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Spectrum and Pattern of Harmful Traditional Practices Affecting Children Among Mothers in Rural Sub-Saharan Africa

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Abstract: *Background*: Despite the improvement and innovation in maternal and child health care services globally, and several legislations against harmful practices on children, the use of harmful traditional practices on children with the attendant child morbidity is still a common place especially in rural sub-Saharan Africa. This study aimed at identifying the spectrum and pattern of harmful traditional practices affecting the health of children especially under five years old children, among mothers in rural Southern Nigerian Community. *Materials and Methods*: This was a cross-sectional community wide study involving 237 consenting women of child-bearing age (15-49years) at EkpeneObom Community in Etinan Local Government Area of Akwa Ibom State, South-South Nigeria between May and July 2022. They were selected through house to house contacts with the use of interviewer administered questionnaire which contained socio-demographic characteristics of the respondents, harmful traditional practices and rationale for the practices. *Results*: Their age ranged from 15-49 years with mean and standard deviation of 32.41+ 8.50 years. Results show that most of the women, 37.55%, belonged to middle reproductive age, 30-39 years. More than half of them, 56.54% had secondary education while most of the respondents, 56.12%, were of lower monthly income. Among the harmful traditional practices identified, the use of enema with unorthodox substances was the most prevalent practice, 86.65%, followed by use of palm kernel seed oil (Manyanga) on a febrile child, 73.42%. Of the reasons given for the practices, 70.04% admitted that the practices were based on their age long tradition. Statistical analysis showed that most of the mothers who engaged in the practices were of higher age, married, of lower educational status, had lower monthly income. There was significant statistical association between sociodemographic variables and some harmful practices including parity and use of enema (p=0.024), employment status and use of palm kernel oil (p=0.0001) as well as income level and ear piercing (p=0.0014). *Conclusion*: The study revealed unacceptably high prevalence and wide spectrum of harmful traditional practices used on children in rural setting. These practices have the tendency to endanger the health of the affected children either acutely or chronically. It calls for health education and a more committed and concentrated campaign against these practices. The importance of making conventional medicine accessible to rural population through functional and workable primary health care system cannot be overemphasized.

Keywords: Harmful Traditional Practices, Mothers, Rural Areas, Sub-Saharan Africa

1. Introduction

Despite elaborate scientific discoveries, improvement and innovations in maternal and child health care services globally, studies have shown that the use of harmful traditional practices on children is still a common place especially in rural communities in sub-Saharan Africa [1, 2]

These harmful practices constitute a public health concern considering their broad spectrum and wide-spread use across all cultures, religious beliefs, socioeconomic and educational status among the users, as well as their complications and adverse effects on the children which may be immediate, short or long term [1, 3, 4]. Of utmost consideration is the fact that despite the various legislations and conventions against these practices on children, they are found to be entrenched in various cultures and resistant to change. [2, 3, 5-7].

While their utilization vary from culture and locality, the common harmful practices found in most environments in sub-Saharan Africa include: various food taboos where children are restricted from certain nutritious diet, use of herbal remedies in various preparations, keeping babies from exposure to sunlight, feeding newborn babies with fresh butter, forceful feeding, delayed breastfeeding initiation to newborns, application of animal dung and other unhygienic substances on umbilical stumps of neonates, use of enema on sick child and application of palm kernel oil (manganga) on a febrile child. The practicesalso include various crude surgical procedures such as female genital mutilation, milk teeth extraction, blood letting, uvula cutting (uvulectomy), scarification, ear piercing and eye brows incisions [3, 4, 8-10]. Even though these practices are well thought out by the users to ameliorate the health of sick children, they are associated with various complications which could be physical, psychosocial or both. The complications may include severe pain, haemorrhage, anaemia, malnutrition, transmission of infections including tetanus and HIV; damage to adjacent tissues and organs, sexual and several other problems which could impair development of the affected children [10-13]. There could be outright mortality in severe cases [8, 10, 14].

The continued use of these practices on children with the devastating consequences constitutes violation of the right of these children to accessing conventional health care practices with the acruing benefits [15]. It may also interfere with the attainment of the relevant targets of the sustainable development goals (SDS) bothering on children health [16].

This study therefore is an attempt to identify the spectrum and prevalence of harmful traditional practices affecting the health of children especially under five years old children by mothers in a rural community of South-South Nigeria. It is believed that findings from this study will provide relevant data onspectrum of these practices and form the basis for campaign against the use of harmful traditional practices on children.

2. Materials and Methods

This was a cross-sectional community- based study among 237 women of child bearing age (15-49years) at EkpeneObom Community in Etinan Local Government Area of AkwaIbom State, South-South Nigeria. EkpeneObom is a typical rural community with about 305 households and a population of over 2600 residents according to the last population census. Most residents of the community are farmers and also engage in small scale trading mostly on food items. The community plays host to Qua Iboe Church Leprosy Hospital (QICLH), one of the renown leprosaria in West Africa which also serves as a secondary health care facility for EkpeneObom and the surrounding communities. There were 237 respondents selected through house to house contacts and interaction using interviewer administered questionnaire which contained socio-demographic variables, harmfultraditional practices and rationale for the practices.

Research assistants comprised of a senior registrar and a senior medical officer from family medicine department of University of Uyo Teaching Hospital (UUTH) and a primary school teacher from the community. Respondents with no formal education were assisted with use of local dialect on the contents of the questionnaire. Inclusion criteria were women of child bearing age (15-49years), consenting women and parous women as well as those who have ever used these practices on their children. Exclusion criteria were women outside the studied age bracket (15-49years), those who did not consent and women considered too ill to participate in the study. Ethical approval for the study was given by AkwaIbom State Health Research and Ethical Committee via the letter: MH/PRS/99/Vol.V/823. Also a formal approval was obtained from the head of EkpeneObom Community. Family heads gave permission while verbal consents were obtained from therespondents before collection of data. Data obtained from the study were analysed using Epi-Info statistical package (CDC). The percentage of independent and dependent variables were determined. The level of statistical significance was set at $p<0.05$. Tables were used to display data.

3. Results

A total of 237 women of child bearing age participated in the study. The results obtained are as shown below:

Table 1. *Sociodemographic characteristics of the respondents.*

Characteristic	Frequency (n=237)	Percentage (%)
Age (years):		
15-19	18	7.60
20-29	74	31.22
30-39	89	37.55
40-49	56	23.63
Marital Status: Currently Married		
Yes	190	

Characteristic	Frequency (n=237)	Percentage (%)
No	47	80.17
Educational Status:		19.83
No Formal Education	16	6.75
Primary Education	77	32.49
Secondary Education	134	56.54
Tertiary Education	10	4.22
Occupation: *		
Not Employed	21	8.86
Trading	173	73.00
Farming	148	62.45
Seamstress	27	11.39
Catering	16	6.75
Civil Servant	15	6.35
Schooling	6	2.53
Average Monthly Income (₦000)		
< 30	133	56.12
30-50	89	37.55
51-99	15	6.33
Parity		
1-2	45	18.99
3-4	89	37.55
>5	103	43.46

* Most of the respondents had more than one occupation.

Table 1 describes the sociodemographic characteristics of the women. Their age arranged from 15 to 49 years with mean and standard deviation of 32.41+ 8.50 years. Most of the women, 37.55% belonged to middle reproductive age (30-39 years). More than half of the respondents, 56.54%, had secondary education while majority of the women, 73.00%, were traders. Greater percentage of the respondents, 56.12%, were of low income group.

Table 2. *Harmful traditional practices used by the women on theirchildren.*

Harmful Practices	Frequency (n=237)*	Percentage (%)
Use of Enema	203	85.65
Use of palm kernel oil (Manyanga) onfebrile child	174	73.42
Ear Piercing	158	66.67
Scarification	142	59.92
Local (traditional) tonsillectomy	71	29.96
Blood letting on asick child	52	21.94
Forceful feeding	42	17.72
Unhygienic treatment of umbilicus	33	13.92
Food deprivation	15	633
Delayed breastfeeding initiation	9	3.80
Female circumcision	6	2.53

* Some women practiced multiple harmful traditional practices on their children

Table 2 displays some harmful traditional practices used by the rural women on their children in the study. Useof enema on a sick child had the highest frequency, 85.65%, followed by use of manyanga (application of palm kernel oil on the skin of a febrile child), 73.42%while female circumcision, 2.53%, was the least of the practices.

Table 3. *Sources of knowledge on the harmful practices.*

Characteristic	Frequency (n=237)**	Percentage (%)
Family	214	90.29
Community	123	52.00
Friends	16	6.75

** Some women obtained the knowledge of the practices from multiplesources.

As shown in table 3, almost all the women, 90.29%, obtained knowledge on the practices from the family while 6.75% of them obtained from friends.

Table 4. *Reasons for the harmful traditional practices among the respondents.*

Reasons	Frequency (n=237)***	Percentage (%)
It is our tradition	166	70.04
My parents did same to me	149	62.87
They are cheaper	55	23.21
They are more accessible than conventional practices	45	18.99

***Some respondents gave multiple reasons for the traditional practices

Table 4 shows reasons given for using the harmful traditional practices by the mothers. More than two thirds, 70.04%, of the women admitted that the practices were part of their tradition while the least number of them, 45 (18.99%), said the practices were more accessible than conventional medical practices.

Table 5. *Association between Sociodemographic variables and some harmful traditional practices- use of enema.*

SociodemographicVariables	Use of EnemaUsed N (%)	Not used N (%)	Statistical Test and Values
Age (years):			
<30	80 (86.02)	13 (13.97	X^2=0.017
>30	123 (85.42)	21 (14.58)	P=0.897
Marital Status:			
Yes	163 (85.79)	27 (14.21)	X=0.018
No	40 (85.11)	7 (14.89)	P=0.894
Educational Status*			
Lower level	194 (85.46)	33 (14.54)	X^2 = 0.277
Higher Level	8 (80.00)	2 (20.00)	P=0.634
Occupation:			
Not Employed	23 (85.18)	4 (14.82)	X^2 =2.291
Employed	235 (85.75	24 (14.25)	P=0.130
Monthly Income ₦000			
<30	114 (85.71)	19 (14.29)	X^2=0.001
>30	89 (85.58)	15 (14.42)	P=0.976
Parity:			
<4	15 (85.82)	19 (14.18)	X^2=0.092
>4	88 (85.44)	15 (14.56)	P.0.024

Table 5 shows association between sociodemographic variables and use of enema, the most popular harmful traditional practice among the respondents. Most of the women who practiced the use of enema were above 30 years, married, of lower educational status, had occupation, were of lower income group and lower parity. Practice of use of enema was statistically associated with lower parity (P=0.024).

Table 6. *Association between Sociodemographic variables and some harmful traditional practices-use of palm kernel oil (manyanga).*

SociodemographicVariables	Use of manyangaused N (%)	Not used N (%)	Statistical Test and Values
Age (years):			
<30	67 (72.83)	25 (49.17)	X^2=0.027
>30	107 (73.79)	38 (26.21)	P=0.8696
Marital Status: Currently Married:			
Yes	149 (78.42)	41 (21.83)	X^2=0.792
No	34 (72.34)	13 (27.66)	P=0.374
Educational Status*			
Lower level	68 (73.12)	25 (26.88)	X^2=0.007
Higher Level	106 (73.61)	38 (26.39)	P=0.933
Occupation**			
Not Employed	12 (44.44)	15 (55.56)	X^2=36.08
Employed	278 (73.35)	101 (26.65)	P=0.0001
Monthly Income ₦000			
<30	98 (93.13)	35 (26.87)	X^2=0.011
>30	76 (73.77)	28 (26.21)	P=0.916
Parity:			
<4	98 (73.68)	35 (26.32)	X^2=0.011
>4	76 (73.08)	28 (26.92)	P=0.916

The association between sociodemographic characteristics and use of palm kernel oil (manyanga) on a febrile child is shown on table 6. It shows that use of manyanga was practiced mostly by women above 30 years, married, of higher education status, employed, of lower monthly average income and lower parity. Use of manyanga on febrile children was statistically associated with employment status of the women.

Table 7. *Association between Sociodemographic variables and some harmful traditional practices-Ear Piercing.*

SociodemographicVariables	Ear Piercing Done N (%)	Not Done N (%)	Statistical Test and Values
Age (years):			
<30	61 (66.30)	31 (33.70)	X^2=0.009
>30	97 (66.90)	48 (33.10)	P=0.925
Marital Status: Currently Married:			
Yes	127 (66.84)	63 (33.16)	X^2=0.013
No	31 (65.96)	16 (34.04)	P=0.908
Educational Status:			
Lower level	62 (66.67)	31 (33.33)	X^2=0.000
Higher Level	96 (66.67)	48 (33.33)	P=1.00
Occupation:			
Not Employed	18 (66.67)	9 (33.33)	X^2=0.0004
Employed	252 (66.49)	127 (33.51)	P=0.985
Monthly Income ₦000			
<30	89 (66.92)	44 (33.08)	X^2=10.19
>30	69 (47.92)	75 (52.08)	P=0.0014
Parity:			
<4	89 (66.42)	45 (33.58)	X2=0.009
>4	69 (66.99)	34 (33.01)	P=0.925

Table 7 shows association between sociodemographic characteristics and practice of ear piercing among the rural women. The practice of ear piercing was done mostly by women of higher reproductive age (>30 years), married, higher educational status, employed, of lower monthly income level and lower parity. There was a significant statistical association between monthly income and ear piercing (p=0.0014).

4. Discussion

The study has shown wide spectrum and unique pattern of use of harmful traditional practices on children by mothers in EkpeneObom Community of Southern Nigeria. The identified harmful practices include use of enema on sick children, use of palm kernel oil (manyanga) on a febrile child, delayed breastfeeding initiation, ear piercing, scarification, application of unhygienic substances on neonatal umbilicus, traditional (local) tonsilectomy, bloodletting on a sick child, forceful feeding, food deprivation and female circumcision. These identified practices can be classified into invasive and non-invasive harmful traditional practices. Studies done in other parts of the world including Jordan, Scotland, Ethiopia and other least developed countries of the world, show similar spectrum and pattern of presentation of harmful traditional practices among mothers [1, 8, 12, 17, 18]. In Nigeria, Undelikwo et al and Agbaje, etal made similar findings in Imo State, South-East and Cross River State, South- South Nigeria respectively [19, 20].

However use of enema on a sick child, application ofunhygienic substances (including herbs) on neonatal umbilicus and use of palm kernel oil on a febrile child, as identified in the study, are a unique findings which pose serious harm to the health of under five year old children. Enema done at home can cause nausea, damage to gastrointestinal tract, electrolyte imbalance; alter gut flora and introduce infection to the gut [21]. Also use of unhygienic substances on the umbilicus of neonates has the tendency to contaminate the stump thereby causing neonatal tetanus [22]. Moreover observation studies have shown that application of palm kernel oil (manyanga) on a febrile child has the tendency to conserve heat, worsening the fever, with the possibility of causing hyperpyrexia with resultant febrile convulsion [23, 24]. These are all harmful to the health of under five year old children.

Considering the grave implications and complications associated with the use of these practices on children, including outright child mortality, there is an overwhelming need to intensify health education and awareness campaign against these practices on children.

Analysis of the association between the sociodemographic variables and use of these practices show that most of the women involved in the practices were of higher age, married, of lower education and income status, occupied and of lower parity. These findings are similar to findings from other studies on use of harmful traditional practices on children by mothers [4, 12, 23, 24]. It emphasizes the important of girl child education, socio-economic empowerment of young mothers, improvement of overall living condition of rural women.

The reasons given by the women for the practices, in this study, include community tradition, experience from the parents, affordability and accessibility of the practices. These are similar to reasons identified for the practices in other studies [1, 4, 7, 8]. However, none of the above reasons justifies the use of these practices when weighed against the complications associated with the practices. This calls for organizedstrategies to challenge these harmful age long traditions through health education and implementation of various conventions and laws against these practices. Again the need to make orthodox medical care available, affordable and accessible to rural communities through workable and functional primary health care system as a mean of combating and averting these harmful traditional practices, cannot be overemphasized.

5. Conclusion

The study shows high prevalence, diverse pattern and wide spectrum of harmful traditional practices used on children in rural setting of sub-Saharan Africa. These age-long practices, which are deeply entrenched in the rural communities and seemingly resistant to change, have the tendency to endanger the health of the children either acutely or chronically. It therefore calls for health education and a more committed and targeted campaign against these harmful practices. The importance of making conventional medicine accessible and affordable to rural population through functional and workable primary health care system cannot be overemphasized.

Conflict of Interest

We hereby declare that there is no conflict of interest among the authors in this study.

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