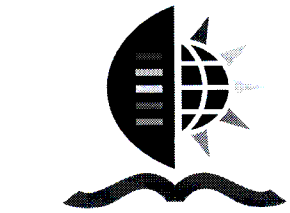


# HEALTH INFORMATION NEEDS OF CARETAKERS OF ORPHANS AT MPHATSO ORPHAN DAY CARE CENTER, IN LILONGWE, MALAWI.

**In partial fulfilment of the requirements for Masters Degree in Maternal and Child Health Nursing, University of KwaZulu-Natal**

**BY**

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**MARCH, 2009**

**DECLARATION**

I, Annie Nancy Msosa, declare that this dissertation entitled, "Health Information Needs of Caretakers of Orphans at Mphatso Orphan Day Care Centre in Lilongwe, Malawi" is my original work which is being submitted solely for the attainment of a coursework Master's Degree in Maternal and Child Health Nursing. It has not been submitted previously to any university for the attainment of a degree. All the references used in the study have been acknowledged by means of referencing.

Student's Signature: ..... Date: 27/03/2009

Supervisor's Signature: ..... Date: 24th March, 2009

Co Supervisor's Signature: ..... Date 27/03/2009

## DEDICATION

I dedicate this study to my family especially my wonderful husband Edson Msosa who has been outstanding in his understanding, encouragement, patience, support and prayers while I was studying away from home.

I also dedicate the study to my two daughters, Annie and Florence, who were deprived of my caring role whilst I was executing my studies. Their prayers and visit made me feel loved, encouraged and supported despite my two years of being away from them. To them, I promise to do the best I can to support them.

I also dedicate the study to my mother, who filled the gap I created in my home during my absence.

Finally, I dedicate the study to all the orphans and their caretakers who are going through stressful moments due to HIV/AIDS affecting the world today.

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## ABSTRACT

**Introduction:** the number of orphans world wide including Malawi, has increased greatly due to the Acquired Immune-Deficiency Syndrome (AIDS). The increased number of orphans has led to the development of community based strategies for continuity of care to orphans. People in various communities offer themselves as volunteers to care for the orphans with an aim to providing the best care possible. Due to the increased number of orphans, the caretakers are challenged in the provision of care, to promote the health status of the children.

**Purpose:** The purpose of the study was to determine the knowledge and health information needs of caretakers in orphan care at the Mphatso day care centre in Lilongwe, Malawi.

**Methodology:** A descriptive qualitative approach was used to determine the knowledge and health information needs of caretakers of orphans. Using a descriptive qualitative research method, the researcher interviewed eight participants working as volunteers at Mphatso Orphan Day Care Centre in Lilongwe, Malawi.

**Data analysis:** In the study, a general content analysis approach was used. In this approach, the audio taped data were transcribed verbatim and translated from Chichewa to English soon after data collection prior to the next day of interview. Transcribing verbatim was done by listening to the tape recorded interviews several times until all the data were captured. Data were thereafter, displayed, reduced and organized into categories and sub categories.

**Results:** Results generated from the study revealed that the caretakers benefit from training prior to the adoption of the caring role. The caretakers were also knowledgeable about the health challenges of the orphans, the concept of caring and health information needs that can help them provide the best care possible to the orphans.

**Conclusion:** Children are facing the tragedy of losing one or both parents to AIDS. If one parent is infected with HIV, there is a high probability that the other parent is also infected and so the entire family faces the threat of illness and later on death. Despite the death of these parents, the children left behind require the continuity of care. Volunteers shoulder the responsibility of caring for the children left by the deceased families. As such, there is need to support those who have dedicated their time to the orphans. Apart from material and financial resources, there is need to support the caretakers of orphans in institutions of care with health information relevant to orphan care.

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| | |
|---|---|
| UN | United Nations |
| HBM | Health Belief Model |
| HIV | Human Immunodeficiency Virus |
| AIDS | Acquired Immune Deficiency Syndrome |
| STI | Sexually Transmitted Infections |
| ARVs | Antiretral Viral Drugs |
| WHO | World Health Organisation |
| UNICEF | United Nations International Children Education Fund |

# Chapter 1
# Introduction

## 1.1 Background to the study

Since 1990, the number of orphans world wide, has increased greatly due to the Human Immuno Deficiency Virus (HIV) and the Acquired Immune-Deficiency Syndrome (AIDS). According to the global HIV and AIDS estimates, there are about 39.5 million people living with HIV and AIDS and 37.2 million of these are adults (UNAIDS/WHO, 2006). It is further reported that about 2.9 million deaths of adults due to AIDS had occurred by 2006, with 2.1 million deaths being in Sub-Saharan Africa alone. This figure represents 72% of the global AIDS deaths by the end of 2006 (UNAIDS/WHO, 2006). In 2005, it was estimated that more than 15 million children under 18 years, worldwide, would be orphaned as a result of AIDS and predictions were made that by 2010 there will be around 15.7 million AIDS orphans in Sub-Saharan Africa (AIDS Orphans, 2007). However, in 2006, it was reported that AIDS had left about 12 million children AIDS orphans and the number could be slightly more when one considers the deaths of adults due to other causes (UNAIDS/WHO, 2006).

In Malawi, the number of people living with HIV and AIDS was estimated to be 850,000 by the year 2005. Furthermore, 78.000 people between the ages of 15 and 49 had died because of AIDS (World Health Organisation, 2005). In Malawi alone, more than 550.000 children have lost one or both parents to the disease (AIDS Orphans, 2007). Most orphans are cared for by the surviving parent, grandparents, brothers or sisters of the deceased parents. However, due to the increased number of orphans in many countries, the development of community based strategies, to provide care and support for orphaned children and vulnerable children is now common in many communities, including Malawi. People in various communities offer themselves as volunteers to care for the orphans with an aim to providing the best care possible (Alliance Family Health

International, 2007). Due to the increased number of orphans, the caretakers are challenged in the provision of care, to promote the health status of the children.

Caring, be it in the home or an institution, poses a challenge to the caretakers. According to Grotberg (2004) caretakers of children with special needs experience stress as they adapt to, and learn to care for their special children. It is further reported that stress in caregivers can lead to a variety of undesired outcomes, with depression being a major one. Grotberg (2004) reports that, information on what to expect of the child at any given time helps the caretakers to adjust to their caring role. It becomes easier for them to manage some of the challenges they encounter in the caring role. However, Grotberg (2004) posits that more research is needed to identify the type of information the caretakers need for the children with special needs, such as orphans.

### 1.2 Problem Statement

Due to the increased number of orphans in many countries, patterns of care of children are changing. While orphans are being cared for by the extended families many households are struggling to meet the needs of orphans under their care. Most of these households are headed by elderly people and women who already live at the edge of poverty (Challenges Faced by Households in Caring for Orphans and Vulnerable Children, 2004). The orphans' needs are often unmet and they face the challenges of malnutrition, poor physical and mental health and experience educational disadvantage. Adolescent girls are vulnerable to sexual abuse (Kidman, Petrow and Heyman, 2007). Different countries and their communities are adopting orphan care strategies that best suit their situations to reduce the burden on the extended families and grandparents. Some of the models of care include the establishment of orphanages and orphan day care centers with the aim of meeting the material, emotional, physical and psychological needs of the children. These are mostly supported by the government, non governmental organizations and faith based organizations.

According to Marlow and Redding (1998) health promotion, prevention of illness, health maintenance and restoration are three areas of care to be considered when caring for

children. Thus the caretakers entrusted with such responsibilities require health education and supportive health measures to successfully take up the challenge of the caring role.

In Malawi, most of the orphans are cared for by grandparents because the young parents have died of AIDS (Mutume, 2001). However, with the increased number of orphans and poverty, the burden is unbearable for the grandparents. Therefore the government in collaboration with the communities has adopted the model of Orphanages and Orphan Day Care Centres to meet the demands of the children. Funding from the government, non governmental organizations, faith based organisations and the communities themselves is not adequate and this has resulted in some communities starting their own day care facilities for the orphans. These centers are staffed by volunteers from the community. Orphans are children who require special care and attention because they come from deprived economic backgrounds following the ill health and death of the parents (Alban and Andersen, 2007). They have probably experienced psychological trauma and may be HIV positive themselves.

Efforts are being made by the day care centers and volunteers to promote the welfare of the orphans by ensuring that they have food, education and shelter. However little is known about whether the caretakers have the knowledge and adequate information of how to care for and promote the health of the orphaned children. As such, there is need to determine the existing knowledge and health care needs of the caretakers at the orphan day care centre in order to establish the health information needs of the caretakers. This analysis was undertaken at Mphatso Orphan Day Care Centre since this was the only day care center in the Area 25 community. Ideally, this study should have been conducted in more than one community, but due to time constraints and having to collect data during one vacation spent in Malawi, this was not possible. The study could be considered to be a pilot study and the findings may warrant further consideration in a larger study.

### 1.3 Background of Mphatso Orphan Day Care Centre

As stated earlier, Malawi is one of the countries hardest effected by HIV and AIDS with 78,000 people dead by 2005, and leaving 550,000 orphans who have lost one or both parents (AIDS Orphans, 2007). Poverty is endemic and it affects the majority of Malawians in both the rural and urban populations. The high poverty levels and the increase in the number of orphans has caused severe strains on the limited available resources and on the extended family coping mechanisms with a greater burden of caring being placed on the grandparents. In response to this burden, the government of Malawi developed a National Policy on orphans and other vulnerable children in 1992 with a mission of promoting an environment in which orphans and other vulnerable children would be adequately cared for, supported and protected physically, psychologically, materially, socially, morally, spiritually and legally, in order for the children to develop and grow to their full potential (Republic of Malawi National Policy on Orphans and Other Vulnerable Children, 2003). Some of the guiding principles of the policy are that the extended family would still remain a primary support structure for the orphans, community based approaches would be emphasized, care programs and activities integrated and harmonized with other interventions and services relating to the care and welfare of the children. It further states that no child shall be discriminated against. This policy led to the development of the orphan day care centres as a response by the community to meet the needs of the orphans because the majority of the orphans were being looked after by the grandparents. Mphatso Orphan Day Care Centre is one of these centres.

It was established in 1995 by one of the community members who was concerned about the situation of the orphans in the community and the increased burden on the grandparents. The number of orphans who joined at first were mostly the under fives, who were brought to the centre in the morning. The aim was to provide meals in the morning, midday and afternoon for the children and for them to be sent back home in the evening. They also had kindergarten lessons. However, within a few months of its establishment, the number of orphans attending the centre increased greatly, and has risen

to 500 comprising of children from 0 to 18 years of age. The older children come for breakfast, lunch and early supper while attending various primary and secondary schools within the community. The government, faith based organizations and other well wishers support the children with food, learning resources and sometimes with clothing. The children are looked after by volunteers. They assist at the centre from morning till late in the evening with no payment and have helped to keep the centre staffed. Apart from the meals, the center provides preschool education, supports children who are in primary schools, as well as those in secondary schools, by sourcing funds for them to continue their education.

## 1.4 Purpose of the Study

The purpose of the study was to determine the knowledge and health information needs of caretakers in orphan care at the Mphatso day care center in Lilongwe, Malawi.

## 1.5 Specific Objectives

1. To identify the knowledge of caretakers in orphan care
2. To identify health information needs of caretakers at the centre.
3. To determine the caretakers beliefs about orphan care and the perceived benefits of orphan care.
4. To determine the caretakers' perceptions about the susceptibility of orphans to health problems.

### 1.5.1 Research Questions

#### 1.5.1.1 Objective 1: Knowledge of caretakers on orphan care

Research questions:

1. What knowledge do the caretakers have about orphan care?
2. Have they had any training in orphan care? If so, what training have they had?

#### 1.5.1.2 Objective 2: Health information needs

1. What type of health information needs do the caretakers require in orphan care?
2. What health messages do they give the orphans as vulnerable children?

3. What health information would help in carrying out their work?

#### 1.5.1.3 Objective 3: Caretakers beliefs about orphan care and the perceived benefits

1. What do you believe orphan care should include?

#### 1.5.1.4 Objective 4: Caretakers beliefs on the susceptibility of orphans to health problems

1. Do you believe that orphans are at risk of developing health problems?

## 1.6 Significance of the Study

The research findings will be helpful to the Ministry of Health and Population services, researchers, community health workers and other health care agencies in planning for the formulation of health information packages for caretakers in orphanages. Thus adequate preparation of the caretakers will be of benefit to the orphaned children and the caretakers themselves, and indirectly to the families of the caretakers. The research findings will be utilized by the community health workers to plan the activities that can benefit caretakers and the orphans in the various communities.

## 1.7 Definitions of Terms

According to UNICEF and UNAIDS (1999) and Monasch and Boerma (2004) an **orphan** is defined as a child under 15 years of age who has lost one or both parents while the government of Malawi defines an orphan as "a child who has lost one or both parents because of death and is under the age of 18 years (National Policy on Orphans and Vulnerable Children, 2003)."

**Caretakers** are the people who look after the orphaned children (UNICEF and UNAIDS, 1999).

**Care** is defined as the proper allocation of resources including emotions, knowledge, and material support and as an interpersonal phenomenon among human beings where one pays attention to the needs and the well being of the other (Christiansen, 2003).

### 1.7.1 Operational Definitions

For the purpose of this study, the following definitions will apply:

**Caretakers** are the people who provide care to orphans at the day care center. They are also referred to as volunteers because they do not receive a salary.

**Orphans** are the children up to 18 years of age who have lost one or both parents.

**Health information** refers to health information messages that help caretakers to provide care ( Kozier, Glenora, Berman and Snyder,2004).

**Health information needs** are the knowledge gaps in health information issues the caretakers might have in providing orphan care.

## 1.8 Summary

In this chapter, the background, purpose, significance and objectives of the study were described. The increased numbers of orphans and the strategies to meet the needs of orphans have been highlighted. Support for care, protection and development of the children in a coordinated manner is essential to realize the full rights and potential of the children.

# Chapter 2
# Literature Review

## 2.1 Introduction

This chapter will review relevant literature relevant to the subject topic. The following concepts are discussed: the prevalence of orphans in Sub Saharan Africa, the impact of orphanhood in the Sub-Saharan region and in Malawi and challenges faced by orphans and caretakers. Finally, the conceptual framework for the study is described. However, most of the literature that was reviewed focused on the challenges faced by orphans and by home caretakers of orphans for example grandparents. Very few studies have been done to assess health information needs and the challenges faced by caretakers in institutions of care, such as day care centres.

## 2.2 Prevalence of Orphans in Sub-Saharan Africa

The AIDS pandemic has caused a substantial increase in the mortality of adults of reproductive age (AIDS Orphans, 2007). This has contributed to the rapid increase in the number of orphaned children. According to UNAIDS estimates, Sub-Saharan Africa accounts for more than two thirds of the world's HIV infected individuals and as much as 80 % of the world's orphans are as a result of AIDS (Monasch and Boerma, 2004). Most of the orphans, who live outside Africa, live in Asia where the total number of orphans for all reasons exceeds 73 million (AIDS Orphans, 2007). The number of orphans varies between countries and regions depending on the HIV prevalence rates. There are also marked differences between the rural and urban areas (AIDS Orphans, 2007).

According to the memorandum submitted by the Centre for International Child Health (2004), out of the 12 million orphans present in the sub Saharan region, approximately

15% of them are under five years of age and 35% are aged between five to nine years and the rest are ten years and above. This poses a challenge for caretakers because the children require care in their education, physical, emotional and spiritual well being.

## 2.3 Impact of AIDS on Orphan hood

Children whose parents have AIDS often experience many negative changes in their lives and start suffering from neglect long before they are orphaned. Eventually the death of parents' results in emotional trauma and the children tend to suffer from exploitation and abuse later in their lives (AIDS Orphans, 2007).

The overwhelming majority of orphans in many Sub- Saharan African countries are looked after by the extended family members. Traditionally paternal uncles, aunts and grandmothers are the ones who look after the orphans. However, with the increase in the number of deaths of young adults, the majority of the children are raised by their grandparents in households with severe poverty and poor living conditions (Dawes, Merwe and Brandt, 2004). The burden on the grandparents in orphan care has contributed to the birth of other models of care by different countries such as orphanages or day care centres.

In a report by Gumbonzvanda (2004), a 60 year old lady in Butula in Kenya complained of the number of orphans who were coming to her because they had been chased away by the aunts and uncles so that they could take the children's property. She reported on the heavy burden of feeding, sheltering and clothing the children. She further commented on the increased number of young girls who were looking for her counseling and support to protect them from sexual abuse. There were also costs related to health care and education.

In another study undertaken by the Human Sciences Research Council (2004), in Botswana, poor families found it challenging to provide the basic needs of orphans because they often had other dependents in their care. It was also reported that some

orphans were denied food in some families, for example teenagers were told that they were old enough to buy their own food.

Similarly in a report by the Congressional Research Service (2005) on orphans and vulnerable children in countries hardest hit by the pandemic, it was stated that children who live in homes that take in orphans may see a decline in the quantity and quality of food, education, love and nurturing and may be stigmatized. As a result, some of the children are forced to leave school, engage in labour or prostitution, suffer from depression and anger or engage in high risk behaviour that makes them vulnerable to HIV and AIDS, sexually transmitted infections (STI) and unwanted pregnancies for girls.

In northern Uganda it was reported that the main problems faced by orphans were lack of shelter, inability to pay school fees and buy equipment, food, bedding, clothing, medical care and the provision of care to young siblings (Ntozi et al, 1999).

### 2.4 Problems Faced By Orphans

In a study carried out in Uganda (AIDS Orphans, 2007), high levels of psychological distress were found in children who had been orphaned. Anxiety, depression and anger were common in the orphans compared with non orphaned children. About 12 % of the children who were orphaned wished they were dead compared to 3% of the other children who were interviewed (AIDS Orphans, 2007).It was further stated that the psychological problems can become more severe if a child is forced to separate from other siblings if caretakers want to share responsibility.

Similarly, Foster et al's (1997) study in Zimbabwe identified psychological trauma as one of the major problems faced by orphans. They reported that children suffer from anxiety and fear during the years of parental illness and grief and trauma following the death of a parent. The contributing factors were mainly stigma, dropping out of school, increased work-load, change of environment and dietary habits, property confiscation by relatives of the deceased and social isolation.

According to Tahir, Finger and Ruland (2005) orphaned children have less access to education, have more psychological distress and face a greater degree of child neglect, abandonment and abuse when compared to non orphaned children. They also commented that adding to these disadvantages, orphaned adolescents become more vulnerable to many risks including HIV infection, sexually transmitted infections and unintended pregnancies. It was pointed out that apart from the general needs; the adolescents require different kinds of assistance such as education, sexual and reproductive health education and services, psychosocial and social support for the difficult transition to independence and adulthood.

Hait (2002) reports that neglect of children's basic physical and emotional needs particularly during infancy may result in a reactive attachment disorder where the child develops a social interaction disturbance. It was found that the children had problems in initiating social interaction with others later in life. They also had extreme fear and anxiety.

In their study Kikafunda and Namusoke (2006) identified malnutrition as one of the major problems in orphaned children living with elderly caretakers. The main contributing factors that were identified included poverty, the effects of HIV infection in some children and lack of nutrition information.

In another study the Masiela Trust Fund in collaboration with the Human Sciences Research Council in Palapye, Botswana, found child abuse as one of the major challenges faced by orphans (Human Sciences Research Council, 2007). The study revealed that there were many orphans and vulnerable children who experienced abuse in varying forms such as physical, economic, sexual and emotional abuse. It was reported that some children were taught to go on the streets to beg, whilst others were encouraged to become prostitutes and bring money home. Others reported being given undesirable jobs, like selling beer and some were coerced into sexual acts by adults.

In South Africa Cluver and Gardner (2006) identified high levels of psychological distress in children orphaned by AIDS. In the study, children orphaned by AIDS, children orphaned by other causes and non-orphaned children were interviewed in the neighborhoods of Cape Town. The results revealed that children orphaned by AIDS had significantly poorer psychological health than other children in the study and suffered levels of post-traumatic stress equivalent to those of children experiencing sexual abuse (ibid, 2006).

## 2.5 Problems Faced By Caretakers

The increasing number of orphans is becoming a global concern. Most orphans and vulnerable children in developing countries are cared for by family members of the deceased, community volunteers, and some by fellow children. Just like the orphans, the caretakers also experience stress due to several factors such as excessive workload, increased personal involvement in issues relating to the children, poverty and sometimes due to stigma and discrimination relating to AIDS (Alliance Family Health International, 2007).

In a study done by Juma, Okeyo and Kidenda (2004) on the challenges to caregivers of AIDS patients and orphaned children in Kenya, lack of knowledge on what food to cook for the patients and children, how to prepare the food and what food items constitute a balanced diet was identified as a challenge for caretakers. The caretakers also lacked information on some of the diseases affecting the children and how to handle the infections to prevent spreading the disease. The study also revealed that many caretakers lacked skills for disciplining children. As a result, some orphans were being harshly punished, while others were not punished at all, for fear they would run away.

Kikafunda and Namusoke (2006) conducted another study on the nutrition of orphaned children living with grandparents. The purpose of the study was to assess the nutritional status of HIV/AIDS orphaned children living with elderly caretakers in Rakai district in Uganda compared to non orphaned children. The children's status was measured

anthropometrically using the weight for age nutrition indicator. The results revealed high levels of malnutrition among orphaned children with half of the children being underweight. The contributing factors to malnutrition included poverty, lack of information on nutrition, illiteracy and big family sizes. The recommendations after the study were that there is need to increase material support and information to improve the quality of food given to orphans.

In their in Uganda, Brouwer et al (2000) identified psychological stress due to poverty, illness of the orphaned children and increased workload as major challenges faced by the caretakers. This was worse in the elderly caretakers. Thus, caretakers, be it at household or community level, are confronted with challenges due to lack of material support, the increased numbers of orphans and the lack of health information. In addition, most of the caretakers at household level are young children or elderly people.

Another study done by the Boston University School of Public Health Centre for International Health Development Botswana, it was revealed that caretakers of children orphaned by AIDS were significantly more likely to report ill health suggesting the high burden of care being placed on them (Miller, Gruskin, Subramnian and Heyman, 2007). The caretakers had a history of caring for a sick adult in the previous year and after the death of the adult, the orphaned children became part of their already existing responsibilities of caring for their own children and the orphans.

In a report by Ananworanich (2004) about orphans in Thailand, one of the caregivers reported that some orphans have HIV and AIDS from their parents. This poses a greater challenge for the caretakers. It is reported that these children come to the orphanages in bad health, malnourished and with skin infections. As a result the children undergo thorough medical examinations by a physician, so as to ensure holistic care. It is further reported that the cost of medical care for one child is $100 per month. However the caretakers' goal is to prepare these children for adulthood with love and care.

In another report by the Family Health International (2000) from Haiti, it was stated that families in the different communities could not accept the orphans into their homes because of poverty, lack of organization and skills and fear of HIV and stigma experienced by the AIDS affected families. They further indicated that they were willing to have orphans in their homes only if they were trained in orphan care, HIV and AIDS prevention and home based care of the affected and were provided with psychosocial assistance. The orphans are therefore placed in orphanages that are run by the social welfare officers supported by the government. However this approach has negative implications for the government and the orphans for the following reasons- the orphanages are difficult and expensive to regulate and monitor effectively, orphanages encourage dependency on external sources of support with potential disastrous consequences when they are withdrawn, it is difficult to maintain and integrate children into families, the children have difficulty in adjusting to social life when they leave the institutions and they lose their land, property and contact with the relatives of their parents.

In a study done in Zimbabwe in 1992 on the situation of orphans and their caretakers the following challenges in caring for orphans were identified: infectious morbidity, nutrition and growth difficulties, cognitive development disorders and physical and sexual abuse (Foster et al, 1992). The caretakers had difficulty in providing the best care possible and were frustrated in the end. As such the study findings suggested that caretakers ought to be trained in how to diagnose psychosocial problems, counsel the children and be able to refer the children for hospital care at the right time. It was also recommended that even teachers in primary and secondary schools should go through special training for them to be able to handle the orphans appropriately when at school.

According to the United Nations (2002), older people as caregivers carry an extraordinary burden in care provision. In the report, grandparents explained that looking after orphans is like starting life all over again because one has to work hard on the farm and in the house, feed the children and buy school needs despite their advanced age.

## 2.6 The Situation of Orphans in Malawi

Orphanhood due to the death of parents because of AIDS is the worst event a child experiences in his or her life (United Nations, 2002). This is because the children start experiencing the tough moments during the prolonged period of illness of the parents. Often the death of one parent means the other parent will eventually follow. Therefore the children experience various traumatic changes which are worse when the children are not prepared for the future by the dying parents. The prolonged illness of the parents drains the few resources they may have. When the parents die, the children are left with little or nothing to survive on. If the family had property, it is often taken away by those who claim to help the children. However, with the severe poverty situation in the country, the children do not benefit from whatever has been left behind by their parents (United Nations, 2002).

According to the Republic of Malawi National Policy on Orphans and other Vulnerable Children (2003), economic deprivation, increased workload and rejection were identified as some of the challenges of orphans. Economic deprivation makes it hard for the children to have food, clothing, school fees and other essential things for their normal growth and development. Rejection makes the children feel isolated. Their self esteem is devalued and the children lack emotional support. This in turn has psychological consequences in terms of depression, anxiety, anger and confusion. Within the adopted home situation, the orphaned children are often given heavier workloads to manage as compared with the caretaker's own children. This results in psychological stress and physical strain in the orphaned children. Often the workloads are beyond the expectations of their age related ability.

## 2.7 Conceptual Framework: The Health Belief Model

### 2.7.1 Introduction

The Health Belief Model (HBM) was one of the first theories of health behaviour developed in the 1950's by a group of United States Public Health service social psychologists (National Cancer Institute, 2005). The model focuses on the attitudes and beliefs of individuals. However, the researcher has adapted this model to focus on the beliefs of caretakers of orphans.

The aim of the model was to explain why few people participated in programs to prevent and detect disease. During that time, the Public Health Service was sending mobile x-ray units out to neighborhoods to offer free chest x-rays for screening tuberculosis. Despite the fact that this service was offered without charge in a variety of convenient locations, the program was of limited success. In view of this, the social psychologists examined what was encouraging or discouraging people from participating in the programs. They theorized that peoples' beliefs about whether or not they were susceptible to disease and their perceptions of the beliefs of trying to avoid it influenced their readiness to act. This led to the identification of six main constructs that influence people's decisions about whether to take action to prevent, screen for and control illness (National Cancer Institute, 2005). They argued that people are ready to act if they:

- Believe that they are susceptible to the condition (perceived susceptibility)
- Believe that the condition has serious consequences( perceived severity)
- Believe that taking action would reduce their susceptibility to the condition or its severity ( perceived benefits)
- Believe that the costs of taking action are outweighed by the benefits (perceived barriers
- Are exposed to factors that prompt action such as watching a television about HIV/AIDS prevention among adolescents (cue to action).
- Are confident in their ability to successfully perform an action (self efficacy)

### 2.7.2 Definitions of the concepts

**Perceived Susceptibility** refers to the beliefs about the chances an individual has of getting the disease or condition.

**Perceived Severity** is the belief about the seriousness of a condition or its consequences.

**Perceived benefits** are the beliefs about the effectiveness of taking action to reduce risk or its seriousness

**Perceived barriers** are the beliefs about the material and psychological costs of taking action.

**Cues to action** are the factors that activate readiness to change.

**Self efficacy** refers to the confidence in one's ability to take action.

### 2.7.3 Application of HBM to the study

The purpose of this study was to determine the knowledge and health information needs of caretakers in orphan care in Malawi. It is believed that orphans are one of the most vulnerable population groups in society who need special attention and proper child growth and development. The caretakers' beliefs about orphan care determine the outcome of care the orphans will receive at the day care centre (University of Twente, 2004).

In this study, the following concepts were applied: Perceived Susceptibility, Perceived Severity, Perceived benefits, Cues to action and Self efficacy (see Figure 2.1)

#### 2.7.3.1 Perceived Susceptibility and Perceived severity

The beliefs of the caretakers on how susceptible the orphans and they themselves are to diseases or infections will determine their response to caring for the orphans. The orphaned children at Mphatso Orphan Day care center in Lilongwe are between the ages of 0 to 18 years of age. They have different health risks depending on their age. For

example, the under five children are at risk of developing malnutrition, diarrhea diseases, anaemia and other childhood illnesses. As such, the knowledge and beliefs of the caretakers on how susceptible the orphans are to health problems will influence their response in the care of the under five children at the centre. On the other hand, young girls and boys are at risk of child abuse in terms of sexual abuse, physical abuse and child labour. They are also at risk of drug and alcohol abuse. The beliefs of the caretakers about the severity of these problems may also affect their response to caring.

#### 2.7.3.2 Perceived benefits, cues to action and self efficacy

Perceived benefits of orphan care by the caretakers on the effectiveness of their caring role to reduce the health risks among the orphans may promote their response to caring. The benefits are mainly disease prevention and psychological support of the children to promote normal child growth and development.

The perceived benefits by the caretakers might motivate them in providing the appropriate care to the children. It is also perceived that if the caretakers are given proper orientation to orphan care and its challenges, prior to the actual care, it may contribute to better caring services. As such, health information on safety, food, nutrition, personal hygiene, sex education, alcohol and drug substance use can help in the improvement of quality and efficient care of the orphans (Kemm and Close, 1995). Being equipped with the health information and the challenges in orphan care will promote confidence in the caretakers in the provision of care to the orphans.

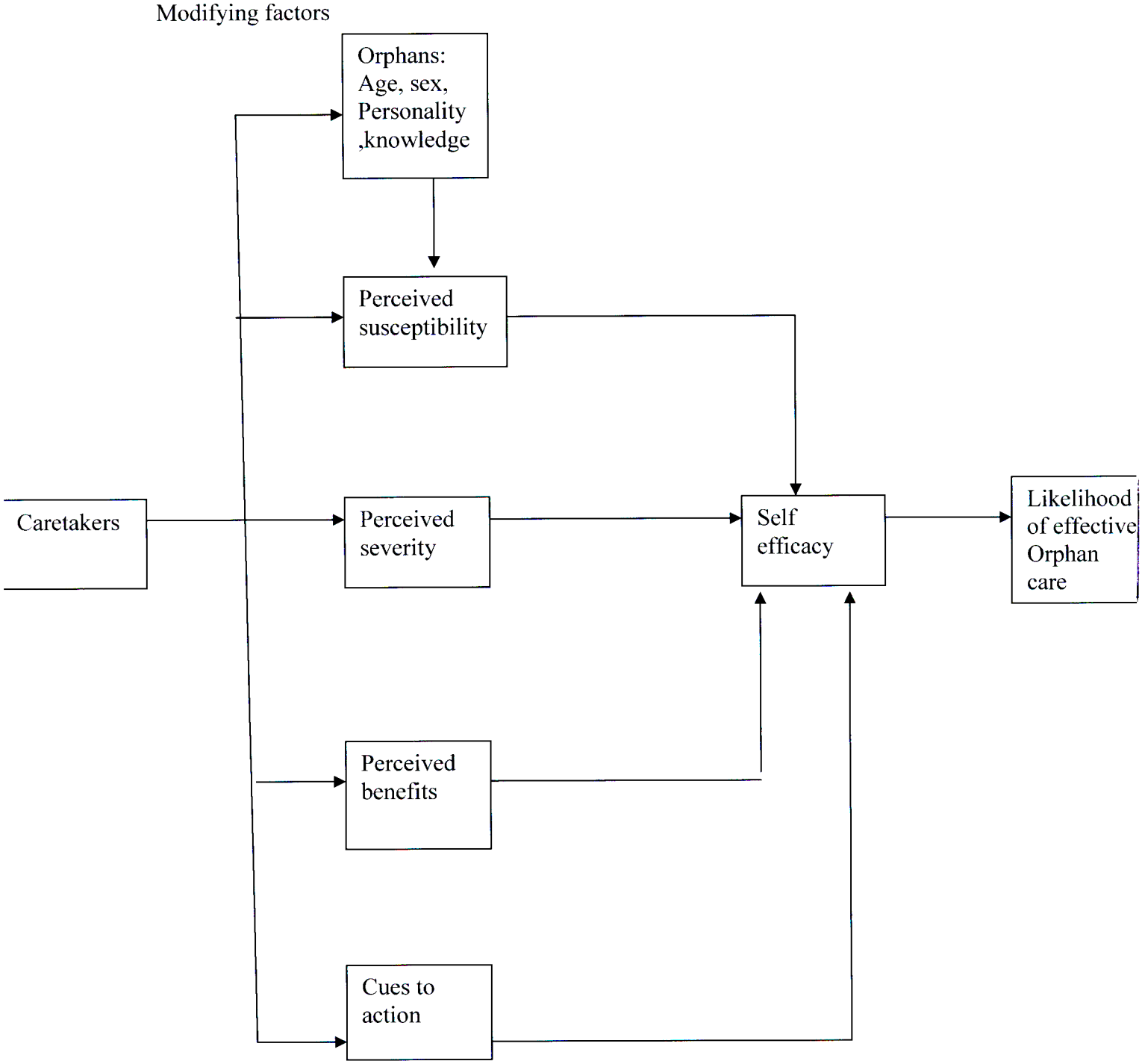


**Figure 2.1: Diagrammatic representation of the adaptation of the Health Belief Model (Adapted from Glanz et al 2002 at the University of Twente 2004)**

## 2.9 Summary

In this chapter, literature relevant to the study was reviewed and discussed. On the whole, discussions centered on the prevalence of orphanhood in the Sub Saharan Africa, challenge of orphans and caretakers, the impact of HIV and AIDS on orphanhood and the situation of orphans in Malawi. It also covered the conceptual framework that was used in the study.

# Chapter 3
# Research Methodology

## 3.1 Introduction

This chapter presents the methodology used in the study is described. The study will also present the research approach, population, sampling procedure and sample size, methods of data collection, data analysis as well as ethical issues involved.

## 3.2 Research Approach

A descriptive qualitative approach was used to determine the knowledge and health information needs of caretakers. The descriptive approach enabled the researcher to document, analyse and interpret attributes, patterns and characteristics of phenomena under study (Field and Morse 2002). This approach was appropriate because the researcher was able to describe in depth, the knowledge and health information needs of the caretakers in orphan care. It also enabled the researcher to make sense of the reality of the caretakers' knowledge and health information needs in orphan caring.

## 3.3 Population, Sample and Sample size

### 3.3.1 Population

Population is the entire set of individuals having some common characteristics (Polit and Beck, 2004). The population for this study included all the ten caretakers working as volunteers at Mphatso Orphan day care Center in Lilongwe, Malawi.

### 3.3.2 Sampling and Sample Size

Sampling is the process of selecting a portion of the population to represent the entire population. Qualitative studies usually use small non random samples with the aim of discovering meaning and uncovering multiple realities (Polit and Beck, 2004). A purposive sampling technique was used in this study. It is a technique in which the researcher chooses the sample on the basis of known characteristics or experiences (Clifford, 1997). This type of sampling was used because the researcher wanted participants who were knowledgeable in orphan care. It was assumed that they had knowledge of their needs in relation to orphan care (Polit and Beck, 2004).

The targeted sample was the ten caretakers at the centre. The researcher had planned to include only those caretakers who had worked at the orphan day care centre for six months or more. All the caretakers had worked at the centre for more than two years and therefore all were included in the sample. However, only nine caretakers participated in the study because they were available at the time of data collection. One caretaker was not included because she was not available during the time of data collection due to unforeseen circumstances.

### 3.4 Data Collection

Data for the study were collected from the caretakers at Mphatso day care centre through in-depth interviews in January 2008, after permission from the relevant authorities was sought and obtained (See Appendices D, E, and F). The interviews were conducted in a quiet room to ensure privacy and prevent disturbances from other people. An interview schedule was used to collect information on the knowledge and health information needs of caretakers at the centre (See appendix A). A maximum of two caretakers were interviewed per day for about 30 minutes. Data were collected using the vernacular language, *Chichewa* because it is the language in which participants were able to express themselves fully. Data were collected by the researcher and recorded through writing and

audiotapes. The recorded interviews were then transcribed and translated from *Chichewa* to English immediately, prior to the next data collection day. Data collection continued until all the available participants during the time of data collection were interviewed. Thus, the entire data collection process took place over a period of two weeks.

### 3.5 Instrument for Data Collection

An interview schedule was used for data collection and it was translated into Chichewa (See Appendix A). The translated interview schedule was reread by an expert in research with expertise in Chichewa language to prevent it from losing it's meaning. The schedule had two sections, a section for demographic data and a section containing open ended questions. Additional probes were used to encourage the respondents to elaborate more on the topic and it allowed them to talk more freely on all the topics in the interview schedule.

### 3.6 Data Analysis

Qualitative data analysis is a challenging activity which involves comprehending, synthesizing, theorizing and recontextualizing data (Polit and Beck 2004). For this study the general content analysis approach was used. Content analysis is a process of analyzing data using words rather than figures (Clifford, 1997). The analysis started immediately after the first interviews. In this approach, the audiotaped data were written down word for word from what was recorded on the tape and translated from Chichewa to English immediately after data collection, prior to the next day of interviews ( See Appendix G) . The transcribed data was rechecked by the research supervisor and another researcher with expertise in Chichewa language to prevent loss of meaning and researcher's bias. Data were thereafter, displayed, reduced and organized into categories and sub categories. Data were analysed manually.

### 3.7 Data Management and Handling

After data collection and during analysis, the recorded interviews, written documents and the transcribed and translated material were kept in a locked cupboard in the researcher's

office. The materials will be securely stored for five years. Only the researcher and the research supervisor had access to this material.

### 3.8 Ethical Consideration

Permission to undertake the study was sought from all the relevant authorities and permission was granted. The authorities were:

- The participants (See Appendix B )
- University of KwaZulu-Natal ethics committee (See Appendix D)
- Kamuzu College of Nursing ethics committee through COMREC (See Appendix E)
- The overall in charge of Mphatso Orphan day care center (See Appendix F )

### 3.9 Informed Consent

To the participant, a full explanation of the purpose of the study was given. Each participant was supplied with a subject information sheet which had been translated into *Chichewa*. Then when they were willing to participate, they gave written consent (See Appendix B). Participants' names were not used. The researcher used numbers as a means of ensuring anonymity and confidentiality. The participants were told that their participation was voluntary and that they were free to withdraw from the study if the need arose or should they wish. The participants were told that the data collected would not be accessible or disclosed to other people except the researcher and the research supervisor.

### 3.10 Issues of Academic Rigour

The issues of academic rigour of the research were addressed by using the general criterion model by Lincoln and Guba (cited in Field and Morse, 2002). Four strategies were used to ensure trustworthiness:-credibility, applicability, consistency and neutrality.

**3.10.1 Truth value or credibility** of a study is the degree to which one can rely on the concepts and methods used in the study. Truth value refers to confidence in the truth of the data whereas credibility refers to quality of deserving to be believed and trusted (Polit and Hungler, 1997). In the study, data collection methods and analysis was followed as planned in the research design. The researcher established a relationship with the participants to build trust in them and to encourage them to speak the truth. The researcher also transcribed the data word for word to prevent bias during the analysis process. The transcribed data was also rechecked by another researcher with expertise in Chichewa language and the research supervisor.

**3.10.2 Applicability** refers to the transferability or fit of the research. The findings were applicable to the site and population under study. The findings cannot be generalised to all orphan day care centers in Malawi because the sample was small and the researcher did not use triangulation methods. However, the principles of the study can be applied in other research studies in similar settings. Data collection was conducted in a natural setting to minimize the variabilities of the research.

**3.10.3 Consistency** refers to the dependability of the research (Polit and Beck, 2004). This was achieved through a clear description of the research process. Furthermore, consistency was ensured by asking the participants the same questions and in the same order. Prior to the data collection process, an initial interview was undertaken with one of the caretakers as a trial interview in order to determine whether the questions posed, elicited the information required. The interview schedule did not require amendment and the interview was included in the study. A trial interview provides clues about the success of the intervention and about ways in which the intervention can be modified or strengthened. The same instrument was used throughout the data collection process to ensure consistency in the responses to the questions posed.

**3.10.4 Neutrality or confirmability** refers to the freedom of the researcher from bias in the research procedure and interpretation of the results. The researcher used memos and tape recording of the information to reduce bias. Transcription was done word for word to minimize bias.

### 3.11 Limitations of the study

The greatest limitation in the study is the translation of the data from Chichewa to English and the loss of depth of meaning which may have resulted. Time for data collection was also a limiting factor because data were collected during holidays. The findings are limited to one site and population. Therefore, the study findings cannot be generalized.

### 3.12 Summary

This chapter provided an overview of the research methodology, research design, population, sampling and sample size, method of data collection and data analysis. The limitations of the study and the ethical considerations that were observed during the implementation of the study are also discussed.

# Chapter 4

# Analysis and Presentation of Findings

## 4.1 Introduction

This chapter will analyze the findings of the study. It will also present the purpose of the study purpose and objectives of the study. The purpose of the study was to determine the knowledge and health information needs of caretakers of orphans at Mphatso orphan day care centre in Malawi. The objectives of the study were to identify the knowledge of caretakers in orphan care, the health information needs of caretakers at the centre, and to determine the caretakers' beliefs about orphan care and the perceived benefits of orphan care as well as the caretakers' perceptions about the susceptibility of orphans to health problems.

The data were collected, utilising an interview schedule as a guide, by the researcher over a period of two weeks and will be presented in two parts. The first part is comprised of demographic information and the second part is comprised of the responses of the participants from the questions that were asked during the interviews.

A total of nine participants were interviewed at Mphatso orphan day care centre. All of them work as volunteers at the centre. Although I intended to interview ten participants, this was not possible because one caretaker was not available during the period of data collection.

Data transcription was undertaken with the use of a tape recorder. The transcribed data were analysed manually using general content analysis. Data were displayed, reduced and categorized into categories and sub categories. Four major categories emerged from the interviews involving the caretakers about their knowledge and health information

needs in orphan care. The categories were: experiences of the caretakers, perceived health issues affecting the orphans, health information issues in orphan caring and the perception of caretakers about the concept of orphan care.

In section A the demographic information related to the caretakers is presented and in section B the categories and sub categories of data are discussed.

### 4.2 Section A: Demographic Information

This section focuses on the demographic characteristics of the participants. The demographic data collected were related to sex, age, level of education, number of children and the number of years in orphan care experience at the centre. Of the nine caretakers interviewed, eight caretakers were female and one was male. All had worked as caretakers for more than two years. Their ages ranged from 23 to 42 years, with most of the caretakers being between the age of 38 and 42 years. The number of children of their own ranged from one to ten. Only one caretaker was looking after orphans, in addition to her own children. Eight caretakers had completed primary school education and one caretaker had completed secondary school education.

### 4.3 Section B: Categories and Sub Categories of the Findings

In this section, the categories and sub categories identified are discussed (See Table 1).

Table 1. **Categories and Sub Categories that were identified**

| Categories | Sub Categories |
|---|---|
| Experiences of caretakers | • Loss of a loved one<br>• Individual motivating factors<br>• Preparation for the caretaking role |
| Perceived health issues affecting orphans | • Health risks and common health conditions<br>• Material needs and social problems<br>• Management of the common health conditions, material needs and the social problems. |
| Health information issues in orphan caring | • Actual information given to the orphans<br>• Useful information in orphan caring<br>• Sources of information |
| Perception of the concept of "orphan care" | • Teaching the orphans some skills<br>• Social support |

#### 4.3.1 EXPERIENCES OF THE CARETAKERS

In this category, the participants described their experiences, background and the reasons for joining the centre. The study findings revealed that all the female caretakers were housewives before joining the centre and that some female caretakers had lost their husbands some years ago. The center had one male caretaker. They all had experience in child care because all the participants had one or more children. At the time of the interviews, all the participants had more than two years of experience in the actual caring

of orphans, except for those who had joined the center because of tailoring. The loss of a loved one and other individual motivating factors such as tailoring and a passion for children were identified as the common factors that led to their joining the centre. Most of them did not have prior preparation in the caring role.

#### 4.3.1.1 Loss of a Loved One

The loss of a husband had prompted female participants to bring some of their children to the centre. However, one participant was influenced by the death of her sister who left four children, and she had decided to keep two of the children and send the other two to her home village. The loss of the loved one, coupled with being a housewife, influenced their decisions to bring some of the children to the centre for support after the death of the spouses and the sister. The increasing number of children, lack of support from the relatives on the husbands' sides posed a challenge to the widowed mothers.

One participant stated that:

"*I am a mother of 6 children and my husband died two years ago. With the death of my husband I started having problems in supporting the children because I was a house wife. Then the director of this place, who is my neighbour, encouraged me to take some of the children to this place for support. Then I decided to take the children to this centre. Later on, I joined as a volunteer to help in the care of the orphans*".

Another participant narrated that:

"*I joined this center because of the death of my sister who left four children……Having six children was not easy for me. After enrollment of the children to this center, one of the volunteers came home and invited one of us, my mother or myself, to join the centre to look after the orphans. Then my mother started coming to this center to look after the orphans and I did not. However, one day, my mother was told that she has to go for training on how to look after the orphans. My mother refused because she does not know how to read and write. Then she requested me to go on her behalf and I went on her behalf. After my arrival from the training, I continued with my daily household chores.*

*Then one day I just saw one of the volunteers from the center coming home and she brought the news that the director wanted me to assist with the care of the orphans...".*

#### 4.3.1.2 Individual Motivating Factors

Tailoring and a passion for the orphans were some of the motivating factors for some of the caretakers in joining the centre. Some well-wishers donated sewing machines to the centre that led to an advertisement for a training programme in tailoring. Widows and all women interested in tailoring were invited to a training programme, offered free of charge. As such, some women became interested and they came for the training which was run for one and half years. Thereafter, some women were invited to join the centre to assist in sewing clothes and uniforms for orphans as well as sewing clothes for other people in the community at a fee, as part of an income generating activity for the centre.

One participant said that:

"*I am a married woman and a housewife with five children.* My *husband works at a tobacco company. I came to know about this place because of an advert about tailoring lessons. Then I applied to try my luck because I had the desire to learn tailoring and I was successful. At the end of the training, three of us were requested to be tailors for the orphans on a voluntary basis. Then, after discussing it with my husband, I decided to join this centre".*

On the other hand, one caretaker was motivated due to a concern for the orphans.

He said that:

*"I am a volunteer who joined the centre three years ago. I am married with one child. I have the passion for orphans and then I decided to join this centre to assist in orphan care".*

#### 4.3.1.3. Preparation for the Caretaking Role

With the exception of the participant who took her mother's place in the training, none of the other participants had had any prior preparation in orphan care before commencing

work at the centre. However, some of the caretakers were trained later, after joining the centre. At the time of the study, some of the caretakers had not received any training in orphan care. The participants who were trained were basically trained in life skills issues which affect the children. The content covered were related to child caring in general, developmental changes of children, the need for love and patience towards orphans and the need to encourage orphans to go to school.

One participant reported that:

*"I did not have any other preparation apart from the training which I had at Nathenje after joining the centre. I learnt that orphans need love and that we have to treat them in the same way we treat our children. This information helped me when I just joined the center. Right now, I cannot remember most of the information because I was trained sometime back".*

In another interview, one participant narrated that:

*"I did not go for any special training before I came to this place. I just came on my own. However after a few months, I formed a youth group for both orphans and non orphans. Then, I was invited for training for a week. In that training, we had lessons about child development, youth transformation and psychosocial care of orphans. This information helps me in running the youth club".*

On the other hand, some caretakers had not had any training since they joined the centre. One participant said:

*"I have never been trained in orphan care. Being trained would give me an insight on how I should treat the orphans".*

In summary, most of the female respondents were widows who brought their children to the center for support. They were then requested by the director to come and assist with orphan care at the centre. Only the male participant joined the centre without an invitation from the director. However, some participants were motivated by tailoring and a passion for the orphans. Most of the participants had not had any preparation in orphan

caring, except one participant who went for training prior to joining the centre. However, some were prepared through a training which was done after joining the centre and some had not been trained at the time of data collection

### 4.3.3 PERCEIVED HEALTH ISSUES AFFECTING ORPHANS

The participants were asked what they perceived to be the health issues affecting the orphans at the center. The following subcategories emerged from the interviews: Health risks and common health conditions, material needs and social problems and the management of common health conditions. Malnutrition, bilhazia, malaria, teenage pregnancy, the Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome and sexually transmitted infections were believed to be the health risks to which the orphans are exposed. On the other hand, the common conditions affecting the orphans were malaria, diarrhea, skin infections and fungal infections affecting the head. In addition, material needs and social problems were also mentioned. These included insufficient food, lack of shoes, bed nets and early marriage. Finally, the participants gave explanations on how they manage the common health conditions, material needs and the social problems.

#### 4.3.3.1 Health Risks and Common Health Conditions

The centre has children who range in age from 2 years to 18 years. All the children are fed in the morning, and are given lunch and an early supper every day. The health risks and common health conditions were specific to either the under fives or those in their teen years.

#### 4.3.3.1 Health Risks

##### 4.3.3.1.1 Malnutrition

The participants pointed out that many orphans depend on the food provided by the centre. This includes the evening meals. It was noted that the number of orphans had

been increasing gradually in the months of January, February, March and April of every year, making it difficult for the centre to provide the appropriate food nutrients in the right quantities to the orphans. It was noted that the children rarely eat in the homes they come from. As such malnutrition was one of the health risks especially to the under five children. This was described as follows:

*"They stay with people that are poor and they do not manage to give them extra food when they go back to their homes where they stay..... Therefore, children can develop nutrition problems".*

One participant said that:

*"Mmm, the children do not have adequate food especially in the months of February, March and April because many children are enrolled at the centre.....and the director struggles in these months to provide adequate food to all the children".*

#### 4.3.3.1.2 Bilharzias and Malaria

Bilhazia and malaria were some health risks that were mentioned and were attributed to poverty. The participants commented that most of the orphans do not have shoes and do not use mosquito bed nets in the homes where they spend their nights. Poverty was seen as a major contributing factor to these health risks.

One participant said:

*"Yes, orphans are at risk of malaria attacks and bilhazia. Many of these orphans do not use mosquito nets at night and they lack proper hygiene because of poverty. They also lack support. Most of the children walk bare footed, putting them at risk of bilhazia especially during this rainy season".*

Another participant narrated that orphans are at risk because of home circumstances. It was commented that orphans:

"...are *at risk because they lack support in proper care. The majority of the orphans are taken care of by the grandmothers or fathers who are poor. They do not have resources like adequate money to buy shoes or nets for the children, food and clothing".*

#### 4.3.3.1.3 Teenage Pregnancy and Early Marriages

Teenage pregnancy and early marriage were some of the health risks seen in girls. It was attributed to the lack of guidance and support from adults. Participants observed that girls are easily abused by adults in the name of supporting them with basic needs and resources for their upkeep. One of the participants stated that:

"*They have food problems because most of the children depend on food provided at the center, they lack proper care because they don't have people to give them proper advice. This has resulted in many girls having sexual relations with adults resulting in unwanted pregnancy, early marriages and many girls drop out of school*".

### 4.3.3.2 Common Health Conditions

The specific common health conditions affecting the children at the centre were malaria, diarrhea, skin infections and fungal infections affecting the head.

Some of the responses from the participants were as follows:
"*Since I came here, the common problems are Malaria and diarrhea*".

One participant said "*Malaria is one of the common problems and also body sores and some fungal infections that affect the head especially the young children.*"

Another participant had this to say "*Mostly the children come with skin infections, dirty clothes...*".
Most of these health conditions were common in the under five children. The common challenges for the older orphans were the material needs and social problems described in the next section.

#### 4.3.3.1.4 Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome and Sexually Transmitted Infections

Participants perceived that being an orphan places the children at risk of contracting HIV/AIDS and STIs. It was felt that many teenagers fail to cope with the psychological stresses of life in the homes in which they stay. Lack of support, food, love, advice and attention encourages girls' relationships with older men. It becomes easier for them to have sexual partners for material and financial support and comfort. As a result, having unprotected sex and being infected with HIV/AIDS and STIs can be the end result as described:

*"Yes orphans are at risk of developing health problems because many orphans lack adequate support, love and advice. They stay with people that are poor and they do not manage to give them food, clothing and other necessities. Therefore girls marry at their tender age when they are supposed to be in school. Some end up having relationships with older men for money and they get pregnant or acquire HIV".*

### 4.3.3.2 Material Needs and Social Problems

Apart from the diseases affecting these children, lack of material needs and social problems were also some of the challenges faced by both the under five and older children at the centre. Inadequate food, lack of bed nets in the homes, shoes and other needs were some of the predisposing factors to the medical conditions affecting them. It was also reported that inadequate food occurs mostly during the months of January through April, because this is a time when many orphans tend to join the centre since most families experience food shortage. This is a time when Malawians plant their fields for the next season. Therefore, most of the food reserves are depleted making it difficult for the families who had orphans in their homes to continue feeding them. Therefore, the orphans are enrolled at the center for food.

Some participants mentioned, teenage pregnancy, early marriages as one of the challenges affecting the children and school dropouts.

One participant narrated that:

*"During the rainy season, the common problems include inadequate food because the number of orphans enrolled to this centre is high".*

One reported that:

*".....girls marry while very young, when they are supposed to be in school. Some end up having relationships with older men for money and they get pregnant".*

#### 4.3.3.3 Management of the Common Health Conditions, Material Needs and the Social Problems

##### 4.3.3.3.1 Common Health Conditions

The participants reported that when the children are sick, they are treated at a government health centre. If it is not an emergency, they contact the relatives of the children prior to going to the hospital. When it is an emergency, nearby private clinics which are a few kilometers away from the centre are used and the relatives are informed later.

The participants described the following:

*"Sick children are often times taken to the hospital with the support of their guardians. However, in times of emergency, we take the children to the nearest private hospitals for treatment thereafter; we escort them to their homes".*

Children with skin infections were currently being treated at the centre. Medication was provided by some doctors who visited the centre. One participant said that:

*"We have been using medications which were brought by one of the doctors who visited this place some months ago for most of the skin infections".*

#### 4.3.3.4.1 Material Needs and the Social Problems

The centre relied heavily on well wishers for the supply of clothing and food supplies. Older children benefited from the advice given on the prevention of pregnancy and were encouraged to finish their education. Another source of support and information were the youth club sessions conducted by one of the caretakers at the centre. This was one of the descriptions:

*"The children with no clothing are given some clothes when well wishers donate to the center. The teenagers are usually given advice to prevent teenage pregnancies and to encourage them to go to school for them to have a better future. The older ones are involved in the youth club where most of their challenges are discussed".*

### 4.3.4 HEALTH INFORMATION ISSUES IN ORPHAN CARING

In this category, the views of participants on whether they give health information to the orphans, the sources of information and what information they need to facilitate the orphan caring role were captured. From the responses given, some caretakers are able to teach the children, while some do not teach the children because they do not have the time, apart from doing the other household chores at the center. The female participants indicated that they give health information in the form of advice when the children come for their meals. The male volunteer has planned teaching sessions for the kindergarten children and those who attend the youth club. The caretakers who do the tailoring at the center are not involved in health information giving sessions. The subcategories that emerged from this category were: actual information given to the orphans, sources of information and useful information required in orphan caring.

#### 4.3.4.1 Actual Information Given to the Orphans

The common topics covered with the children at the centre included the consequences of teenage pregnancy, abortion and early marriages, prevention of HIV/AIDS and STI, the importance of working hard and finishing school and issues of body hygiene.

One participant reported that

"*Yes, I give health messages. I teach them about the importance of protecting oneself from HIV and STs, the importance of exercises and finishing school. We also discuss issues about the influence of peer pressure, the consequences of teenage pregnancy and early marriages.*"

On the other hand, one participant said "*No I have never taught them anything. Maybe my friends have done it.*"

#### 4.3.4.2 Sources of Information

The participants reported that they did not have specific organizations or institutions which provided them with information. Instead they usually told the director who made arrangements with outside resources knowledgeable in the subject to assist the caretakers with information. Some participants reported that they used the knowledge they had about health issues.

"*In most cases when we are in need of health information, we tell the director our needs and arrangements are made with organizations that have the information. Then, they do come to give us the information. We do not have any specific organizations or institutions that support us with information.*"

On the other hand it was reported that:

"*I just use the knowledge I have about some health problems.*"

#### 4.3.4.3 Useful Information in Orphan Care

The participants were asked about the health information needs that would be useful in orphan care. A variety of responses were offered. These included health information about:

- HIV/AIDS and STIs
- Dangers of teenage pregnancy and abortion
- Child abuse
- Prevention of communicable diseases
- Food, body and environmental hygiene
- The new treatment of malaria
- Spiritual messages
- The importance of education

The participants felt that they needed this information as a guide in the provision of care for the orphans to have a better future.

One participant had this to say:

*"....Therefore, messages about the dangers of abortion and teenage pregnancy are necessary. We also need information about HIV/AIDS prevention and prevention of malaria and other communicable diseases because the children need this information for them to have a better future."*

Another participant had this to say:

*"I think we need information on the effects of teenage pregnancy, HIV, effects of abortion, hygiene and the issues of child abuse because some orphans are abused in the homes they come from. Issues of child abuse are difficult for us to handle even though we still try to give them some advice."*

Apart from the above information, participants further expressed the need for health workers to provide health education to the orphans, as experts in health issues. They also expressed the need for material items like gloves for protection and the supply of anti-

malaria treatment for the under five children, because the children have frequent attacks of malaria.

One participant stated that:
"I *think working hand in hand with health care workers can help us a lot because they are the experts in most of these health issues. The health workers can also help us with some gloves because we often times need them.*"

### 4.3.5 PERCEPTION OF THE CONCEPT OF "ORPHAN CARE"

The participants believed that the concept of orphan care comprised of teaching the children some skills and offering social support for their development.

#### 4.3.5.1 Teaching the Orphans Skills

The participants stated that orphans, like any other children, have to be taught skills like cooking, washing clothes and keeping the environment clean.

One described the concept of orphan care in the following way:
"*I think orphans are like any other children. They need to learn how to wash their own clothes and they have to be taught some skills like cooking, sweeping and good body hygiene*".

#### 4.3.5.2 Social Support

The participants believed that the concept of orphan care involves providing spiritual care, nutritional support, educational and career guidance about their future. It was also believed that the children should be taught about their cultural values and that they need some disciplinary measures when the need rises.

One participant narrated the following:

*"I think caring of orphans is not different from the caring of any other children. It involves encouraging them to go to school, monitoring their behaviour, disciplining them when need arises, giving spiritual care and teaching them about culture".*

Some participants pointed out that orphans need career guidance just like any other children. One participant said:

*"I think it involves teaching the children cultural beliefs, spiritual guidance and they also need support in career guidance just like any other children".*

In addition to the above, it was reported that orphans need support from all people including the government and other non governmental organizations for them to grow into productive adults.

One participant expressed her thoughts as follows:

*"I also think that every one has to take part in orphan care even the government and non governmental organizations. Orphans need support in so many ways and the director needs support too because the number of orphans is increasing now and then".*

Another participant had this to say *"It needs all people to work together because orphans need the support of every one".*

In summary, the concept of orphan care was described as teaching the children skills such as cooking, sweeping, good body hygiene and giving them social support and career guidance for a better future. It was also recommended that orphans need the support of everyone including the government and other stakeholders. The perceived benefits of orphan care were that the children would be equipped with the necessary skills and information for them to have a better future.

## 4.4 Conclusion

In this chapter, the focus was on the analysis and presentation of the study findings. The findings have been presented in two sections, the demographic data and the categories of data from the responses of the participants. Five major categories emerged from the interviews involving the caretakers of orphans at Mphatso orphan day care centre about their knowledge and health information needs in orphan care. The categories were: experiences of the caretakers, preparation for the caretaking role, perceived health issues affecting the orphans, health information issues in orphan caring and the perceptions of caretakers about the concept of orphan care.

Rich descriptions of the categories and sub-categories have been described. The next chapter will focus on the discussion of the above findings in relation to the findings of other studies which have been conducted on caretakers of orphans.

# Chapter 5

# Discussion of Findings, Recommendations and Conclusion of the Study

## 5.1 Introduction

This chapter focuses on the discussion of the major findings, recommendations and conclusions in line with the study purpose and its objectives. The researcher will also highlight the relationship of the study findings to aspects of the conceptual framework and some literature that was reviewed. The purpose of the study was to determine the knowledge and health information needs of caretakers of orphans at Mphatso orphan day care center in Lilongwe, Malawi.

The specific objectives of the study were:

1. To identify the knowledge of caretakers in orphan care
2. To determine the caretakers' perceptions about the susceptibility of orphans to health problems.
3. To identify health information needs of caretakers at the centre.
4. To determine the caretakers beliefs about orphan care and the perceived benefits of orphan care.

As already highlighted in the literature review, very few studies have been conducted into the health information needs of caretakers of orphans. Most studies have been done on caretakers of orphans in a home setting. In many of these studies, the main focus has been on material needs of the caretakers of orphans and the orphans themselves and not on health information needs. In addition to the above, most of the findings were not related to the previous literature reviewed. As such, the researcher has based her discussion on the available literature and studies done in home settings on health information needs of caretakers other than research findings directly conducted on caretakers of orphans in orphan day care centres.

## 5.2 Discussion of Demographic information

### 5.2.1 Sex and Age

Some of the demographic data collected in the study related to sex and age. The demographic data revealed that most of the volunteers at the centre were women. Eight caretakers of orphans at the centre were female with only one male caretaker. They were all volunteers with different backgrounds and experiences. The age range of the caretakers was between 23 and 42 years with the majority of the caretakers being between the age of 38 and 42 years. They came from the same community but were motivated to be volunteers because of the different experiences they had had in life as described in the second part of the study findings in the previous chapter.

These findings were similar to the findings of a study conducted by Mutandwa and Muganiwa (2008) in Chimanimani District in Zimbabwe. The results in their study showed that the majority of the volunteers in orphan care were women and they constituted about 94%, with men constituting 6% of the total number of volunteers. It was also further identified that the volunteers were mostly women aged 35 years and above, they belonged to the same community as the orphans and they shared years of common experience with the deceased parents. As such, the volunteers were obliged to respond to the needs of the orphans. Women were identified as the ones taking the leading role in caring because the gender roles of women tend to confine them to do more of the domestic chores and child care than men (Mutandwa and Muganiwa, 2008).

The motivating factors were different from those of the current study. Sharing a common experience with the deceased parents and coming from the same community (Mutandwa and Muganiwa, 2008) were the motivating factors while in the current study, the motivating factors for joining the center were loss of a loved one, tailoring and passion and the enrollment of some of their own children at the center for support, after the death of their loved one.

In line with the findings on women being the key players in orphan care, Family Health International (2008) commented that although men might be identified as children's carers, the burden of caring falls mainly on women.

Contrary to the findings of age in the current study, other study findings revealed old women as the main caregivers of orphans especially in household settings (Gumbonzvanda, 2004, Cox et al, 2006). In their studies, old women were the ones who were responsible for the care of the orphans. Women aged 60 years complained about the heavy burden of feeding, sheltering and clothing the children.

However, Cox et al (2006) found that older children, 18 years and below, were identified as caretakers of the young siblings in home settings. These children were mostly from the same family and had assumed the responsibility of caring while the parents were sick.

### 5.2.2 Number of Children

Another characteristic that was common among the caretakers was that all the caretakers at the centre had experience in caring for the children. They all had children themselves with an age range of one to ten years. They had some background on how children behave and what to expect of them. Cox et al (2006) found that most of the caretakers were grandmothers or fathers or extended family members with several children of their own. They also found that care was being provided by older siblings or child mothers who acted as primary mothers, without the capacity to provide child care on their own. This was a challenge to the carers themselves as well as the children being cared for. They could not provide the necessary care to the young ones and yet they too needed to be cared for.

### 5.2.3 Educational Background

Eight female caretakers had completed primary school education, whilst the male caretaker had completed secondary school education. They were all able to read and write. The women did not go further with their education. They had completed their primary education, which the researcher assumes was a contributing factor for their status as housewives.

In summary, the demographic findings revealed that the caretakers' ages ranged between 23 and 42 years with the majority being between 38 and 42 years. They all had experience in caring for their own children and had completed primary education with the exception of the male caretaker who had completed secondary education.

## 5.3 Discussion of the findings

### 5.3.1 EXPERIENCES OF CARETAKERS

The participants described their experiences, background and the reasons for joining the centre. The female caretakers were housewives prior to becoming caretakers of orphans and some had lost their husbands some years ago. Others joined the centre because of the training in tailoring which was conducted at the centre some years ago while the male caretaker joined because he had a passion for orphans which he realised soon after finishing his secondary education.

Caretakers who had lost their husbands were housewives left with the responsibility of caring for children with no support from the relatives of the deceased partner. According to a report on the Economic Commission for Africa (2004) women are economically dependant on men and have less access to assets and land. As such, death of the husband creates numerous challenges for these women.

The finding that caretakers used the centre as a source of support after the death of their loved one is consistent with Oleke et al's (2007) study in Uganda. In their study, orphans cared for by widows, experienced hardship due to poverty. The need to provide for the children and the lack of support from the relatives on the husband's side posed a challenge to the widowed mothers.

Despite the loss of a loved one, the female caretakers had the energy to care for other children as commented by Adato et al (2005). They commented that mothers still have the urgency to provide care to other children even in the most difficult times.

The findings were also similar to the findings of a study conducted by the Boston University School of Public Health Centre for International Health Development (Miller et al, 2007). In their study, the caretakers had a history of caring for a sick adult in the previous year and after the death of the adult, the orphaned children became part of their already existing responsibilities of caring for their own children and the orphans.

On the other hand, individual motivating factors such as tailoring and a passion for orphans were the motivating factors to joining the centre. The tailors were busy with sewing clothes and uniforms for the orphans and not directly in contact with the orphans. Their major contribution to the orphans was the income generating activity through the sewing of clothes and uniforms for the children and the sewing of clothes at a fee for the surrounding community. The male caretaker who had passion for the orphans was responsible for teaching kindergarten children and running the youth club.

Contrary to the above findings were the study findings of Freeman and Nkomo (2006) in South Africa. In their findings they found that, the motivating factors for caring for orphans were the conditions that the caretakers would be given financial support and that they would be supported by a trained person who would be visiting the orphans. They were also willing to care for HIV negative orphans. In contrast in another report by the Family Health International (2000) from Haiti stated that families in the different

communities would not accept the orphans into their homes because of poverty, lack of skills and fear of HIV and stigma experienced by the AIDS affected families.

In another community in Zimbabwe, the community volunteers were recruited through a local church and only those who demonstrated a concern for orphans were accepted (Mutandwa and Muganiwa, 2008). It was further commented that this system was preferred because there was trust and retention of the volunteers at the centre.

Among the participants, some were trained in orphan care while others were not. Where training had been received, it was for one week and was mainly in relation to life skills. The content covered was basically on general child care, developmental changes in children, and the need for love and patience towards the orphans and the need for encouraging the children to go to school. In Uganda, the common topics included during caretakers' training were basic first aid, nutrition, child minding, socialisation skills for children and hygiene (Cox et al, 2006). The training of volunteers promotes effectiveness of the services provided to the orphans since it provides knowledge and skills that are relevant in orphan care (Ntata, 1998). Ntata further stated that training increases the caretakers' self confidence.

At the time of the interviews, the female caretakers could not recall what they covered but said that they were able to use the information at first. However, as time passed they could not remember much of the information. They, therefore use their general knowledge in caring and not necessarily what they learned in the training. One could attribute their lack of retention to their low educational background and perhaps the level at which the information had been provided. In comparison, the male participant who had completed his secondary education was able to recall most of the information covered during his training. He further reported that this information helped him to run the youth club he had formed.

The above findings were different from the recommendations made by Mokhtar (2008). He recommends that caretakers of orphans need special and adequate preparation at

degree level in psychology and sociology for successful caring. She further states that they need adequate experience and knowledge about the developmental stages of children and that they need to undergo a personality assessment before joining the centre. It was further recommended that these children need caretakers with adequate knowledge and experience in caring; to assist the orphans recover to their physical and emotional well being in order to realize their full potential.

According to Family Health International (2008), it is suggested that the caretakers of orphans and vulnerable children need to have access to complete, relevant information and appropriate health care including clinical and preventive health care services, nutritional support and appropriate health and home based care in order to provide maximum well being for these children. It is further stated that providing training to the caretakers of orphans is one way of developing coping mechanisms when caretakers themselves experience stress.

In addition, UNICEF (2006) recommends that training programmes and all initiatives targeting orphans must be guided by the child development theory which addresses the needs of the children at different ages. UNICEF (2006) advocates that the preparation of the caretakers should incorporate child developmental issues according to the different age groups in the orphan centres. Similarly, the Presidents Emergency Plan for the AIDS Relief Office of the United States Global AIDS (2006) campaign advocates the training and direct provision of support to caregivers including adolescent heads of household to improve their ability to care for the vulnerable children. Adequate preparation of caretakers of orphans can make a great difference in the caring role and in the end have a greater impact on the orphans (Ntata, 1998).

Adato et al's (2005) study in South Africa revealed that the caretakers were prepared in advance by the HIV positive parents, that they would be responsible for the care of their children after their death. They identified potential caregivers, they hoped, would be able to cope with the burden of care once they died.

Cox et al (2006) in their study found that family members are often unprepared and unequipped to provide for basic needs such as clothing, school fees, and good nutrition, let alone be able to provide psychosocial support and care to orphans after the death of their parents.

In summary, the preparation of caretakers of orphans is an important issue when planning for the care of orphans. It is believed that adequate preparation of caretakers might contribute to the successful transition from childhood to adulthood.

### 5.3.3 PERCEIVED HEALTH ISSUES AFFECTING ORPHANS

In this category, the following subcategories emerged: health risks and common health conditions, material needs and social problems and the management of the common health conditions, material needs and the social problems.

#### 5.3.3.1 Health Risks and the Common Health Conditions

The participants narrated that the orphans were at risk of bilhazia, malaria, malnutrition, teenage pregnancy, early marriages, HIV/AIDS and STIs. These findings are similar to the findings of a study conducted by Tahir, Finger and Ruland (2005). In their study, they found that orphaned adolescents are at greater vulnerability to many risks, including HIV infection, sexually transmitted infections and unintended pregnancies.

Children at the center were reported to suffer from malaria, diarrheal diseases, skin infections affecting the head and the body such as scabies. The findings are partly similar to the findings reported by Ananworanich (2004) about orphans in Thailand. It was reported that the children came to the orphanages in bad health, malnourished and with skin infections. The caregivers reported that some orphans had contacted HIV and AIDS from their parents. This posed a challenge for the caretakers in Thailand. However, at Mphatso orphan day care centre, malnutrition was considered a risk but it was not common for the children to develop malnutrition. It is also not known whether the

infections in the children could be HIV related infections, because the status of the deceased parents was not known. On the other hand, it would be appropriate to determine whether there is any relationship between the skin infections and the diarrheal diseases and poor hygienic measures or the HIV status of the orphans. HIV/AIDS counseling and testing of the children should be considered with a view to providing antiretroviral therapy if necessary.

The findings were contrary to the findings of a study done in Zimbabwe in 1992 on the situation of orphans and their caretakers (Foster, Chinemana and Shakespeare, 1992). The following challenges in orphans were identified as common health conditions among the orphans- infectious diseases, nutrition and growth difficulties, cognitive development disorders and physical and sexual abuse. The caretakers had difficulty in providing the best care possible and were frustrated. The study suggested that caretakers ought to be trained in how to diagnose psychosocial problems, counsel the children and be able to refer the children for hospital care at the right time.

#### 5.3.3.2 Material Resources and the Social Challenges

Lack of material resources was one of the challenges faced by the centre. The material needs for the orphans were mostly clothes, bed nets, shoes especially during the rainy season and food in the months of February, March and April. The centre has the highest numbers of orphans during these months because the relatives do not have adequate food to feed their families and the orphans.

The increased numbers of orphans makes it difficult for the centre to meet the food requirements of the orphaned children who are permanently enrolled at the centre. The children who depend solely on the centre for their evening meals are the ones mostly affected because they do not get enough for the evening.

According to the Republic of Malawi National Policy on Orphans and other Vulnerable Children (2003), economic deprivation, increased workload and rejection were identified

as some of the challenges of orphans. Economic deprivation makes it hard for the children to have food, clothing, school fees and other essential things for their normal growth and development.

The findings related to food problems are similar to the challenges of caretakers of orphans at Shalom in Tanzania. At their center it is said that only 25 children are provided with food because the center cannot afford to provide the food to all the children at the center. The provision of adequate supplies of food has been identified as one of the common challenges in Sub Sahara Africa (Wagt and Connolly 2008; UNICEF, 2006; Nyambedha et al, 2003).

The challenges in caring for the older children were different from those of the young children. Teenage pregnancy, early marriages and HIV/AIDS, STIs were identified as the health risks of this older group of orphans. This is mostly attributed to their developmental adjustments in physical, emotional and sexual maturity (Ruland et al, 2005). It is further stated that with maturation comes the need to understand relationships, intimacy and peer pressure. As such, the adolescent youth experience difficulties in life adjustment if there is no one to provide the guidance during puberty, for a successful move toward independence and adulthood.

Brouwer et al's (2004) study in Uganda, found that poverty, illness of the orphaned children and increased workload were identified as some of the greatest challenges faced by the caretakers. Caretakers were confronted with challenges due to lack of material support, the increased numbers of orphans and the lack of health information. According to the United Nations (2002), older people as caregivers described the caring of orphans as starting life all over again, because one has to work hard on the farm and in the house, feed the children and buy school needs despite an advanced age. One still has to think of ways of meeting the needs of these children at the end of the day.

Mutandwa and Muganiwa (2008) in their study identified misunderstandings between the orphans and the caretakers. The orphans had a misconception that the caretakers were

receiving benefits from non-governmental organizations for their own benefit. The researcher did not identify this problem at the centre despite the financial constraints experienced by the centre.

### 5.3.3.2 Management of the Common Health Conditions, Material Needs and the Social Problem

#### 5.3.3.2.1 Management of the Common Health Conditions

The management of the sick children was basically through the nearby health clinics. In case of emergencies, the children were treated at private clinics. The costs were met by the centre. This was done so that immediate care was obtained to save the lives of the children. At the time of the study, treatment of fungal infections was being provided at the centre, using medications that had been donated by doctors who had visited the centre. This is in contrast with what happens in one of the orphan day care centres in Tanzania (Seoane et al, 2006). The centre has an arrangement with a nearby medical facility which has all the basic services necessary for child care including a dispensary and an outpatient AIDS clinic. The children are treated at the clinic and referred whenever there is need, free of charge. On the other hand, in other day care centres in the same country, it is reported that medical care for the orphans is very expensive (ibid, 2006). This makes it difficult for the orphans to receive appropriate care.

#### 5.3.3.2.2 Material Needs and the Social Problems

This study revealed that the centre maintains the same quantities of food even when the numbers of children increase. It was not possible for the centre to have more food supplies. This is in contrast to Tanzania at the Village of Hope orphanage. The centre has several cows, pigs and fruit trees which contribute greatly to the nutritional needs of the children (Seoane, Mason and Cade, 2006).

In this study it was found that children are given clothes that well wishers donate to the centre. The older children benefited from the advice given on prevention of pregnancy,

HIV/AIDS, STI and are encouraged to finish their education and from the youth club sessions.

Seoane et al (2006) state that group counseling sessions take place in the evening with the children in Tanzania. They all sit together and talk and pray for one hour. The caretakers have a belief that prayer is necessary for these children to feel loved and to help distract them from their difficult upbringings.

### 5.3.4 HEALTH INFORMATION ISSUES IN ORPHAN CARING

The participants indicated that they give health information in the form of advice when the children come for their meals. The actual information given is on the consequences of teenage pregnancy, abortion and early marriages, prevention of HIV/AIDS and STIs, the importance of working hard, finishing school, the importance of exercises and hygiene. The male participant has planned activities for the kindergarten children and the youth club. The youth are the ones who have a chance of regular teachings. Different from what happens in this center, is the fact that in some orphanages in Africa the children are taught skills such as farming to enable them to farm and earn a living during their school holidays (Economic Commission for Africa, 2004).

The topics that the participants felt were relevant in orphan care included information about HIV/AIDS and STIs, dangers of teenage pregnancy and abortion, child abuse, prevention of communicable diseases, food, body and environmental hygiene. Cox et al (2006), advocate that caretakers of orphans need information on child psychosocial and cognitive development, nutrition, health, hygiene, socialization and counseling skills. They comment that this information will help caretakers to use specific techniques to encourage and stimulate the children to the next level of development.

The centre does not have specific organizations or institutions that provide them with information. Instead the director makes arrangements with people that are knowledgeable in that area to come and assist the caretakers with information. Oleke et al (2007) in their

survey found that the caretakers of orphans did not have any assistance from any agency be it from government or nongovernmental organizations despite the availability of policies and programmes in Uganda.

### 5.3.5 THE PERCEPTION OF CARETAKERS ABOUT ORPHAN CARE

The subcategories that formed the concept of orphan care included teaching the children skills and offering support for them to have a successful development to adulthood. The findings show that the concept of orphan care is not different from the caring of any ordinary children. The participants explained that caring is composed of teaching the children some skills such as like cooking, washing clothes and keeping the environment clean. They believe that caring involves providing spiritual care, nutritional support and educational and career guidance. It was also noted that the children should be taught about their cultural values and that they need some disciplinary measures when need arises. This was not far from how Weisners' (1997, cited by Christiansen 2003) description of what caring means. He described caring as a social phenomenon that involves many aspects of everyday social life such as affection, physical comfort, assistance, shared solutions to problems, provision of food and other resources, protection against harm, coherent moral and cultural understanding .

## 5.4 Relationship of the Study Findings with the Conceptual Framework

The purpose of the researcher was to determine the knowledge and health information needs of caretakers in orphan care at Mphatso orphan day care centre in Lilongwe, Malawi. It is believed that orphans are one of the most vulnerable population groups in society who need special attention. In this study, the following concepts were applied from the Health Belief Model: perceived susceptibility, perceived severity, perceived benefits, cues to action and self efficacy.

**5.4.1 Perceived Susceptibility** refers to the beliefs about the chances an individual has of getting the disease or condition. The caretakers were knowledgeable about the health risks such as bilharzias, malaria, malnutrition, teenage pregnancy, HIV/AIDS and STIs. The common health conditions mentioned were malaria, diarrhea, skin infections and fungal infections affecting the head. They were able to manage these conditions by taking the children to the nearby health clinics.

**5.4.2 Perceived severity** is the belief about the seriousness of a condition or its consequences. The participants knew the dangers of malaria, diarrhea, skin infections and the fungal infections which was seen in their action of taking the children to the hospital when they were ill. They also suggested that it would be good for them to have malaria treatment available at the centre since it was one of the common conditions at the centre that requires immediate treatment.

**5.4.3 Perceived benefits** are the beliefs about the effectiveness of taking action to reduce risk or its seriousness. The study findings revealed that the participants were able to give some counseling and teaching sessions on the dangers of HIV/AIDS, early school drop out, early marriages and teenage pregnancy.

**5.4.4 Cues to action** are the factors that activate readiness to change. This concept did not come out clearly in the study findings. However, the findings did reveal that when a child was sick, they were taken to private clinics and if the condition was considered an emergency, help was sought immediately without the relatives' permission. The relatives of the child were informed after the child had received treatment.

**5.4.5 Self efficacy** refers to the confidence in one's ability to take action. It can be assumed that by accepting the invitation from the director of the centre, the caretakers were demonstrating confidence that they were capable of providing the appropriate care to the orphans.

The study findings revealed that the caretakers were knowledgeable about the health risks and common health and social challenges affecting the orphans at the centre. They were able to take the children to the hospital when sick, and provide some information which they perceived as useful for the future development of the children. They also demonstrated knowledge about the concept of orphan care.

## 5.5 RECOMMENDATIONS

Children are facing the tragedy of losing one or both parents to AIDS. If one parent is infected with HIV, there is a high probability that the other parent is also infected and so the entire family is facing the threat of illness and later on death (UNICEF, 2003). Despite the death of these parents, the children left behind require and deserve the continuity of care. Relatives or other volunteers have to shoulder the responsibility of caring for the children left by the deceased families. With proper care, support and protection the orphaned children can rebuild their hope for the future and lead healthy lives and be productive citizens of a country. Some recommendations which can be derived from the research are:

### 5.5.1 Recommendations to the Health Sector

The Ministry of Health and the Christian Health Association coordinates the entire public health sector in the country. All hospitals, even those that have some degree of autonomy, fall under their jurisdiction. It therefore recommended these bodies develop a curriculum for the training of caretakers of orphans for all the hospitals and increase the funding to the hospitals for them to be able to extend their services to the orphans to support the caretakers that have taken the initiative of caring the orphans on voluntary basis. This will maintain standardization in all the hospitals since the health sector has the responsibility to provide the care and health information to the public. They provide health services to all vulnerable populations and are therefore the key players in providing information and support to the caretakers of orphans in society. They need to develop programmes specifically to target orphans in various institutions of care. Apart

from the orphans themselves, the caretakers of orphans too, need support with information for them to be able to care for the orphans comprehensively. The provision of health information and the actual involvement of the health care professionals to promote child development might improve the outcome of the orphans in future and ease the burden of caring on the caretakers. They can also provide the caretakers with other basic resources such as gloves.

### 5.5.2 Recommendations to the Surrounding Community

The findings have revealed that more orphans join the centre in the months of January through April because these are the months that many people experience food shortage. There is need to find means of food sustainability in the community. Instead of the community sending more orphans to the centre, the communities should be the ones providing more food resources to the centre for the orphans to have adequate food supply throughout the year.

### 5.5.3 Recommendation for further Research

With the current situation of orphans in the world and Malawi in particular, there is need to conduct more research into the health information needs of caretakers of orphans since this research was done on a small scale for generalization of the findings. Children need to go through several developmental stages for them to grow into productive adults and be able to face the challenges of adulthood successfully. They need information and counseling for them to grow into healthy adults. As such there is need to conduct more research on health information needs of caretakers of orphans to generate more knowledge on a wider perspective.

## 5.6 Conclusion of the Study

This study has highlighted the knowledge of the caretakers of orphans in orphan caring and their perceptions on the susceptibility of orphans to health and social problems and the health information needs in orphan caring in one of the orphan day care centres in Malawi. The findings have revealed the need for health information among the caretakers of orphans. There is need to conduct more research on the health information needs and mobilize support from the different perspectives to support the caretakers of orphans in order for the orphans to benefit from the care being rendered at the centre.

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## APPENDICES

APPENDIX A

**TITLE: HEALTH INFORMATION NEEDS OF CARETAKERS OF ORPHANS**

**Interview Schedule for Demographic Data**

I would like to ask you a few questions about yourself.

Sex: M ☐

F ☐

Would you mind telling me how old you are?

Age: 18-22 ☐

23-27 ☐

28-32 ☐

33-37 ☐

38-42 ☐

What is the highest standard of schooling that you have completed?

Primary ☐

Secondary ☐

Tertiary ☐

No formal education ☐

How many children do you have?

0 ☐

1-5 ☐

6-10 ☐

12-15 ☐

How long have you been working at this centre?

Months ☐

Years ☐

**Question Guide on Health Information Needs of Caretakers of Orphans.**

Now, I would like to ask you about the health information needs of caretakers of orphans.

1) Will you tell me about your background?
2) What preparation did you have prior to your role as a caretaker of orphans?

(Probe) Did you attend any training? If yes, describe what you were taught?

3) Do you believe that orphans are at risk of developing health problems? If so why?
4) What are the common health challenges of orphans at this centre?
5) How do you manage the challenges?
6) What are your health risks as caretakers of orphans?
7) What type of health information do you need as caretakers in order to meet the challenges of the orphans?
8) Do you give any health messages to the orphans?

(Probe)If yes, what health information do you give? May you give an example?.

9) When you are in need of health information, where do you get the information?
10) What do you believe the concept of "orphan care includes"?

**APPENDIX A (translated version of instrument for data collection)**

Tsopano ndikufuna Ndikufunseni mafunso pang'ono okhudza inuyo.

Mwamuna ☐

Mkazi ☐

Kodi muli ndi zaka zingati?

18-22 ☐

23-27 ☐

28-32 ☐

33-37 ☐

38-42 ☐

Kodi munalekezera sitandadi chiani?

Pulayimale ☐

Sekondale ☐

Kolegi ☐

sindinaphunzire ☐

d) Nambala ya ana omwe muli nawo

0 ☐

1-5 ☐

6-10 ☐

11 or more ☐

Kodi mwagwira ntchito kwanthawi yayitali bwanji pamalo ano?

Miyezi ☐

Zaka ☐

Gawo lachiwiri

Tsopano ndikufunsani za mauthenga a zaumoyo omwe osamalira ana a masiye amawafuna.

1. Kodi inu munayamba bwanji ntchito imeneyi?
2. Munakonzekera motani musanayambe kusamalira ana a masiye? Kodi munalandira maphunziro ena ali onse okhudzana ndi kasamalidwe ka ana a masiye? Ngati ndi choncho, munaphunzira zotani?
3. Mukukhulupilira kuti ana amasiye ali pa chiopsyezo choti akhonza kukhala ndi mavuta okhudza thanzi lawo? Ngati ndi choncho, chifukwa chake ndi chiani?
4. kodi ndi mavuto anji a za umoyo amene ana a masiye amakumana nawo pafupi pafupi pamalo ano?
5. Nanga mavuto amenewa mumathana nawo bwanji?
6. Nanga inu muli pa choopsya chanji pamene mukusamalira ana amasiyewa?

7. Kodi ana a masiyewa mumawauza ma uthenga a za umoyo? Ngati ndi choncho, mungapeleke chitsanzo?
8. Ndi mauthenga anji a za umoyo amene ali ofunika pofuna kuthetsa mavuto a za umoyo a ana amasiye?
9. Mumapeza kuti mauthenga a za umoyo mukawafuna?
10. kodi mukukhulupirira kuti chisamaliro cha ana a masiye chimakhudzanso mbali ziti?/ kodi ndi uthenganso uti omwe umafunikira posamalira ana amasiye?
11. Kodi mukukhulupirira kuti chisamaliro cha mwana wamasiye chiyenera kukhuza mbari ziti?

APPENDIX B

**INFORMED CONSENT FOR THE PARTICIPANT**

My name is Annie Msosa, working at Kamuzu College of Nursing as an Assistant Lecturer but currently studying at University of KwaZulu-Natal in South Africa. I am conducting a research study on health information needs of caretakers of orphans because of the increasing challenge in caring for the number of orphans. As such, determining the health information needs of the caretakers of orphans will benefit both the orphans and the caretakers.

For this study, information is required from you because of the experiences you have had whilst working with orphans. The study involves answering a few questions. Your name will not be used to ensure anonymity and confidentiality. All the information will be treated as confidential. The interview will last 30 to 45 minutes and a tape recorder will be used to record all the information. The data will be accessible to the researcher and the supervisor only. The storage of data will be under lock in a cupboard for five years. Your participation is voluntary. Therefore, if you wish to withdraw from the study at any time, you are free to do so.

For more information about the study, contact Professor Patricia Mcinerney at University of Kwazulu-Natal, Durban, South Africa. Her telephone number is 031-260-2497.

Declaration

I.....hereby confirm that I understand the contents of this document and the nature of this research project and I consent to participation in this project

I understand that I am at liberty to withdraw from this project at any time should I so desire.

..... .....

Signature / thumb print of Participant Date

APPENDIX B (Translated informed consent in chichewa)

Chilolezo Cha Otenga Mbali Mukafufuku Uyu

Ine ndine mai Annie Msosa ndipo ndimagwira ntchito ku Kamuzu College of Nursing. Panopa ndikupitiliza maphunziro okhudza ntchito yanga ku University of KwaZulu-Natal, ku South Africa. Ndabwere kuno kudzachita kafukufuku womwe mutu wake ndi "Kusowa kwa Uthenga wa za Umoyo Pakati pa Ogwira Ntchito a Ana Amasiye". Cholinga cha kafufuku ameneyu ndikufuna kufufuza chosowa cha uthenga wa za umoyo pakati pa anthu ogwira ntchito yolera ana a masiye.

Chotero inu ndi mmodzi wa anthu amene mungandifotokere zambiri pa nkhani imeneyi popeza mwakhala mukugwira ntchito ndi ana amasiyewa. Mukafukufuku uyu, mutenga mbali yoyankha mafunso angapo omwe kwa mphindi 30 kapena 45. Mukafukufuku ameneyu, musatchule dzina lanu pofuna kusunga chinsinsi. Komanso zomwe tikambirane pano ndi za chinsinsi. Munthu wina aliyense ndiwosaloledwa kuwona kapena kudziwa zomwe tikambirane pano.

Pofuna kutsatira bwino ndondomeko ya zokambirana zathu, ndikhala ndikulemba komanso ndigwiritsa ntchito wayilesi kutepa zones zomwe tikambirane pano. Kutenga mbali kwanu sikokakamiza. Muli ndi ufulu kusiya osatenga mbali mukafukufuku uyu nthawi ina iliyonse. Ngati mungafune kudziwa zambiri za kafukufuku ameneyu, mukhoza kufunsa kwa Professor Patricia Mcinerney omwe amagwira ntchito ku University of Kwazulu-Natal, ku South Africa, ndipo foni yawo ndi 0312602497.

Pofuna kusonyeza kut mavomeleza kutenga nawo mbali mukafukufuku uyu, lembani dzina lanu pa mizere yotsatirayi.

Ine mai/bambo.....(dzina la otenga mbali) ndamvetsetsa bwino bwino cholinga cha kafukufuku uyu ndipo ndavomeleza kutenga nawo mbali.

## APPENDIX C

**Sample Letter of Permission to the Relevant Authorities**

University of Kwazulu- Natal,
Howard College Campus,
Faculty of Health Sciences,
School of Nursing,
Durban 4041.
South Africa.

The Ethics Committee,
University of KwaZulu-Natal,
Howard College Campus,
Faculty of Health Sciences,
School of Nursing,
Durban 4041.
South Africa.

Dear Sir / Madam,

**RE: SEEKING FOR PERMISSION TO CONDUCT A STUDY AT MPHATSO ORPHAN DAY CARE CENTER IN LILONGWE, MALAWI.**

I am Mrs. Annie Nancy Msosa, an assistant lecturer at Kamuzu College of Nursing currently pursuing a master's degree in Maternal and Child Health at the University of KwaZulu-Natal, Durban, South Africa. As part of the requirement of the degree, I am expected to conduct a research study. My research topic is on "Health Information Needs of Caretakers of orphans in Lilongwe, Malawi".

Data will be collected by means of in depth interview schedule. The participants will be the caretakers of orphans working as volunteers at Mphatso orphan day care centre in

Lilongwe, Malawi. On ethical consideration, the participants' names will not be used and informed consent will be obtained from them. The data collected will not be accessible to other persons except the researcher.

I hereby seek your permission to conduct the study in Lilongwe, Malawi. I will endeavour to abide by the rules and regulation as laid down by the committee and authorities. Enclosed is a copy of the proposal and informed consent for the participants for your attention.

Yours faithfully,

Annie Msosa (Mrs.)

APPENDIX "C"

UNIVERSITY OF
KWAZULU-NATAL

RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 – 2603587
EMAIL: ximbap@ukzn.ac.za

5 FEBRUARY 2008

MRS. A MSOSA (207521600)
SCHOOL OF NURSING

Dear Mrs. Msosa

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/0711/07M

I wish to confirm that ethical clearance has been granted for the following project:

"Health information needs of caretakers of Orphans in Lilongwe, Malawi"

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years

Yours faithfully

Ximba
MS. PHUMELELE XIMBA

cc. Supervisor (Prof. Mohlenkoj)
cc. Mr. S Reddy

APPENDIX E

UNIVERSITY OF MALAWI

Principal

Prof. R.L. Broadhead, MBBS, FRCP, FRCPCH, DCH

Our Ref.:

Your Ref.: P.12/07/602

College of Medicine
Private Bag 360
Chichiri
Blantyre 3
Malawi
Telephone: 677 245
677 281
Fax: 674 700
Telex: 40744

29th January, 2008

Mrs Annie Nancy Msosa
KCN Bt Campus
P O Box 415
Blantyre

Dear Mrs Msosa,

P.12/07/602 – Health Information needs of caretakers of orphans at Mphatso Orphan Day Care Centre in Lilongwe.

I write to inform you that COMREC reviewed your proposal mentioned above which you resubmitted. I am pleased to inform you that your proposal was approved on 29th January, 2008 after considering that you addressed all the queries which were raised in an earlier review.

As you proceed with the implementation of your study I would like you to take note that all requirements by the college are followed as indicated on the attached page.

Please note that the ICH guideline 3.2.1 had been followed during the voting process.

Sincerely,

Prof. E. Borgstein
CHAIRMAN - COMREC

REQUIREMENTS FOR ALL COMREC APPROVED RESEARCH PROTOCOLS

1. Pay the research fees as required by College of Medicine for all approved studies.
2. You should note that the follow-up committee will monitor the conduct of the approved protocol and any deviation from the approved protocol may result in your study being stopped.
3. You will provide an interim report in the course of the study and an end of study report
4. You are required to obtain a continuation approval after 12 months from the date of approval.
5. All investigators must be fully registered with the Medical Council of Malawi

APPENDIX F

FROM: ORPHAN CARE + SOCIAL REHABILITATION
P.O. BOX 30200
CAPITAL CITY
LILONGWE 3

DATE: 6/01/08

TO: MRS MSOSA (MEDICAL DOCTOR)
P.O. BOX ...
LILONGWE

Chikondi and Miphatso
Orphan Care Centre
16 JAN 2009
P.O. Box 30200
Lilongwe 3 - Malawi

RE: LETTER FOR RECOGNITION

You are hereby recognised to conduct y
at the centre as per your request.

Please feel free and arrange the stay

Yours.
James Mwakasungula
for Administration

## Appendix G: A sample of the Transcribed Data

**Will you tell me your background**?

I am a married woman and a housewife with five children. My husband works at a tobacco company. I came to know about this place because of an advert about tailoring lessons. It was advertised to all women interested and widows were of priority. Then I tried my lack because I had the desire to learn tailoring and I was successful. At the end of the training, three of us were requested to be tailors for the orphans on a voluntary basis. Then after discussing it with my husband, I decided to join this centre.

**What preparation did you have prior to your role as a caretaker of orphans?**

Aaa, I did not have any preparation because they just requested me to join this centre to assist with tailoring of the uniforms and clothes for the orphans.

**Apart form the tailoring, were you trained in orphan care?** Mmm, no. I have never been trained in orphan care.

**Do you believe that orphans are at risk of developing health problems**?

Yes, orphans are at risk of skin infections, malaria attacks and bilhazia. **Why is this so**? Because many of these orphans do not have nets and they lack proper hygiene because of poverty. They also lack support. Most of the children walk without shoes, putting them at risk of bilhazia especially during this rainy season.

**What are the common health challenges at this orphan centre?**

The common problems we have seen are the skin infections that ooze pus. The other problems are scabies and malaria.

**How do they manage these challenges?**

Usually, the children are taken to the health centre for treatment. However, if there is treatment in the centre, the children are treated here.

**Do you give any health messages to the orphans? If yes what messages do you give? May you give an example?**

Many times we are busy with tailoring and we rarely speak to them unless if we are sewing something for them.

**What type of health information do you think caretakers of orphans need in order to meet the challenges of the orphans?**

Orphan care is a challenge. Our friends who work with the orphans directly need information on prevention of HIV/AIDS, environmental sanitation, food hygiene, and the consequences of unwanted pregnancies in young girls.

**What do you believe the concept of orphan care includes?**

Care of these children is not different from what other children receive. They need spiritual encouragement, proper hygiene, support in their education and they have to know the cultural values.

**Thank you for accepting that I can speak with you**