you to seek outside care?

*Figure 13.2 Indicators that prompt outside care*
14. Ability of Caregivers to Follow Health Workers’ Advice on Treatment, Follow-up and Referral

14.1 Do you give medications as directed by health worker?

Figure 14.1 Administration of medication according to health workers’ directives

14.2 When do you stop medications?

Figure 14.2 Termination of medication
14.3 Do you patronize drug vendors who ‘mix’ drugs for patients?

*Figure 14.3 Patronage of drug vendors*
Detailed Analysis of the Five Days’ Observation

Observation Figure 1: Responsive Feeding

Only one out of the nine caregivers fed a child responsively and this was observed on the fifth day.
On the first and second days of the observation, all the caregivers were seen at one point or another, cuddling the children. However, only eight out of nine were found doing so from the third to the fifth day.

Two of the caregivers played with the children on the second day, three on the first and fifth day and four did so on the third and fourth day.
**Observation Figure 4: Shouting at Children**

On the first and second days, six caregivers were seen shouting at the children, five were seen on the third and fourth days and four on the fifth day.

**Observation Figure 5: Good Facial Expression When Holding Children**

Only one caregiver consistently showed a good facial expression when holding the children.
Observation Figure 6: Washing of Hands before Handling Food

Not all the caregivers washed their hands before handling food. The number, who did, ranged from two to five.

Observation Figure 7: Washing of Hands after Changing Diapers

The number who practiced handwashing after changing diapers ranged from four to seven.
Observation Figure 8: Washing Vegetables Before Slicing

Sometimes, vegetables are not washed before they are sliced.

Summary of Findings

Fourteen caring practices were assessed in two Motherless Babies Homes in Abia State, Nigeria: Agape Motherless Babies’ Home Ubakala, and Compassionate Home Ahiaeke. The assessment was done by drafting an interview questionnaire which was used to interview the caregivers, and also by observation of activities in the homes.

Six out of the 10 caregivers in Compassionate Home and all three caregivers in Agape Home were interviewed. The total sample size was nine. Each caregiver was interviewed in isolation to avoid inputs from other caregivers in the responses.

From the responses and observations:

- There seems to be a low rate of routine immunization, or the children are immunized and this is not recorded in the child health cards.
- The complementary foods of the children are not adequate.
- The children in the homes look mentally withdrawn.
The last point could be attributed to the fact that the children lack mental stimulation, and this agrees with one of the major findings of the study. Also, as cited in the literature review, Ford and Kroll (1995, in McKenzie, n.d.) report that long term institutionalization in childhood leads to recurrent problems in interpersonal relationships.
CHAPTER 5: DISCUSSION

Fourteen caring practices were assessed, and their effect on the nutrition, health and psychosocial development of the children in the orphanages are discussed in this chapter.

Children under six months in the homes were fed infant formula and water. Some are even given complementary foods before the age of six months. This practice is contrary to the WHO/UNICEF recommendation of exclusive breastfeeding for the first six months, addition of complementary foods from six months, and continued breastfeeding until two years. The difficulty in obtaining breast milk for the children is understood. This practice, however, precludes the children from obtaining the benefits of breast milk especially as regards their brain development.

As part of the complementary feeding regime, the children receive a thick maize porridge with a little powdered milk added to it. The maize grains are not germinated before processing to reduce the viscosity and increase the energy density. This is contrary to the recommendation of Allen and Gillespie (2001).

The findings reveal that majority of the children (aged 12-24 months) feed themselves. At this age, children need to be fed to ensure that they have adequate food intake. From observations, the caregivers do not practice responsive feeding. This does not make for optimal development; as Engle et al. (1997) point out, affection and responsiveness are critical to a child’s survival, growth and development.
No symptoms of polio or the other children’s killer diseases were seen and this could be attributed to the immunizations given to the children during the National Immunization Days (NIDs).

There might be confusion in the caregivers’ understanding of iron supplements. In the local language, iron tablet is referred to as “blood tablet” and many people regard children’s vitamin drops as “blood medicine.” The fact that vitamin A is administered during NIDs might be a reason for a higher percentage of caregivers reporting that children receive vitamin A. Salt iodization is a food fortification strategy of combating iodine deficiency and ‘Dangote’ and ‘Cassava’ brands of salt are iodized.

Some of the children in the homes have fathers who are alive, but they are regarded as orphans because their mothers are dead. This falls in line with Ruiz-Casares’ (n.d.) definition of orphan.

The free play that the children engage in is certainly helpful for their muscle development, but the fact that they do not have toys that encourage exploration and mental stimulation is a concern. Few adults caring for many children (as is the case in the Compassionate Home Ahiake) could be the reason why children are just dumped in cots or cribs until they start crying for attention. This does not make for adequate child-caregiver interaction. Engle (1999) advocates having a consistent caregiver as being important for frequent positive interactions. Many caregivers reported in the interviews that they play with the children, but the observation of the writer was to the contrary. Sometimes interviewees give the “ideal” or expected answers.
On recovering from illness, a child is usually offered more food than usual. The reason for this practice might be the improvement in the appetite of the child or that the caregiver makes a conscious effort for the child to regain lost weight. The medication given when the children have coughs suggest that coughs might be accompanied by fevers.

The first objective of this study was to develop a list of the caring practices in the homes that enhance child development. The study has shown that the following practices were observed in the homes:

- Commencing complementary feeding after 6 months.
- Proper faeces disposal.
- Immunization (during National Immunization Days).
- Giving home treatment for infections.
- Recognizing when sick children need treatment outside the home and taking them for care from appropriate providers.

The second objective was to build the capacity of the caregivers so that they would be able to offer adequate care to the orphans. The nutrition training was conducted to build the capacity of the caregivers and it is expected that the quality of care being offered to the orphans would improve.

This study has found out that in the two homes, more attention has been given to the health aspects of care than to the nutritional or psychosocial aspects. This may be as a result of the public health campaigns and health education talks by nurses and other health workers. The psychosocial aspect of care is almost absent. The findings have therefore revealed the need for more sensitization and awareness creation on the
psychosocial development of children. Recommendations as a result of the findings and discussions are presented in the last chapter.
CHAPTER 6: CONCLUSIONS

According to Engle (1999), caring practices and resources vary tremendously by culture. However, children’s basic needs for food, health care, protection, shelter and love are the same in all cultures. Not only culture, but also economic conditions, governmental policies and the ecological environment can influence care practices and resources for care.

As mentioned earlier, reduction in under-five mortality rate was the challenge to which WHO and UNICEF were responding when they developed the Family and Community Practices that promote child survival, growth and development. These are also known as Caring Practices.

In recent times, these practices have been promoted in communities as a major strategy for child survival, growth and development. There has been capacity building for mothers and caregivers at home and early child centres. This study has targeted caregivers in Motherless Babies’ Homes (orphanages) to better equip them to face the challenge of the probable population increase in these homes resulting from HIV/AIDS, and also because they seem to be left out in the capacity building of caregivers in the communities.

Fourteen out of the sixteen practices recommended by WHO were assessed. The fact that only five of these practices are being carried out in the homes could be attributed to lack of information, insufficient funds to purchase nutritious foods and insufficient time on the part of the caregivers to engage in child stimulating activities.

During the nutrition training program, inappropriate practices of food preparation were discouraged, for example, washing vegetables after slicing. At the
end of the training (during general discussions), caregivers were encouraged to continue with all the aspects of care, with a mention of the ideal caring behaviour for each practice.
CHAPTER 7: RECOMMENDATIONS

This study is one of the pioneer works, if not the first, on caring practices in orphanages in Nigeria. Based on the findings the following recommendations are presented to enhance the caring capacity of caregivers and subsequently improve the care of children:

1. More support should come from Government, especially with regard to the payment of caregivers and provision of water and materials for indoor and outdoor games for the children.

2. Government should employ more nutritionists whose job it is to give dietary advice.

3. Soya bean flour should be used to enrich children’s complementary foods.

4. Routine immunization and growth monitoring should be encouraged until the child is six years old. Administration of vitamin A routinely would further help to strengthen the immune system of the children and protect them from constant coughs and fevers.

5. Children should be provided with more toys that would stimulate them mentally.

6. Hand-washing (by caregivers) after the change of diapers should be encouraged.

7. Fathers should be educated on the importance of their interactions with their children when they visit, especially to encourage bonding.

8. The caregivers should be trained not only on nutrition but also on health and psychosocial aspects of the development of the children.
9. Since Government has shown interest in this study, I recommend that the work be carried out in all the Motherless Babies Homes (orphanages) in the state and that the work should be sponsored by Government.

10. Finally, Government should take over the running of the private orphanages, instead of leaving them to be run by donations from the public.
REFERENCES


Public Health Intervention Research Unit, Department of Epidemiology and Population Health, London School of Hygiene and Tropical Medicine.


APPENDIX I: LETTER OF INTRODUCTION FROM GOVERNMENT

GOVERNMENT OF ABIA STATE OF NIGERIA
ABIA STATE PLANNING COMMISSION

TELEGRAMS:

TELEPHONE:

Your Ref............................

Our Ref........ASP.C/S.295/11/257
(All replies to be addressed to the Executive Secretary)

Dear Sir/Madam,

CARING PRACTICE FOR MOTHERLESS BABIES HOMES
IN ABIA STATE OF NIGERIA WITH PARTICULAR
EMPHASIS TO IMPROVE NUTRITION OF CHILDREN

We write to refer to the above subject matter and to introduce
to you the Chief Nutrition Officer in the State Ministry of Health
- Mrs. OLIVE AKOMAS.
2. The State Planning Commission has deemed it wise to introduce
the above-named to you after careful study of her proposal to
contribute towards the improvement, development and delivery
of Nutrition Training Programme in some selected Motherless
Babies Homes in the State.

3. It is our belief that your maximum cooperation to the bearer
on the above project would bring about improved caring practices
in our Motherless Babies Homes as well as ensure quality life
and nutritional care of children. The project intends to support,
encourage and strengthen good and appropriate practices to
care-giving of which you are one.

4. May God bless you as you offer your maximum cooperation
on this matter, please.

Yours sincerely,

CHIEF HOPE O. A. ONYEKWERE,
EXECUTIVE SECRETARY.
APPENDIX II: THE KEY FAMILY PRACTICES WHICH IMPROVE CHILD HEALTH AND DEVELOPMENT

- Breastfeed babies exclusively for six months (HIV-positive mothers need special counselling on infant feeding to understand and practice the safest options).

- From six months, give children good quality complementary foods while continuing to breastfeed for two years or longer.

- Ensure that children receive enough micronutrients – such as vitamin A and iron – in their diet or through supplements.

- Dispose of all faeces safely and wash hands after defecation, before preparing meals and before feeding children.

- Take children to complete a full course of immunization before their first birthday.

- Protect children in malaria-endemic areas by ensuring they sleep under insecticide-treated bed nets.

- Promote mental and social development by responding to a child’s needs for care and by playing, talking and providing a stimulating environment.

- Continue to feed and to offer more fluids, including breast milk, to children when they are sick.

- Give sick children appropriate home treatments for infections.

- Recognize when sick children need treatment outside the home and take them for care from appropriate providers.

- Follow the health worker’s advice on treatment, follow-up and referral.
• Ensure that every pregnant woman has adequate antenatal care and seeks care at the time of delivery and afterwards.

Further important practices that protect vulnerable children:

• Provide appropriate care for HIV/AIDS affected people, especially orphans, and take action to prevent further HIV infections.
• Protect children from injury and accident and provide treatment when necessary.
• Prevent child abuse and neglect and take action when it does occur.
• Involve fathers in the care of their children and in reproductive health.

*Adapted from WHO (n.d.) Improving Child Health in the Community.
APPENDIX III: NUTRITION TRAINING PROGRAM

Nutrition has been expressed as a right in international human rights instruments since 1924. In 1959, the Declaration of the Rights of the Child, adopted by the UN General Assembly, states in principle that children “shall be entitled to grow and develop in health” and that children “shall have the right to adequate nutrition, housing, recreation and medical services” (UNICEF, 1998).

Enfamil (n.d.) states: “Good nutrition is key to your child’s growth and development at every age – as a baby, a toddler, a school aged child, and even as a teenager. The foods you choose to give your child help him grow and develop physically. But, good nutrition is just as important to social-emotional, cognitive and language development.

Observations in the orphanages (by the researcher) were centered on:

- The caregiver-child interactions at mealtimes.
- The caregiver-child interactions outside mealtimes.
- The food preparation methods.
- The sanitary condition of the food preparation area.
- The sanitary condition of the orphanages in general.

The training program was developed to meet the requirements of the homes. These requirements were determined during the observations. Certain behaviours were expected of caregivers at the end of the training, and these were used to determine the training objectives. The topics in the contents section of the program were elaborated on, and taught over eight training sessions.
AIM:

This training is targeted at the caregivers in the orphanages (motherless babies’ homes), and aims to equip them with information and skills required to meet the nutritional requirements of a growing child.

KEY MESSAGES:

• An adequate diet should include a member of each of the food groups from the Food Guide.

• Keep hands, utensils and work area clean to limit the transfer of bacteria from one food to another.

• Ensure that raw foods do not contaminate cooked foods, either directly by contact or indirectly.

• Responsivity of the feeder (including the affective relationship between the child and the feeder/caregiver) when feeding the child.

• Weigh every child (0-5 years) monthly.

EQUIPMENT:

Flip chart, markers, posters, weighing scale, child health cards, food guide.

FEEDBACK:

Q & A Session.
APPENDIX IV: ASSESSMENT TOOL FOR THE CARING PRACTICES IN TWO MOTHERLESS BABIES’ HOMES IN ABIA STATE, NIGERIA

Please fill in the boxes with the number that provides the appropriate answer to each question.

1. COMPLEMENTARY FEEDING

1.1 At what age do you start giving additional foods other than infant formula to children?

1= 0-3 months
2= 4-5 months
3= 6-9 months
4= above 9 months
5= Don’t know

1.2 At what age do you stop giving infant formula to a child in this home?

1= <3 months
2= 3-6 months
3= 6-9 months
4= 9-12 months
5= >1 year
1.3. How many times a day do you feed the children and who feeds them?

<table>
<thead>
<tr>
<th>Age of child (months)</th>
<th>Number of feeds</th>
<th>Feeds self</th>
<th>Fed by adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-6</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>7-12</td>
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<tr>
<td>13-24</td>
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<td>25-36</td>
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<tr>
<td>37-59</td>
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</tbody>
</table>

1.4 Do you feed maize porridge to children 6-24 months?

1= Yes  
2= No

1.5 If the answer to 1.4 is yes, what kind of porridge is it?

1= Thin  
2= Thick

1.6. Do you add anything to this porridge as you prepare it?

1= Yes  
2= No
1.7 If the answer to 1.6 is yes, what do you add?

1= Sugar
2= Margarine
3= Palm oil
4= Pounded Groundnuts
5= Soya beans
6= Milk
7= Ground dry fish
8= Other (specify) __________________

2. MICRONUTRIENT SUPPLEMENTATION

2.1 What brand of salt do you use for cooking?

1= Cassava
2= Dangote
3= No name
4= Any other (please specify) __________________
5= Don’t know

2.2 Do the children receive iron supplements?

1= Yes
2= No
3= Don’t know
3. FAECES DISPOSAL AND GENERAL HYGIENE

3.1 How do you handle or dispose of children’s faeces?

1= Children always use toilet
2= Faeces are thrown into latrine
3= Faeces are buried in the compound
4= Faeces are thrown into the nearest bush
5= Faeces are eaten by dogs
6= Other (specify) __________________

3.2 On which occasions do you wash hands using soap?

Circle the correct numbers.

1= After use of toilet
2= After attending to a child who has defecated
3= Before preparing food
4= Before feeding child
5= Before eating
6= After eating
7= Other (specify) __________________

3.3 What is the source of water in this home?

Circle the correct number(s).

1= River
2= Stream
3= Well
4= Borehole
5= Pond
6= Rain water

4. IMMUNIZATION SCHEDULE

4.1 How often are the children in this home immunized?

1= Whenever vaccines are available
2= Whenever the immunization team visits us
3= During National Immunization Days (NIDs)
4= Regularly
5= Once in a while

4.2 Ask to see the individual immunization cards of the children and check the vaccines/supplements received.

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Immunization Card</th>
</tr>
</thead>
<tbody>
<tr>
<td>BCG</td>
<td></td>
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<tr>
<td>POLIO 0</td>
<td></td>
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<tr>
<td>POLIO 1</td>
<td></td>
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<tr>
<td>POLIO 2</td>
<td></td>
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<tr>
<td>POLIO 3</td>
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<tr>
<td>DPT 1</td>
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<td>DPT 2</td>
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<td>DPT 3</td>
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<tr>
<td>MEASLES</td>
<td></td>
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<tr>
<td>VITAMIN A</td>
<td></td>
</tr>
</tbody>
</table>
4.3 How often do you weigh the children?

1= When they bring them in
2= Monthly
3= Regularly
4= When they are sick
5= When we have a good weighing scale
6= Never

4.4 If the answer to 4.3 is Never, why not?

1= No weighing scale
2= It is not necessary
3= Don’t know the importance

4.5 If children are weighed in 4.3: What do you do with the weights you get?

1= Plot them on individual Child Health Cards
2= Keep them and show to doctor
3= Don’t do anything with it
4= Don’t know what to do with it
5= Any other

4.6 What are your sources of advice on feeding the children?

1= None
2= Doctors
3= Nutritionists

5. PROTECTION AGAINST MALARIA

5.1. In your opinion, what causes malaria?
5.2 What methods do you use to prevent malaria?

1= Mosquito coils
2= Insecticides
3= Screening doors and windows
4= Cleaning the environment
5= No methods
6= Local herbs
7= Others (please specify)

5.3. What type of nets do you use?

1= Ordinary nets
2= Insecticide treated nets

5.4 Are the nets ever treated with a product that kills mosquitoes?

1= Yes
2= No
3= Don’t know

5.5. If yes, at what intervals are the nets treated with a product that kills mosquitoes?

1= <2 months
2= 3 months
6. CHILD STIMULATION

6.1 How do you communicate with the children?

1= Through songs
2= Talking to them
3= Telling them stories
4= Do not communicate with them
5= Playing with them

6.2 If you do communicate with them, how often?

<table>
<thead>
<tr>
<th></th>
<th>songs</th>
<th>talking</th>
<th>stories</th>
<th>playing</th>
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<tbody>
<tr>
<td>&lt;once/week</td>
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<tr>
<td>1-5 times/week</td>
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<tr>
<td>6-10 times/week</td>
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<tr>
<td>&gt; 10 times/week</td>
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</tbody>
</table>
6.3. What type of recreational activities do the children engage in?

1= Children encouraged to play amongst themselves
2= Children given toys to play with individually
3= Caregivers play with children

7. NUTRITIONAL CARE OF THE SICK CHILD

7.1 During which children’s illness do you withhold fluids?

1= Diarrhea
2= Malaria
3= Measles
4= Any other (please specify) __________________________

7.2 During which child’s illness do you offer more food?

1= Diarrhea
2= Malaria
3= Measles
4= Other (please specify) __________________________

7.3 During which children’s illness do you offer more fluid?

1= Diarrhea
2= Malaria
3= Measles
4= Other (please specify) __________________________

7.4 During which children’s illness do you offer more food?

1= Diarrhea
2= Malaria
7.5 After the child gets well, how much food do you offer?

1= Less than usual
2= Same as usual
3= More than usual

8. CARE FOR HIV/AIDS ORPHANS AND ACTIONS AGAINST FURTHER HIV INFECTION.

8.1 Have you ever heard of HIV/AIDS before?

1= Yes
2= No

8.2 How can HIV/AIDS be prevented?

1= Don’t know
2= Screening before blood transfusion
3= Safe sex
4= Avoid sharing barbing instruments

8.3 How many of the children in this home have been screened for the virus?

1= None
2= All
3= Don’t know
4= We don’t screen

8.4 If they have been screened, how many are HIV positive?

1= None
8.5 If any have been found to be HIV positive, how are the other children being protected?

1= Sterilization of barbing instruments
2= Avoid sharing of needles for injections
3= Avoid sharing of toothbrushes
4= Sex education for older ones
5= Any other

9. PROTECTION AGAINST INJURY

9.1 Which of the following precautions do you take against child injury?

1= Fencing of ponds
2= Locking gates
3= Ensuring that floors are not slippery
4= Keeping sharp instruments out of children’s reach
5= Plugging electric sockets
6= Other (list)

9.2. Does any caregiver attend to/supervise the children when they are playing?

1= Yes
2= No
10. PREVENTION OF ABUSE AND NEGLECT

10.1 How do you discipline the children?
   1= Beat them with small sticks
   2= Beat them with hand
   3= Spank them on their buttocks
   4= Scold them

10.2 What type of work do the children help with in the home?
   1= None
   2= Fetching water
   3= Sweeping
   4= Fetching fuel wood
   5= Any other (please specify)

10.3 At what age do you circumcise the female orphans?
   1= Never circumcise
   2= Within the first year of life

11. FATHER’S INVOLVEMENT IN CHILDCARE

   (For the children whose fathers are alive)

11.1 How often do the fathers visit?
   1= More than once a month
   2= Once a month
   3= Every other month
   4= Every three months
   5= Every four months
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6= Twice a year
7= Never

11.2. What are the fathers’ interests when they visit?

1= To see if they are ready to be taken home
2= To see if they are getting fatter
3= To see if there’s some sort of contribution they’ll make
4= Overall well-being of the child

12. HOME TREATMENT OF INFECTION

12.1 What infections are children in this home prone to?

1= None
2= Diarrhea
3= Measles
4= Cough
5= Malaria

12.2 What do you do for the children in the home during an infection/illness before seeking advice or treatment outside the home? (Circle the applicable number)

1= Nothing
2= Give special food/drink
3= Give herbal medicine
4= Perform tepid sponging
5= Give pain relieving tablets
6= Give malaria medicine
7= Other (specify)_____________________________
13. ABILITY OF CAREGIVERS TO RECOGNIZE WHEN SICK CHILDREN NEED TREATMENT OUTSIDE THE HOME

13.1 After how many days of illness do you normally go to seek care?

1 = 1 day
2 = Within 1 week
3 = After 1 week

13.2 What are the indicators that prompt you to seek outside care? [Circle the applicable number(s)].

1 = Fever refusing to subside
2 = Child refusing to eat
3 = Child is weak
4 = Other complications/symptoms present
5 = Illness persisting despite home care
6 = Any other reasons (specify)
14. ABILITY OF CAREGIVERS TO FOLLOW HEALTH WORKERS’ ADVICE
ON TREATMENT, FOLLOW-UP AND REFERRAL

14.1 Do you give medication as directed by the health worker?

1 = Yes
2 = No

14.2 When do you stop medications?

1 = As soon as child’s illness symptoms disappear
2 = When the medication is finished
3 = When the child starts rejecting it
4 = Any other (please specify)

14.3 Do you patronize drug vendors who ‘mix’ drug for patients?

1 = Yes
2 = No

THANK YOU.
### APPENDIX V: OBSERVATION CHECKLIST

<table>
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<tr>
<th>BEHAVIOUR</th>
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<td>Cuddling children</td>
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<td>Good facial expression when holding children</td>
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<tr>
<td>Washing of hands before handling food</td>
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<td>Washing of hands after changing diapers</td>
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<td>Washing vegetables before slicing</td>
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