The health status and needs of displaced children in Windhoek, Namibia

By

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I declare that ***the description of the health status of displaced children in Windhoek, Namibia*** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

.....

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ABSTRACT

The health status and needs of displaced children in Foster Homes in Windhoek, Namibia

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The purpose of this paper was to determine the health status of displaced children in Windhoek, Namibia. Specific objectives were to determine health profiles of the children and to assess their health needs and status. One hundred and fifty nine children between the age of eight months and twenty years took part in the study. The children were staying at four foster homes in Windhoek. To achieve the objectives, a checklist was used to do the physical assessment of the children.

The physical examination revealed four major health concerns:

1) Ear, nose and throat problems.
2) Eye problems, the majority of which was poor sight.
3) Skin problems; and
4) Urogenital problems

Recommendations based on this study are that yearly physical examination of foster children must be conducted to promote their health.

DEDICATION

This thesis is proudly dedicated to all the professional nurses who contributed to my educational development.

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LIST OF ABBREVIATIONS

M.O.H.H.S.	Ministry of Health and Social Services
N.S.R.C.	National Statistics Research Council
S.O.S.	Save our souls
W.H.O.	World Health Organisaiton

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CHAPTER 1

THE HEALTH STATUS AND NEEDS OF DISPLACED CHILDREN IN WINDHOEK , NAMIBIA.

Countries worldwide are increasingly sharing similar social concerns. Some of these concerns include, escalating violence and domestic abuse, devastating poverty, high divorce rates, multiculturalism, unprecedented migration, and an increasing number of children living without one or both parents. These changes impact family structure and affect children because children are removed from their source of security and compromise their physical health, social and psychological well being. The WHO (World Health Organization) defines health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (WHO 1987). Under these circumstances they become juveniles and run always and therefore are neglected and abuse. The family then no longer fulfill its role expectations and as a result social welfare has to take over the role of the family, in caring for this children (Giddens 1993:390). That is why some of these children land in foster care and others make the street their homes.

According to Cockburn (1991:12) UNICEF findings indicated that there are as many as 30 million street children worldwide and, it was identified that this phenomenon was a worldwide concern as well as in Namibia. It is estimated that there are more than eight million young people between the ages of eight and sixteen years that live independently from their families. Ennew (1987:39) quoted in Family violence is also on the increase, and poverty and economic difficulty, are related to family violence cited Popenoe (1998:283).

Murray Strauss (1980:455) argued that parenthood provides a license, for dealing with their children and that the "marriage license, is a hitting license". This includes estrangement and disconnection of these children from their families, thus these

children are often referred to as street children, urbanize strollers, pick pockets or parking boys. These concerns contribute directly to the displacement of children in all societies since they are forced to leave their homes and families, to survive on the streets. Life of this kind makes children vulnerable to countless dangers, which compromise their health and wellbeing.

General statistics indicated that the social phenomenon of street children is increasing in the Third World population group. Four out of ten urban dwellers are expected to be less than 18 years of age by the year 2000. That number is expected to increase to six out of ten by 2025. It was estimated to that 100 million children live and work on the streets in the developing countries, and twenty five percent live on the streets. There were as many as 100 million children in cities like Cairo and Lima who called the street their home (Dalglish 1997:1).

In African cities such as Maputo and Luanda tens of thousands of girls and boys displaced by war begged for spare crumbs to fill their stomachs. In the European Union there were three million children and adolescents, that worked and lived on the streets Dalglish (1997:1).

In America, one in five children, live in poverty. The lifestyles of these children are such that thousands of children sniff glue and gasoline to ward of cold and boredom. In Australia, and in the developing world, these children sleep in abandoned buildings, and bridges in doorways, or in public parks. They survive by petty theft and prostitution. Most of them are addicted to inhalants such as cobbler's glue', which offers them an escape from reality. In order to meet basic survival needs which only money can buy, these children need a source of income. The International Labour Organization found that almost 90 million children between the ages of 11 and 15 years serve in the world's workforce (Dalglish 1997:1).

Takayama et al (1998:201) conducted a study in order to determine the specific

reasons for placements of children in foster homes and found that 50 % of the children were below the age of six, 30 % were neglected, 25 % were physically abused and 25% had no available caretaker. According to Pradhan (1990:7) children who are admitted to foster homes or who live on the streets are usually categorized in to three groups, namely runaway children, orphans, or abandoned children. Children that are in these positions have a much higher incidence of health problems, substance abuse, and an earlier onset of sexual activity (Ensign 1997:817, Ruptier 1997:290). Furthermore, it was found that the majority of children living under these circumstances had never been in school, and were therefore illiterate. Most of these children worked as rag pickers or porters, while the remainder survived by begging or stealing. Also peer groups were frequently organized, to fight against each other. (Pradhan et al 1990: 1-7). The major health problems that displaced children experience are, malnutrition; skin conditions, such as abscesses, cuts, scabies, acne, mouth lesions; respiratory conditions; urinary problems; trauma injuries, like fractures of the legs and arms; sexually transmitted diseases, like HIV/AIDS; teenage pregnancies; and depression (Nzimakwe & Brookes 1994:29 & Scanlon et al 1998 :1569 Rosenfeld, A. 1997:448).

ANALYSIS OF THE PROBLEM

In Namibia, as in the rest of the world, many children run away from home, or are abandoned by family members. Studies done in Namibia revealed that children ran away from home because they felt unwanted, or they were physically abused and neglected by parents. They also did not know their biological fathers and for many of them both parents were deceased (Rose 1992: 7& Le Beau 1992:10). According to Tacon (1991:8) there could be as many as 46,000 displaced children in Namibia, of which 700 - 800 are in Windhoek. They are mostly male and between the ages of 11–14 years.

A working document that was formulated by the Ministry of Local Government and Housing with the support of UNICEF Windhoek in 1991, and the help of a international consultant, Peter Tacon, illuminated the situation of street children in Namibia. It was a survey of street children in three urban areas in Namibia. The areas were Windhoek, the nation's capital, Rundu and the Kavango region in the north and Keetmanshoop in the south. The findings correspond with findings by Schurink & Schurink (1993:8).

The age of the children varied between 11 -14 years and there were more males than females. The children were from poor families with low socio- economic status. The mother was the head of the family and in most cases unemployed. The children were physically and psychologically abused and ill treated at home, and they were familiar with alcohol and drug abuse. They attended school but quit, while they were still in primary school. Despite the hardship, these children worked on the street, and had a certain degree of self-esteem. They were keen to learn and willing to improve their situation.

The survey findings imply that children whose family life and security are interrupted are more likely to land in the streets in Namibia, as is the case in other countries as well. Displaced children will remain on the streets or they could be admitted to foster homes. The Children's Act of Namibia, NO 33 of 1960 section 18 (1) indicates that any child who is abandoned, abused, neglected or seduced for street trading and public entertainment, can be removed to a place of safety by any police officer, social worker or prescribed officer to a place of safety. Children in Namibia who live on the streets or who are admitted to foster homes are classified as "state patients" and are allowed to receive free medical care. However, due to the disadvantaged life they have had they will need detailed systematic health assessment on a regular basis to identify any existing health problems, due to their past experience or current situation.

In foster homes children are looked after by substitute parents who are lay persons and are usually looking after up to ten children of different age groups. Given the

history of the children, it is uncertain whether foster parents are in a position to identify early enough "hidden" health problems, e.g. hearing impairment, sight and eye problems, heart and digestive problems, health concerns related to a diagnosis of HIV/Aids, just to name a few.

NAMIBIAN CHILDREN'S HOMES

Churches in Namibia were the first social institutions to initiate Foster Homes. These foster homes were establish in terms of the Children Act (Act no.33 of 1960) started in 1988 under the name of the Southwest Children's Home, and controlled by the Dutch Reformed Church of Namibia. This home, subsidized by the government, was first taken over by the Ministry of Health and Social Services in July 1991, whereafter the Ministry of Woman Affairs and Child Welfare took control in November 2000. Accommodation, if available, is provided on request of communities applying from different regions. The home accommodates 108 children. Most of these children's parents abuse alcohol. Some of the children had been abandoned by their parents. Children are sometimes admitted in the hospitals and parents fail to collect them. Other children coming back from exile and repatriated to Namibia could not locate family members. All these children, who for many different reasons do not have a home are quickly placed in foster families.

The **S.O.S. Chidren Village Association of Namibia** was founded in 1984. At present it accommodates children who live with a mother figure, in separate houses with 10 to 12 other children. Here one will encounter children whose parents cannot take responsibility for them, because of various social reasons. These children were admitted to S.O.S. Children Village Association by court order based on the Children's Act of 1960. Children's act No 33 of 1960. (Workshop report at Harmony centre of children under difficult circumstances 1992:9). The Children's Act is there to protect the children from abuse, abduction, exploitation and prostitution.

The Netherlands Children home of Namibia is registered with the Ministry of Health in terms of the Children's Act (Act no 33 of 1960) as well. It commenced it's operation in January 1977 as a private institution under the care of the Dutch Reform Church of Namibia. This home spread forth out of the Namibian children home. Although this children home is registered at the Ministry of Health and Social Services, it is not funded or subsidized by the government. The home is dependent on the church, public for donation. In total 20 children, boys and girls can be accommodated in this institution. The children are taken care of by a married Christian couple and one extra house mother as a relief worker, who has a good knowledge of child education. Children that are accommodated in this institution. The children are mainly from dysfunctional families with multi social problems including abuse of alcohol & marriage problems.

Children are admitted to any of the foster homes by order of a court of law after extensive investigation and a report by a social welfare official to a child commissioner. Both parent and child are summoned to appear in court. If the court is unable to find suitable foster parents for a child in the community, the court places such a child in a foster home. The foster homes all make use of the multidisciplinary team approach to assist children with reconstructive services in order to recover from their abuse or trauma. The team consists of a school psychologist, pastors, and social workers.

Several years ago a very caring and religious woman started a shelter and children's home, in Katutura. The Moira Grace Home, was registered at the Ministry of Health and Social Services in 1999. The "housemother" collected children from streets and "the pipes", and cared for them in her home with minimal facilities, money, or food. There are always approximately 100 boys and girls, that must be fed, clothed, kept warm, and nurtured in this home.

A complex array of factors influence the health of children who are displaced. Furthermore, what these children experience is often difficult to imagine, but directly

referred to as their health status. Therefore, it is important that children have opportunities to voice their experiences concerning health and illness and the meaning that these experiences have for them. Health workers must understand the "lived experience" of all people and the meanings and values that they attach to their health and quality of life. In the care of children this is even more critical, because so little is known about them and because there are not always structures or willing foster parents to accommodate these children.

PROBLEM STATEMENT

Although there are facilities available to care for displaced children and to cater for their health needs, it is not sure exactly how effectively this is done. The question that guided the study is: What are the health needs, concerns, and patterns of displaced children living in foster homes in Windhoek, Namibia.

PURPOSE OF THE STUDY AND OBJECTIVES

The purpose of this study is to explore and describe the health status and needs of children who were admitted to foster homes in Windhoek, and the role and function of the community health nurse in the early identification of health problems of displaced children in foster homes.

The research objectives of the study are to;

(1) To assess and describe displaced children's health profile or health patterns.

(2) Describe the role and function of the community health nurse with regard to promoting the health and health care of children in foster homes.

SIGNIFICANCE OF THE STUDY

This study of the health status and health needs of displaced children is important for the nursing profession. Nurses are part of the community and it is important that they understand the experiences and health needs, concerns and patterns of these children.

Some of these children will be admitted to health centres, clinics and hospitals, where nurse's practice and it will be expected from them to care for these children. On the other hand, nurses can play an important role in the community by assisting community leaders, to care for these children and to do health education in preparing young people for parenthood. According to Stanhope & Lancaster (1992:379) it is a essential for the nurse to establish trust with the displaced children, by providing health services which can serve them. Trust will develop through a sequence of trusting and trustworthy actions and the nurse must treat these children with respect and understand their chaotic circumstances.

OPERATIONAL DEFINITION/TERMINOLOGY

The following definitions were used throughout this study.

Needs

Maslow defines physiological needs as the most basic. These include hunger, thirst, sleep and material needs. Safety needs include security, stability, and the need for order and protection. Above these needs, are the affiliation and love needs including friendship and sexual needs? The esteem needs are strength achievement, mastering and competence. Esteem also includes, reputation, prestige, and dignity. Self-actualization is the highest class of needs and is concerned with fulfillment. These needs differ from person to person. However, if a person lacks these basic needs, and experiences hunger, thirst, etc. all the other needs become secondary Woolfolk (1990).

Health

The World Health Organization (WHO) defines health as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity (WHO 1978).

Place of Safety

*M*eans a temporary place suitable for the reception of a child into which the owner, occupier, or person in charge is willing to receive the child. A place of safety includes a police station, a hospital or other institution, which is willing to receive a child in need Vlok (1991:564).

Foster Care/Parent

A foster parent is an adult who receives a child on a temporary basis for board to care. The placement is made either by the social welfare department, or by family welfare agencies under the direction of the commissioner of child welfare. Placement can be short or long Vlok (1996:405).

Family

The family refers to a group of people who live together and who are expected to perform specific functions especially in reference to the children involved Tower (1998:22).

Street Children

For purpose of this study a street child is defined as those children who have been abandoned by their families, school, and immediate communities before they are 16 years of age (Richter 1988:6). UNICEF 1987 regards street children as those children who make the street their real home. In Namibia street children are labeled as urchins, vagabonds, delinquents, street Arabs, parking boys, or pokey boys.

Displaced Children

Displaced children are children who are refugees, left homeless or unable or unwilling to return to their home country Horn & Cowie (1974:249). Displaced children include street children.

CHAPTER 2

LITERATURE REVIEW

The aim of the literature review was to examine what was known about the health status of displaced children, including children who have live on the streets and are then admitted to foster homes. Views and opinions of different authors as well as various research findings will be discussed. Certain factors, which have an influence on health, are prominent in the literature and these will be discussed under the following headings:

- Family and its role and responsibilities
- Reasons for placement in foster care.
- Health problems experienced by the children
- Physical health
- Social problems and mental health
- Sexual problems
- Malnutrition

THE FAMILY AND ITS ROLE AND RESPONSIBILITIES

The family is an institution that is as old as humankind itself. The term family refers to a group of people who live together and are expected to perform specific functions such as raising children Tower (1998: 23). According to (Searle, Brink & Grobbelaar 1992; 420, Lauer 1995; 4337 & Tower 1998:22) the functions of a family differ from society to society and from culture to culture but certain functions are basically universal, for example the reproductive function and care of the infants.

Firstly, there are reproductive functions. No society can survive, without replacing its members. Secondly, care of infants and the young. Babies and children need care

and protection until puberty. Thirdly, families of socialized children in the formation of intimate relationships, and well as provide understanding and support to the young child. The child also becomes fluent in languages, social values, norms, cultural practices, religion, and education. According to Popenoe (1998:270), socialization begins at home. Children learn who they are, what is expected of them in life, and how to behave towards others. The effectiveness of the family, in its role of socialization is also enhanced by the fact that the child's progress can be closely monitored and adjustments can be made in behavior as required. Fourthly are the regulations functions. Some cultures do not accept extra marital sexual relationship, while others are more liberal. Fifthly, the family provides emotional support and love. This is vital to human functioning. Husbands and wives have to work for most of the day in an environment where emotions may be suppressed, and thus the expression of emotions is so important in the family setup.

The WHO (1987:17) describes the family as a social unit, which has to provide a framework, for health. Overall the family can be seen as an institution that should maintain its structure by keeping its members together Tower (1998:23), but owing to many factors that bring about change in family structures, it no longer functions as "useful," as before Lauer (1995:450). According to Popenoe (1998:270), no other social institution has changed as rapidly as the family. A few generations ago the family consisted of a man and a woman married to each other, with several children. The husband was the breadwinner, and the wife remained home in order to look after the children. Many factors influenced the changes that occurred in the family. Industrialization, which created opportunities for women to get out and work, in addition to caring for their families. This created a social revolution.

Additionally, demographic and social trends have shortened the child bearing and child rearing stages of the family life cycle and overlooked the strategies needed to cope with these changes in the family (Popenoe 1998:283). These influences caused people to feel that the concept of the family is disappearing and the existence of entire societies

are endangered. Some believe that the normal family is doomed because of its inadequacy in fulfilling its functions and that this contributes to greater misery for individuals within the family (Lantz, Schulz & O' Hare1977: Lauer 1995:430). Other literature supports that has contributed to the demise of the family. High divorce rates, violence, and poverty are all cited as contributing to problems for the sustainment of the family. Tower (1998:34) categorizes these problems as follows: The failure to complete basic family tasks like providing food, protection, and education; the failure in dealing with changes associated with developmental tasks, such as behavior, and the failure to deal with social pressure and pressure from different cultures. However, according to the literature these are the factors that have caused children to flee to the streets or shelters to survive. On the streets or shelter homes the problems continue and there is a need to change the behavior of the children.

The following problems usually prevail.

Reasons for placement in foster homes

Local authorities must intervene when families are unable to care for their children. Children might be separated from their parents for a number of different reasons already discussed, and related to the break down of family relationship or parental ill health. Rose (1992:6) wrote about 300 children living in difficult circumstances in areas of Rehoboth and Mariental in Namibia. Rose summarized the main reasons for children who deliberately preferred to leave their homes were as follows: They were unwanted, or they knew that their conception was a mistake. Children whose fathers were absent from the family unit also often left home and 47% of children in these areas had no father, and 30% had never heard of their biological fathers. Another reason children left home was poverty and lack of clothing.

Caretakers in four foster homes in Namibia, stated that the main reasons for children running to the streets are family breakdown, alcohol and drug abuse, poverty, young and single mothers parents deceased. According to parents on farms. Jacobs, J.

(1989:10) stated that the reasons for children leaving home include family problems, unemployment, over crowding in the home, and alcoholism. Smith, (1989:8) indicated that the reasons why these children leave the home is that there is severe poverty, overcrowding, alcoholism violence and sexual abuse.

According to Takayama et. al (1998:201), the degenerating structure of the family is to blame for over 500,000 children being placed into foster care annually Takayama further conducted research in order to determine specific characteristics of children and reasons for their placement in foster homes. Takayama further look at children's health status during initial placement and the relationship among these factors. Findings indicated in percentages the following:

- 50% of children were below the age of six.
- 30% of children were neglected.
- 25% of children were physically abused.
- 25% had no available caretakers.
- 9% suffering abandonment
- 7% were in a situation of failed placement
- 3% having been were sexually abused
- 5% having practised substance abuse

It is interesting to note that 30% of the parents of these children abused substances. When the reason for foster care placement was neglected, parental alcohol abuse increased to 51%. (Takayama, et al. 1998:201)

HEALTH PROBLEMS EXPERIENCED BY STREET CHILDREN

Physical health

Health is defined by the WHO as a state of complete physical, mental and social wellbeing. To reach this stage, people must be able to realize and, satisfy basic needs and change or cope with the environment. Denmill et al (1995:11). By implication this means that street children are not healthy. Due to their disadvantaged backgrounds their health needs for physical, mental and social well-being are seriously neglected. The consequence is that they usually suffer chronic health problems (Brodie et al 1997:386). Infections of the ear, nose and throat, skin, urinary tract and digestive system are common. Injuries and malformations due to untreated fractures are also evident. (Nzimakwe & Brookes 1994: Brodie & Berridge et al 1997:386 Weinreb (1998:554). Skin problems like rashes, scabies, acne, ring worm, and tinea capitis were found to be common condition among these children due to lack of water to wash them self Nzimakwe & Brookes (1994).

SOCIAL PROBLEMS AND MENTAL HEALTH

When personality growth and development go awry because of psychotic, social, cultural or biological influences, the person may become mentally ill. Thomson et al (1997:1345). Due to the trauma of abuse and neglect many displaced children develop emotional, social and psychological problems. Studies on street children revealed that abuse of alcohol, drugs and inhalation or sniffing rubber or dangerous substances are very common. Drugs affect children's brains, weaken their will power and reduce their resistance to sickness. While they are under the influence of drugs they may be violent and commit any sort of felony. Dallape (1987: 101), Rose (1992:7), Nzimakwe & Brookes (1994:30) Ruptier (1997:290), Poggenpoel & Myburgh (1998:49).

The abuse of alcohol drugs caused dependence with devastating effects on the human body physically and mentally. The reasons given by children for using alcohol and

drugs is the euphoria which makes it very appealing and alcohol relieves physical, mental and psychological pain. Poggenpoel & ,Myburgh (1998:49). According to Thomson et al (1997:1358), effects of substance abuse are psychomotor agitation, confusion, anxiety, paranoia, impaired judgement, and impaired social functioning. The impact on individuals who abuse substances as well as the impact on their families and on society varies for each substance. Productivity losses illness, accidents and premature deaths are only some of the consequences. Crime and juvenile detention play a major role in illicit drug use and the related costs to society. Fortinash & Holoday et. al. (1996:344). The smoking of glues specifically affects the cognitive functioning, and can cause death directly or indirectly. Poggenpoel & Myburgh (1998:50). Smoking can cause premature deaths due to lung cancer, coronary heart disease and chronic bronchitis, emphysema and other smoke related lung disorders. Fortinash & Holoday et. al. (1996:344).

Children with problems of substance abuse need intensive medical and psychological treatment and extensive caring. If they are admitted to foster homes this can be arranged. Community health nurses can also play an important role in this regard by assisting foster care homes in caring for these children. There may be self-care deficits related to a depressed mood where nurses can assist with bathing and personal hygiene. Also nurses can assist to establish a supportive, nonjudgmental relationship, assist the child to identify feelings of anxiety and stress, and help them to practice assertiveness skills to increase the child's self esteem. If they are not admitted to foster care, community health nurses can assist community leaders and churches to care for these children. The street child's relationship with his peer group is viewed as very important. The peer group is considered the quasi-family and plays as very important role in the life of the street child, because it provides support, acceptance, empathy, and defers exploitation and crime (Conolly 1990: 142). Swart and Kruger et al 1994:116. Once the street child is removed from the street and put into foster homes this relationship ends and it is also traumatic for the child. It is important that staff of foster homes take this into consideration.

SEXUAL PROBLEMS

Many of the sexual problems of the children started within the family. Finkelher (1984) cited in Popenoe pointed this out in a study that he did. It was found that sexual abuse was a widespread phenomenon and happens in the context of the family. There was an increase of 600 percent in reported cases between the years 1976-1982 in the United States of America alone (Giddens 1993:414). Giddens (1993:415) also found in his study on prostitutes, juvenile offenders, adolescent runaways, and drug users, that a high proportion of these individuals had a history of a child sexual abuse. Mason (1997:20) also reported after consultation with more than fifty young people that a wide range of health issues were evident, including sexual problems.

The literature indicates that sexual activities in disrupted families started on a very young age, between 12 - 13 years. The first reason is financial. The United Nations Human Rights Commission reported that globally 10 million children under the age of 17 years are regularly engaged in sex for money, and in parts of Asia a virtual industry has grown up around sexual exploitation of young boys and girls. Parents, step parents, and family members also abuse children sexually, and if these children run to the streets, they are exposed to an early onset of sexual activity. Ensign (1997:819). The consequences of sexual activity are, sexually transmitted diseases and H I V / AIDS amongst children.

In a study that was done by Scanlon (1998:1596) in Latin America on 199 home-based children and 195 street-based children it was found that sexual practices of street children started at the age of 8 years for boys and 12 years for girls. Teenage pregnancies were universal. Over 25% of teen girls on the streets were pregnant, 6 % have been reported with HIV/AIDS and 3% with syphilis. What is even more disturbing is the fact that these children participated in the so-called survival sex- sex for money, or food or shelter. Victimization, criminal behavior, substance abuse and pregnancies accompanied survival sex Green (1999: 1406).

MALNUTRITION

Studies revealed that malnutrition is a condition, which almost all the displaced children suffer from because they do not get adequate food. Children survive on left overs, on food of the rubbish bin as well as drinking dirty water. Pradhan 1990: Nzimakwe & Brookes1994). The physical development of a child is to a large extent a manifestation of his nutritional and health status. Those trying to improve the health of peasant communities place much emphasis on health education and suggest also that nutrition education is important. Unfortunately, educational programmes are often inadequate. In particular they often fail to ensure that the education is relevant to those most in need i.e., children in the poorest families Morley & Woodland (1992:76).

Malnutrition means incorrect or poor feeding. It is due to either excess or to a deficiency of one or more food constituents. Previous research in South Africa shows that children within black as well as coloured groups with low socio-economic status, are at risk of suffering the effects of under nutrition. Undernutrition leads to intellectual backwardness, tuberculosis, gastro-enteritis and pneumonia. The results of a nutritional study done in 1975 by the Health Department In Gauteng in South Africa found that one third of the Indian, one quarter of the coloured and one fifth of the black communities were suffering from malnutrition. Vlok (1996:205). According to UNICEF the state of the world's children in 1991, was not very good. Diarrhoea, measles, and respiratory infections were responsible for taking away a child's appetite and inhibiting absorption, burning calories, and draining nutrients. When such sickness are frequent, malnutrition is the result (UNICEF 1991 & Sanders & Carver 1996:21).

THE ROLE AND FUNCTION OF THE COMMUNITY HEALTH NURSE

Nine years ago Namibia has adopted the Primary Health Care (PHC) strategy as a means of achieving the goal of health for all, by the year 2000 and beyond. Since 1991 health workers have been removing existing barriers and moving towards integrating hospitals into comprehensive health care units consistent with the PHC approach. Community participation and intersectoral collaboration in disease prevention and health promotion largely depend on a sound support system, for example churches, woman and youth organizations, and non governmental organizations (MOHSS 1995).

A survey done by Le Beau (1992:4) in Namibia found that 76% of children indicated that they came from poor or very poor families. These families mostly lived in iron shacks or cinder block houses and in most cases the house was over crowded with 4 adults and 5 children. Forty two percent (42%) of the children said that their mothers were responsible for feeding the family; 14% lived with relatives other than their parents; and 20% lived with their biological parents. Several children indicated that their mothers brewed beer, begged, were alcoholics, or sold food informally for a living. Due to these circumstances children ran away from their home and made the street their homes. Some ended up in foster homes. Those on the street and in the foster homes are traumatized and they will suffer from physical and psychological health problems.

Communities in Namibia become weak due to social problem like abuse of alcohol and drugs, high divorce rates, child abuse, sexually transmitted diseases, HIV/AIDS, tuberculosis, malaria, suicide, poverty and unemployment. Foster children and street children will remain and increase due to such factors. At this point, the community health nurse can play an important role. She has to visit foster homes to assess the health needs of these children, promote health, prevent ill health, and care for these children and rehabilitate them to use their remaining abilities optimally. The community health nurse in primary health care is a generalist with community health, midwifery,

and psychiatry. She/he is registered with the nursing board and her/his actions are guided with the Nursing Act. No. 50 of 1978 as amended by the Professional Act No. 30 of 1993. She/he is the first contact person with the community and she is the one who does home visits to determine the needs of children, assess their situations at home, and act as a mediator between the parents and children to reconcile the family again. She/he guides the family to find solutions for their problems. The community health nurse also does promotion of health through regular physical examination of the eleven (11) systems of the body including hearing, eye tests and dental care for children in foster care. Treatment or advice can be given, or referrals can be made with regard to the above. Health education concerning personal hygiene of hair, teeth, and eye care can also be given as well as advice on a balanced diet. The roles and functions of the community health nurses are categorized on the basis of their client-orientated role, delivery -orientated roles, and group-orientated roles. The needs of communities can differ, that is why nurses do not engage in each of the roles all the time (Clark 1996:61). The group-orientated role involves direct provision of client service. These include roles of care giver, educator, counselor, referral resource, role modal, advocate, primary care provider and case manager. In this case the community health nurse will be a care giver by applying the nursing process to care for the foster child at all levels and will assess the needs of the child and plan appropriate intervention to implement the plan of care and to evaluate the nursing care plan and its out comes.

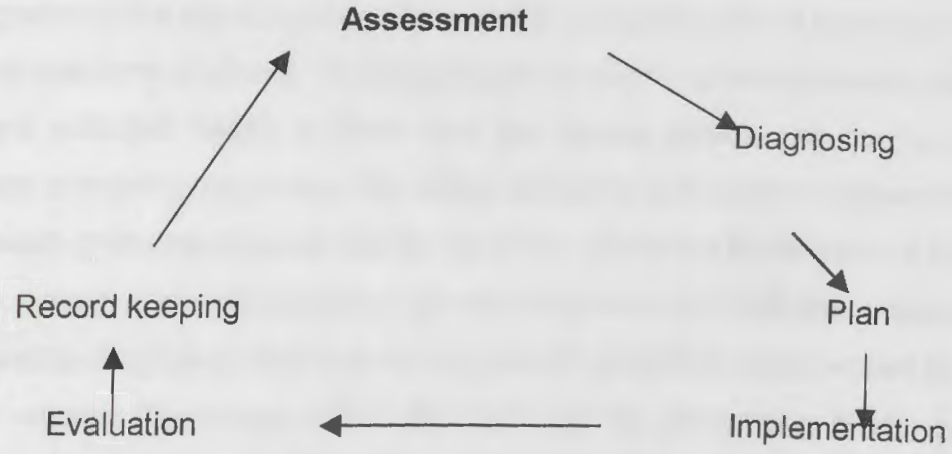
Health education is the backbone of the community health nurses' practice and that is why nurses are educators'. Education is the process where by knowledge and skills are provided to clients in order to initiate change in the client's (in this case foster children's) behavior. The community health nurse can also be counselor to help the foster child to over come trauma that he/she has experienced. The first step is to assist the client to identify and clarify the problem to be solved. As a referral source, the community health nurse refers the foster child to another resource, for example the psychologist, if the child has emotional problems.

Advocacy has been defined as a process of promoting the client's right of self-determination. Most of the time children cannot speak for them selves. The nurse can intervene here to prevent the child from developing an emotional or and psychological handicap. The aim of intervening is to help the foster child to overcome and forget any trauma experienced. The community health nurse is also in the position of being a coordinator of care because of his/ her their awareness of the foster child's needs as a whole, i.e. the physical, social, emotional and spiritual needs. In such a position the nurse can arrange a conference to include foster child, and health workers of the multi disciplinary team. To assist with nursing care in the foster homes, the community health nurse can use the nursing process.

The community health nurse-client relationship in the framework of the nursing model

The nursing process is a model, which gives order and direction to nursing practice. It is both an intervention and a research method within the nursing discipline. Nursing process helps the community health nurse practitioner with decision making and the prediction of expected out comes and planned interventions. The nursing process can be defined as a purposeful and intellectual activity where by nursing practice is approached in an orderly and systematic way George (1990:13). The nursing process involves a series of six steps. These steps are assessments, diagnosing, planning, implementation, evaluation and record keeping.

FRAMEWORK



ASSESSMENT

Assessment is the first step in the nursing process. It is the systematic gathering of relevant data. The purpose of assessment is to provide data about the client, concerning health and illness, deviations from normal, strengths, coping abilities, and risk factors for health problems. The nursing assessment focuses on responses to health problems (Wilkonson 1995:44). Assessment data may be collected by several methods including by interview, physical examination, and review of records. (Clark 1996:78). The precise format of these methods will depend on whether the data is subjective or objective. Subjective as well as objective data are needed to determine the client's health status. Subjective data can be verified only by personal experiences. Such data is not measurable, and can only be obtained from what the client tells you. Physical examination provides objective data that can be used to validate the subjective data obtained in the interview to clarify the effect of the clients disease on her ability to function and the meaning a person/client attributes to disease or health crisis. (Wilkonson 1995:45&58).

NURSING DIAGNOSES

The diagnoses is the second phase of the nursing process and it is based on the basic needs and reactions of clients. Nursing diagnosis also functions to identify the client's actual and potential health problem and the factors contributing to the problem. Statements of nursing diagnoses may reflect strengths and positive states of health as well as health problems experienced by the client. There are three types of diagnostic concepts: actual nursing diagnoses, high-risk diagnoses and wellness diagnosis. The actual nursing diagnoses describe existing health problems experienced by clients. High-risk nursing diagnoses reflect the potential for developing health problems because of the presence of identifiable risk factors. An example could be when the community nurse make a diagnosis of tonsillitis; it could be the actual diagnoses but it could be a high risk factor as well. If the child is not receiving treatment the heart may be affected and this leads to Rheumatic heart disease, which leads to long term treatment and is expense. Wellness nursing diagnoses reflect client states that may be enhanced to higher levels. All types of diagnostic statements include a description of the client's health state, but the actual diagnosis includes etiologic factors where as the high-risk diagnosis reflects risk factors present in the client situation Clark (1996:82).

PLANNING

Planning is the third step in the nursing process. Planning for nursing care can be describe as the process of determining the actions to be taken in order to solve the clients problems. George (1990:19) states that during this planning phase the nurse interacts very closely with the client in order to involve the client in finding solutions and by doing so, a professional relationship is established between the nurse and client. The outcome is trusting in the nurse's professional integrity, based on empathy which the nurse should portray continuously. It is useful to consider Maslows hierachy of basic human needs as a way of establishing priorities among problems.

The planning component consist of six basic intervention which are based on the prioritising of the client's problems, developing goals and objectives establishing critical criteria for potential means of achieving goals selecting appropriate means for goal achievement, designing nursing interventions, and planning for interventions. Therefore, planning is the process of setting a goal and objectives with realistic targets and data Mellish, Brink & Paton (1998:157).

IMPLEMENTATION

Implementing is the fourth step of the nursing process. Implementation refers to the actions that are taken to reach the objectives which were set during the planning phase. During implementation actual nursing care takes place (George 1990:2). The first task of implementation is identifying the knowledge and skills needed to implement the plan. For example, knowledge of nutrition and skills in developing menus on a limited budget are required. Good interpersonal skills are also needed when caring for street children. The second task of implementation is delegating responsibilities for carrying out the planned intervention. The persons designated with responsibilities should at least have some required skills and knowledge to implement the plan of care. Delegating responsibility for implementing aspects of the plan of care to others involves three primary considerations. The first is the presence or absence of needed knowledge and behavioural skills in the person to whom the activity is being delegated. For example, the nurse may need to instruct the foster parent to give the child the insulin injection. The second consideration in delegation is whether the plan of care is consistent with the self- interest of the person to whom it is being delegated. The final consideration in delegation is whether the client firmly believes that the suggested action is necessary. Referral for outside assistance is another approach that may be used. Other considerations include providing necessary information to the clients and the referral agency and follow up.

EVALUATION

Evaluating is an ongoing step in the nursing process in which the nurse determines the client's progress, using goals of care as criteria Kozier & Erb (1987:214). Evaluation is a comparison of client's health patterns with the outcomes. Outcome evaluation is the assessment of the outcome of nursing intervention. Process evaluation is the examination of the quality of action taken and the processes used to achieve the outcome. Activities involved in evaluation include collecting evaluation data, comparing data with established evaluation criteria and using findings to make decisions regarding care (Clark 1996:88). Evaluation includes analyzing the findings and comparing them with previous research results. Research reports should provide a clear documentation of what was done and when it was done. What was not found and what was not found in the study also needs to be reported.

RECORDING

Every action and outcome in the nursing process is recorded. According to Tobin Yoder & Hull (1979:38) records are designed to provide data based information. Such documents provide information concerning statistical data, activities, follow-up evaluation, and reference needs. The record keeping must be flexible, comprehensive and easily adapted as new areas of information needs arise.

SUMMARY

The family has a huge role in promoting the health of children. Many of the health problems experienced by street children are directly related to the breakdown of their families. Physical health, social problems, sexual problems and malnutrition are reasons why children enter foster homes. The role and function of the registered nurse with regard to the health care of children in foster homes is also huge. In addition to health assessment the nurse is a resource link, a health counselor, advocate and essential in the coordination of health care for foster children.

CHAPTER 3

METHODOLOGY

This chapter describes analyzes, the health profile of the children in foster homes in Windhoek. These descriptions are based on the computerized analysis of data derived from the physical examination that was done.

RESEARCH

This research methods used in this study are focused on identifying the health needs of children in foster homes in Windhoek. A descriptive study was employed to provide information in this regard. Seaman (1987:182) describes a descriptive study as a factor searching study, which can be used in the clinical area. The descriptive study may lead to new ways of thinking about important health needs and problems of foster children, which may lead to changes in nursing practice.

POPULATION AND SAMPLE

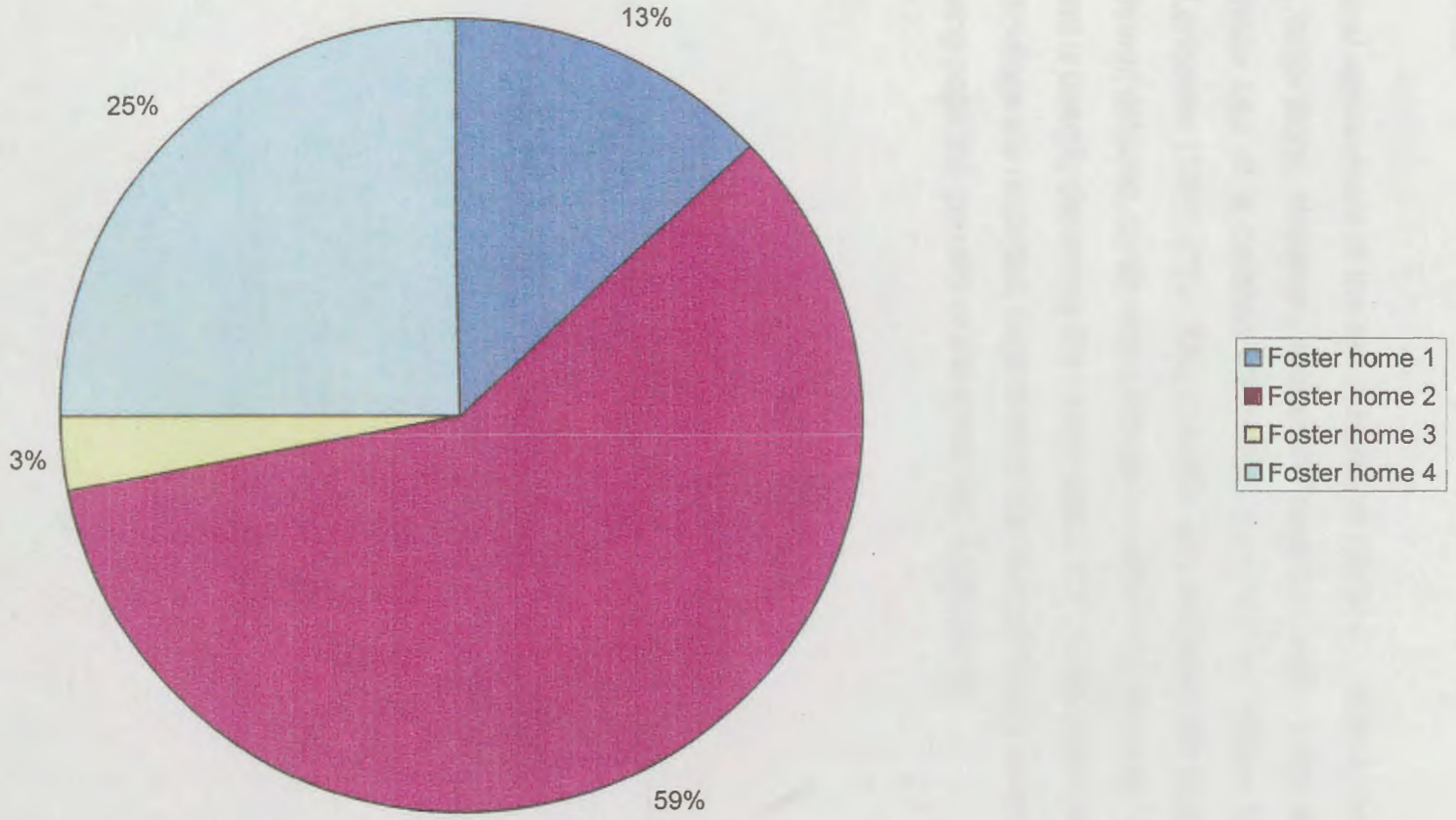
Four foster homes in Windhoek were chosen for this particular study. These homes have a heterogeneous population, namely White, Basters, Coloureds, Damaras, Ovambos and Herero. These home also offered clinical practice for the third year comprehensive diploma students who needed an experience in physical health assessment of school children. The homes are centrally situated and therefore accessible in terms of transport.

Table 1 Description of sample of respondents

Respondents	Description	Rational
Population/sample of Respondents	Children in Foster homes in Windhoek (N = 159) Total population	The total population was included in this study. To be completely representative of all children. All the children from birth up to 18 years of age were included

Graph 1 represents the four foster homes and the percentage of the number of children that participated in this study.

Graph 1: Foster homes & the % children, from each home participating in this study



INSTRUMENT

For the physical assessment of the ten systems of the body, namely the eyes, ears, nose, throat, respiratory, abdomen, urogenital cardiovascular, limbs and skin, the researcher made use of a detailed check-list, compiled by Viljoen (1988:18-20), Stanhope & Lancaster (1995:523). This checklist was preferred because it had been tested and it is well detailed, containing information useful for community health nurses. This instrument is used to determine the health status of children. Both the positive and the negative findings are recorded, regardless of the form of history taken into account. On the following page the content of the check-list is discussed.

Table 2 Content of the check list

Part 1	Personal data
Part 2	Daily Activities
Part 3	Immunization status
Part 4	Parameters & General appearance
Part 5	Gait
Part 6	Fatigue
Part 7	Nutritional status
Part 8	Skin
Part 9	Skin
Part 10	Eyes
Part 11	Ear Nose and throat
Part 12	Ear nose and throat
Part 13	Ear Nose and throat
Part 14	Respiratory problems
Part 15	Breast examination
Part16	Cardiovascular
Part 17	Hand and fingers
Part 18	Gastro intestinal
Part19	Urogenital
Part 20	Limbs
Part 21	Other problems

See Annexure C for other details on the checklist (Viljoen 988:18 - 20).

PRE-TESTING THE INSTRUMENT AND CHECKLIST

Pre-testing of the checklist was done in following manner: One professional nurse and eight nursing students in their third year of education were asked to examine children and complete the checklists according to the examination done. These eight students were taught how to use the list and how to examine the children. It was found that the checklist is part of there clinical practice so they did not find it difficult to complete. The checklist was also distributed to other lectures and professional nurses for review. Their suggestions were than incorporated into the final check list and examination process.

VALIDITY AND RELIABILITY

According to Polit & Hungler (1987: 323) validity refers to the degree to which an instrument measures what it is supposed to measure for the study. This instrument was valid because it directed the researcher to document the children's physical health with was completeness and accuracy. The instrument verified to be reliability when the same results are obtained after two different observers evaluated the same child.

COLLECTING OF DATA

Data were collected during March, July and August, 1999. Collection of data were mainly done through physical examination at the four foster homes in Windhoek.

PERMISSION TO COLLECT DATA

Permission to conduct the study was granted by four foster homes, parents, the regional counselor and the director of social welfare of the Ministry of Health and Social Services (MOHSS). See Annexure B. Permission letters to the various foster homes and to MOHHS are found in Annexure A.

GATHERING OF DATA

Data were collected through a checklist at the four foster homes. Children were examined from head to toe. Parameters like length, weight, blood pressure and urine tests were also done. Physical examinations were mostly done in the afternoons after school and sometimes on Saturdays. Twenty children were examined at a time. Tests could only be done on children that were available for examinations. One foster home requested that all children should be examined. Eight third year nursing students and one Registered Nurse participated in this exercise. They were trained as to how to use the checklist.

ETHICAL CONSIDERATION

Respondents voluntary agreed to take part in the research and those respondents who did not agree, were not forced. Respondents were protected from any physical and psychological harm or discomfort. Anonymity and confidentiality was considered at all times

DATA ANALYSIS

Data were analyzed using descriptive statistics. Microsoft Excel and Word programs were used to assist in the compilation of statistical data.

SUMMARY

Four foster homes in Windhoek were chosen to participate in the study. These foster homes have a heterogeneous population. A total of 159 children under went physically. A checklist were used. Permission was given by the foster homes as well as the children. Anonymity and confidentiality was considered all the time. Data were analyzed using descriptive statistics. In the following page the analytical interpretation of data will be discussed.

CHAPTER 4

ANALYTICAL INTERPRETATION OF DATA

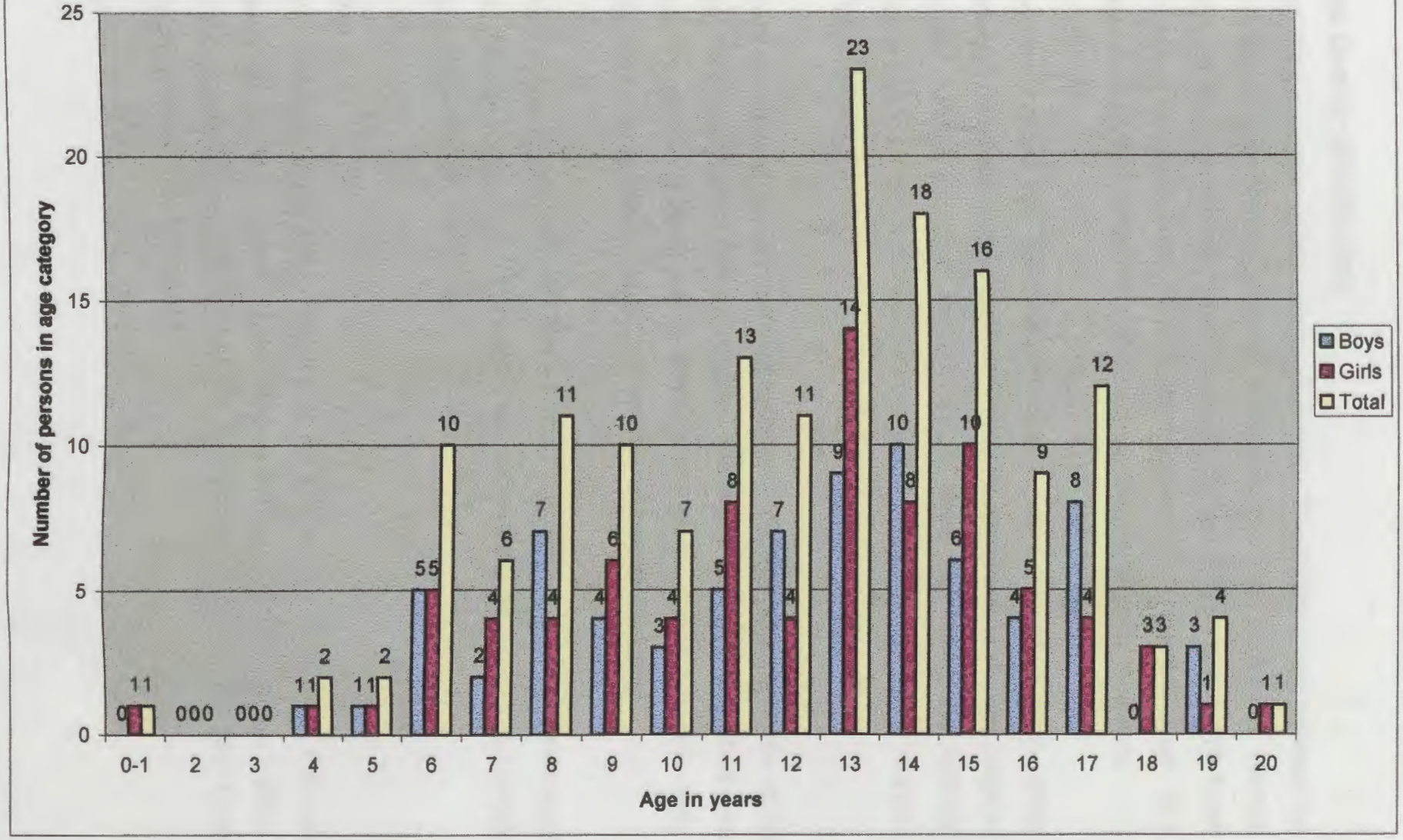
This chapter presents the findings of the research. It includes personal data, activities of daily living, immunizations, blood pressure, and the heights and weights of the children. The respiratory, cardiovascular, ear, nose and throat systems as well as the urogenital system, glands, muscular and central nervous systems of all the respondents were also examined and findings presented.

PERSONAL DATA

Personal data is descriptive of the children and the circumstances out of which they come. These data are necessary to find out their life-style because these life-style also affects their health. Dalglish (1989) describes foster children, as having extreme courage, and says that their survival is a true testimony of the strength of human spirit. This opinion is highly respected, since Dalglish has worked with boys and girls living on the streets of the worlds largest cities (Dalglish, Unicef,1987).

On the following page is Graph 2 which describes the age and gender distribution of the foster children in this study.

Graph 2 : Age & gender distribution OF CHILDREN IN FOSTER HOMES.



Age and Gender Distribution

A total of 159 respondents participated in this study. The children were between the ages of 1 and 20 years. The 20-year-old is the only late male adolescent. He was included in the study as he forms part of the group. He is employed by one of the foster homes. Of the 159 respondents, 84 (53%) were females' 75 (47%) were males. This contradicts the literature which lists males as most likely to leave their parents.

The 13-year-old group was the most prominent. It had a total of 23 respondents, representing 14% of the total participants. These respondents are in the stage of puberty and need information concerning this stage. According the MOHHS reproductive health policy for the adolescence is that the age group 10 and 19 years should be sensitized.

The 1 to 12 months and the 20-year old age groups had the least respondents, which represent 0,63% each of the total participants. The infants' growth and nutrition were important to monitor in order to pick up abnormalities early. The 20 year olds need health education on substance abuse and sexually transmitted disease.

The majority of the participants were in the 11 to 17 year age group, which represented 64.2% of the total participants. In this age group it is important to start support groups to discuss problems they experience.

Religion

All of the respondents state that they are of the Christian faith, which is Catholic, Lutheran or the Dutch Reformed. It is important to know in which religious tradition these respondents follow. Religions like Jehovah Witnesses don't take blood transfusions and transplant of organs.

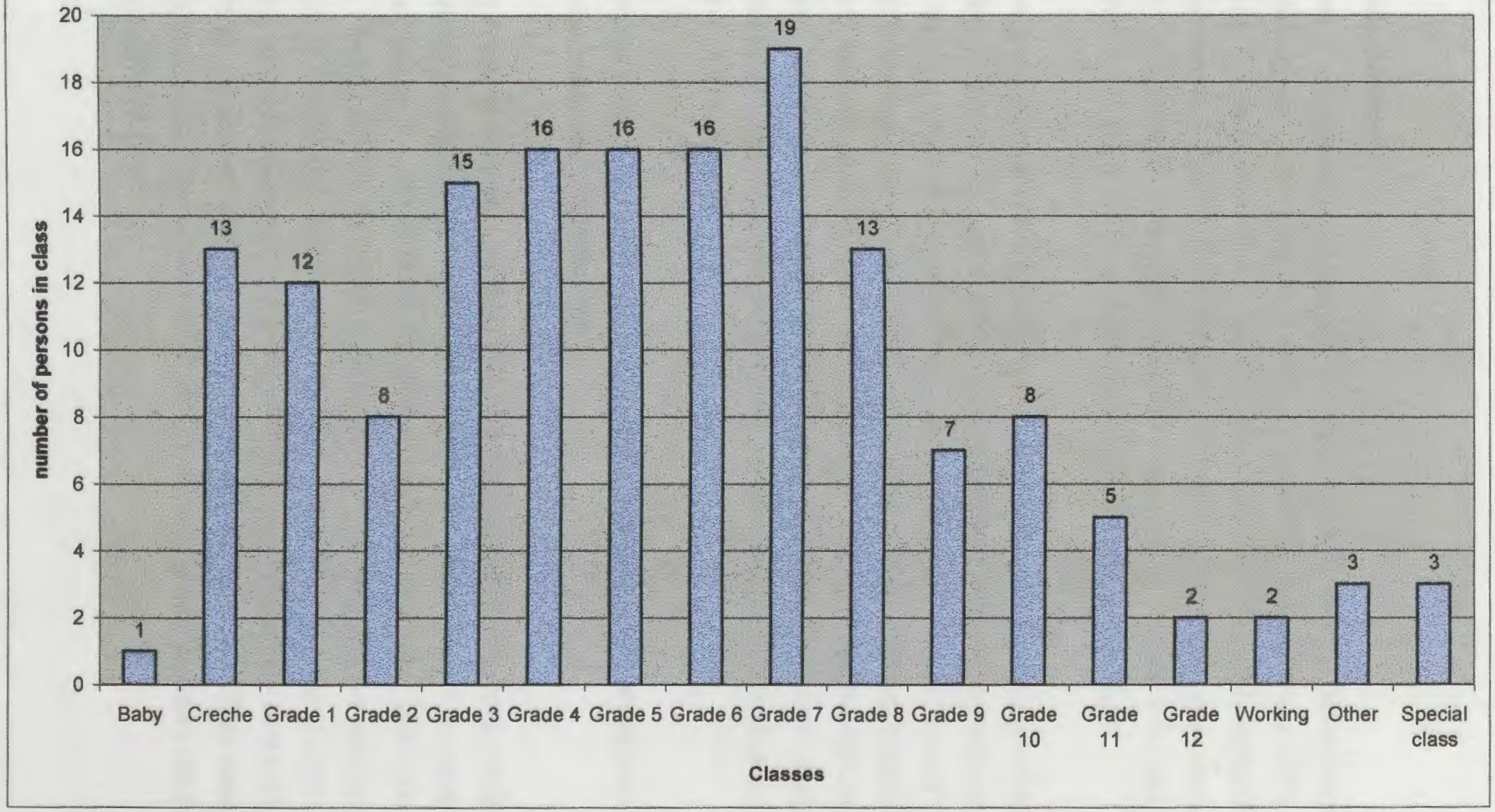
Race

The population of respondents was hetrogenous since they either formed part of the White, Herero, Damara, Nama, Ovambo, and or Coloured population groups. There is a

multi cultural society in Namibia because it has eleven ethnical groups. This diversity in cultures gave the respondents the opportunity to come in contact with different norms and values. This can lead to cultural adaptation.

- The following page there is Graph 3 that describes the educational status of the respondents.

Graph 3 Educational status of children in foster homes.



Educational Status

The classes, in which participants fall, vary from being a baby to attending school and taking special classes. The "any other" category represents participants who at the time were not available. There is only 1 (0.62%) baby, which constitutes the minority of all the participants 1,37% of the participants will be completing their secondary education in the year. The 8-month-old infant suffers from Hepatomegaly. The foster mother needs to be taught growth and nutrition and how to care for this child.

The crèche group represents 13 respondents. These children fall under the age of five and needed immunizations against the six killer diseases. Growth monitoring and nutritious feedings were also important. The grade 1 to 3 group is in the age range of 7 to 9 years. These respondents needs intensive care and should be monitored closely to detect early learning problems which can be caused by different factors such as hearing, sight and dyslexia. Grade 4, 5 and 6 participants are equal in number. Each of these classes had 16 (10%) participants. In total grade 4, 5 and 6 together represent ±30% of the total participants.

These participants are in the age range 10 –12 years. They need special attention on hygiene and health reproductive issues.

The grade 7 class is the most prominent. It has a total of 19 participants representing 12% of the total participants. Grade 8 represents 13 respondents, grade 9 contained 7 respondents, and grade 10 had 8 respondents. They were in the age range 13 to 16 years. This age group is the most vulnerable because they would like to experiment all spheres of life like sex, and substance abuse. Therefore, they are at risk of contracting diseases which are harmful to their health. They need special care to be sensitized on the positive and negative influence of the environment They need education on hygiene, reproductive health and how to manage peer pressure which can be negative or positive.

Grades 11 had 5 respondents and grade 12 had 2 respondents. They were 19 years of age. They are matured and need sensitization on occupational choices, reproductive health, substance abuse etc.

The educational standards of the participants were important to the health planners for correction between effectiveness of health education and literacy. All the respondents have the opportunity to benefit from health education.

School attended and place of birth

About one hundred and fifty five (155) (97.5%) of respondents were born in Windhoek and 4 which is 2.5% of the respondents, were born outside Windhoek. On average, most of the parents of these respondents are still alive, while only a few are deceased. This question is also important to know in order to reunite participants with their families after rehabilitation. Only 5 (3.14%) respondents had knowledge concerning their parents occupation. This question was posed to participants to find out how much communication they had with their parents.

ACTIVITIES OF DAILY LIVING

Smoking

Out of the 159 respondents, only 5 (3,14%) of the respondents smoke cigarettes. This figure may be wrong due to the fact that participants were shy to come out with the truth. None of the respondents were found to be smoking marijuana (dagga). This question was also important to know because if the respondents were using it they may act strangely.

Alcohol

Seven (7) (4%) respondents indicated that they used alcohol. These respondents, indicated that they consumed hard liquor, while four (4) (2.5%) of the respondents

said they consumed wine and only 3 (1.9%) consumed beer. This habit is normally practices during weekends and during parties. However, it could lead to alcohol abuse.

Drugs

None of the respondents were found to be using drugs.

Sexual Activities

- Five (5) (3.14%) of the older respondents (16-19 years) indicated that they were sexually active. All of these 5 respondents used protection in the form of either condoms (2.5%) and or injections (0.63%).

Sexual Diseases

The number of respondents having knowledge of sexual diseases were as follows:-

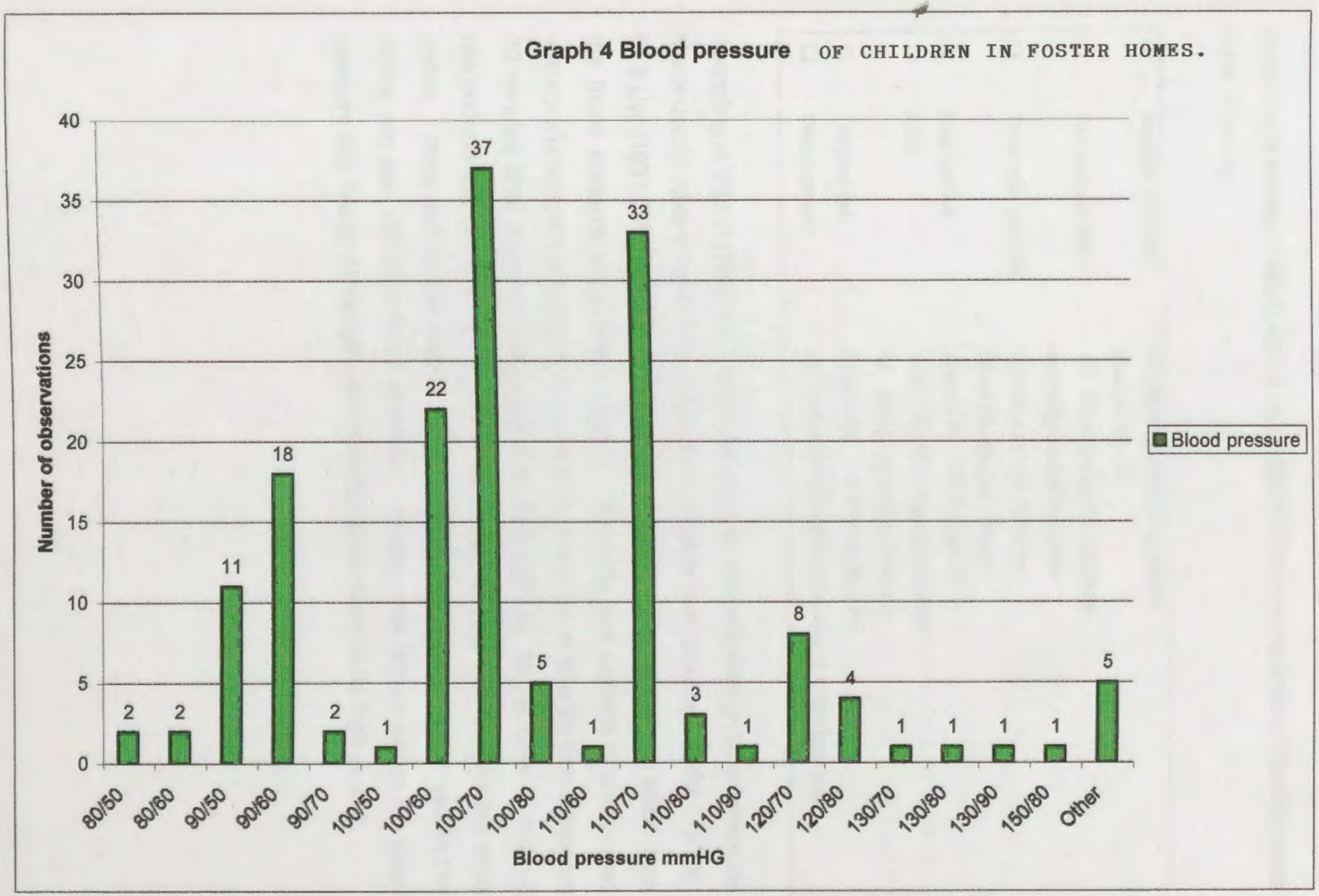
Syphilis	7 (4.4%)
Aids / HIV	28 (17.6%)
Gonorrhea	7 (4.4%)

Only 1 (0.63%) respondent suffered from a sexual disease, namely AIDS. It was important to find out what the knowledge of the respondents was so that their knowledge could be strengthen. A family member molested the one respondent and this is how she contracted AIDS. Some traditional healers tell AIDS sufferers that they will be healed if they sleep with an under age virgin.

IMMUNIZATION

All of the participants were fully immunized against the six "killer" communicable diseases. Immunization is important all over the world as well as in Namibia . Girls age 15 and above, were sensitized to Tetanus vaccination, which is normally given in the reproductive age.

Graph 4 indicates the blood pressure distribution of the respondents. Five respondents did not undergo blood pressure screening due to extra school activities. Two male respondents had slightly elevated blood pressures: 130/90 and 150/80. This could have been due to exercise. Research shows that physical activity causes an increase in cardiac output, which results in an increase in blood pressure. On the average, the respondents in this study had normal blood pressures.


Graph 4 Blood pressure OF CHILDREN IN FOSTER HOMES.
Number of observations
Blood pressure mmHG
Blood pressure
0
5
10
15
20
25
30
35
40
2
2
11
18
2
1
22
37
5
1
33
3
1
8
4
1
1
1
1
5
80/50
80/60
90/50
90/60
90/70
100/50
100/60
100/70
100/80
110/60
110/70
110/80
110/90
120/70
120/80
130/70
130/80
130/90
150/80
Other

According to Mulder (1999:59-61) & Uys (1999,135) the normal limits of blood pressure is the following:

❑	Neonate Newborn	-	40 - 70mmHg systolic pressure diastolic 40 – 50
❑	Two year old child	-	80 - 90mmHg systolic pressure 46mmHg diastolic pressure
❑	Three year old child	-	90mmHg systolic pressure 60mmHg diastolic pressure
❑	Five year old	-	Systolic 90 - 100 diastolic 65
❑	Adult	-	110 - 140mmHg systolic pressure 60 - 90mmHg systolic pressure
❑	Ten year old	-	Systolic 95 - 110 diastolic 65 – 70
❑	Elderly person	-	As for an adult or slightly higher due to arteriosclerosis

According to Viljoen (1996:42) Gender can have an also influence on blood pressure. Males usually have a higher blood pressure in puberty than females. Mulder 1997:59 - 61 & Uys (1991:155) finds that blood pressure can be influenced by drugs which lower the blood pressure while others raise it. Smoking and caffeine intake causes vasoconstriction with consequent hypertension. It is better to take the blood pressure 30 minutes after a person has smoked or had caffeine. In the case of the two respondents who had slightly elevated blood pressures, they both smoked and drank coffee. Race and various factors, such as heredity, climate and a high salt and fat intake can also influence blood pressure. Anxiety and tension raises the blood pressure too. Being overweight causes the blood pressure to be high as well.

GENERAL APPEARANCE

Posture

The postures of all 159 respondents were in normal range which is an indication of the absence of musculoskeletal injuries.

Physical Measurement

The weight and length distributions of 154 respondents have been displayed in this section. Five respondents were omitted due to their attendance of school activities. Graph 5 on page 48 display the weight and lengths of the respondents from babyhood (8 months) to late adolescence (20 years). From the graph, it can be observed that the respondents' weight and lengths differ slightly with a centimeter or two.

The researcher made use of growth charts (percentiles) to monitor the respondents' growth and length. There are three types of grids, namely one for girls, from birth to 36 months, one for boys, from 2 years to 18 years and one for girls, from 2 years to 18 years. See the growth charts in the Annexure 5. The growth charts and anthropometric datas shown in Annexure 5b, 5c and 5d is adopted from Hamill as cited in Cataldo Physical growth: National Centre for Health Statistics percentiles (NCHS percentiles). These growth charts allow health care professionals to evaluate the growth and development of children from birth to 18 years of age (Cataldo &Whitney 1998:12).

The following tables give a description of the weight, length, and percentile of various age groups of children in the foster homes in Windhoek.

Table 3 **For the infants (1 infant)**

Age	Gender	Percentile	Kg	Percentile	Cm
8 Months	F	On 10th	7	On 3rd	56

The infant had a low birth weight. She is not growing well due to a serious illness Hepatomegaly and is not malnourished. According to the author a child's length normally increases by 6 cm per year. Between 8 and 12 months, the child's weight gain is 15 gram per day Uys (1999:101). Common problems in abnormal growth patterns are malnutrition and under nutrition, acute and chronic infections, endocrine disturbances, congenital abnormalities and genetic defects. Inadequate stimulation and deprivation of mothers' love may lead to poor growth of the baby Uys (1999:100).

Table 4 **For 4 Years old group (2 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
4 Years	M	3 – 10	13	Under 3	96
4 Years	F	25 – 50	16	50 – 75	103

The ages of the toddlers' ranged from 1 to 3 years. During this phase there is rapid growth and development. These years are marked by achievements of physical competencies Stanhope and Lancaster (1988:440).

Table 5 **For the 5 year group (2 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
5 Years	F	Under 3	14	Under 3	98cm
5 Years	F	On 10	16	25 – 50	106cm

Table 6 **For the 6 year group (10 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
6 Years	F	On 50	20	On 25	111
6 Years	F	50-75	21	50-75	115
6 Years	F	Over 97	38	10-25	110
6 Years	M	On 10th	18	On 50	115
6 Years	M	25-50	21	Under 3	104
6 Years	M	Under 3	14	Under 3	102
6 Years	F	25-50	19	Under 3	104
6 years	F	On 50	20	3-10	107
6 Years	M	25-50	23	10-25	112
6 years	M	25-50	19	Over 97	146

Most respondents' weight falls in the normal range. Two males and one female are under the 3rd percentile. They do not appear ill or under nourished. For their age, these children are under weight and present the larger group of malnourished children. One male (0,64%) is over the 97 percentile, indicating a weight gain. He looks healthy and active although children that are over weight can suffer from heart problems and Diabetes Mellitus. In Namibia there are eleven ethnic groups, some of these groups have a small bone structure which is normal. Other groups have a big bone structure. The ages of preschool children range from 3 to 6 years. Physical growth and development continue, but at a slower pace than the toddlers. Limb growth is greater in proportion to trunk growth. Growth and development is affected by expansion of life experiences and the families' ability to cope if the mother is working. Stanhope & Lancaster (1988:440). According to the author, the average height of the 3 year- old is 94cm and weights approximately 15 kg, the 4 - year - old height is 104 cm and weight 17 kg, the 5- year- old, 110-130 cm and weight approximately (18-23 kg) the average weight for a 6-year-old boy is 21.75kg and the average height 116cm. Height increases about 5cm yearly Murray & Zentner (1997:391).

Growth retardation is common in children who came out of difficult circumstances of neglect, abuse, and no proper nutrition. According to Wyatt, et. al. (1997: 841-815) growth retardation is widespread in children placed in foster care, with almost half showing catch-up growth after placement. Height is not a good predictor of future growth, and cut-off percentiles will miss the great majority of children who will show catch-up growth. A study done on 47 children who were adopted from the former

Soviet Union and Eastern Europe revealed growth delay for weight on 44% of children and height in 68% of children . Developmental delays were also identified. Alberts et.al. (1997:922).

Table 7 **For the 7 year group (6 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
7 Years	M	Under 3	15	Under 3	101
7 Years	F	Over97	37	3 –10	111
7 Years	F	Under 3	14	Under 3	100
7 Years	M	3 –10	18	Under 3	103
7 Years	F	10-25	19	On 50	120
7 Years	F	On 50	22	50 – 75	121

The 7-year-old group consists of 4 females and 2 males. One male and one female fall under the 3rd percentile which indicates that these children are under weight and malnourished but these children do not appear malnourished seeing that in Namibia there groups with small bone structures. Two males and one female's length fall under the 3rd percentile, indicating that they are shorter than other children of the same age. Although they appear short they are healthy and active.

Table 8 **For the 8 year group (9 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
8 Years	F	Under 3	17	3 –10	116
8 Years	F	On 25	23	On75	130
8 Years	M	On 10	21	3 – 10	118
8 Years	M	On 50	25	10 –25	122
8 Years	M	50 –75	27	50 – 75	128
8 Years	M	10 –25	22	On 50	127
8 Years	M	Over 97	54	75 –90	130
8 Years	F	3 –10	19	10 –25	119
8 Years	F	3 –10	20	25 –50	123

This group consists of five (5) males and four (4) females. One female's weight is under the 3rd percentile indicating that she is under weight and presents the larger group of malnourished children. This respondent appears healthy and fit due to a smaller bone structure. All the other respondents' weights and lengths fall in the normal range. The average schoolchild grows (5 - 6 cm) per year to gain (30-60 cm) in height by age 12 Murray & Zentner et. al. (1997:437).

Table 9 **For 9 years (10 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
9 Years	F	10 –25	25	25 – 50	129
9 Years	F	10 –25	24	10 – 25	126
9 Years	F	On 75	33	On 75	136
9 Years	M	On 50	28	3 –10	124
9 Years	M	3 – 10	22	25 –50	129
9 Years	M	10 – 25	24	25 – 50	129
9 Years	F	3 –10	22	3 – 10	121
9 Years	M	On 10	23	3 – 10	122
9 Years	M	On 25	26	50 – 75	133
9 Years	F	50 – 75	30	On 10	123

This age group consists of five (5) males and five (5) females. Their lengths fall in the normal range and only differ by a few centimeters.

Table 10 **For 10 year group (7 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
10 Years	F	On 10	26	25 – 50	136
10 Years	F	Under 3	19	3-10	127
10 Years	M	3 – 10	25	3 – 10	129
10 Years	M	Under 3	22	under 3	123
10 Years	F	Under 3	18	3 – 10	127
10 Years	M	10 – 25	28	on 25	133
10 Years	F	Under 3	18	under 3	118

The ten-year-old group consists of three (3) boys and four (4) girls. One boy and one girl are under the 3rd percentile, which means that both these respondents, for their age group are underweight and therefore falls in the malnourish group. These respondents do not appear under weight, they are healthy and active. The rest of the group is in normal range Uys (1999:101).

Children's weight from 3 - 12 years of age can be calculated with the following formula: (age x 2 + 8) = weight in kilograms Uys (1999:101). According to this formula this group should weight 28 kg. Some lie on 28 kg, others are short of two or eight kg. Two respondents fall between the 90th - 97th percentile and need to be monitored and given advice on diet. All the others form a normal growth curve. Literature review shows that the age group 6 - 12 years are characterized by steady physical growth, neuromuscular refinement.

Physical growth in the younger school age is reflected by an average annual gain of 5.5 cm in height and 2.5 kg in weight. Boys are generally 1 inch taller and 1kg 2 pounds heavier until the age of 9 - 10 years. In time girls start to grow in height and weight and by the age of 12 girls are 1 kg heavier and (5.5 cm) 1 inch taller than boys. The pre-adolescent growth development usually begins between the 9 - 14 years for girls and between 12 and 16 years for boys Stanhope and Lancaster (1988:443). At the age of 12, the child's weight is between 36 - 41kg and is 147cm tall on average. Children with a smaller bone structure tend to be smaller in height and weight Murray & Zentner (1979:161).

Table 11 **For 11 year group (6 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
11 Years	M	Over 50	37	3 –10	131
11 Years	F	10 –25	31	3 –10	133
11 Years	F	50 –75	39	50 – 75	147
11 years	M	On 10	28	3 – 10	137
11 Years	F	Under 3	24	3 – 10	133
11 years	F	10 – 25	32	10 – 25	137

The 11-year-old group consists of 2 males and 4 females. The weight and lengths in these group is normal for their age.

Table 12 **For 12 year group (15 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
12 Years	M	Over 97	62	90 – 97	112
12 years	F	Under 3	25	under 3	132
12 Years	M	Under 3	25	under 3	131
12 Years	M	Under 3	26	under 3	133
12 Years	M	On 3	27	under 3	127
12 Years	F	Under 3	21	under 3	127
12 Years	F	50 –75	46	90 – 97	163
12 Years	M	Under 3	25	3 – 10	137
12 Years	F	25 – 50	38	3 – 10	140
12 years	M	10 –25	33	On 3	135
12 years	F	50 –75	41	Under 3	116
12 years	F	10 –25	35	On 75	156
12 Years	M	On 1	32	10 –25	14
12 Years	M	3 –10	31	On 50	149
12 years	38	25 –50	38	10 –25	145

The 12-year-old group consists of 7 females and 8 males. Three female and three boys falls under the 3rd percentile which is malnourished. However, the children do not look malnourished. They fall under the ethnical group with a small bone structure.

Table 13 **For 13 year group (24 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
13 Years	M	10 –25	38	3-10	142
13 Years	M	3 –10	34	20 –50	151
13 Years	F	3 –10	35	50 – 75	158
13 Years	F	On 3	32	10 – 25	148
13 Years	F	3 –10	36	Under 3	141
13 Years	F	10 – 25	38	10 – 25	149
13 Years	M	On 10	36	25 –50	153
13 Years	F	10-25	38	10 – 25	150
13 Years	F	10 –25	39	25- 50	154
13 Years	F	3 –10	33	Under 3	140
13 years	F	3 –10	35	Under 3	140
13 years	M	Under 3	28	under 3	131
13 Years	M	10 – 25	37	25 – 50	153
13 Years	M	On 10	36	25 – 50	148
13 Years	F	3 –10	34	3 – 10	147
13 years	M	On 10	36	10 – 25	146
13 years	F	10 – 25	37	3 -10	146
13 years	F	10 – 25	37	25 – 50	153
13 years	F	On 50	47	25 -50	156
13 years	F	3 –10	33	10-25	149
13 years	M	Under 3	25	under 3	139
13 Years	M	3 – 10	35	10 - 25	145
13 years	M	3 – 10	31	10- 25	142
13 years	F	10 – 25	37	25 - 50	153

The 13-year age group consists of 14 girls and 10 boys. Three female and three male participants falls under the 3rd percentile. They need to be monitored for malnourishment. All the others are in normal range.

Table 14 **For 14 year group**

Age	Gender	Percentile	Kg	Percentile	Cm
14 Years	F	Under 3	35	under 3	143
14 Years	M	25 –50	49	25 - 50	157
14 years	F	25 –50	47	On 50	110
14 years	M	Under 3	32	3 - 10	151
14 years	M	Under 3	35	3 - 10	151
14 years	M	3 – 10	36	25 –50	158
14 years	M	On 3	51	75 – 90	169
14 years	M	On 3	35	3 – 10	151
14 years	F	25 –50	47	50- 75	163
14 years	M	On 3	35	Under 3	145
14 years	M	On 10	40	25-50	160
14 Years	F	39	39	On 25	155
14 years	M	10 –25	41	25 -50	157
14 years	M	3 – 10	37	3 -10	150
14 years	F	3 –10	40	3 - 10	147
14 years	M	Under 3	32	3 - 10	149
14 years	F	3 – 10	36	3 - 10	149
14 years	F	50 –75	50	25 - 50	156

The age group 10 - 14 is the puberty period of physiological change. The early adolescence period is where puberty begins when physical growth proceed 12 to 14 years for females and 14 to 16 for males Murray & Zentner (1979:207).

The 14-year age group consists of 7 girls and 11 boys. One female and two males' fall under the 3rd percentile with weight, which is underweight and falls in the category of malnourishment. These respondents do not look under weight but falls under the group that has small bone structure. One male and one female length fall under the 3rd percentile indicating that they are too short for their age. Although they are short they are healthy and active. The other participants are in normal range. Males and females differ in skeletal growth; males have greater length in arms and legs and trunk size because of prolonged puberty growth Murray & Zentner (1979:212).

Table15 **For the 15 year group (14 children)**

Age	Gender	Percentile	Kg	Percentile	Cm
15 Years	F	3 – 10	42	10 - 25	157
15 years	M	3 –10	45	25 - 50	167
15 years	M	Under 3	36	On 25	163
15 years	M	3 – 10	43	3 - 10	157
15 years	F	On 3	38	Under 3	148
15 years	F	25 –50	49	10-25	156
15 years	F	On 3	38	3-10	151
15 years	F	3 – 10	41	Under 3	148
15 years	F	On 50	54	Under 3	147
15 years	M	50 –75	52	25 - 50	168
15 years	M	75 – 90	71	Over 97	186
15 years	F	3 –10	40	3 - 10	152
15 years	F	3 –10	43	50 – 75	152
15 years	F	3 – 10	43	50 -75	163.5

Middle adolescence begins when physical growth is completed and usually extends from age 15 to 18 for females and 16 - 20 for males Murray & Zentner (1979:207). The 15-year age group consists of 5 boys and 9 girls. Their weight is in normal range. The lengths of 3 girls are in the 3rd percentile indicating that they are to short for their age. One male participant is over the 97 percentile, which shows that he is very tall for his age.

Table 16 **For the 16 year group**

Age	Gender	Percentile	Kg	Percentile	Cm
16	F	Over 97	84	Under 3	147
16	M	25 – 50	61	25 - 50	171
16	F	10 –25	48	25-50	158
16	M	Under 3	29	Under 3	143
16	F	50 – 75	57	10 - 25	156
16	F	3 – 10	43	On 97	174
16	F	On 50	56	10 - 25	155
16	M	3 – 10	49	50 - 75	175
16	F	10 – 25	50	Under 3	147

The 16-year-old group consists of 6 girls and 3 boys. One male is under the 3rd percentile, which is underweight, and nutritional growth need to be monitored. One female participant is over the 97 percentile indicating overweight. The length of one male and female is under 3rd percentile, which is too short for their age group.

Table 17 **For the 17 year group**

Age	Gender	Percentile	Kg	Percentile	Cm
17	F	Under 3	40	On 25	158
17	M	10 – 25	59	10 - 25	169
17	M	25 – 50	63	50 - 75	180
17	M	3 – 10	52	10- 25	170
17	M	Under 3	46	10 - 25	171
17	F	75 – 90	70	50 - 75	162
17	F	25 – 50	53	75 - 90	169
17	M	25 – 50	63	50 - 75	176
17	M	10 –25	59	10 - 25	171
17	M	3 – 10	53	10 - 25	171
17	M	10 –25	59	On 97	189
17	F	Under 3	37	under 3	145

The group of the 17-year consists of 8 boys and 4 girls. Two girls and 1 boy is under 3rd percentile which is underweight for the age group. One girl's length fall under the 3rd percentile which is short.

Table 18 **For the 18 year group**

Age	Gender	Percentile	Kg	Percentile	Cm
18	F	3 –10	43	3 – 10	154
18	F	3 – 10	44	3 – 10	152
18	F	3 – 10	45	10- 25	156

This group consists of 3 girls. Their weight and length is in normal range.

Table 19 **For the 19 year group**

Age	Gender	Kg	Cm
19	M	64	172
19	M	55	176
19	M	50	171

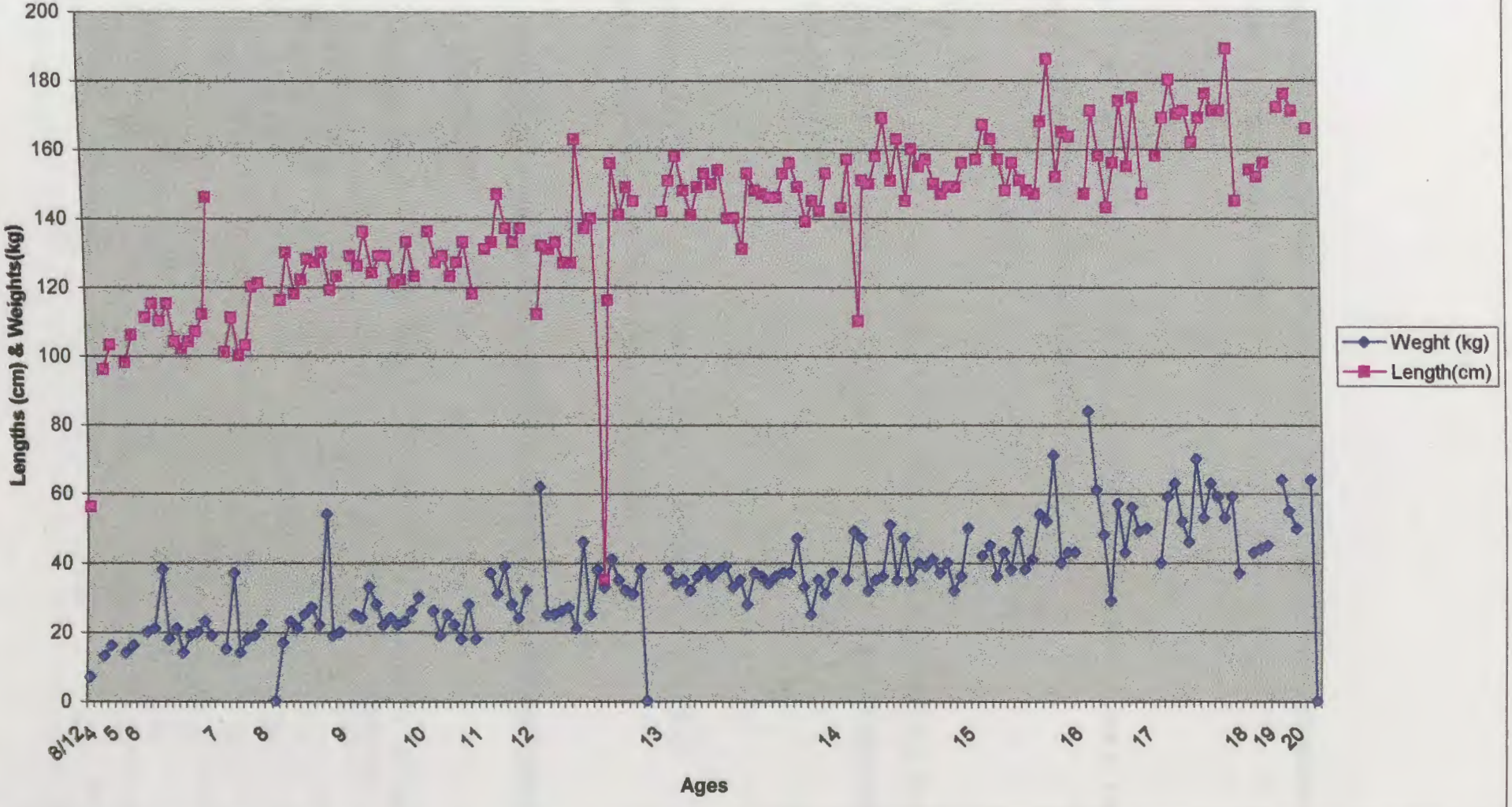
The 19-year group consists of 3 males. Their weight and length is normal.

Table 20 **For the 20 year group**

Age	Gender	Kg	Cm
20	M	64	166

According to Murray & Zentner (1997:262), finds that the average adult person has never really been described. Height and weight depends upon many factors like heredity, sex, socio economic class, food habits and preference and emotional and physical environment. Unfortunately, many height and weight tables do not consider the individual. Many weight and height tables are prepared by insurance companies therefore it is doubtful that they are representative of the total population. Murray & Zentner (1997:262). A study that has been done by Gebers (1990:5) in Cape Town on 159 street children both in institutions between May and November 1989 shows that of the 67 examined 32,8% were below 90% of expected height for age, 44,8 of expected weight for age. Graph 5 on the next page displays weight and length distribution of the children.

Graph 5 : Weight and length distribution



Gaits

Gaits of respondents were relaxed without limping. Usually these children presents with fractures of arms or legs due to abuse.

Fatigue

Most of the children appeared fit, only one (1) baby has hepatomegaly and was ill. The baby is under treatment and need tender love and care.

Nutrition

About 85 % Of the children are well fed 15% of the children fall under the third percentile which is the malnourish group although they do not appeared to be under fed for further details see part four.

Skin

Skin problems ranked thirdly on the list of ailments, which represent 18.87% of the total respondents. See table 18 on the following page.

Table 21 Description of the different skin problems of head and other body parts

System	Health problem	Girls	Boys	Total	% of sub-group	% of total children
Skin	Tinea Capitis	4	2	6	20.00	3.77
	Tinea vercicoler	2	2	4	13.33	2.52
	Skin rash	2	4	6	20.00	3.77
	Acne	3	0	3	10.00	1.89
	Sores	3	4	7	23.33	4.40
	Scars	0	1	1	3.33	0.63
	Ring worm	0	3	3	10.00	1.89
		1	**16**	**30**	**100**	**18.87**

Tinea Capitis

About six (6) (3.77%) respondents suffer from this condition tinea capitis. Tinea capitis is an infection that is severely contagious and it normally affects children. It causes itching of the scalp and breaking of the hair. The affected areas are round in shape, scaly and gritty. These children were treated with Whitefield's ointment.

Sores

Seven (7) of the respondents (4.40%) suffered from sores. The age group who presents with sores were from six up to fourteen years. Most were male respondents and only two were girls. Scratching or falling normally causes sores. These wounds were treated with ointment.

Skin rashes

Skin rashes plagued 6 (3.77%) of the respondents. Different types of skin rashes exist e.g. macules, papules, pastules, vesicles, nodules and tumors. Allergic condition and certain communicable diseases cause skin rashes e.g. measles, rubella, chicken pox, contact with drugs, food, bites, and AIDS.

Tinea versicoler

Tinea versicoler was present in 4 (2.52%) of the respondents. This is a fungal infection which is pale spots on the skin and sometimes itches It can be treated with Benzoic acid ointment according to the Treatment manual off Ministry of Health and Social Services (230) This condition is under control. By rubbing the affected area with ointment regularly.

Acne

Acne was present in 18.9% of the total participants. Acne is an inflammatory disease of the sebaceous glands. It affects people in their puberty and adulthood. It occurs in the form of black heads and white heads, pastules and dark red knots over the face, chest, back and shoulders Viljoen & Uys (1987:457).

Tinea cruris (Ringworm)

Ringworm was detected in 1.89% of the total participants. This condition is caused by a worm, which you find in the stools of animals. It comes under the skin of children and forms a ring. Bath daily; dry thoroughly. Use antifungal cream. It takes four to six months to heal Murray & Zentner (1997:520). Viljoen & Uys (1987: 459) Children who play in the sand and do not wash regularly are most prone to contracting ringworm.

Scars

Scars are old wounds that have healed. These were detected in (10.63%) of the total participants. In a study done on institutionalized children in Durban, South Africa, it was found those skin conditions such as cuts, scabies, abscesses, acne and mouth lesions were common. Some children had sores that were already healed Nzimakwe & Brookes (1994: 29). A researcher, Gebers found in a study done in Cape Town in 1989 on 159 children that 56 % had skin problems including lice and scabies. Another study done on displaced children in Katmandu, Nepals in 1990 found common medical problems afflicting children like skin infections, lice, scabies cuts and burns and diaper rash Pradhan (1990:1).

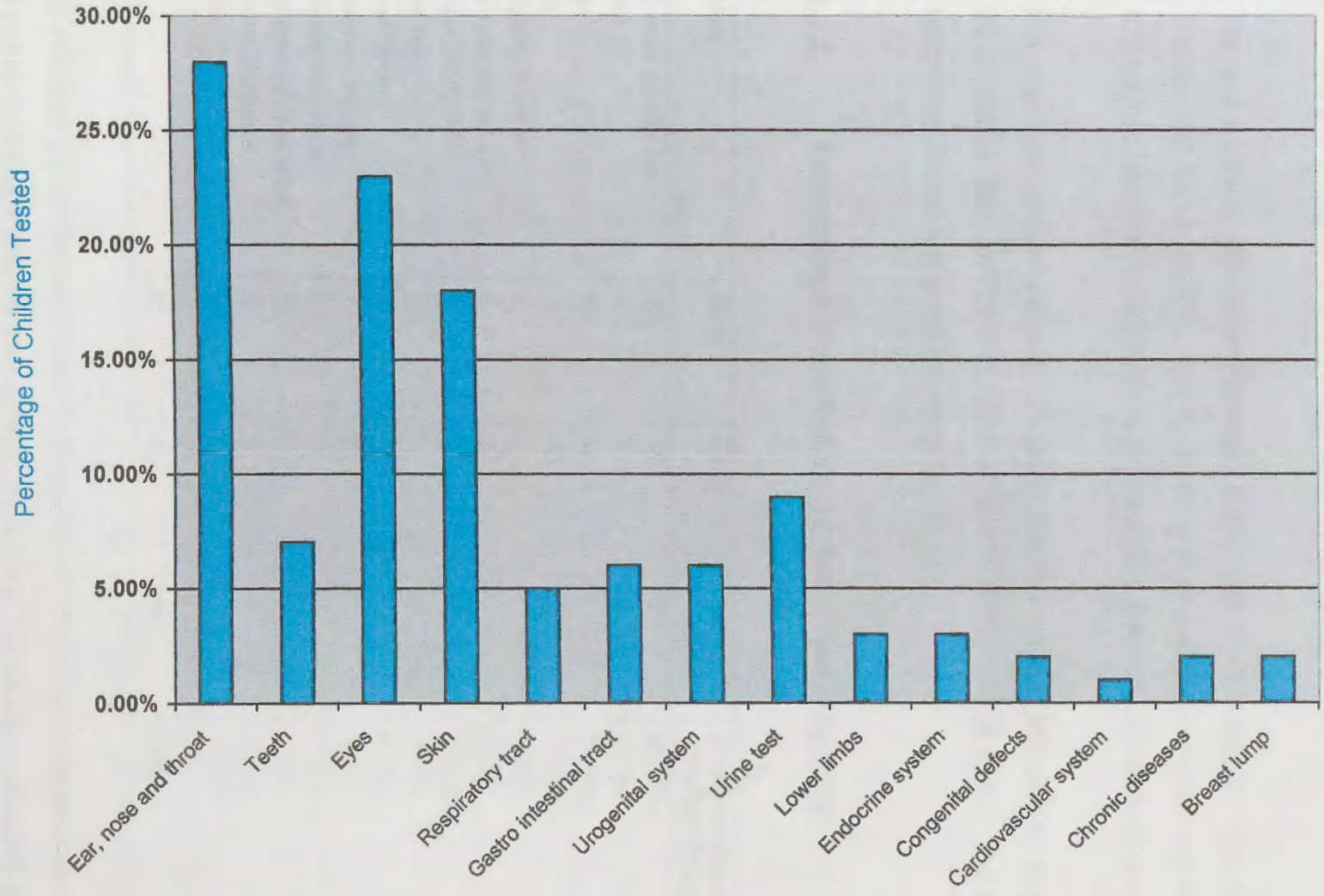
Hair

There were no respondents with lice, dandruff or hair loss. Usually children in these circumstances are unhygienic due to lack of water.

Facial expression

All the children's facial expression was happy. It seems that the children already adjust to their circumstances and except the foster homes as their habitat. On the following page is Graph 6 which gives a distribution of the different diseases found in all the systems of the foster children.

Graph 6: Distribution of illnesses of 159 Children Tested



Graph 6 is a histogram indicating the percentage distribution of detected illnesses. From the histogram diagram the following factors are highlighted:

1) There is a total of 180 detected illness in the total of 159 children. This simply means that some children may have more than one illness/health condition, since all children, who participated in this study, were tested for each illness.

2) Ear, nose and throat illness 45 (28.30%) is in the majority followed by eyes 36 (22.64%). Skin 30 (18.87%) and urine deficiencies 15 (9.43%). The other health conditions represent the minority.

Table 22 **Percentage Distribution of detected illnesses**

System	Girls	Boys	Total	% distribution of detected illness
Ear, nose and throat	26	19	45	28.30%
Teeth	3	7	10	6.29%
Eyes	18	18	36	22.64%
Skin	14	16	30	18.87%
Respiratory tract	4	4	8	5.03%
Gastrointestinal tract	6	3	9	5.66%
Urogenital system	3	6	9	5.66%
Urine test	10	5	15	9.43%
Lower limbs	2	3	5	3.14%
Endocrine system	3	2	5	3.14%
Congenital defects	0	2	2	1.26%
Cardiovascular system	1	0	1	0.63%
Chronic Diseases	2	0	2	1.26%
Breast	2	0	2	1.26%
	94	**85**	**179**	**100%**

Graph 6 indicates the relationship between the different types of body systems i.e. their related health conditions and the percentage of the total 159 children. Graph 6 gives the reader a global view on the various systems problems.

Eyes

The eyes represented the second highest illness among the participants which is 22,64% of the total participants. Table 2 represents various eye problems which where detected among the participants.

Table 23 Description of health problems associated with the eyes

System	Health Condition	Girls	Boys	Total	% of sub group	% of total children
Eyes	Poor vision	14	17	31	86.11	19.50
	Allergic conjunctivitis	2	1	3	8.33	1.89
	Pterygium	1	0	1	2.78	0.63
	Injured eye	1	0	1	2.78	0.63
		18	**18**	**36**	**100**	**22.64**

Vision was tested with the Snellen eye chart. Participants were positioned 20 feet away from the chart. Participants, who wear glasses, were tested, wearing their glasses. Covering one eye with a card, to prevent any peeping tested these children. The other eye had to read the letters on the Snellen eye chart. Difficulty with far vision this is called myopia Bates (1995:168). According to the Ministry of Health and Social Services treatment manual (246). Persons, who cannot see far, are short sighted. persons who cannot read well are far sighted. Persons who see double or squint or can see nothing with one eye have cataracts. Poor vision can cause a respondent to have difficulty progressing in school. A study done by Gebers (1990:11) in Cape Town, South Africa it was found that 159 street children 15,7% complained of visual problems. Brodie, et. al. (1997:387) found in a study done on 40,000 children that poor eye sight may remain undetected due to insufficient management of physical examination in institutions.

Allergic Conjunctivitis

Allergic conjunctivitis was the second highest health problems affecting in the eyes. This condition is mostly associated with hay fever. Symptoms are irritation, itchiness of eyes, a sandy feeling in both eyes and an increased secretion of tears. This eye problem is usually treated with antihistamine eye drops.

Trauma

Trauma can be of different types. Minor trauma is due to foreign bodies. Blunt trauma, causes a blue eye and subconjunctival bleeding. Penetrating trauma is due to sharp or big object that has penetrated the eyeball is the most serious. Burn wounds, chemical, and heat can also cause eye injury. Ministry of Health and Social Services Treatment Manual (1994: 239).

Ear, Nose & Throat

Below in Table 22 find a description of the ear, nose and throat problems.

Table 24 Description of the Various Ear, Nose and Throat Illness

Health condition	Girls	Boys	Total	% of Sub Group	% of Total
Small Nostrils	1	0	1	2.22	0.63
Tonsillitis	3	2	5	11.11	3.14
Enlarged Tonsils	1	2	3	6.67	1.89
Gum Thickening	0	1	1	2.22	0.63
Tongue Tie	1	0	1	2.22	0.63
Geographic Tongue	0	2	2	4.44	1.26
Ear Perforation	1	1	2	4.44	1.26
Acute Otitis Media	4	1	5	11.11	3.14
Hearing Problem	1	1	2	4.44	1.26
Serum Obstruction	14	8	22	48.89	13.84
Discharge Blood in Ear	0	1	1	2.22	0.63
	26	**19**	**45**	**100**	**28.3**

Serum obstruction or wax

Twenty two (22) respondents which is 48.89% suffered from wax. This condition is not life threatening as the wax can be removed. Serum obstruction (wax) is an accumulation of excessive wax in the ear. It causes itching, pain and loss of hearing. To remove the wax you can use Luke warm olive oil or glycerin, and then rinse the ear out with room temperature water Viljoen & Uys (1987:541).

Tonsillitis

According to Bates (1995:219) tonsillitis is inflammation of the tonsils in the throat. It is accompanied by enlarged lymph glands under the neck. In the posterior are of the neck. It can be caused by streptococcal infection. In this study 5 respondents which is 3.4% suffered from tonsillitis and 3, which is 1.89%, suffered from enlarged tonsils. These respondents suffered from fever, sore throat and headache. Respondents received immediate treatment for this condition.

A study done on institutionalized children in Durban, South Africa, found that inflamed tonsils ranked fifth on the list of minor ailments Nzimakwe & Brookes (1994:30).

Acute Otitis Media

About five (5) children who are 11.11% suffer from this condition. If this condition does not get attention it could cause deafness. Acute Otitis Media is caused by a bacterial infection symptoms include earache, fever, hearing loss. The eardrum reddens loses its landmarks, and bulges laterally toward the examiners eyes. Acute purulent otitis media is much more common in children than in adults Bates (1995:214). According to Viljoen & Uys. (1995:541) children at the age of 6 years are most at risk to otitis media.

Ear perforation

About two (2) respondents, which is 1.26%, suffer from ear perforations. There are holes in the eardrum that usually result from purulent infections of the middle ear. They are classified as central perforation, which do not extend to the margin of the drum. A perforation of the eardrum often closes in the healing process Bates (1995:294).

Discharge blood ear

One (1) respondent which is 0.63% suffered from blood in the ear which can be caused by trauma on the ear or by a sharp instrument used to scratch in the ear. This is a matter of concern. There is always a possibility of concealed damage and hearing loss Viljoen & Uys (1987:544) stated that there are three types of hearing loss. The first one is edema lesion formation due to perforation of the tympanum. This can also cause conductive hearing loss. Treatment focuses on surgical procedures like tympanoplasty. The second hearing loss is the perceptual hearing loss. The corti of the inner ear and the nervous trochlearis can be affected. There is specific treatment and Hearing Aids can help. Third is congenital deafness. This can be genetic or caused by Rubella during pregnancy, syphilis, and certain drugs. There is no type of treatment for this deafness.

Geographic Tongue

Two (2) respondents which is 1.26% presents with geographic tongue. That is, their tongues showed scattered smooth red areas that are denied of papillae, together with the normal rough and coated areas. Geographic tongue gives a maplike pattern that changes over time. The condition is malignant Bates (1995:225). These respondents were referred immediately for medical attention.

Tongue Tie

One (1) respondent which is 0.63% suffered from this condition. Tongue-tie is a heavy fibrous frenulum that extends to the lip of the tongue and may interfere with its protusion. No difficulties will be encountered with nursing or speech. The tongue can

be extended as far forward as the anterior mandibular gum line Bates (1995:601). This respondent experienced no problem with speech.

Gum Thickening

One (1) respondent, which were 0.63%, suffered from this condition. This respondent is Healthy and he was referred for treatment. Gum thickening, or marginal gingivitis, is common among teenagers and young adults. The gingival margins are reddened and swollen. Brushing makes the gums bleed. Vitamin shortage, long term use of Epanutin, salivary salts, protein, and bacteria that covers the teeth, can leads to gingivitis Bates (1995:222).

Small Nostrils

One (1) participant was born with one small nostril opening. She experiences difficulty in breathing. This child was referred to the ear, nose and throat specialist for treatment.

Respiratory tract

Respiratory problems ranked seventh on the list of ailments. Eight (8) respondents which were 5.03% suffer from this condition. Table 23 gives an illustration of the different types of the respiratory tract problems.

Table 25 Respiratory Tract Infection

System	Health problem	Girls	Boys	Total	% of sub Total	% of total children
Respiratory	Cough	1	1	2	25	1.26
	Cold	2	1	3	37.5	1.89
	Crepitating	1	0	1	12.5	0.63
	Chest deformities	O	2	2	25	1'26
		4	4	8	100	5.03

Respiratory Tract Infections

Cold

Three (3) respondents presented, which is 1.89%, with common cold. This is caused by a virus and is infectious. The symptoms include headaches, tiredness, weakness, muscular pains, an unproductive or productive cough, sore throat and running nose. The signs of a cold include a cough, inflamed red throat and difficulty in feeding. Coughs can be treated in the clinic.

Cough

Two (2) respondents, who were 1.26%, have cough. It is a sign of a respiratory disease. It cleans the trachea. Coughs can also appear during fear and anxiety. A cough can be productive and non-productive. Symptoms of coughs include sleeplessness and muscular pains. The respondents were treated at the time of the investigation.

Chest deformities

Two (2) respondents, who were 1.26%, had these chest deformities. They were healthy with no breathing problems. There are various deformities. In *pigeon chest* the sternum is displaced anteriorly, increasing the anterioposterior diameter. Protruding sternum are depressed. The *funnel chest* is characterized by a depression in the lower portion of the sternum. Compression of the heart and the great vessels may cause murmurs. *Barrel chest* has increased anterioposterior diameter. The shape is normal during infancy. This is mostly observed in normal aging. *Traumatic flail chest* can be found in multiple rib fractures Bates (1995:253).

Crepitations

One respondents, which is 0.63%, suffer from Crepitations. This condition may be due to abnormalities of the lung pneumonia, fibroses, early congestive heart failure, and bronchitis. There are other abnormal sound like wheezing and ronchi. Bates (1995:

246). *Coarse Crepitations* that can be heard by auscultation shows inflammation of the bronchial tree. *Fine Crepitations* that could be heard by auscultation shows fluid in the trachea due to pneumonia. Respondent was treated for bronchitis during the time of the investigation. A study done by Gebers 1990 in Cape Town, South Africa, on 159 children found that 37,1% perceived colds and chest pains as the main health problems. It was also confirmed that 69,2 % had a history of respiratory problems.

A survey done on displaced children in Katmandu in Nepal by Pradhan (1990:1) the common medical problems affecting these children include respiratory tract infection. Out of a total of 100 children and average of 20 children receive treatment for cough and colds. Twenty children out of one hundred children show signs of acute or chronic Tuberculoses.

Breast examination

Lumps in the breast represents 1,26% of the total respondents. It was two females. This health condition is ranked tenth on the list of health problems.

Table 26 **Breast problems**

System	Health problem	Girls	Boys	Total	% of sub group	% of total children
Breast	Lump	2		2	100	1.26
		2	0	2	100	1.26

According to Bates (1997:317) it was found that normally the adult breast is soft but often feels granular, nodular or lumpy. This texture is normal. It is often bilateral. It may be in some parts of the breast or throughout the breast. Sometimes the breast where often enlarge and becomes tender and painful. The two participants in which breast lumps where detected where referred to a medical practitioner and under treatnent further treatment.

Cardiovasculer system

Cardiovascular problems rank eleventh on the list of health problems. Under this section a mummer was detected in one respondent (0.63%). See Table 14 below.

Table 27 Cardiovasculer problems

System	Health problem	Girls	Boys	Total	% Sub group	%Total children
Cardiac	Murmur	1	0	1	100	0.63

Bates (1991:265) stated that heart murmurs could be distinguished from heart sounds to a longer duration. An abnormally narrowed valve, that obstructs the flow of blood, causes the blood to flow into another direction. It is good to identify where the murmurs can be heard best. The one respondent with a heart murmur was referred to a medical practitioner.

Hand and fingers

There were no children with anemia or drumstick fingers. Some nails were however not so well cared for.

Gastrointestinal (abdomen)

Gastrointestinal problems ranked sixth on the list of ailments who were 9 respondents 5.66%. Below in table 25 find a description of the gastro- intestinal problems.

Table 28 Gastrointestinal Problems

System	Health problem	Girls	Boys	Total	%of sub group	% of total children
Stomach	Pain	5	2	7	77.78	4.40
	Distention	1	0	1	11.11	0.63
	Umbilical hernia	0	1	1	11.11	0.63
		6	**3**	**9**	**100**	**5.66**

Abdominal pain

This health condition was detected in seven (7) respondents who were 4.4% of the total children tested. This condition can be the cause of gastritis, gall stones, hepatitis, malaria, poisoning and ulcers. In children it can also be due to worms. Abdominal pains can also be due to dysmenorrhoea, pelvic infections, urethritis, colitis, (MOHSS treatment manual 1994) In this case the cause could be menstrual pain and worms.

Literature shows that one hundred children of Katmandu in Nepal found that intestinal disease are common among them e.g. stomach ache and diarrhoea. Twenty children received treatment Pradhan (1990:1).

Abdominal distension

Abdominal distension was detected in one (1) (0.63%) of the total respondents. This condition can be due malnutrition, Kwashiorkor, parasites, intestinal obstruction,

hepatosplenomegaly, and obesity in children. Hepatosplenomegaly leads to fluid accumulation in the third spaces which could account for the distended abdomen.

Umbilical Hernia

Umbilical hernia was found in one (1) (0.63%) of the total respondents. During the project it was mentioned that the child will be observed, and if no regression, surgery will be consider. This condition is found in babies according to Pretorius (1983:79). This condition heals spontaneously up to the age of six years otherwise the hernia must be surgically removed.

Urogenital system

Urogenital problems are also ranked sixth together with Gastro Intestinal Tract on the list of ailments. It represents 9 respondents 5,66% of total participants. Table 7 gives a description of the different types of health conditions associated with the urogenital system.

Table 29 Urogental problems

System	Health conditions	Girls	Boys	Total	% of sub-group	% of total children
Urogenital	Vaginal discharge	1	0	1	11.11	0.63
	Phimoses	0	3	3	33.33	1.89
	Undescended testis	0	3	3	33.33	1.89
	Irregular Menstruation	1	0	1	11.11	0.63
	Enuresis	1	0	1	11.11	0.63
		3	**6**	**9**	**100**	**5.66**

Phimosis

About three (3), 1.89% respondents presents with Phimosis which is the state where the foreskin of the penis is too tight to be pulled over the glens after the age of six years. In this case it was one nine, eleven, thirteen year old . The foreskin will blow up like a balloon if the child when the child urinates. Circumcision is necessary. MOHSS Treatment manual (1994:170). During the project these respondents were referred for surgery.

Undescended testis

About three (3), 1.89% respondents presents with undescended testis The age group of these respondents were nine , seventeen and nineteen years old. This condition means that only one testis is in the scrotum. The other testis is still in the abdominal cavity. If

this condition is not treated timeously the child can become infertile after puberty and it can also become malignant. An operation is required between the ages five to seven years should the condition not improve. During the time of the investigation respondents were referred to the health centre.

Enuresis

Enuresis is urinating during the sleep. This condition is usually of a psychological of nature Viljoen & Uys (1987: 75). One respondent (0,63%) a female of fifthteen years old suffered from this condition and was referred to a medical practitioner.

Irregular menstruation

This condition was found in one (1) (0.63 %) respondents. Various factors are responsible for this condition, namely foreign objects, vaginites and sexual abuse. Viljoen & Uys (1987:112). This condition were referred to the health facility. This condition is very urgent because menstruation is important for young girls.

Vaginal discharge

Gardnerella Vaginalis, Trichomonus vaginalis and vaginitis and pelvic infection can cause vaginal discharge, also due to sexual transmitted diseases. This condition was detected in 1 (0.63%) respondents Viljoen & Uys (1987:112).

During the time of the investigation this respondent received treatment.

Urine Test

Urine abnormalities was found in 15 (9,43%) of the respondents. This problem ranked fourth on the list of ailments. Urine problems can b e seen in Table 4.

Table 30 Abnormalities found during urine tests

System	Health conditions	Girls	Boys	Total	% Of Sub-total	% Of Total Children
Urine Tests	Ketones	7	4	11	73.33	6.92
	Nitrites	1	1	2	13.33	1.26
	Proteins	2	0	2	13.33	1.26
		10	**5**	**15**	**100**	**9.43**

Ketones

Ketones detected represented 11 6,92% of total respondents. Normally Ketones are not present in urine. Ketones can occur in diabetic patients but it can also occur in non-diabetic patients who take excessive quantities of aspirin, starve themselves, are dehydrated, vomit, have severe diarrhoea, diet to lose weight, severe stress or fever due infection Mulder (1999: 258). In this case respondents were test just after school while they were hungry. After a few days the urine were tested again and there were no trace of ketones.

Nitrates

Nitrates detected in 2 (1,26%) respondents. This condition does not usually occur in urine. If present it indicates urinary tract infection e.g. cystitis, urethritis and prostatitis. The following bacteria are nitrates forming e.g. E-coli, Proteas and klebsiella. The respondent were refer to the health facility for further treatment.

Proteins

Proteins in urine were detected in 2 (1,26%) of the respondents. Protein does occur in urine when a high protein diet is followed, excessive exercise, exposures to colds and when high levels of stress are being experienced Mulder (1999: 259). In this case protein may be due to exercise, and menstruation. Respondents were refer to yhe health facility. Nzimakwe and Brookes (1994:29-30) has done a study on istatutionalised children in Durban, South Africa and found that blood in urine was more common in boys than in girls. Protein in urine was found in both girls and boys. Isabella Brodie et al (1997:387) found that in England and Wales on 40 000 childen in the care

of local authorities get more infections and hve more problems with enuresis than those not in care. This problem is due to stress before coming and during care.

Injuries of the lower limbs

Injuries of the limbs are ranked 8th on the list of ailments. Injuries of the lower limbs were detected in 5 (3.15%) respondents.

Table 31 Deviations of lower limbs

System	Health conditions	girls	Boys	Total	% Of Sub-group	% Of Total Children
Lower Limbs	Cracking knees	0	1	1	20	0.63
	Knee fracture	1	0	1	20	0.63
	Leg fracture	0	1	1	20	0.63
	Corns	0	1	1	20	0.63
	Injured leg	1	0	1	20	0.63
		2	**3**	**5**	**100**	**3.15**

Cracking knee (Audible joint sound)

This injury was detected in 1 (0.63%) respondents, while participating in sport exercises. This was discovered when he heard a cracking sound while bending his knees. No pain was felt and the movement of the knee is satisfactory. A palpable audible crunching or grating is produced by movement of joints or tendans. Cracking or snapping sounds may occur in normal joints such as the knees Bates (1995:464).

Leg fractures

Leg fractures were detected in one 1, 0.63% of total respondents.This respondent were involved in a car accident and have already healed. The MOHSS, treatment manual (1994) described two types of fractures eg, X-rays are often necessary to diagnose fractures. Fractures do not only damage the bone, but also the surrounding bloodvessels, nerves, muscles tendons and ligaments. Sometimes inlema organs can be damaged. Many factors influence the healing eg, the type of fracture, amount of damage to blood vessels, nutrition and age. Fractures in children heal twice as fast as that of adults.

Corns

Corns were found 1 respondent (0.63%). A corn is a thickening of the skin resulting from previous pressure on thin skin. This could be due to small shoes. Corns appear over bony prominences. Advice were given to wear the correct shoes.

Injured Leg

Leg injuries were found 1 respondent (0.63%). This injury was detected in one respondent. The cause is due to a kick. Treatment was given to the respondent during the time of the investigation. Previous research done on institutionalized children in Durban, South Africa found that injuries ranked thirdly on the list of ailments and consisted out of injuries to upper and lower limbs, fractures of arms legs and feet. Some children had untreated fractures of arms and legs, which resulted in deformities of limbs Nzimakwe & Brookes (1994:30).

Knee fractures

Knee fractures were found one (1) respondent (0.63%). Fractures of knees need immobilization. The injured leg needs to be strapped to the other leg. If no pulse is felt, pull it gently. Immobilize the foot in the position if the pulse returns then rush the patient to hospital (Treatment manual 1994: 81, MOHSS). Gebers (1990:11) has done a cross sectional study on 159 street children and found that 47.2% had suffered trauma and had to seek hospital attention.

According to Pradhan (1990:1) a survey done in Kathmandu in Nepals finds a higher incidence in trauma cases in displaced children. All these children with limb injuries were referred to the Doctor for treatment.

OTHER HEALTH PROBLEMS

Glands (Endocrine) system

An endocrine ailment ranks eighth, together with injuries on the lower limbs. The glands system represents 3,15% of total participants. Below is a Table 10 showing the different Gland problems.

Table 32 Different Glands(Endocrine) problems

System	Health problem	Girls	Boys	Total	% of sub group	%of total children
Glands	Parotid-gland	3	1	4	80	2.25
	Sweating hands	0	1	1	20	0.63
		3	2	5	100	3.15

Parotid gland

Parotid glands can be present due to tonsillitis. It was found in 4 (2,52%) of the

respondents. The respondents were treated for tonsillitis during the investigation.

Sweating hands

This condition can be due to anxiety or fear and it can also be a sign of Hipertiriodisme. Sweating hands was found in 1 (0.63%) respondents. In this case the respondent did not showed any signs of enlarged thyroid gland, in this case may be due to fear. Respondent was referred to a health Facility during the investigation.

Chronic diseases

Chronic diseases ranked ninth on the list of ailments. Chronic diseases is about 3 respondents (1. 89 %) of total population. Table gives a description of chronic diseases detected in the respondents.

Table 33 Different chronic diseases

System	Health problems	Girls	Boys	Total	% Sub-group	% Total
Chronic diseases	**Aids**	**1**	**0**	**1**	**33.33**	**0.63**
	Epileptic	1	0	1	33.33	0.63
	Hepatomegaly	1	0	1	33.33	0.63
		3	**0**	**3**	**100**	**1.89**

AIDS

Aids were detected in 1 (0.63%) respondents of total population. The H .I.V virus causes aids and there is no cure for it. Children acquire the infection through perinatal transmission (in utero during birth, through breast-feeding) also blood transfusion of infected blood products or from sexual abuse. Factors that increase risk of perinatal include placental membrane inflammation, premature birth, maternal anemia, and maternal fever. About one third of H.I.V infected children develop serious complications of aids within the first year of life. Forty percent of these children received Zidovudine for medication. Children and pregnant woman who are victims of sexual abuse should be offered voluntary testing for HIV(Carmichael et al. 1995:119-120).

Health maintenance is important for counseling these children on nutrition, learning family how to handle blood and bloody secretions from H.I.V infected children. Encourage normal schooling for these children. Psychosocial assessment and supportive counseling (Carmichael. et al 1995:123). According Muma . et al, (1997:371) the fear of contagion was most frightening when the disease was first diagnosed because guidelines for protection of Aids was not yet formulated. Caregivers become over taxed, stressed, fatigued and fearful of being overwhelmed by the burden of the complicated care Muma (1997: 83) stated that the first Aids case of a child was identified in 1982. During June 1996 a total of 7,296 cases were reported. Of these group 57% were black, 23% were Hispanic and 18% were white. Children with the HIV infection are at high risk for childhood illnesses can be fatal like measles and chickenpox Muma et al (1997:116).

Epileptic

The Epileptic disease was detected in 1 (0.63%) respondents. It is a condition of brain dysfunction characterized by periodic deviation in the cerebral change in attitude and thoughts. Epileptic disease can be classified according to the International League against "Epilepsy". The first one is the primary, general epilepsy, is the grandmal, petit mal. The second one is the (petit mal) partly epilepsy. Thirdly is the secondary general epilepsy, psychomotor seizure. Fourthly is the one under children. Fifthly is the unclassified epilepsy. Epileptic cannot be cured but can be healed spontaneously. Patient and family must be educated concerning the treatment. Viljoen & Uys (1987:428-429). This respondent is already on epileptic treatment and is controlled.

Hepatomegaly

Hepatomegaly was found in 1 (0.63%) respondents. This infant is already on treatment. Physicians can not do any thing more for this infant except tender love and care . Hepatomegaly is a complication of liver cirrhoses, cancer and hepatitis B. A palpable liver does not indicate Hepatomegaly.

Diverse (Congenital) Deffects

Diverse defects were detected in 2 respondents (1.26%) .It ranked tenth, together with lumps in breast, on the list of ailments.

Table 34 **Diverse (Congenital) deviations**

System	Health Conditions	Girls	Boys	Total	% Sub-group	% Of Total Children
Deviations	Slow movement	0	1	1	50	0.63
	Looks handicapped	0	1	1	50	0.63
		0	2	2	100	1.26

Diverse is a subjective criteria to describe movement and appearance. There were one respondent with slow movements. He took very long to complete a task that was given to him. The one respondent with that look handicapped showed features of Downs

Syndrome. He also attends normal school. These respondents were referred to the health facility for further investigation. Usually when the children complains of not feeling well, the housemother will took the child to the clinic.

SUMMARY

The analytical interpretation of data was done. It was found that some of the respondents smoke 3,14% and 7 respondents 4% use alcohol and 5 (3.14%) were sexual active. The physical assessment revealed the following ear nose and throoat problems were 45 (28.30%). Eye problems were 36 (22.64%). Skin problems 3 (18,87%). Abnormalities in urine is 15 (9.43%). Health needs is a problem among foster children in Namibia. In the following chapter the findings, limitations conclusion and implications and recommendation will be discussed.

CHAPTER 5

SUMMARY OF FINDINGS, LIMITATIONS CONCLUSIONS IMPLICATIONS AND RECOMMENDATIONS

In the previous chapter, the findings of the study were described and discussed in detail after data were analyzed. These findings centered on the physical assessment of the children in foster homes. In this chapter the limitations of the study, summary of the findings, implications, conclusions, and recommendations will be discussed. The purpose of the study was to explore and describe the health status and needs of the children who were admitted to foster homes in Windhoek, and discuss the role and functions of the community health nurse in the early identification of health problems of displaced children in foster homes.

FINDINGS

A total of 159 respondents were involved in the study. The ages varied from one to twenty years. The twenty year old was in his late adolescent years and is part of the foster home and is working as a handy man on the facility. Concerning gender, 84 (53%) were girls, and 75(47%) were boys. All 159 (100%) belongs to the Christian faith which is Catholic, Lutheran, and Dutch Reformed, and Apostolic. All the children attended schools in Windhoek. The respondents were a heterogenic group, which consisted of Whites, Basters, and Coloureds, Damaras and Ovambos. The educational statuses in which respondents fall vary from a baby to group of students working and some attending special classes. The grade7 classes were the most prominent group. See Graph 4.

All 154 (98.11%) attended schools in Windhoek. Most of the respondents were born in Windhoek and 4 (2.5%) were born in Rehoboth. Most parents of the children were alive; only 15 (9.43 %) were deceased. Most of the children were unaware of their parent's occupation. The daily live styles activities of children shows that most of the children were non-smoking, only 5 (3.14%) smoked regularly. All 159 (100%) of respondents stated they did not use marijuana (dagga) or drugs. Seven were using alcohol in the form of beer 3 (1.9%) and 4 (2.5%) wine. Five of the older children were sexual active 5 (3.14%) and for protection 4 (2.5%) use condoms and one young woman used injection as a contraceptive method.

Knowledge concerning sexual transmitted diseases was limited. Seven respondents were aware of gonorrhea 7 (4.4%)% and seven were knowledgeable about syphilis 7 (4.4%). One (0.63%) respondent suffered from AIDS, but 28 or 17.6% stated they were aware of HIV and how one contracted the disease. All 159 (100%) respondents were fully immunized. All respondents' 159 (100%) postures were upright and no limping with their gait.

Weight and length of 154 (96.85%) were taken. (See Graph 5). Growth charts percentiles are in Annexure 5. Several respondents fell on the under 3rd percentile (30 or 19.48%) although they did not look malnourished. The two that fell over the 97 percentile were given advice concerning nutrition. Blood pressure of 5 (3.14%) were not taken. In the study 2 (1.26-%) respondents had with a slightly high blood pressure 130/90 and 150/80.

Ear, nose and throat problems were experienced by 45 (28.30%) in which wax plugs were the highest 22 (13.84%). Acute otitis media was evident in 5 (3.14%) respondents. Tonsillitis was 5 (3.14%). Enlarged tonsils were 3 (1.89%). Geographic tongues were 2 (1.26%).

Ear perforations were 2(1.26%) experience by respondents. Hearing problems were found 2 (1.26-%) respondents. Small nostrils were 1 (0.63%) Gum thickening were1 (0.63%). Tongue-tie was 1(0.63%) respondents. Blood in ear were 1 (0.63%). Eye problems were 36 (22.64%) respondents in which poor vision was the highest 31 (19.50%). Allergic conjunctivitis were experienced by 3 (1.89%) respondents. Pterygium were 1 (0.63%). Injured eyes were 1 (0.63%) respondents.

Skin problems were 30 (18.87%) respondents in which sores were the highest 7 (4.40%). Tinea capitis was 6 (3.77%) respondents. Tinea versicoler were 4 (2.52%). Ringworm was 3 (1.89-%) respondents. Skin rashes were 6 (3.77%) respondents. Acne was 3 (1.89-%) respondents. Scars were1 (0.63%).

Urine problems were 15 (9.43%) respondents in which ketones were 11 (6.92%). Nitrate 2 (1.26%). Proteins were 2 (1.26-%) Respondents. Urogenital problems were 9 (5.66%) respondents in which phimoses were 3 (1.89%) and undescended testis were 3 (1.89%) of respondents. Irregular menstruation were 1 (0.63%). Enuresis were 1 (0.63%).

Dental problems were 10 (6.29%) respondents in which orthodontic problems were the highest 6 (3.77%). Dental caries were 4 (2.52%) respondents.

Respiratory tract infections were 8 (5.03%) in which colds were the highest range 3 (1.89%). Chest deformities were 2 (1.28-%) respondents. Crepitalian sounds were 1 (0.63%).

Breast problems were 2 (1.26-%) respondents with breast lumps.

Cardiovascular problems were only 1 (0.63%) respondent with a murmur. Gastro intestinal problems were 9 (5.66%) respondents in which abdominal pain were the highest 7 (4.40%) Abdominal distension 1 (0.63%). Umbilical hernia 1 (0.63%0).

Lower limbs problems 5 (3.14%) in which creaking of knees 1 (0.63%). Old fractures knee 1 (0.63%) respondent. Corns were 1 (0.63%) respondents. Injured legs were 1 (0.63%) respondents.

Endocrine system problems were 5 (3.14%) respondents. Submandubiler glands were 4 (2.52%) Problems with hand sweating were 1 (0.63%) respondents.

Congenital defects were 2 (1.26%) respondents in which 1 (0.63%) respondents had slow movements and 1 (0.63%) with features of Downsindrome. Chronic diseases were only 1 (0.63%) suffering from Epileptic disease. One (0.63%) respondent was suffering from Hepatomegaly and 1 (0.63%) respondent were suffering from Aids.

LIMITATIONS OF THE STUDY

One of the main limitations of the study was the inability to have communication with the parents of these children to find out more background information.

IMPLICATIONS OF THE STUDY

It was found that chronic diseases, such as, that is HIV/ AIDS, Epilepsy, and Hepatomegaly, can cause depression and sadness. It is long term and can also be expensive. Children may become aggressive, progressively dependent, develop feelings of inferiority and become socially withdrawn. This behavior and attitude can also influence the behavior of the other children and family members. Pretorius (1986:140). If nothing is being done to correct hearing and visual problems, the consequences can lead to the child not progressing well at school, lack of concentration, and absence from school for long periods of time.

Skin problems were experienced by only 18.87%, of the respondents. These are conditions that can be improved by personal hygiene, and by washing with tetmosol

soap, and by applying whitefields ointment regularly. Urinary problems such as phimoses can be treated, but if untreated it can lead to painful and difficult urination and cystitis. Enuresis can be due to psychological problems and it takes a long time to treat. Undescended testis if not treated it could lead to infertility. Dental problems like caries can be treated, orthodontic problems needing repair are expensive and take a long time. The repair of orthodontic problems will improve the appearrence of these respondents. Respiratory problems were 5.03% if colds and coughs are not treated it may lead to Pneumonia and Brongitis.

Masses in breast if not early detected and treated it may lead to breast cancer and lost of the one breast. Heart murmurs if not detected early it may lead to major heart problems which took a long time to heal. Respondents with abnormalities should be observed and school progress monitored if no progress children should be placed in special classes. The respondents who were smoking and using alcohol need health education on the dangers of substance abuse before the condition get worse. There is a need for family education to prevent teenage pregnancy and sexual transmitted diseases and HIV/AIDS. The respondents are already deprived from the love of a parent, and for this reason they feel insecure and become mentally unhealthy. Both the new parents and foster children are exposed to tension and behavior problems escalate Pretorius (1986:147).

RECOMMENDATIONS

Recommendations will be discussed under the following headings:
Infant, toddler, preschool child, school child and adolescent/youth. The nursing process, which is planning, implementation evaluation and record keeping, will then be used to describe the role of the nurse in health promotion. Health promotion is geared to health prevention towards individuals, families and communities and this level involves activities designed to improve and maintain health status.

Infant

Children belonging to this group are in their first year of life.foster parents should be encouraged to monitor growth and development of the infants, by visiting a health facility at least once a month to be weight. Parents' nurturing behavior towards the baby should be encouraged and behavior to wards the child, in order to strengthen the mother and child bond, should be explained and practiced. Parents must be taught to understand and to interpret the growth chart and to identify when the child is under weight, over weight or within normal weight range. Gradually introduce complementary feeding semi – solid and solid food to the diet of the infant. Foods to provide extra energy like protein, iron, and vitamin C. Also require special attention.

Toddlers

Toddlers fall into the age group of 12 months to 3 years. Growth and development is important during this time, and thus parents should also visit health facility regularly to monitor growth and development. Play is an important part of the child's daily activities since the child learns how to socialize, learn what is right from wrong, thus early moral development and emotional tension, such as aggression can also be released feelings translated. Knowing about the nutritional needs of toddlers, will mean that the importance of serving of products such as meat or fish, egg or cheese and other diary products green and yellow vegetables, fruit, cereal, and bread, to meet nutritional needs. Adequate rest and sleep, should also be encouraged 10 –12hours sleeps at night as well as daytime rest periods. General personal hygiene is also important for a healthy body free from any skin diseases. All the above mentioned will promote normal growth and development.

Preschool child

The preschool years include children of 3 to 5 years of age, and these years form a crucial part of a persons' life, this means that parents must be aware that the child's' growth is slower and that the child still requires the four basic food groups including meat, vegetables, fruit dairy and cereals and bread. Sleep of 9 - 11 hours which is

needed during the night, should also be encouraged and once again the importance of play for this group is comparable to the importance of work for an adult. This is also the time that the child start asking questions about sexuality, implying that parents should prepare themselves to answer these questions adequately to, and in general the child asks many why questions which requires a real patience from parents, in order not to make children feel that their questions and they are inferior or unimportant.

School child

Parents should know that rest and exercise is important for the child's muscular development, coordination and balance and that fine motor and perceptual skills are important for school progress. School children need 9 - 11 hours sleep at night. Nutritional requirements are greater than that of the adult. Parents must also know that these children have usually not social skills in terms of eating and table manners and thus they then fill their mouths with food, that while eating and frequently spill food. Parents should accept this behavior as an opportunity to teach their children correct eating habits. Children must also be encouraging to drink 6 - 8 glasses of water daily.

Adolescent/Youth;

Puberty is a period of physiological changes accompanied in many cases by emotional liability when male and female sexual organs mature. In females this stage continues for 3 years, from 10 -14 years. In males it occurs later between 12 - 16 years. The stage of Adolescence begins with puberty and continues for 8 or 10 years. Parents need information about the physical, psychological and social changes that take place in the children so that they can handle these changes in their adolescent appropriately. Good nutritional habits are still essential, as well as drinking 6 - 8 glasses of water daily.

Encourage children to participate in physical exercises in order to promote fitness and prevent the possibility of being over weight as well as the development of specific motor skills. More rest and sleep is needed for the additional benefit of contributing to the effectiveness of their immune system. Sweat glands, sebaceous glands are more

active as in previous stages that is why personal hygiene is important in this phase. All the age groups require routine immunizations to prevent communicable diseases like measles, poliomyelitis, tetanus, diphtheria and mumps and german measles, and it is the duty of parents to take these children to health facility for this. Yearly medical examination, are also recommended to determine health needs of an early stage and to refer to specialist services if required. Very common childhood ailments which could be detected include middle ear infections, common colds, respiratory problems, urogenital problems in girls due to a short urethra, to undescended testis, ear nose and throat problems, visual and hearing impairment, dental caries, allergies, asthma, epilepsy, mental retardation, and emotional illness. Regular visits to the dentist should be encouraged and children should be taught to brush their teeth effectively after meals.

Safety - education courses should also be offered to every adolescent, including driver education, knowledge of safety programs in the community, instruction in water safety, routine safety practices and emergency care or first aid. Since adolescence is usually the time period when risk taking behavior is evident, groups to educate adolescents on issues such as substance abuse, sexual transmitted diseases and sexual education should be addressed. It is also helpful for parents to know the signs and symptoms of diseases, their causes and methods of prevention.

Nursing Actions and Role: The Nursing Process

Curative aspects of health care focus on early identification and treatment of health problems and takes place after health problems have occurred. Parents should receive training on the management of chronic diseases from health professionals and relevant literary sources since it is a long-term condition and thus expensive and requires regular follow ups and treatment on a daily basis. Parents should also know about on the contraindication and adverse effects of medication. Support and counseling groups hold the benefits of allowing family members and the to share their experiences and give advice on how to handle problems, which also serves to shorten and speed up the healing process.

The implementation phase of the nursing process is aimed at returning the client to the highest level of functioning possible and thus parents should be advised to help their children in a manner as to allow them to use the capabilities they have to promote maximal. Independence in every day tasks, and to assist them in that while they are unable to do in various manners depending on their disability. Support groups should also be established to deal with disabled children, teenage pregnancies and services should be established or existing services promoted and used for the health deficits which have been identified during this study. Health education programmes should be employed by institutions like the university of Namibia to train parents, to care for the children with chronic diseases, in order to offer optimal care.

Counseling services are also needed, for example the need for social worker to deal with social and emotional problems of children, and in conjunction with this spiritual needs can be addressed by the church for children and their family members. Parents should also be made aware of, and employ the valuable services of other health team members, such as the occupational therapist for learning and perceptual problems, amongst other services, physiotherapists for biomechanical problems and the speech therapist for speech, language and hearing problems.

Health worker training

The curriculum for nurses should incorporate the dynamics of foster children. And knowledge and skills of different cultures with specific reference to foster Chidren.

Personnel, foster parents

Skills to negotiate for funds and supplies are required and should be developed to ease financial strain and provide the best facilities and services possible In order to plan a, to promote and maitain health status of children parents and health workers should be assisted to compile weekly, monthly and yearly plans. Emphasize the importance of family and community gatherings, so that the child can learn how to communicate with the outside world and obtain valuable social skills. Strengthen counseling and inter-

personnel skills should also be facilitated, in order to help adults to know how to communicate with children according to their needs and developmental stage and facilitate development skills. The importance of involving children in projects to prevent boredom and to stimulate the child should also be recognized.

Non governmental organization

Inter and intra sectoral collaborations are important aspects to be branded in order for NGO'S to function efficiently, NGO'S can become involved in activities for foster children by involving the community to partake in functions at foster homes. To involve the community to participate in functions at the children's home. Update on the referral systems.

NGO'S should also be part of the management of the foster homes and provide financial assistance for further studies, as well as providing support to by supplying equipment and playing material to stimulate the children. Updating referral systems can also be an important function of NGO'S.

Research

For further research the following topics are recommended:-

- The same studies could be done in other areas of Namibia.
- To describe the life experiences of foster children.
- Caring of AIDS orphans.

CONCLUSION

The study revealed that there are health problems among the foster children. These can be seen on Table 20 which indicate that ear nose and throat problems were 28,3%, eye problems 22,64% and skin problems 18,87% as the three (3) highest. The findings of the study made it possible to highlight certain problems and make recommendations

with regard to the health status of foster children. It is clear that this group of children need attention as far as health care is concerned. Every child is precious and unique, to be protected. They can be helped to become a strong and intelligent force to help their communities.

The role of the community health nurse should be to do the physical assesment in order to detect health problems among these children at an early stage. Communities should be stimulated to understand their importance of the role they can play in caring for these children. Politicians and government leaders should be obliged to contribute to the elimination of the causes of poverty, unemployment poor housing misery, and abandoned children, and improve health services to address health problems effectively at preventative, curative and rehabilitative levels.

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Annexure 1

Applications for permission letter

To: **Ms. Batseba Katjiuongua**
Director of Social Services
Ministry of Health and Social Services

From **Ms. Joan M. Kloppers**
University of Namibia

Re: **Permission for Working with the Children of Foster Home in Eros**

Currently I am a lecturer of University of Namibia doing my Masters program on Determination of Health Status of Children in Foster Homes.

This letter serves to seek for permission to do this study, since it would enable me to complete my study successfully.

The content of my investigation intails the following:

- Physical examination on:
  - Ear, Nose and Throat
  - Hearing Test
  - Eye Test
  - Abdomen
  - Respiratory System
  - Urogenital System
  - Limbs
  - Skin
- Questionnaire concerning knowledge of children regarding
  - Smoking
  - Alcohol/Drugs
  - HIV/AIDS

- Listening to some children's life experiences.

In conclusion I would appreciate if you can furnish me with a written permission for reference.

I thank you in anticipation.

May God bless you.

Yours faithfully.

.....
J.M. Kloppers

23.06.1999

Chief Social Worker
Mr. J. De Witt
Nederduits Gereformeerde Kinderhuis
P.O. Box 2826
Windhoek
Veld Straat

Dear Mr. J. De Witt

RE: PERMISSION FOR WORKING WITH CHILDREN OF CHURCH OF NETHERLANDS

Referring to our telephone conversation on the 18th June 1999 where I have asked for permission to do research on the children of the Foster House of the Church of Netherlands, this is now the full details of what I am envaging to do.

Currently I am a lecturer of University of Namibia doing my Masters program on Determination of Health Status of Children in Foster Homes. This study would enable me to complete my study successfully.

The content of my investigation will entails the following:

- Physical examination:
  - Ear, Nose and Throat
  - Hearing Test
  - Eye Test
  - Abdomen
  - Respiratory System

- Urogenital System
- Limbs
- Skin

- Questionnaire concerning knowledge of children regarding
- Smoking
- Alcohol/Drugs
- HIV/AIDS

- Listening to some children's life experiences.

In conclusion I would appreciate if you can furnish me with a written permission for reference.

I thank you in anticipation.

May God bless you.

Yours faithfully.

.....
J.M. Kloppers

17 November 1998

The Regional Governor
Mr. J. Pandeni

Dear Mr. J. Pandeni

RE:PERMISSION FOR WORKING WITH CHILDREN OF "MORIA GRACE - OUR SHELTER"

Referred to our telephone conversation on the 13th of November 1998, where I have asked permission to do research on the children of the "Moria Grace our Shelter".

The reasons for this request are firstly to detect timeously for the presence of any abnormalities and secondly to enable me to complete sucessfully such examination for the advancement of my studies.

I would appreciate it if you could give me a written permission for reference.

May God bless you.

Yours faithfully

.....
J.M. Kloppers

23.06.1999

Mr. Dongua
SOS Children Village
Khomasdal
Windhoek

Dear Mr. Dongua

RE: PERMISSION FOR WORKING WITH CHILDREN OF CHURCH OF NETHERLANDS

Referring to our conversation on the 22th June 1999 at Katutura Clinic where I have asked permission to do research on the children of the SOS Children's Village, this is now the full details of what I am envaging to do.

Currently I am a lecturer of University of Namibia doing my Masters program on Determination of Health Status of Children in Foster Homes. This study would enable me to complete my study successfully.

The content of my investigation will entails the following:

- Physical examination:
  - Ear, Nose and Throat
  - Hearing Test
  - Eye Test
  - Abdomen
  - Respiratory System

- Urogenital System
- Limbs
- Skin

- Questionnaire concerning knowledge of children regarding
- Smoking
- Alcohol/Drugs
- HIV/AIDS

- Listening to some children's life experiences.

In conclusion I would appreciate if you can furnish me with a written permission for reference.

I thank you in anticipation.

May God bless you.

Yours faithfully.

.....
J.M. Kloppers

Annexure 2

Letter of approval

9 - 0 / 0001

REPUBLIC OF NAMIBIA

Ministry of Health and Social Services

Private Bag 13198
Windhoek
Namibia

Ministerial Building
Harvey Street
Windhoek

Tel: (061)203-2859/60
Telefax: (061) 227607 (Local)
264-61-227607 (International)
Email-socserv.iafrica.com.na

Enquiries: **Ms B U Katjiuongua** Reference No: Date: **8 June 2000**

OFFICE OF THE PERMANENT SECRETARY

MS. KLOPPERS
PRIVATE BAG 13301
WINDHOEK
NAMIBIA

DEAR MS KLOPPERS

REQUEST FOR PERMISSION TO CONDUCT PHYSICAL ASSESSMENT AND CHILDREN LIFE EXPERIENCE AT THE NAMIBIA CHILDREN'S HOME MAY/JUNE 1999

This letter serves to officially confirm the permission that was granted to you and verbally communicated to conduct the above assessment.

We believe that you have now completed this assessment and in the process of finalising the report. As part of the condition attached to the undertaking of the assessment, the Ministry of Health and Social Services is to be furnished with a copy of the final report, for which we are awaiting.

Thanking you in anticipation.

Yours sincerely

MINISTRY OF HEALTH AND SOCIAL SERVICES REPUBLIC OF NAMIBIA

Dr. K. Shangula
PERMANENT SECRETARY

Forward with Health for all Namibians by the Year 2000!

Ned. Geref. Kerk in Namibië

SINODALE KOMM. VIR DIE DIENS VAN BARMHARTIGHEID-PRAKTYKLEIDING
SINODALE KANTORE, FELDSTRAAT 34, WINDHOEK (W.O. 8)

Ons. verw. nr.:

U verw. nr.:

☎ (09264-61-) 237296
✉ 2826
WINDHOEK
Faxno.(061)227287

CHIEF SOCIAL WORKER
Mr J de Witt

13 July 1999

FOR ATTENTION: MRS J M KLOPPERS

Lecturer: Nursing Faculty
University of Namibia
Private Bag 13301
WINDHOEK

Dear Mrs Kloppers

APPLICATION: INVESTIGATION ON HEALTH STATUS: CHILDREN OF DUTCH REFORMED CHILDREN'S HOME, WINDHOEK

With reference to your letter dated 23 June 1999.

Your request to determine the health status of the children at present in the Dutch Reformed Children's Home, as part of your Masters Degree, was considered.

As was discussed with you telephonically, is it vital that the parents of the said children, should give beforehand written consent for the envisaged physical examination, as well as for the other part of your investigation. The children concerned, should also have the opportunity to give written consent for such an examination.

It would therefor be appreciated if the required questionnaires could be forwarded to this organisation

Thanking you in anticipation.

Yours sincerely

Mr J de Witt
CHIEF SOCIAL WORKER

SOS Namibia

SOS Children's Village Windhoek

P.O. Box 23134
Windhoek, Namibia
Tel. (061) 212582
Fax (061) 248956

TO WHOM IT MAY CONCERN

This is to confirm that Mrs. J. Kloppers has been granted permission to do her research at SOS Children's Village Windhoek on June 1999.

Kind regards

Ilidio Dongua
Village Director

SOS CHILDREN'S VILLAGE
P. O. Box 23134
WINDHOEK
NAMIBIA

Annexure 3

Informed consent form

Dear Respondent

Permission for Physical Examination

I request your permission to carry out a physical examination on you. This examination will be strictly confidential. The reasons for this request are firstly to detect timeously for the presence of any abnormalities and secondly to enable me to complete successfully such examination for the advancement of my studies.

Yours faithfully

Ms, ...

Signature of respondent: .....

Signature of supervisor: .....

Date: .....

9 July 1999

Dear Parents

Permission for Physical Examination

I cordially request your permission to perform a physical examination on your child. These findings during this examination will be confidential.

The reason for this examination is to detect the presence of any abnormalities and to enable me to complete successfully such examination for the advancement of my studies.

I thank you.

Yours faithfully

Ms: .....

Please complete the following consent form

I/we ..... as a parent/guardian give permission to you to perform a physical examination on our child .....

Signature of Parent/Gardian: .....

Date: .....

Annexure 4

Checklist

1. Personal Data

a. Date

b. Sex male ☐ c. Female ☐

d. Date of birth ..... e. Age: .....

f. Religion g. Ethnic group:.....

h. Grade: ..... I. School: .....

j. Place of birth: .....

k. Parents still alive l. Father - Parents occupation .....

Yes ☐ No ☐ Father: .....

Other: ..... Mother: .....

2. Daily activities of life style activities

a. Smoking: Yes ☐ No ☐

If yes. What type? Cigarettes Yes ☐ No ☐

How many per day Dagga: Yes ☐ No ☐

Other: .....

b. Alcohol Yes: No: .....

If yes: What type? Spiritism Yes: ☐ No: ☐

Wine Yes ☐ No: ☐

Beer Yes ☐ No: ☐

c. Drugs: Yes ☐ No: ☐

If yes: What type? LSD Sniff glue
Cocaine
Medication

d. Sexual Activities: Yes ☐ No: ☐

d. Are you sexual active? Yes ☐ No ☐

Are you use any protection? Yes ☐ No ☐

If yes, what type: Condom
Pills
Injection
Other

E. Sexual diseases

Any knowledge of sexual transmitted diseases:

	Yes	No
Syphilis	☐	☐
HIV/AIDS	☐	☐
Gonorrhoea	☐	☐

Other: .....

F. Did you suffer from these disease

Yes ☐ No ☐

If yes which one: .....

Did you went for treatment? Yes ☐ No ☐

3. **Immunization**

Immunization	**Indicate with in case of previous immunization**	**Date administered**
DWT Polio Measles BCG German Measles		

If a follow-up "booster" has been given indicate with a B next to date administered.

	YES	NO	NA
4. General appearance a. Posture: Released			
° Upright ° Position			
Physical measurements b. Length (without shoes) ..... c. Weight (with clothes but without jacket or jersey) ..... d. Cleanliness of body, hair, cloths			
5. Gait a. Walk without looking down			
b. Walk relaxed			
c. Limbing			
6. Fatigue a. Appeared fit			
b. Appeared tired			
7. Nutrition a. Well fed			
b. Obese			
c. Malnourished			
8. The Head 8.1 Hair + scalp a. Abnormal hair loss b. Dandruff c. White patches d. Lice + nits e. Clean f. Ringworm			
9. Face a. Pimples			

	YES	NO	NA
b. Chloasma			
c. Dry or oily skin			
Other			
d. Facial expression happy unhappy			
10. Eyes a. Position and alignment - normal - abnormal b. Eye lids Drooping Close properly or not Swollen Normal c. Lid margin Sty Swollen Normal d. Conjunctiva Red Swollen Normal e. Cornea Abrasions Pigmentations/opaque f. Pupil Reaction to light g. Eye movements 4 directions * normal * abnormalities h. Sight **R** Eye **L** Eye Remarks:			

	YES	NO	NA
11. The Ear • Shape of pinna Normal: ..... Abnormal: ..... Describe:			
a. Signs of pain Describe:			
b. Signs of infection redness swelling Describe:			
c. Signs of secretions pus blood wax			
d. Eardrum perforations foreign objects Yes ☐ No ☐			
Hearing **L** ear a **R** ear loss normal			

	YES	NO	NA
12. **The Nose** a. Secretions b. Redness c. Any blockage d. Any septum defect e. Smelling Normal Abnormal			
13. **Mouth:** a. Lips - dry - sores - herpes simplex b. Mucous membranes - healthy (pink) - sores - anaemic c. Gums: - gingivitis: - swelling - ulcers - retraction - penclonditis - healthy - bleeding Tongue: - deposits - tongue tie - geographic tongue - healthy e. Teeth Teeth - dental caries - discolouration f. Throat - redness - enlarged tonsils - discharge - halitosis			
14. **The Chest** a. Shape - cone - barrel			

	YES	NO	NA
- pigeon - funnel			
b. General appearance - rashes - operation marks - lesions - stab wounds - striae Front + Back indicate which			
c. Inhalation painful - rate - rhythm			
d. Exhalation - painful			
e. Symmetry - diminished movement - weakening of respiratory movements			
f. Palpation of chest - mobility of neck different positions - neck lymph nodes - enlarged or normal - position of trachea: normal (central) abnormal (displaced)			
g. Skin - elastic - moist - temperature - tenderness			
h. Depth of respiratory normal If not?			
Remarks:			

	YES	NO	NA
I. Symmetry respiratory movements Normal If not describe: ..... J. Thoracic vertebrae - tenderness - pain - swelling - vertical line Remarks: .... K. Percussion Back - normal sounds Front - normal sounds Mid axillary line-normal sounds Tympanic sound Dull sound Hyper-resonance L. Auscultation - Ronchi - Wheezing - Crepitations - Normal sounds - vescular + bronchial respirations			
15. Breast examination a. Lumps b. Scars			
16. Heart a. Murmers			
17. Hands and fingers a. Fingers - drumstick - anaemia b. Nails - dirty - long			

	YES	NO	NA
c. Any other abnormalities:			
18. The Abdomen a. Shape: flat round b. swellings c. enlarged organs d. hernias e. masses f. Palpation g. pain h. tenderness i - lymphs j. - distentions k. Percussion l. Tympanic sounds m. Dull sounds n. Auscultation 0. - Bowl sounds P. - Aortic murmers q. - Worms r. - Diarrhoea s. - Constipation			
19. **Urogenital Tract** a. The male b. Penis c. Glans - ulcers - oedema - nodules d. Fimosis or parafimosis e. Urethral discharge - White - Yellow - Blood f. Testis - Descended - Undescended			

	YES	NO	NA
g. Scrotum hydrocele - Pain - Tenderness - Bed wetting h. Female i. Vulva j. Discharge - White - Yellow - Blood k. Dysuria l. Contraceptions Type? ..... m. Pain n. Tenderness o. Itchiness p. Bedwetting q. L.M.P. r. Dysmenorrhoea s. Urine test			
20. Lower limbs a. Skin: lesions corns sores rashes b. Soles of feet plantarwarts flat feet c. Nails splinter haemorrhages horny other d. Musle wasting atrophy			

	YES	NO	NA
e. Bones and joints knock knees bow legs shortening of legs deformities lymph nodes			

Annexure 5

Growth charts (percentiles)

TH 452 B
5011299

DOGTERS:

Geboorte tot 36 maande

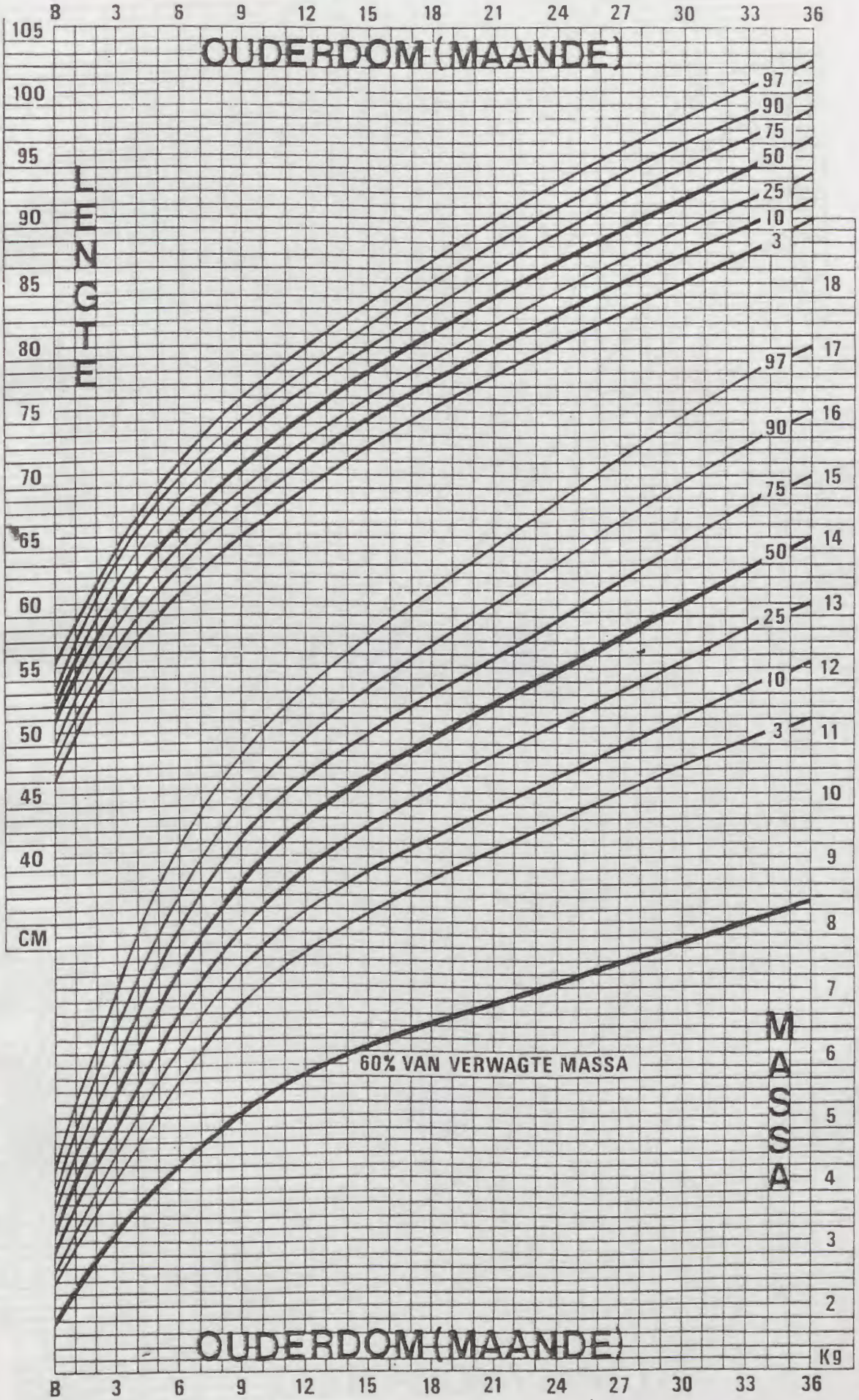
Van en Voorletters:
Surname and Initials: .....

Lêer Nr.
Folder No .....

Geboortedatum
Date of Birth: .....

Ras/Geslag:
Race/Sex: .....

Saal/Afdeling:
Ward/Department: .....



SEUNS:
2 tot 18 jaar

Van en Voorletters.
Surname and Initials. . . . . .

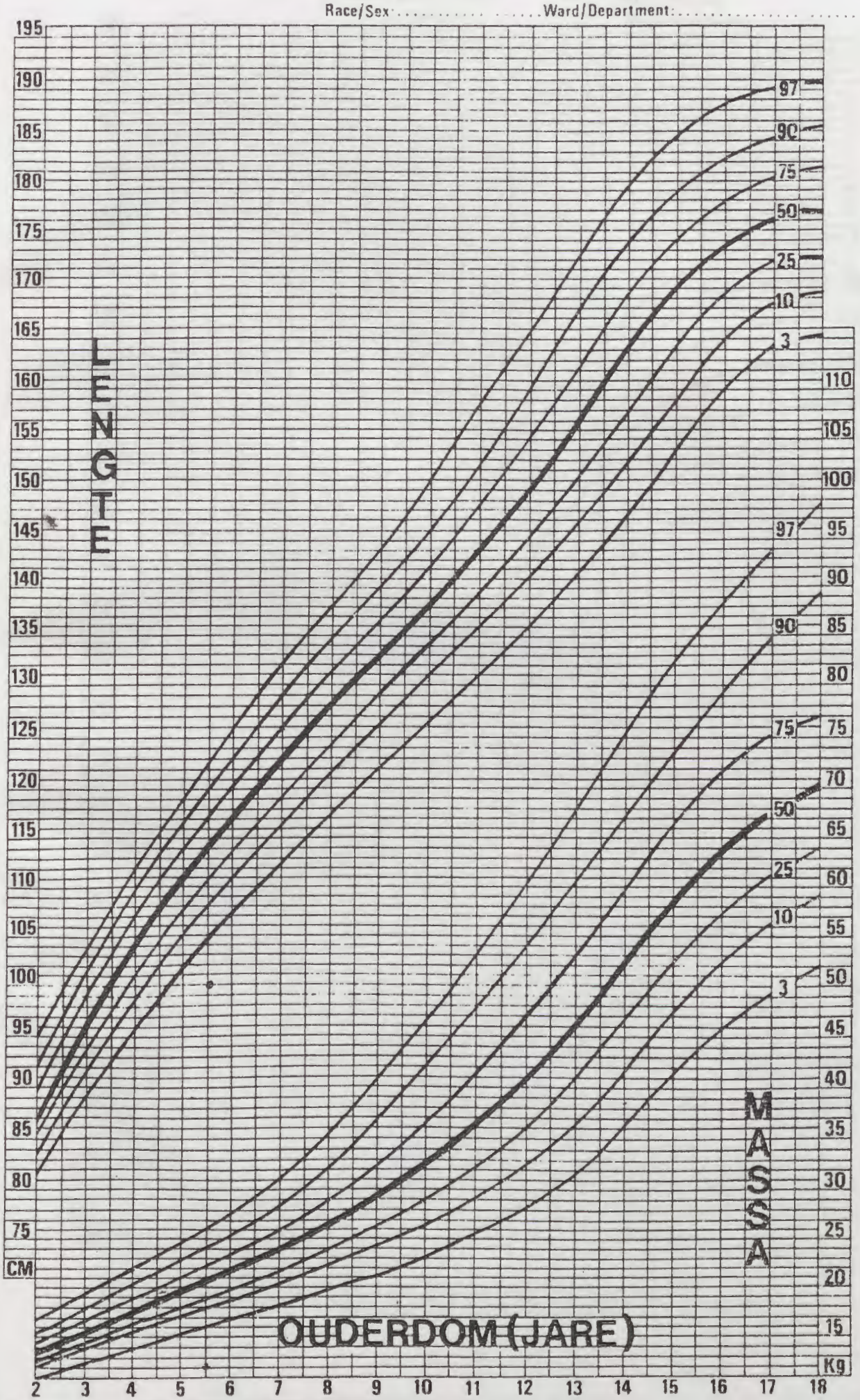
TH 452 C
5011310

Lêer Nr.
Folder No . . . . . .

Geboortedatum
Date of Birth: . . . . . .

Ras/Geslag
Race/Sex . . . . . .

Saal/Afdeling:
Ward/Department: . . . . . .



TH 452 A
5011299

Dogters:
2 tot 18 jaar

Van en Voorletters:
Surname and Initials: . . . . . .

Lêer Nr.
Folder No . . . . . .

Geboortedatum
Date of Birth: . . . . . .

Ras/Geslag:
Race/Sex: . . . . . .

Saal/Afdeling:
Ward/Department: . . . . . .