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Health and Nutritional Status of Orphan Children's Living in Orphanages with Special Reference to District Anantnag of Jammu and Kashmir

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ABSTRACT

The practice of placing deprived children having least or no emotional and material resources, in orphanages has since long been prevailing in socio -economically poor Asian countries. A sample of 30 children residing in orphanage in district Anantnag in the age group of 13-18 years was selected for the present study. Most of the children were found socially and psychologically disturbed. As per Indian Academy Paediatrics (IAP) classification with respect to weight for age the condition was not bad that as approximately 67% percent of the children were found to be normal. In the same way height for age as per Waterloo's classification shown that more than half of the children were normal. On clinical examination approximately 47% of children were normal, while as rest were suffering from dispigmentation of hair, moon face, xerosis of skin cheilosis, magenta tongue, spongy bleeding gums, oedema, conjuctival xerosis, and mottled dental enamel. The findings indicated that nutritional intake was deficient for all nutrients when compared to, Recommended Daily Allowances Chart (RDA) for all age groups which may be linked to poor planning of menus in orphanages.

Keywords: *Orphanage, Orphans, Nutritional Status, Nutritional Intake.*

As a result of long term chronic violence in Kashmir, A study conducted by save the children organization in December, 2006 about 120,000 children is orphans in Jammu and Kashmir in which most of them are institutionalized. In the report of the United Nations General Assembly (2010), it was mentioned that UNICEF (United Nations Children's Fund) estimates that there are about 1 million orphans in Kashmir. According to a report, titled "Ignored orphans of Jammu and Kashmir", published in Kashmir Watch under the Human Rights section in its December, 2011 issue, the number of orphans in the state is around 600,000 children. The children who have lost their parents are most vulnerable, because they do not have the emotional and physical

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maturity to address their psychological disturbance connected with parental loss. In the society, orphan children can be considered to be at more risk than average children (Subbarao and Coury, 2004). An orphanage is an institution devoted to the care and rearing of children who have lost their parents. Traditionally, such institutions were quite prevalent in Western societies in the past. More than 60 years of research provides persuasive evidence that the type of institutional care provided in western countries has a unfavourable effect on behavioural, emotional cognition, and social development of children. But in some poor countries it has been observed that the children in orphanages have improved chances of cognitive development, when the children were confident to participate along with the staff in the decisions that influenced them in the institutions. It is possible that when professional skills are fuelled by education and understanding, orphanages can provide a caring social environment that offers a close and stable relationship between members. With regards to rising up in an orphanage, modern studies from Africa suggest that the children who develop into adults in orphanages have remarkably well long term like adaptations. Most recent studies on children in conflict zones have stressed that children can survive shocking situations if they feel cared for. While they may provide some of the nurture, typical institutions do not provide the holistic care that children are entitled to for all round development. Recent researches has shown that children in institutions be deficient in basic and traditionally accepted social and cultural skills to work in their societies. Orphanages have inferior levels of educational attainment; have problems adjusting to independence after separation the orphanage, be deficient in basic living skills; have more difficulties with relationship, be short of parental skills and some of them often have a misplaced sense of entitlement without a parallel sense of responsibility (Powell 1999 ; Wright 1999).Children raised in institutions struggle to be accepted or fit into traditional rituals and ceremonies as well as contracts and alliance arrangements Most general problems faced by orphans include loss of home, social downfall, child labours and drug abuse. High dropout rate from school, lack of health care and problems with immunization,

It has been seen through world that each person, each family, each organization recognizes the need and care for looking after its children. Particularly orphans, destitute or abandoned children who are looked after mainly through child care institution run by government and non - government organization and in some cases through fosters families. There has been shown differences in health and nutrition related after the independence number of schemes for welfare of orphan and destitute children the government of India has launched, Such as "Scheme for welfare of orphan and impoverished children'' The motive of this program is to prevent impoverishment of orphan children's. Under this provision the destitute and orphan children are provided shelter, in order to provide good healthy atmosphere and good nutrition. The present study is an attempt to generate relevant information and data on health and nutritional status of impoverished children living in Anantnag Distract in Jammu and Kashmir.

REVIEW OF LITERATURE

Van Den et. al.(2010). reveals that the influence of pre-adoption foster against institutional rearing seems more pronounced for cognitive and motor development than for physical development and hormonal stress regulation. They recommend that pre-adoption foster care is less detrimental to children's cognitive and motor development than institutional rearing. **Sadik (2010).** in his study found that low intake of both macro and micronutrients except protein by orphanage children in Ghana. Nutritional status indicated that 10% and 15% of the children were severely stunted and wasted respectively. A study conducted by **Peace et.al. (1989)** does not support the hypothesis that institutional care is analytically connected with poorer wellbeing than community care for OAC aged 6–12 in those countries facing the greatest OAC burden. Much greater variability among children within care settings was observed than among non care settings type. **Case et al (2002)** reports reveals that most orphans are placed both in extended families or in fostering households. So far this common arrangement, creditable as it is, may come at the cost of utilization shock to households who have taken in orphans. If the households that have absorbed orphans are already poor may translate itself into deeper poverty. **UNICEF study by Deininger et al (2003)** reports that orphans are more likely to be underdeveloped in their growth and less likely to be enrolled in school than children living with both parents. Poor nutrition and incomplete access to health services put orphans at increased risk of starvation, illness and death. Without fostering from a loving parent or guardian, children's emotional development may be shortened as well. **Bicego et al. (2003)** in their study finds that full orphans were particularly deprived and loss of a mother was more detrimental for schooling than loss of a father. The disadvantage was more pronounced for primary education than secondary education.

METHODOLOGY

Objectives

1. To analyse the nutritional status of the orphan children living in orphan institution of Anantnag City
2. To find relevant information and data on health status of children living in orphanages
3. To contrast the nutritional status of orphans with standard growth chart and Recommended Daily Allowances Chart (RDA)

The present study has been conducted to assess the Health and Nutritional Status of Institutionalized Orphan children's in the Age Group of 13-18 years in Anantnag District of J&K State. The study was carried out on 30 children's in one orphanage and the orphanage was selected through purposive sampling.

For present study Questionnaire was divided into following categories:

A. General Information.

B. Anthropometric Measurements that is measurement and study of human body

Body Weight: - Weight was recorded in Kilograms (KGs) using an electronic weighing balance with minimum clothing and without shoes.

Height: - Height of the respondents was recorded in centimetres (Cms) using a height measuring rod. The respondent was asked to stand straight on a definite level ground, against a flat vertical surface without shoes.

(C) Nutritional or Dietary Assessment

24-Hour Dietary Recall: To gather information regarding the nutritional intake of the sample 24-hour dietary recollect method was used. The food eating during the last 24 hours was recorded in order to obtain the information regarding the eating of calories, proteins, iron, and calcium vitamins A

(B) Food regularity Method:

This procedure included evaluation of the frequency of consumption of different foods-daily, 3 – 4 times a week, weekly, fortnightly, monthly or occasionally.

(D) Clinical Assessment:

In clinical assessment changes in external tissues, particularly the skin, eyes, hair, gums, nails and in the organs near the surface of the body like the thyroid gland were observed.

RESULTS AND DISCUSSIONS

The findings from the present study are presented as follows:

Table 1. Distribution of respondents for Weight for Age as per Indian Academy Paediatrics.

Classification	**Age**						
	13 Years	**14 Years**	**15 Years**	**16 Years**	**17 Years**	**18 Years**	**Total**
Normal	2	3	3	4	3	5	20
Grade-first-Malnutrition	1	_	1	2	1	2	7
Grade-second-Malnutrition	1	_	1	_	_	1	3
Total	4	3	5	6	4	8	30

From the above table 1 According to classification of Indian Academy Paediatrics (IAP), it has been found that Classification of Weight for Age of 30 respondents. Twenty were Normal, seven had Grade first Malnutrition and three had Grade second Malnutrition.

Table 2: Distribution of respondents for Height for Age as per Waterloo Classification

Classification	Age						
	13 Years	14 Years	15 Years	16 Years	17 Years	18 Years	Total
Normal	2	3	2	4	3	5	19
Mild Malnutrition	1	_	1	1	_	1	4
Moderate Malnutrition	_	_	1	1	1	1	4
severe Malnutrition	1	_	1	_	_	1	3
Total	4	3	5	6	4	8	30

From table 2 according to Waterloo's classification As far as height is concerned for Age, it was found that out of 30 respondents, Nineteen were normal, four had mild -malnutrition, Four had moderate malnutrition, and Three had severe malnutrition.

Table 3 Distribution of orphans as per clinic examination.

Signs/Symptoms	No of children in different age groups						
	13 years	14 years	15 years	16 years	17 years	18 years	Total
Normal	2	2	1	3	2	4	14
Dispigmentation of hair	1	1	-	2	-	3	7
Muscle Wasting	-	-	-	-	-	-	-
Moon Face	-	2	-	-	1	1	4
Flunky Paint dermatitis	-	-	-	-	-	-	-
Oedema	1	-	-	-	1	-	2
Bitots Spots	-	-	-	-	-	-	-
Conjuctival xerosis	-	-	-	-	-	-	-
Xerosis of skin	2	1	1	2	-	3	9
Cheilosis	-	2	-	1	-	2	5
Magenta Tongue	-	1	2	-	-	1	4
Loss of Ankle/ Knee Jerk	-		-	-	-	-	-
Spongy Bleeding Gums	2	1	-	2	3	2	10
Bow legs	-	-	-	-	-	-	-
Thyroid Enlargement	-	-	-	-	-	-	-
Mottled Dental Enamel	1	2	1	2	-	4	10

In table third, During clinical examination various important symptoms among orphan children's were found. The important symptoms found were: dis-pigmentation of hair, moon

face, xerosis of skin, cheilosis, magenta tongue, spongy bleeding gums, and mottled dental enamel. Out of 30 orphans children's eighteen approximately (47%) respondents were normal while approximately 53% were suffering from symptoms.

Table 4 Average Dietary Recall of 24 Hours

Meal	Menu	Ingredients	Amt. (g)	Energy (kcal)	Protein (g)	Iron (mg)	Vit. A (µg)	Vit. C (mg)
Morning tea	Tea Chapatti	Milk, Wheat flour	50 40	33.5 136.4	1.6 4.84	0.1 0.016	26.5 11.6	1 -
Lunch	Boiled rice, dal and salad	Rice, Rajmah, Onion, Oil Radish Carrot	150 75 10 10 10 10	510 259.75 4.8 90 1.7 4.8	9.6 17.175 0.18 0 0.07 0.09	1.5 3.825 0.12 0 0.04 0.13	- - 1.5 - 0.3 189	- - 0.2 - 1.5 0.3
Evening tea	Namkeen tea	Milk, Wheat flour	50 40	33.5 136.4	1.6 4.84	0.1 0.016	26.5 11.6	
Dinner	Boiled rice, sabzi and salad	Rice, Rajmah, Onion, Oil Radish Carrot	150 75 10 10 10 10	510 259.75 4.8 90 1.7 4.8	9.6 17.175 0.18 0 0.07 0.09	1.5 3.825 0.12 0 0.04 0.13	- - 1.5 - 0.3 189	- - 0.2 - 1.5 0.3
Total				1927.45	50.55	11.46	469.8	13.5

Through 24-hour recollect method, it was found that orphan children's were consuming less energy, fats, vitamins, proteins and minerals. It was also found that on an average the orphans consumed 1927.45 kcal. energy instead RDA of 2100-2600 kcal. The respondents consumed proteins 50.55g/day as against of 60-65g/day as per RDA. They were consuming 11.46 mg of Iron, 469.8 µg of vitamin A and 13.5 mg of vitamin C as against of 28 -30mg/day, 600 µg/day and 40 mg/day respectively as per RDA for Indian Children and Adolescents as given in above table number 4.

CONCLUSION

The study concludes that the nutritional and health status of the institutionalized orphan children's of age group 13-18 years of Anantnag district was not that dreadful when compared with different standards. Results assigns that dietary intake was incomplete or deficient for all nutrients instead to RDA for all age groups which may be related to poor planning of menus (-) found in orphanages. The hygienic conditions of these orphan children was also found to be poor Further in our study it was also found that sometimes these children were provided with surplus fruits, energy, and protein rich foods, but sometimes these children's were not reaching even a single fruit for months. It is obvious from this interpretation that if the institutions have a high quality residential setup, accurate care giving, balanced food and present modern education, they will be more effective in gathering the emotional requirements of orphans.

RECOMMENDATIONS

Check nutritional status of orphanage children's minimum once in a year.

(a) To increase dietary ingestion in orphanages by giving high calorie diets and by providing variety in the diet

(b) The orphanage caregivers had no knowledge on the issues connected to child nutrition; hence the teachers and administrative departments of the orphanages should take counselling from an expert dietarian.

(c) An NGO in its own way has affected every Kashmiri family. In order to ensure continued support for orphans, the institutions with continuous support of the whole society needs to initiate efforts to become autonomous.

(d) The orphanages should set up links with qualified public health nutrition professional that can provide screening, referral and counselling for nutrition and health related problems for both the orphan children and caregivers.

(e) The management of the orphanage should fully support research to progress the situation in the orphanage.

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