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Fostered children's perception of their health care and illness treatment in Ekiti Yoruba households, Nigeria*

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> *Children's statuses and their relationship to various adults in the household are crucial determinants of the household allocations they will receive (Bledsoe 1990a: 563).*

Abstract

This paper reports the findings from both quantitative and qualitative fieldwork conducted in six Ekiti Yoruba communities of southwestern Nigeria on the treatment of child illness within households. Relying heavily on data from focus group discussions, it shows how fostered children use local proverbs and day-to-day common sayings to describe their perception of the responses to and treatment of their illnesses in a very different way from that of the foster parents. Parents' responses and treatment of fostered and non-fostered children's illnesses were compared. Both the qualitative and quantitative evidence from the study showed that treatments were delayed for foster-children in comparison to own children, and foster-parents were found to be less sensitive to foster-child illness, which they often suspected was used to avoid housework. The different responses to, and treatment of, foster-children's illnesses are important for the understanding of the probable effects on differential morbidity, and possibly mortality, between fostered and non-fostered children.

Child rearing in traditional Yoruba society is hardly a one-person job. One of the Yoruba proverbs is *eni kan lo n bimo, opo eniyan lo n ba'ni to*, meaning that only one person gives birth to a child, but many people take part in rearing the child. The supportive role of both close and distant kinsmen and other family members in child rearing has been documented (Page 1989:402). In recent years, information on the subject has become more plentiful, with substantial contributions from demographers and scholars in related disciplines (Schildkrout 1973; Fiawoo 1978; Goody 1982; Isiugo-Abanihe 1985; Bledsoe and Isiugo-Abanihe 1989; Page 1989; Bledsoe 1990 a, b; Renne 1993).

In traditional society, a child does not belong only to his biological parents, but rather he belongs to both the immediate and the whole extended family. The outsider finds difficulty in

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identifying the actual biological mother of a child in extended-household settings, especially in situations where every other mother regards the child of her sister as her own child (Isiugo-Abanihe 1983:3-7). Children live away from their parents for various reasons, some to attend school in other towns, while some are fostered because of their parents' economic hardship or to become house-helps to relatives or well-to-do business men and women in urban towns.

Child fostering as a practice among the Yoruba carries with it both social and economic benefits. The child benefits from the assistance received from the foster-parents in terms of training and in return works for them, thus making it a mutually beneficial relationship (Isiugo-Abanihe 1983:4; Renne 1993:1). Most previous discussions on child fostering have centred mainly on the positive benefits derived from the practice by both families involved. The experience of the child is more assumed than discussed. Parents sending away their children to live with other kinsmen are primarily interested in either maintaining close kinship ties or in transferring some of the economic burden of raising the child to kinsmen who are in most cases economically better off (Caldwell 1977:91; Bledsoe and Isiugo-Abanihe 1989:442). The questions that have remained unasked are: what is the reaction and experience of the *object* of this practice - the child? How does the child feel about the change in its status? Do parents ever think of the psychological strain of separation from biological parents, especially mothers, that children encounter when they are fostered? How do the foster-parents respond to the illnesses of these children, and how well is the health of the child maintained?

Foster-children usually face a dual problem; first, the problem of psychological strain arising from the separation from their parents, and secondly, that of not being able to question whatever is done to them by their foster-parents in the new environment. The child is normally not expected to report back to the biological parents any difficulties experienced in the foster-home. In instances where children do report back, the tendency is for the biological parents to reprove them for doing so.

Inevitably, foster-children have quite different experiences in their new homes. They have been found to lack good and nutritious food in their foster-homes. They are often deprived of some basic needs and subjected to hard work and numerous household tasks. Non-fostered children are treated better, while foster-children are often mistreated (Bledsoe 1990a:571). Thus, common proverbs state that 'home is sweet, and home is home', and most fostered children look forward to returning to their original homes. Similar proverbs are reported among the Igbo of Eastern Nigeria, as in the saying *agba nyeghi ihu na nya ndi ne leta nwata, obu nke nne na nna muru ya, ebe oga ala chi ri la*, meaning 'no matter how hospitable a foster parent (the rearer) might be, the child belongs to the real parents (the bearer), to which it must ultimately return' (Isiugo-Abanihe 1983:19).

Yoruba proverbs may be in the form of a plain statement of fact, or of a warning. They bring the desired point out more sharply and clearly than ordinary statements by describing a situation in a few striking words. They have been described as self-evident truths which give the gist of a statement in a brief but unmistakable form. The importance of Yoruba proverbs is summarized in another local proverb which says that *owe l'esin oro, bi oro ba sonu, owe ni a fi n wa a*, 'a proverb is a horse which can carry one swiftly to the idea sought' (Delano 1973:77).

More specifically, many Yoruba proverbs relating to fosterage have never been published. The proverbs explain in different ways, from the perspective of both foster-parents and foster-children, the different care and responses given to foster-children in comparison with biological children when they are ill. The relevant proverbs are examined in this paper as they reveal a great deal about the health condition of children in foster-homes.

Fostering, as used in this paper, refers to the transfer of parental role and responsibilities in child rearing from biological parents to others who might be called surrogate parents (Fiawoo 1978:273; Isiugo-Abanihe 1983:3; Page 1989:411; Renne 1993:1).

Methodology

The data employed in this paper were collected in six communities in Ondo State, Nigeria, between April 1993 and February 1994. A total sample of 1538 Yoruba households were covered in the quantitative survey which generated information on fostering and household responses to various child illnesses. In each of the six communities, four clusters were randomly sampled, from which dwelling units were selected on a systematic basis until the quota for each cluster was reached. The first available household in each dwelling unit was selected for interview from which one currently married woman of childbearing age (15-49 years), with at least one surviving child under 15 years of age, was interviewed. In order to cover many households, only one respondent was interviewed from each household.

The first section of the questionnaire was on household listing. Questions were asked of the respondents about the most recent illness to all children living in their households. The questions on illness covered type of illness, symptoms noticed, the person who first noticed the symptoms, the duration between awareness of child illness and seeking treatment, the person who decided where to seek medical help, and the person or persons who paid for the treatment. There were also questions on type of revisits or change of health care providers. The reasons for fostering children in the households were only asked for children whose most recent illnesses were reported.

In addition to the quantitative survey, seven focus-group discussions were held. Six were for all mothers with at least a surviving child, and one for the fathers. Data generated from the focus-group discussions and the in-depth interviews were used to illuminate the findings from the quantitative data. The focus-group discussions were on the perception of illnesses, and the understanding of the causes of illnesses and health behaviour associated with treatment within the households. Common day-to-day proverbs and sayings among the people were discussed and explored to examine how foster-parents respond to and treat foster-children's illnesses. Light was also shed on how fostered children perceive the care they receive from their foster-parents.

Findings

Table 1 shows the distribution of all children aged 0-14 years reported during the survey. A total number of 4,228 children were listed in all the households, out of whom 341 or eight per cent were foster-children. The table shows that the older children were more likely to be fostered than the younger ones.

A total of 2,279 children were reported ill in all the households during the investigation. The breakdown of this number showed that 168 of them were fostered children and the rest non-fostered children. The 168 foster-children represent 49 per cent of all foster-children in the households and the remaining 2,111 represent 54 per cent of all non-fostered children in the households. The breakdown of the 168 fostered children showed that 31 per cent were fostered for the purpose of education or to learn a trade, or were receiving some kind of training; 40 per cent for household work or as a return for financial assistance arising from their parents' financial difficulties, and 13 per cent were fostered as a result of the death of one or both of the biological parents.

Table 1
Age and sex distribution of children aged 0-14 in all the households

		Fostered (n=341)	Non-fostered (n)=3887)
		%	%
age-groups (years)	0-4	13	35
	5-9	32	34
	10-14	55	31
sex	male	43	53
	female	57	47

Note: Percentages may not add to 100 because of rounding

Source: Fieldwork data

Table 2 shows the age distribution of children whose most recent illnesses were reported, while Table 3 shows the distribution of the illnesses reported by the status of the children reported ill.

Table 2
Age distribution of children whose most recent illness was reported

Age groups	Fostered (n=168)	Non-fostered (n=2111)
	%	%
0-11 months	0	5
1-4 years	11	38
5-9 years	24	33
10-14 years	65	25

Note: Percentages may not equal add to 100 because of rounding

Source: Fieldwork data

As can be seen in Table 3, except in a few cases, there was no significant difference in the distribution of illnesses by whether a child is fostered or not. The differences in the distribution for measles and convulsions are a reflection of the age distribution of the children, as these two illnesses are commonest among younger children. Since the percentage of fostered children in the lower age-group was very low, the incidence of these two illnesses among them was low as well.

However, the differences in the distribution of general body pains and skin-related illnesses is probably connected with the fact that foster-children are expected to do heavy household work such as cleaning, cooking and washing clothes, while the differences in the percentage distribution of skin-related illnesses between fostered and non-fostered children is probably a reflection of the different care they receive from the foster-parents. Foster-parents usually care less for the personal hygiene of most children fostered by them in contrast to how they care for their own biological children.

Table 3
Children's illnesses by their status in the household (percentage distribution)

Illness	Fostered (n=168)	Non-fostered (n=2111)
	%	%
Malaria (n=1322)	56	58
Convulsions (n=187)	4	9
Measles (n=179)	4	8
General body pains[a] (n=51)	6	2
Stomach-related illnesses[b] (n=183)	8	8
Skin-related illnesses[c] (n=81)	5	3
Cough-related illnesses[d] (n=141)	6	6
Others[e] (n=45)	4	2
Don't know (n=85)	8	3

[a] General body pains include chest, back, ear, eye pains; rheumatism (*lakuregbe / arunmoleegun*).

[b] Stomach-related illnesses include dysentery, diarrhoea, stomach ache.

[c] Skin-related illnesses include chickenpox and smallpox, body sores (*inarun*), scabies and boils.

[d] Cough-related illnesses include tuberculosis, pneumonia, asthma, cold and catarrh.

[e] Others include not reaching seven days (*makije / bomodije*), fontanelle (*oka-ori*), epilepsy (*warapa*), mumps (*segede*), anaemia, kwashiorkor, accident, bleeding, uvulectomy (*belubelu*), polio, appendicitis and dreadlock hair (*dada*).

Source: Fieldwork data

Table 4 shows the causes of illnesses reported for all children. 'Hard labour' or 'working too much in the sun' was the major cause of illness reported for fostered compared to non-fostered children. Furthermore, 'environmental' problems were reported as the cause of more illnesses among fostered than among non-fostered children. Table 4 confirms the existence of the traditional belief about disease causation: most illnesses were attributed to attack by enemy or evil spirits. The Yoruba have always had a belief in the supernatural, and evil spirits and forces capable of inflicting injuries and sicknesses upon human life. Quite often rituals are carried out to ward off these forces, and sacrifices are made to appease the gods as part of the treatment for illness.

Table 4
Causes of selected illnesses by status of child in households (percentage distribution)

	Selected child illnesses											
	Malaria		**Body pains**		**Dysentery-related**		**Skin-related illness**		**Cough-related**		**Others /don't know**	
Causes of illness	fos (n=94)	non-fos (n=1228)	fos (n=10)	non-fos (n=41)	fos (n=13)	non-fos (n=170)	fos (n=9)	non-fos (n=72)	fos (n=10)	non-fos (n=131)	fos (n=20)	non-fos (n=110)
	%	%	%	%	%	%	%	%	%	%	%	%
Hard labour/in sun	25	17	10	7	-	-	-	-	-	-	5	3
Environmental[a]	4	2	10	2	46	8	22	4	-	8	-	3
Cold/catarrh	-	1	10	2	-	1	-	-	50	34	5	9
Teething/growing up	2	16	-	7	8	30	-	4	-	8	5	19
Mosquito bites	26	28	-	2	8	1	-	3	-	1	-	1
Attack/evil spirit[b]	43	32	40	59	15	21	33	50	30	42	70	53
Worms/impure blood	-	1	30	2	8	13	11	7	-	-	5	1
Food-related[c]	-	1	-	10	15	23	-	3	-	1	-	6
Virus/bacteria	1	2	-	7	-	5	33	29	20	7	10	6

Note: fos = fostered, non-fos = non-fostered

[a] Environmental causes include hereditary causes (eg. sickle-cell anaemia) and lack of immunization, unhygienic environment, bad water in the house.

[b] Attack includes evil spirit attack, enemy attack, unnatural causes, co-wives quarrelling, mother’s new pregnancy, accident, regular monthly sickness.

[c] Food-related includes type of bitter soup, underfeeding etc.

Source: fieldwork data

Awareness of children's illnesses

Seeking an immediate and appropriate treatment for children's illnesses is associated with being aware that the child is sick. Awareness arises from sensitivity to the symptoms manifested by the child. Generally, mothers are quick to notice physical changes that illness may cause in their children.

From this study, it was found that the mother was the first person to notice changes in her own children as a result of the illness. However, the case is different for foster-children. If a foster-child does not complain, it appears nobody takes note of its illness. In 29 per cent of cases of all illnesses to foster-children they actually complained before something was done. This was significantly different from the four per cent in the case of non-fostered children. Considering the age distribution of fostered and non-fostered children in the households, and assuming children under age five cannot describe illness symptoms, if we remove them from the analysis, the data still show that in most instances the fostered children were not treated until they complained of illness. Table 5 shows the distribution of those who first noticed that the child was ill in the households according to the children's status.

The data presented in Table 5 show a significant relationship (statistically significant at 1 per cent level) between the status of the child and the person who first noticed the occurrence of illness in the child. The insensitivity of foster-parents to a foster-child's illness is clearly revealed in the table.

Table 5
Person who first noticed child's illness by child's status in household (percentages)

For children of all ages	**Fostered (n=168)**	**Non-fostered (n=2111)**
	%	%
Mother (respondent)	42	89
Father	4	5
Foster-child's parents	5	-
Child complained	29	4
Other members of household	21	2
$\chi^2 = 251.167$ d/f =4 $p < 0.001$		
For children aged 5 to 14 years	**Fostered (n=149)**	**Non-fostered (n=1217)**
	%	%
Mother (respondent)	39	84
Father	3	7
Foster-child's parents	5	-
Child complained	30	7
Other members of household	22	2
$\chi^2 = 192.99995$ d/f =4 $p < 0.001$		

Source: Fieldwork data

Duration of interval between awareness and first treatment

The interval between the time when someone noticed a child's illness and when treatment was sought reveals the concerns of parents about such illnesses. The duration of the interval measured in days may also depend on the nature of the illness. However, as shown in Table 6, it is clear that treatment was delayed longer for foster-children than for own children. The mean duration of interval was 2.0 days for all child illnesses, 2.0 days for non-fostered

children, and 3.9 days for fostered children. From Table 6, the chi-square test shows that the difference between the duration of interval for fostered and non-fostered children is highly significant: χ^2 of 109.7 with df=7 $p < 0.001$.

Table 7 shows the mean duration of interval between awareness and first treatment for each illness by status of children in households. It is clear from the table that the interval was longer for fostered than non-fostered children in almost all cases.

Table 6
Duration of interval between awareness of illness and seeking treatment by child's status in the household (percentage distribution)

	Fostered (n=168)	Non-fostered (n=2111)
	%	%
Up to 1 day	35	58
2 days	12	19
3 days	10	12
4 days	8	4
5 days	13	3
6 days	6	1
1 week	9	2
8 days and above	8	2

Note: Percentages may not add to 100 because of rounding

Source: Fieldwork data

Table 7
Mean duration of interval between awareness of child's illness and seeking treatment for each illness by status of child in household (days)

Illnesses	All children	Fostered children	Non-fostered children
All illnesses	2.2	3.9	2.0
Malaria	1.7	2.8	1.6
Convulsions	1.4	2.0	1.3
Measles	3.3	7.3	3.1
General body pains	3.9	8.1	2.9
Dysentery-related illnesses	2.1	3.0	2.0
Skin-related illnesses	3.0	5.4	2.7
Cough-related illnesses	2.9	4.1	2.8
Others	4.0	4.2	3.9
Don't know	3.9	7.5	3.2

Source: Fieldwork data

The findings above show in various ways that the responses and treatment given by foster-parents to children's illnesses vary by the status of the child. The biological relationship between a child and its parents is very strong and cannot be compared with any other type of social relationship. This differing response and treatment of child illnesses may be deliberate on the part of the foster-parents, but most often they are not aware of it, and the foster-children are afraid to report illness because of rebukes from their foster-parents. It is important to ask what the foster-children think about their situations and the treatment they receive from their foster-parents, and how they perceive this kind of relationship. This

question is very important because of its implication for health, on the one hand, and for attitudinal change towards the practice of child fostering on the other. This is the focus of examination in the next section.

Fostered children's description of differential response to their illnesses

> *Ti eru ba n se aisan, won a ni alakori, o tun gbe ise re de, ti o ba s'omo eni, won a ni ko roju f'ata senu (Yoruba proverb).*
>
> If the slave is sick, people will say, the idiot has come with his usual behaviour, but if it is one's own child, there will be pleading with the child to please try and sip some pepper soup.

The above is the fostered children's description of responses to, and treatment of their illnesses by foster parents. The proverb explains why treatment is often delayed more for fostered than non-fostered children. Bledsoe in one of her studies noted that fostered children do receive arduous work assignments and guardians are mostly suspicion of their illnesses as being ways to dodge further work (Bledsoe 1990a: 570-571). This is quite different from the perspective of the foster parents, which is the general belief among the Yoruba that *omo ti ko ba jiya ko le gbon* , 'a child who does not suffer will not be wise in the future'. The explanation for this is not far-fetched, for a child that has suffered, been denied parental support, and been ill-treated by guardians, may work hard and succeed in reaching the top in life. For example, Bledsoe found in her study of child fosterage among the Mende of Sierra Leone, that it is often believed that the knowledge and skills that children need to advance in life lie beyond their parents' domain, and that children cannot rise beyond their parents' level without undergoing hardship in life, hence the saying that 'hardship builds character' (Bledsoe 1990a: 571; Bledsoe 1990b: 75-85).

This kind of statement suggests that foster-parents are not unaware of the hardship foster-children go through and the differential care they receive from them. Foster-parents do not regard such treatment as wrong, rather they see it as a way of helping and building the child up for the future. There can be no denying the enormous assistance that foster-children often receive from their foster-parents in terms of education, training and general assistance. But it is also important to note that studies that have examined the relationship between child fosterage and both morbidity and mortality in sub-Saharan Africa have shown that fostered children have a higher risk of malnutrition, morbidity and subsequently mortality than other children in the households as a result of the different care and treatment they receive (Bledsoe 1990a:570-571; Bledsoe and Brandon 1992: 279-302).

This study has shown the differential care experienced by children in households according to their status, and explains how fostered children perceive their experience in order to shed more light on the relationship of child fostering to morbidity, malnutrition and mortality. Various proverbs and day-to-day common sayings illustrate the point of discussion. People often say:

> *Omo olomo la n ran ni'se de toru toru, to ba somo eni, a o so wipe tile ba su ki o sun s'ohun.*
>
> It is other people's children that we often ask to return from late night errands (not easily accomplished tasks) whereas one's children are often warned not to stay out at night.

This statement implies that, when fostered children are sent on errands, their guardians tell them that no matter how late at night they must return home: if the child stays overnight

because of darkness, he or she will not be available for the normal housework the following day. However, when it is their own child, parents will be more concerned about the safety of the child, and tell him or her to stay overnight if it is too late to return home.

Case studies of differential treatment

Qualitative evidence was recorded from respondents who had been previously fostered. One such respondent was a 32-year-old Christian woman, a hairdresser, educated up to the secondary school level and the second wife of her husband. Her experiences as a foster-child are reported below.

> You see, the person I was living with then was not in any way related to me. The way she treated her own children was quite different from the way she treated me. For example, early in the morning, she would give me *gaari*[1] to eat, while she gave her own children rice. I would wash her clothes, those of her husband and all other members of the household, as well as preparing the household food. Living with someone else other than one's parents was quite different. When I was sick, I was afraid to tell her and she would not take any notice. If I told her, she would think I was afraid of house work. She might eventually give some medicine or after other people living in the house had told her about the illness by saying to her, 'look at this child, she is sick or can't you see?'

The second respondent was a 24-year-old Muslim woman who divorced her first husband and remarried as the seventh wife of her new husband. She narrated her experience as a foster-child as follows.

> That proverb you are talking about is true, but everything is based on the notion that someone may be wise. Like me for example, if I had not been sent on late night errands, I would not have been able to know the cooking and preparation of different type of foods that I know now. When I was living with my own mother, I did not know many things about domestic cooking, but when I was living with somebody elsewhere, she would put the alarm of the clock on to wake me up for the day's chores at 5.00 a.m. If the clock alarms and I was not up, the next thing she would say is 'Jonah the sleeper,[2] is it not yet time for you to wake up ?'. She would wake me up with whips. It has now become part of me, there is nothing that can make me remain in bed after 5.00 am. Whereas, if I was

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[1] *Gaari* is processed powder from cassava and is considered not to be a delicacy or favourite food of many people.

[2] 'Jonah the sleeper' is a term for someone who sleeps too much, and the statement has its origin in the Book of Jonah in the Old Testament: the prophet Jonah was running away from God and boarded a ship travelling to Tarshish, to avoid going to preach to sinners in Nineveh as commanded by God.

> But the Lord sent out a great wind into the sea, and there was a mighty tempest in the sea, so that the ship was like to be broken. Then the mariners were afraid, and cried every man unto his god, and cast forth the wares that were in the ship into the sea, to lighten it of them. But Jonah was gone down into the sides of the ship; and he lay, and was fast asleep. So the shipmaster came to him, and said unto him, What meanest thou, O sleeper? arise, call upon thy God... (Jonah 1.4-6).

Hence, anyone found sleeping while something important is going on or is supposed to be done is referred to as 'Jonah the sleeper' (*Jona oloorun*).

> living with my own mother, it would have been difficult for me to cope with my present situation in life. When I was with my foster mother, I was always ill but she hardly took notice of my illness unless it was on for several days, after which she was usually convinced that I was truly ill. Sometimes she would take care of me and exempted me from domestic chores. However, she occasionally threatened that she would send me to the farm to fetch firewood irrespective of my health status, and that would be the end of the illness.

As a result of these experiences by foster-children, there are common sayings such as *orisa bi iya ko si, ta ni je fun ni lobe bi iya eni*: 'There is no god like mother; who can give enough soup except one's mother?'. This reflects the experiences of a fostered child like Mrs Jemwitemi, a 23-year-old secondary-school dropout who later became a sewing mistress. She described her treatment by her foster parents: she had lived with the younger brother of her father and was always at home with his wife; she was then in Primary 4.

> Every morning when we were preparing to go to school, she would give me only one slice of bread and one slice to the other boy also living with her, while she would give three or four slices to each of her own children. On arrival from school in the afternoon, I would be asked to take the left-over tea which had been contaminated by flies with the other fostered boy living with her. I was always anxious to go back to my parents in the village. When we were told to go to the river to fetch water, her own children would be playing at home doing nothing. She was in the habit of whipping us with sticks.

Mrs Majiyagbe, a 25-year-old sewing mistress and a second wife of her husband, reported her experience as a fostered child with a relation. She went through a lot of difficulties as a foster-child:

> *Oju mi ri mewa* - my eyes saw 'ten'[3] where I was living then. I would carry heavy stones from morning till evening as a punishment for any offence committed by me. She would never do that to her own children. She would not give me any food for almost two days, she would only be enjoying eating with her own children.... whenever I was sick, she would not even buy ordinary Panadol or Phensic for me.

The foster-child experiences cited above and the findings from the quantitative data show that foster-children are treated in different ways from non-fostered children in the households. Other proverbs that explain some of these differential treatments include *Oju mewa ko jo oju eni,* 'ten eyes are not like one's own eyes': no matter how good foster-parents might be, the situation cannot be compared with being with one's biological parents. Therefore, in addition to the psychological trauma experienced by fostered children, they are given less nutritious food and receive poorer medical care than children whose mothers are present in the household. This inevitably contributes to the high rates of morbidity and mortality among foster-children (*cf*. Bledsoe and Brandon 1992:280).

If it is true that hardship builds character as noted earlier, and foster-children perceive and describe this kind of hardship from a perspective quite different from that of their guardians, then there remain the thought-provoking questions: does wisdom necessarily have to come through hardship and suffering? Do children need to go through hardship before they become wise? Why were parents sending their children away to live elsewhere not concerned

[3] 'Ten' was used here to describe the numerous and various bad experiences she went through in her foster-homes.

with the welfare of the children? Some other related questions were raised by Bledsoe in her study of how fostered children suffered in their new homes (Bledsoe 1990:75-76).

Answers to some of these questions demand an objective assessment of the perceptions of both foster-parents and fostered children, although it has been demonstrated qualitatively that in many ways fostered children are treated differently from non-fostered children. This does not, however, imply that foster parents are devils. An examination of some other Yoruba proverbs helps to clarify the situation.

Foster parents' responses to, and treatment of fostered children: a cautionary note

Although a causal relationship between the treatment received by fostered children and mortality has not been established, the influence on foster-children's health of their treatment by foster-parents cannot be overlooked (Holman 1973:114). The kind of treatment they receive from their foster-parents affects their attitudes and behaviour in a number of ways. The assumption for this is based on the findings that foster-parents are less sensitive to foster-children and they tend to behave differently to them from the way they behave to their own biological children.

It is possible to have bad foster-children as well as bad foster-parents, and it is possible that the relationship between a foster-child and foster-parents could be reversed so that it is arguable the bad character and attitudes of the fostered children themselves make the foster-parents behave in different ways. Holman (1973:114) suggested that the aggressive behaviour of a fostered child resulting from his earlier treatment at the hands of probably his natural parents could also be the factor that brings about the kind of treatment he now receives from the foster-parents, rather than the bad attitude of the foster-parents. The question then is 'Who is to blame when a child is maltreated? Is it the child or the foster-parents?'

The answers to these questions generate more argument than resolution. Nevertheless, what seems obvious is found in one of the Yoruba proverbs discussed during the fieldwork. The proverb is *oni'le ni s'owo, alejo di s'eru*: 'the landlord [foster parent] has his own peculiarity while the stranger who comes to live with him is also filled with his or her own idiosyncrasies'. The implication of this proverb is that both fostered children and foster parents share the blame for the kind of relationship that exists between them. A common English adage is that 'one good turns deserves another', and the Yoruba are also fond of saying *ohun rere ni nyo obi lapo, oro buburu a yo ida ninu apo*: 'good words bring gifts from the pocket, while bad words bring out the sword from the sheath'. Similarly, the Yoruba believe that *omo to ba mo owo we, yoo ba agba jeun:* 'a child who knows how to wash his hands clean will feast with adults'. All these suggest that fostered children have a role to play in establishing and maintaining cordial relationships between themselves and their foster parents.

Nevertheless, if foster parents are less concerned about the welfare and health of the children they foster, or are insensitive to their illnesses as demonstrated in the analysis, it follows that parents should be more careful in having their children fostered. An attitudinal change in this direction has been observed in an experimental study conducted in a village among the Yoruba (Renne 1993:1). However, it was reported from an Ado- Ekiti survey that there seemed to be no sign of a drop in the proportion of families having at least one of their children fostered, but what seemed obvious from the survey was a massive decline in the proportion of children fostered (Caldwell, Orubuloye and Caldwell 1992: 16). The small proportion of children reported as fostered in this survey (8 per cent) may be a reflection of a continuous decline in the number of children being fostered.

If people who had been fostered themselves and had been treated differently decide not to have their children fostered, the cessation of the economic and social advantage that parents derived from this age-old tradition may have a significant impact on the household budget of the poor families who have been the greatest beneficiaries. The implication of this change for fertility will be worthy of future investigation.

Summary

Fostered children are treated in different ways from non-fostered children by their foster-parents. Yoruba foster-parents are less sensitive to the illnesses of foster-children, and treatments are delayed for them longer than for non-fostered children. Some local proverbs were examined to illuminate the childhood experiences of some of the respondents as foster-children: these local proverbs explained their different treatment. The study has also documented some social phenomena which exert a significant influence on child health among the Yoruba. It was observed that the different care received by foster-children is a matter of the dual relationship between them and the foster-parents, for which both may share the blame. Some attitudinal changes to fostering have probably started among the Yoruba: this may have implications for child fostering and possibly fertility.

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