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RESEARCH

Headship of families and child psycho-environment among Community Directed Distributors in Anambra East Local Government Area, South East Nigeria

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ABSTRACT

Background: A household consists of one or more people who live in the same dwelling or apartment and also share at meals or living accommodation, and may consist of a single family or some other grouping of people. In the context of human society, a family is a group of people affiliated by consanguinity, affinity or co-residence and or shared consumption. A child first environment is the family and could impart positively or negatively on his future and well being. Community Directed Distributors constitute an integral part of a larger community where they exist and supposedly influential to their peers.

Aim: This works aims at finding out the pattern of household headship and method of stimulating the mental development of the children of Community Directed Distributors.

Method: A multi stage sampling technique was used and subjects were community directed distributors of key house hold practices in Anambra East Local Government Area in Anambra State, South-East Nigeria. One hundred and sixty one (161) questionnaires were distributed, returned and analysed. All data were analysed statistically using SPSS version 16.0 and where possible presented as mean± standard deviation. A one-way analysis of variance (ANOVA) and Chi Square were used to compare data. p-value, less or equal to 0.05 was taken as significant.

Results: There was a female predominance among the community directed distributors health workers with a mean age of 29.5±6.5 years. Their educational level was predominantly secondary while a few had no formal education. Out of the 161 CDDs households, 144 were headed by fathers (89.4%). Mothers headed 10(6.2%), male children headed 4(2.5%), female relatives headed 2(1.2%), male relatives had no place in headship of household but, other male had the headship of one (0.6%). More than half of the studied group will send their children to school or teach them about nature as method of stimulating proper mental growth. More than half will praise good behaviour but, disciplines misbehaved children. More than half of the studied group will send their sick children to health facility but a good fraction will seek other non

specified means other than traditional medicine healers. Level of their education had no significant ($p<0.88$) influence in their method of stimulating a child's mental development or ($p<0.12$) influence of educational levels on response of CDDs to a misbehaved child but, secondary level of education had a significant ($p<0.001$) influence in methods of attending to their sick children.

Conclusion: We conclude that the fathers' headship of family is the predominant practise among CDD and is typical of most other Nigerian households. The better educated members seek proper medical advice for their sick children. While most household will discipline a misbehaved child, some will acknowledge good behaviour with gifts and gratifications. The implication of these findings to the community and child's health should be looked into.

Key words: Headship of households; Family; Community Directed Distributors; Child's psycho- environment and mental development.

1. INTRODUCTION

In the context of human society, a family is a group of people affiliated by consanguinity, affinity or co-residence and or shared consumption. Members of the immediate family may include, singularly or plurals, a spouse, parent, brother, sister, son and, or daughter. Members of the extended family may include grandparents, aunts, uncles, cousins, nephews, nieces and, or siblings-in-law. In most societies, the family is the principal institution for the socialization of children as the basic unit for raising children. Pressure on parents and parental relationships and methods of handling the affairs of the children could have both negative and positive effect on their mental state. Take for instance parental stress and home environment play a role in the neurodevelopmental outcomes and may prompt new family-directed interventions and anticipatory guidance for the families of children with Down syndrome who have a congenital heart defect (Visootsak *et al*., 2015).

Behavioural and cognitive-behavioural group-based parenting interventions are effective and cost-effective for improving child conduct problems, parental mental health and parenting skills in the short term (Furlong *et al*., 2013). Attention Deficit Hyperactivity Disorder (ADHD) is a neurodevelopmental disorder characterised by high levels of inattention, hyperactivity and impulsivity that are present before the age of seven years, seen in a range of situations, inconsistent with the child's developmental level and causing social or academic impairment. But, parent training programmes are psychosocial interventions aimed at training parents in techniques to enable them to manage their children's challenging behaviour (Zwi *et al*., 2011).

Promoting mental health and emotional wellbeing (EWB) in children and young people (YP) is vitally important for their psycho-social development thus form key messages for society, policy makers, education and public health and healthcare practitioners for integration into the delivery of services for YP and families that include education on supporting EWB, activities for YP and a multi-agency approach to supporting families within the community (Coverdale and Long, 2015).

In a study carried out in Northern Ireland aimed to identify how the promotion of the health and social wellbeing of looked after young people could be enhanced using a four-stage triangulated research design employing qualitative and quantitative elements; it was found that young people had positive views of health, identified stressors and perceived that too much help was given in relation to health issues; social workers were preferred for discussion of sensitive subjects and was concluded that the multiple needs of young people give excellent opportunities for the development of interdisciplinary working in the context of multi-sectoral involvement to support effective health promotion interventions (Fleming et al., 2005).

Schools are secondary environment and only supportive to the family. The positive associations between school participation and school socio-ecological environment and health and well-being outcomes suggests that pupil health and well-being and school relationships could be improved or sustained by providing or supporting an environment that encourages pupil participation in school life (John-Akinola and Nic-Gabhainn, 2014). For instance approximately 11% of schoolchildren are bullied on a regular basis and it is suggestive that continuous exposure to bullying and other forms of abuses is related to the development of psychotic symptoms (van-Dam *et al*., 2012; Gini and Pozzoli, 2013; Gunnlaugsson and Einarsdottir, 2013).

A child who did not grow up in the hands of a loving caregiver or under traumatic early life experience may develop post-traumatic stress disorder later in life (Giannopoulou, 2012). Post-traumatic stress disorder is however associated with an interaction between the individual genetic susceptibility and the traumatogenic event and a social context thus wide variation (Vandell *et al*., 2005). While social withdrawal in middle childhood significantly explained the observed relation between emotional abuse and decreased competence in adolescence, this process did not emerge as salient in understanding the relation between emotional neglect and adolescent adaptation (Shaffer *et al*., 2009). Parental emotional warmth is a protective factor for irritable bowel syndrome in adolescents and parental punishment, over interference, rejection, and overprotection are risk factors for irritable bowel syndrome in adolescents (Xing et al., 2014)

A household consists of one or more people who live in the same dwelling or apartment and also share at meals or living accommodation, and may consist of a single family or some other grouping of people (Arthur and Steven, 2003). In genera self declared female headed-households in most developing countries tend to be poorer, own less and have less access to job opportunities and in East Africa, the proportion of stunted and underweight pre-schoolers was significantly higher in female headed-households than in the male-headed households while the prevalence of wasting was practically similar (Haidar and Kogi-Makau, 2009).

Asthmatic attack in early childhood seems to have a correlation with a less friendly household environment and there is delay in speech development in such environment (Nelson et al., 2006). Headship of households may appear as a factor on the social environment affecting the child but, there is no evidence that female headship of families affects child morbidity and mortality rate (Nelson *et al*., 2006; Adhikari and Sawangdee, 2011).

Community Directed Distributors (CDDs) are persons appointed or elected by the community, trained by institutionalized health systems to serve their communities in areas of dire health needs (APOC, 2009). According to World Health Organization (2013), CDD was initially set up in the 90s to distribute ivermectin but, has now been integrated to take part in the effective implementation of Community Directed Interventions (CDI). The people selected to become CDDs are generally perceived by the community as being honest and trustworthy, having good conduct, integrity and literacy. As volunteers, their motivation is mainly by gains in recognition, self-esteem and knowledge, rather than cash incentives (APOC, 2009). They are indeed supposed role models in their chosen communities.

2. MATERIALS AND METHODS

Study area

Study area was Anambra East Local Area. Anambra East Local Government Area is one out of the 21 Local Government Areas in Anambra State. Anambra State is one out of the five States in South-Eastern Nigeria. Anambra East Local Government is made of ten major towns and many villages. The towns are Aguleri, Enugwu Aguleri, Eziagulu Otu Aguleri, Enugu Otu Aguleri, Otuocha, Umuoba Anam, Umuleri, Igbariam, Nando and Nsugbe. The Local Government Area has a population of 153,331 comprising 77,804 males and 75,527 females (NPC, 2013). The people are predominantly subsistence farmers and petty traders.

Study Population/Inclusion Criteria

Study population was Community Directed Distributors in Anambra East Local Government Area selected by their various communities and undergoing training or retraining as at the time of data collection. Study Design: The survey employed a descriptive cross- sectional study among Community Directed Distributors selected by their various communities during their one week training or retraining in 2014.

Sampling Technique: A multistage sampling technique (Probability sampling) was adopted for the study (Doctor, 2011). The entire state was divided into 21 Local Government Area (Stage One). Out of the 21 Local Government Areas of the state (Clusters), Anambra East was chosen (Stage Two). Anambra East has about thirty communities with each community selecting between 4 and 7 CDDs (Stage Three). There were two towns with three classes each where CDDs were undergoing training at that period of data collection. Each class had about 30 CDDs making a total of one hundred and eighty (180) CDDs for the whole of the Local Government Area. One hundred and sixty one (161) questionnaires were then distributed.

Sample Size Calculation

The sample size formula was used to test the statistical suitability of the number of questionnaire thus $N = \frac{Z^2PQ}{d^2}$

Where:
N = Minimize Sample Size.
Z = Standard normal deviate (1.96) at 95%confidence limit,
P=Prevalence (10.6% hand washing among CDDs),
Q = 1-P and d = Degree of precision at 5% (0.05).

Extrapolating therefore we have $\frac{(1.96)^2 \times 0.106 \times (1-0.106)}{(0.05)}$

$= \frac{3.85 \times 0.106 \times 0.894}{0.0025.}$

N = 145.936.

Adding 10% attrition to sample size (10% of 145.936 +145.936) = 160.529.
Our desired sample size is therefore at least 160.529 and was taken as 161 CDDs.

Ethical Consideration

The study, its content and purpose were orally explained to the Director of Training of the CDDs at Awka and his consent granted. On the site/field permissions were obtained from Training Coordinator and Resource Persons before access to the CDDs was gained. The contents and purpose of the questionnaire were again explained to the CDDs in languages clearly understood by them and their consent granted before questionnaires were distributed.

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Data Collection

Umulaeri and Agulaeri towns in Anambra East Local Government Area were visited on the 19th day of February, 2014. The CDDs were located at Nneyi Development Hall (Umuleri) with three classes. Another three classes were located at Aguleri Civic Hall to make a total of six classes with total CDDs of 180. Typical and standard questionnaire from CDD/WHO initiative was downloaded and used as such. 161 questionnaires were distributed to the CDDs present at training sites on 19/02/2014. The assistance of their resource persons was solicited to read the questionnaire line after line for all the twenty three line questions and further explain to them in their local languages any clause that was not clear to any of them. There was however no influence on their choice of answer. Most questions required only "Ticking or marking" as sentences were avoided. Completed questionnaires were returned at will whenever completed. There were no given time frame but, all questionnaires were returned on the same day (Ajayi *et al*., 2013).

Statistical Analysis

All returned questionnaires were statistically analysed using Special Statistical Package for Social Sciences (SPSS) 16.0 version. Analysis of variance (ANOVA) was used and where possible presented as mean± standard deviation. Pearson Chi-Square was used for comparative statistics to check for the influence of level of education on certain behavioural pattern (Wayne, 2009).
Probability value (p. Value) of less than or equal to 0.05 was taken as significant (Pokhrel *et al*., 2005).

Some limitations to this study

The work covered only those who were present at the scene of data collection. There were financial and transport challenges in reaching out to the villages to meet the CDDs. Some of the respondents had poor or no understanding at answering some aspects of the questionnaire.

3. RESULTS

Result on demography

All the 161 distributed questionnaires were returned. There was no questionnaire that was wholesomely uncompleted but, some specific questions were not answered in virtually all questionnaires. All unanswered questions were represented as "No Response" in the specific sub-segment. From the survey, there was a female predominance. Out of the 161 CDDs, 109 (67.7%) were females while 52 (32.3%) were males (Table 1). There was a predominance of ages 29-38 with a frequency of 62 (37.2%). This was followed by 18-28 with a frequency of 36 (22.4%). Then those between 39 and 48 took the third position with a frequency of 34(21.1%). The fourth in frequency was the age 49-58 with a frequency of 23(14.3%) while the oldest group, of 59-68 had a frequency of 8(5.0%), (Table 2). Secondary education had predominance with a frequency of 71(44.1%), followed by tertiary education with a frequency of 60 (37.3%). The primary education had a frequency of 22 (13.7%) while those with no formal education had a frequency of 8 (4.9%), (Table 3).

Table 1
Gender distribution of CDDs

Variables	Frequency	Percentage
Females	109	67.7
Males	52	32.3
Total	161	100

Table 2
Age distribution of CDDs

Variables	Frequency	Percentage
18-28	36	22.4
29-38	62	37.2
39-48	32	21.1
49-58	23	14.3
59-68	08	05

Table 3
Educational qualification of CDDs

Variables	Frequency	Percentage
No formal	8	4.9
Primary	22	13.7
Secondary	71	44.1
Tertiary	60	37.3
Total	161	100

Results on Headship of Households

Most households were headed by fathers. Out of the 161 CDDs households, 144 were headed by fathers (89.4%). Mothers headed 10(6.2%), male children headed 4(2.5%), female relatives headed 2(1.2%), male relatives had no place in headship of household but, other male had the headship of one (0.6%), (Table 4).

Table 4
Headship of households among CDDs

Variables	Frequency	Percentage
MOTHERS	10	6.2
FATHERS	144	89.4
TEMALE RELATIVE	2	1.2
MALE CHILD	4	2.5
OTHER MALE	1	.6
TOTAL	161	100.0

Results on psycho-environment of the children

Most households will either teach their children about nature 48 (29.8) or send their children to school 54(33.5%) as a means of providing proper environment to stimulate mental growth. Two (1.2%) households will teach about nature as well as expose the child to experiences that addresses cultural or traditional practices. Teachings about nature as well as other non specified methods were practiced by 4 (2.5%) households while 3 (1.9%) households ensured that child attended school as well as churches. Exposure of the child to experiences that address cultural or traditional practices got the third most popular position among the CDDs with a frequency of 25 (15.5%).

Taking child on special outing was practiced by 6 (3.7%) households while visiting relatives or friends got 5(3.1%) households. Attendance to churches was practised by 8 (5.0%) household while 2 (1.2) will do nothing to stimulate the growth environment. A (0.6%) household, on the other hand will do a non specified thing while 3(1.9%) household would not know what to do (Table 5).

There was no significant (Chi Sq= 34.749) ($p<0.88$) influence of educational qualification on pattern of stimulating child's mental development. A good number of CDDs 92(57.1%) disciplined their children when they misbehaved but, 83 (51.6%) praised the children at times of pleasing behaviour. 61 (37.9%) discussed misbehaviour with child but, 35(21.7%) kissed or hugged their children with pleasing behaviour. While 4(2.5%) CDDs will defer the responsibility over a misbehaved child to the other parent or caregiver, 10 (6.2%) CDDs will give special food or drink to a child with pleasing behaviour. 14 (8.7%) and 10 (6.2%) CDDs will allow a pleasing behaved child to carry out a special activity and offer another gift respectively.

On the other hand while 2 (1.2%) CDDs will do nothing to a misbehaved child, 3 (1.9%) CDDs will do nothing to a child with pleasing behaviour. Again a CDD (0.6%) would not know what to do to a child with pleasing behaviour but, 2 (1.2%) CDDs will respond to pleasingly behaved child in other non specified ways (Table 6). There was no significant (Chi Sq= 22.6) ($p<0.12$) influence of educational levels on response of CDDs to a misbehaved child. Most CDDs will take their sick child to a health facility 115(71.4%) while 21(13%) will give home treatment. 9 (5.6%) CDDs will take the sick child for other treatments outside the home while 2 (1.2%) will only comfort the sick child.

One CCD each (0.6%) will either do other non specified support or nothing for the sick child. While 9 CDDs (5.6%) will pay the child's medical bill, 3(1.9%) will pay extra attention by providing extra food or drinks (Table 7). There was significant (Chi Sq= 62.822) ($p<0.001$) influence of educational levels in the support given to a sick child by the CDDs. Those with secondary education had the clear lead (Fig.1).

Table 5

Pattern of child mental growth promotion among CDDs household

Variables	Frequency	Percentage
1) Teaches child about nature	48	29.8
2) Exposes the child to experiences that address cultural or traditional practices	25	15.5
3) Takes the child on special outings	6	3.7
4) Takes the child to visit relatives and/or friends	5	3.1
5) Takes child to church	8	5.0
6) Ensures that child attends school	54	33.5
7) Others	1	0.6
8) Doesn't know	3	1.9
9) Does nothing	2	1.2
1,2	2	1.2
5,6	3	1.9
1,2,3	4	2.5
Total	161	100.0

Table 6

Actions of CDDs on child's behaviour

Actions on misbehaviour	Frequency	Percent	Actions on pleasing behaviour	Frequency	Percent
Discusses behaviour with the child	61	37.9	Praises the child	83	51.6
Disciplines child	92	57.1	Kisses or hugs	35	21.7
Defers response to other parent or caregiver	4	2.5	Special food or Drink	10	6.2
Does nothing	2	1.2	Another gift	10	6.2
No Response	2	1.2	No Response	3	1.9
Total	161	100.0	Allows child to carry out special activity	14	8.7
			Others	2	1.2
			Doesn't know	1	.6
			Does nothing	3	1.9
			Total	161	100.0

Table 7

Types of supports for the sick child

Variables	Frequency	Percentage
Provides home treatment	21	13.0
Takes child for treatment outside the home	9	5.6
Takes the child to a health facility	115	71.4
Comfort the child(holding ,cuddling, singing)	2	1.2
Pays extra attention(eg providing more food and/ or liquids)	3	1.9
Pays for child's medical care	9	5.6
Others	1	0.6
Does nothing	1	0.6
Total	161	100.0

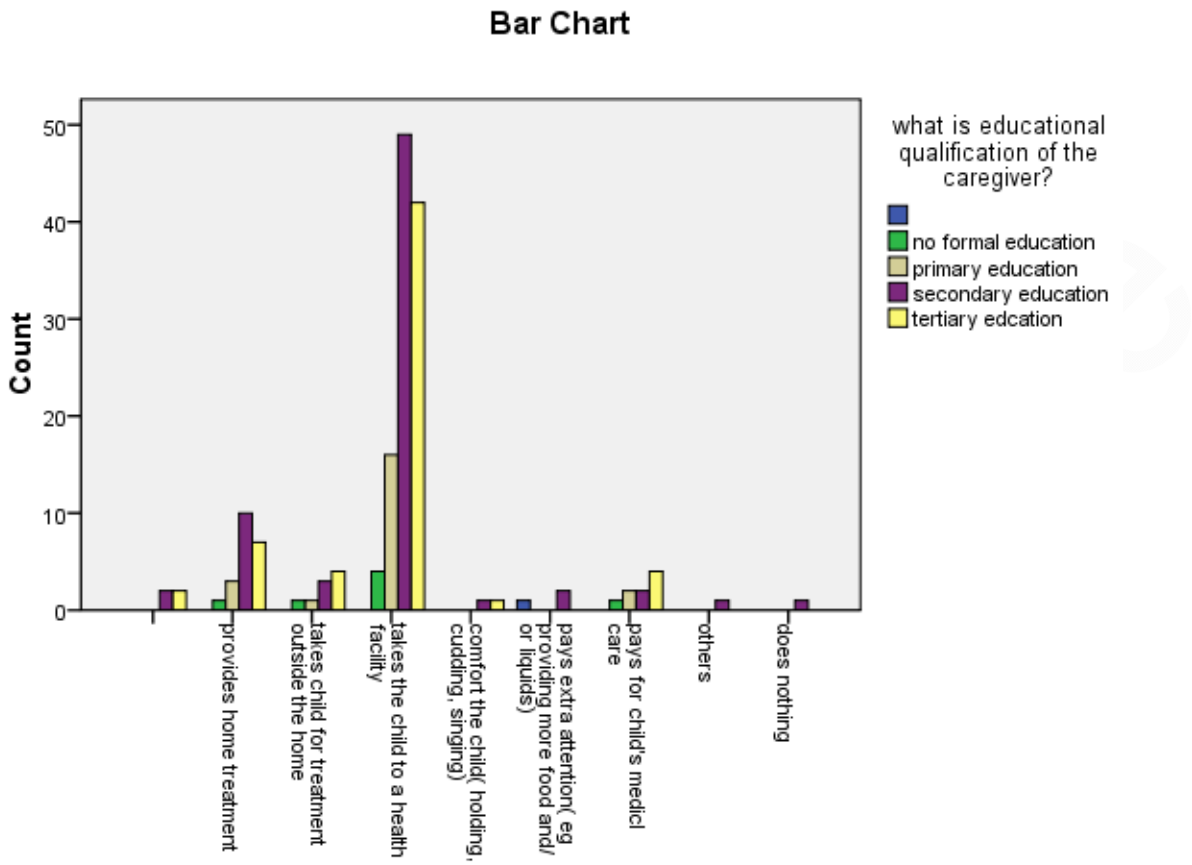

Figure 1
Educational level and the sick child

Figure shows a comparative bar chart representing influence of educational levels on the support given to a sick child by CDDs. A significant (Chi Sq= 62.822) ($p<0.001$) influence was demonstrated. Those with secondary education had a clear lead.

4. DISCUSSION

Most CDDs were females with a predominant age bracket of 29-38. Considering the tasking nature of their duty, this age group is most appropriate. Females also may show more commitment to the health needs of their children than their males' counterpart. Educational level of CDDs gives a lot of reasons to worry about. Majority were secondary levels. Primary educational level and no formal education had 37.2% and 4.3% respectively. One really wonders how such CDDs could understand or go through the task of documentations involved in the health protocols. Little wonder why all sub-segments of our questionnaire were unattended to. Some answers were even more ridiculously worrisome.

For a concept to be psychosocial means it relates to one's psychosocial development in, and interaction with, a social environment. The individual needs not be fully aware of this relationship with his or her environment. It was first commonly used by psychologist Erik Erickson. This phenomenon is contrasted with social psychology which attempts to explain social patterns within the individual. It is usually used in the context of "psychosocial intervention," which is commonly used alongside psycho-education or psycho-pharmacological interventions and points toward solutions for individual challenges in interacting with an element of the social environment (Benony et al., 2007). Children who went to average schools competed and did preferably better than the class of "gifted Children" who had depressive disorders (Benony et al., 2007).

Our work found out that most households commonly will either teach their children about nature 48 (29.8) or send the children to schools 54(33.5%) as a means of providing proper environment to stimulate mental growth. There was no significant influence of educational level on their method and one then but, wonders why. Their understanding of this particular posed question is in doubt. One would naturally have expected that if their selection was based on educational attainment and if their exposure in health sector is anything to go by, they would send their children to school.

Most CDDs will take their sick child to a health facility 111(68.9%) while 21(13%) will give home treatment. These are in line with the cardinal objectives of CDDs but, worrisome that a very good number if not 100% could not be achieved even among this privileged group. Some

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will go to other places of treatment outside health facility and traditional healers, perhaps "prayer houses" of course. "Spear the rod and spoil the child" is a common proverb in Nigeria. Commonly too in our society, praises and pet name calling are used in response to accepted behaviours. It was not therefore unexpected when CDDs 92(57.1%) disciplined their children when they misbehaved but, 83 (51.6%) praised the children at times of pleasing behaviour. Other methods were also in place to handle child's behaviour but, the above two were the most popular and purely in line with the societal detects.

Negative parental rearing patterns appear to contribute to the development of borderline personality disorder (BPD), in China and vary with the gender of the child but, maternal emotional warmth may be a protective factor against BPD (Huang *et al*., 2014). A maltreated child may not have post-maltreatment syndrome but, prolonged and nature of maltreatment is then followed by a section on environmental influences on brain development, demonstrating the dependence of the orderly process of neurodevelopment on the child's environment. Ontogenesis, or the development of the self through self-determination, proceeds in the context of the nature-nurture interaction (Glasser, 2000; Hildyard and Wolfe, 2002). In typical African households, while the strict but, protective caring of the father guides the child to a better prospective future the warm caring and loving nature of mothers gives solace and comfort during illnesses and drawbacks.

From this study fathers headed most households. Out of the 161 CDDs households, 144 were headed by fathers (89.4%). Mothers headed 10(6.2%), male children headed 4(2.5%), female relatives headed 2(1.2%), male relatives had no place in headship of household but, other male had the headship of one (0.6%). Similar work done in China highlighted the importance of the parents, the proper family headship as informal networks in the proper upbringing of children (Starke. 2011). In South Africa, mainstream research and the popular media often equate female-headship with household vulnerability, crisis, and disorganization as well as considerable heterogeneity among rural female-headed households and their access to resources to combat AIDS-related hardship (Schatz *et al*., 2011).

In Nepal, women who were literate, who had ever used family planning methods, who had visited a health facility, who utilized antenatal care for the last pregnancy, and who were from female-headed households were less likely to see a child die than were women in their comparison group (Adhikari and Podhisita,2010). Also in a study in rural community in Nigeria, Doctor, (2011) found that chid-death was higher in male-headed household and concluded that after controlling for other explanatory variables such as age, wealth status, region and place of delivery of recent birth, the study found that household headship remained a strong predictor of child mortality. Families and communities are currently unable to cope with the effects of HIV and AIDS with special emphasis on the care and support of the affected orphans and vulnerable children, who as a result have been compelled to look after themselves giving rise to a new type of family, the child-headed household (Mogotlane *et al*., 2010).

In genera self declared female headed-households in most developing countries tend to be poorer, own less and have less access to job opportunities and in East Africa, the proportion of stunted and underweight pre-schoolers was significantly higher in female headed-households than in the male-headed households while the prevalence of wasting was practically similar (Haidar and Kogi-Makau, 2009). Headship of households may appear as a factor on the social environment affecting the child but, there is no evidence that female headship of family affects child morbidity and mortality rate (Nelson *et al*., 2006; Adhikari and Sawangdee, 2011).

Our finding on headship of households is purely in line with the realities of our society. A normally constituted Nigerian family or household shares complimentary roles of the parents and usually brings about a balanced upbringing of the children. While the males are usually the breadwinner, less emotionally vulnerable and provide the family with some sense of security, the females provide the balanced dietary and other emotional supports. When a female is in charge over a household, she may no doubt seek medical advice at will for both herself and her children but, also may go astray when not properly guided especially for the less educated ones. Demonstrated from our work are cases of CDDs who took their sick children to non standard health care and non-health care facility.

5. CONCLUSION

We conclude that the fathers' headship of family is the predominant practise among CDD and is typical of most other Nigerian households. The better educated members seek proper medical advice for their sick children. While most household will discipline a misbehaved child, some will acknowledge good behaviour with gifts and gratifications. The implication of these findings to the community and child's health should be looked into.

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