CULTURAL ENVIRONMENT, HEALTH SEEKING BEHAVIOUR AND SURVIVAL CHANCES OF UNDER FIVE CHILLDREN IN SOUTH EAST NIGERIA

Ugwueje, Ebere Augustine
Department of Sociology,
Abia State University, Uturu

Abstract

The paper examines the Motherôs Health-seeking Behaviour and Childhood Mortality in South East Nigeria. The data for this study are partly based on the 2008 Nigeria Demographic Health Survey (NDHS), a nationally representative survey covering all six health zones or regions of the country (with particular interest on data from South East Nigeria); and qualitative data collected from Abia State in South East Nigeria. It was found that neonatal, infant, and child mortality rate is the highest among children of mothers aged less than 20 years. The result reveals that the education of mother has significant effect on her health-seeking behavior including attendance to antenatal and postnatal care clinics, choice of place of delivery, time and route of response to child illness and immunization. Motherôs education increases the chances of survival of neonatal, infant and child. The result further revealed that both neonatal and post neonatal mortality was reduced by about 14 percent due to the use of Antenatal Clinic (ANC). Again, among children of mothers with secondary education and above, the mortality advantage continued into the post-neonatal period. The study concludes that the socio-cultural perception of disease, illness and death of children by parents in the study areas often run counter to the biomedical definitions. Mothers perceiving child diseases as caused by human agents (witchcraft activities), ancestral spirits, and breach of taboos than by infection, have their response routes affected and this leads to high mortality. The paper suggests that for the improvement of the health conditions of children in Nigeria, it is necessary to improve the educational status of mothers including health education to reduce ignorance and increase access to health care services.

Introduction

Infant and child mortality has traditionally been considered an important indicator of the overall social and economic well being of a country. Due to the significance of mortality in socio- economic development, every nation desires
to achieve a greater reduction in mortality rates. In the world, deaths of infants and children dropped over the last 25 years. The number of deaths of children under five fell from 15 million in 1980 to about 11 million in 1990 (United Nations, 2001).

The rapid improvements before 1990 gave hope that mortality rates of children under five years could be cut by two-thirds in the following 25 years. But unfortunately, while progress slowed down almost everywhere in the 1990s, in Nigeria, infant and child mortality

rates increased. For example, the Nigeria Demographic and Health Survey (NDHS), 1999 reported that 87 infants out of every 1000 born in Nigeria die before their first birthday and 115 of 1000 children die before reaching age five (FOS, 1992). Though between the 1990 and 1999 NDHS the infant mortality rate dropped from 87 to 75 deaths per 1000 live births, under five mortality rate rose from 115 to 140 deaths per 1,000 live births for the 1995 to 1999 period (NDHS, 1999).

Again report has it that For five years immediately preceding the 1999-2003 survey, the infant mortality rate stood at 100 deaths per 1,000 live births, and the overall under-five mortality rate was 201 deaths per 1,000 live births (NPC, 2004).Generally speaking, there is more problem with child mortality than infant mortality. Progressively, the child mortality rose from 115 deaths per thousand live births in 1999 to 201 deaths per thousand live births in 2003.

However, over the 5 year period (2000-2008) NDH Surveys, under five mortality rate dropped by 22 percent (from 201-157 deaths). Although many studies have identified many causes of under five mortality in Nigeria, many are related to maternal situation (Animashaun, 1977; Caldwell,1979; Adewuyi and Feysetan, 1988 and Ivu, 2002). Looking at maternal situation, the motherôs cultural environment is considered with emphasis on perception, attitude and behavioural practices. This attitude and behavioural practices are influenced by education, especially motherôs education. Education, especially of mother is important because when it is disaggregated, it is found to influence positively such behavioural factors like care, recognition of problems and response, the distribution of food within the family in the right quantity (Federal Ministry of Health and Social Services, 1992).

The unfortunate implication of the gap is that there is still heavy loss of lives of children below five years of age. Consequently, the policy target of reducing the Infant Mortality Rate (IMR) from over 85 deaths per thousand live births in the late 1980s to 50 deaths per thousand live births by the year 1990 and 30 deaths by the year 2000 was not realized; as the infant mortality rate is still as high as 75 deaths per thousand live births and under- five mortality rate of 157 deaths per thousand live births by the year 2008 (NPC, 2009). Most of these deaths are caused by dangerous socio cultural beliefs and practices. Again, these deaths are preventable as they are caused by factors, which if identified early, could be influenced to reduce their deleterious effects on child survival probabilities. Though the Nigerian Health Policy recognizes the need to reduce the current high childhood mortality rates, but peopleôs belief and behavoural practices have not been integrated into the health intervention programme (Ogunjuyigbe, 2004). This will be easier to achieve when the socio cultural determinants of infant and child mortality in Nigeria are clearly identified and their paths of influence known. Thus, the study looked at these questions: How do the cultural perceptions and beliefs of the people affect the survival chances of infants/ children under five years? How does the peopleôs cultural perception shape their illness control measures?

The general objective of this study is to show the cultural and behavioural factors that influence the survival chances of children under- five years of age in Nigeria. Specifically, this study attempts to achieve the following objectives: To examine the pattern of health-seeking behavior of mothers and the effects on child mortality; to examine behavioural and socio-cultural factors that affect the health and survival chances of children under five years of age in terms of utilization of health care services and to identify cultural

perceptions that relate to life, illness and death which shape the peopleôs illness control and nutritional practices that consequently affect the survival chances of under-five children.

Conceptual Insight

Parents in all societies raise their children in a way that is generally compatible with the demands of their physical environment, socio-economic condition, demographic characteristics and the belief system that has been ingrained in the society (Zahid, 1996:719). Women are known and considered all over the world as the first providers of health care in the home. The motherôs behavior in health seeking either as a preventive or curative treatment is a very important determinant of child survivorship. These women are expected by society to implement the child survival revolution by bringing children to be immunized four times during the first year of life, procuring or producing oral rehydration solutions and administering them to a sick child many times over the course of everyday of diarrhea, breast feeding their babies on demand until the child is six months to two years old, processing for feeding proper weaning food in frequent meal to small children at the appropriate ages and bringing children under age five to a weight surveillance program monthly (Zahid, 1996).

Cultural Factors

Economic choices and health practices of individuals are shaped and modified by the cultural beliefs, traditions and norms of the society. In traditional cultures, beliefs about disease causation result in customs and practices that have serious impact on the proximate determinants of child survival. Women and children suffer the grave consequences of the traditional customs and practices. According to the World Bank (1993), about one third of the total disease burden that women face is linked to pregnancy, child birth, abortion, and various reproductive tract disorders. However, proper medical attention and hygienic conditions during delivery can reduce the risk of infections and facilitate management of complications that can cause death of child or various illnesses for the mother or the new born child (Mitra, et.al, 1997; Howlader and Bhulyan, 1999). Therefore, the health seeking behaviour of mothers or couples being shaped by their cultural perceptions affect infant and child mortality (Montgomery, 2000). In every society, most stages of life are often accompanied by rituals and actions to ensure health and welfare, which may include some food and sex taboos to prevent illness in the sucking child (Caldwell, 1977). When there is illness, treatment which may include rituals, are selected according to the presumed cause. This is often the case in a society where modern health facilities exist. However, the recourse to modern health services may be made only when traditional remedies have failed.

Like illness treatment, maternal diet during pregnancy, lactation, patterns of breast-feeding and supplementation are important determinant of child survival. Food preferences affecting maternal diet during pregnancy vary across cultures. In many developing countries, some food taboos and restrictions are also commonly observed during pregnancy, lactation, weaning and illness. For example, among the people of South-Eastern Nigeria, new born babies among the Anambra Igbos, are not given the colostrums (the first yellow - coloured heavy breast milk), because it is thought to be unhealthy for the baby. The baby is therefore given water for two days before breast-feeding commences (Ezemezu, 1993).

Again, in many cultures in Nigeria, there is the tendency to withhold protein-rich foods, such as meat, chicken, and eggs, from infants for cultural reasons because of the

misconception that feeding children with those foods may encourage them to steal later on in life (Policy Project / Nigeria, 2002). These food items are either protective or needed for body building. Thus, avoidance of such food items may increase the risk of nutrient deficiency, which may in turn increase health risks. It is concluded that these cultural norms, practices and beliefs are strongly associated with high neonatal mortality, thus contributing to the sluggish decline of child mortality rate (Ghosh, 2012). Among the Beti in Cameroon and in some places in Akwa-Ibom State, Nigeria, supplementation of breastfeeding may begin with grated ripped banana in the first week of life (Van de Po, 1992). This helps to improve the health of the babies by providing more nutrients to them.

Furthermore, parental differential value for different sexes among their children affects child care and child survival. For example, in Kenya, the girls are valued more because of the bride wealth they attract and as such the males are neglected and they die more than the females. Though this relationship is spurious, it contradicts the position in South Asia where the female dowry is of economic burden to parents (Poffenberger, 1981). However, it can be said that gender differentials in infant and child mortality are associated with cultural values (Kabir, and Ruhul, 1993).

Culture-Bound Theory of Disease This theory is the product of the advancements in Trans Cultural Psychiatry and Medical Anthropology. The work in this two specialized areas of science produced an increased awareness of the different interpretations, which are given to health and disease in different cultures. This theory postulates that ñhealth and diseases are to some extent shaped by cultureò (Erinosho, 1998:18). The socio-cultural factors affect the perception of óHealthô and óNormalityô. This perception differs from society to society. This perception affects the health-seeking behaviour of the people. In some societies, childhood diarrhoea is considered a serious health problem that requires immediate response to seek help. In others, it is perceived as an evidence of teething and as such, no need for medical treatment.

In some societies, parents see fever generally as dangerous but in others; fever is classified as mild. With this classification, some fever is seen as ógoodô or óbadô depending on the duration and outcome of the fever. For Brieger, et al 1996/97 in Onyeneho (2006), good fever ushers in a good change in the life of the child: the child walks, teeths, increases in height, or the motherôs pregnancy is advanced and ready for delivery, as the case may be. This type of fever does not persist. However, on the other hand, the óbadô fever persists and is often accompanied by negative outcomes. In societies with this type of classification, there is delayed response to fever in children as parents wait to define the fever-type. This has implication for infant mortality.

Cultural Explanatory Models Kleinman (1980) refers to the socio-culturally based belief systems among subcultures as explanatory models, which are products of social, cultural and historical factors. These models held by both clients and health practitioners provide explanation for the process by which illness is patterned, interpreted and treated. The lay individualôs explanatory model relates to the way he conceptualizes illness (Patcher, 1994). It refers to an individualôs personal perception and interpretation of disease and it allows a person to find order and significance in the face of a life-threatening disease.

According to Helman (1994:111), cultural explanatory models ñoffer explanations of sickness and treatment to guide choices among available therapies and therapists and to cast personal and social meaning on the experience of sicknessò. This explanation involves the etiology, nature of symptoms, patho-physiological process, diagnosis methods and roles and

expectations of the sick individual as well as the caregiver (Helman, 1994). Those explanatory models are laden with emotional meaning and stem from cultural beliefs, and value, personal and idiosyncratic beliefs, popular conception of illness and biomedical explanations of illness. Explanatory models are not static but are subject to revision over a period of time (Rajaram and Rashidi, 1998 in Onyeneho, 2006). Personal illness control measures shaped by cultural values of the society, the perception of illness and treatment of illness affect infant and child mortality.

Personal Illness Control Factor

Personal response to illness depends largely on the individual perceptions of cause of the illness. Many of the infant and child killer-diseases in developing countries are identified as preventable through appropriate measures and by the use of available health technology. This knowledge is often passed on to mothers through health promotion programme with the understanding that if these mothers take advantage of the available medical services throughout pregnancy and childbirth, that early life mortality would be reduced considerably.

But in some parts of the world, vaccinations coverage has continued to decline. For example, in Nigeria it is reported that some mothers (especially from the northern part of Nigeria) reject tetanus toxoid immunization for fear of its effect on pregnancy, or because they believe it is a family ï planning method (Federal Ministry of Health and Social Services, 1992). Again, much evidence abound that in Nigeria, some mothers do not get their children immunized either for fear of side effects or because of their wrong ideas about immunization (Federal Ministry of Health and Social Services, 1992). All these point to perception problems.

In Nigeria, a study of the effect of perception of disease etiology and choice of treatment method came out with interesting result. It was observed that children whose mothers had rational medical perception of disease etiology, and sought modern medical treatment for measles, and diarrhoea, experience lower rates of infant mortality than their peers whose mothers held onto traditional views and resort to traditional therapeutic remedies (Feyisetan and Adeokun, 1992). Obviously, the health beliefs and perceptions of causes of illness influence the choice of therapy and consequently the mortality rates.

Feyistan and Adeokun (1992) further found out and concluded that in some rural areas of developing countries where modern medical preventive measures are simple and well within the reach of the poorest of the poor, that economic factors (poverty) are therefore considered insufficient explanation for the under utilization of health services in these areas. The problem is that of perception and cultural beliefs.

Data and Method of Analysis

The data for this study are partly from the NDHS of 2008 derived from retrospective maternal history of ever married women aged 15-49. The data of mothers from southeast were created from the information on birth history, biosocial characteristics and health related behaviour. Here the unit of analysis is children born one to five years before the survey. Direct estimates of infant and children were calculated for some categories of independent variables and bivariate analysis carried out. A dichotomous dependent variable on childôs survival status through specific age range was given a value 1 if child failed to survive through specified age and 0 if otherwise. Qualitative data were collected using the

Focus Group Discussion (FGD) method. The FGD was conducted in Abia state. Eight (8) FGD sessions were conducted (4 in the urban and 4 in the rural).

In each audience segment, 10-12 persons were selected bearing in mind such common characteristics as age, sex, education, marital status, urban/rural residence, and occupation. The selection was done using purposive sampling method. The audience include: female primary school teachers in both urban (Umuahia) and rural (Bende) areas, market women, members of Road Transport Workers Union (NURTW), male and female civil servants. Again, in-depth interviews were done selecting purposively from among such groups: market and Guild Association leaders, community women leaders, Male Trade Union Leaders and Heads of Departments of the local government areas.

The major instrument for data collection for this study was the FGD guide. The FGD sessions were conducted with carefully developed FGD guide with questions bordering on issues of reproductive health, health seeking behaviour of the respondents, cultural perceptions, values, norms and socio-cultural practices with regard to sickness, treatment, disease control, and death of infants and children in the study areas. During FGD sessions, instruments like tape recorder, camera, and notebooks were used. The focus group discussions helped to bring out the underlying reasons for the differentials in rates and levels of childhood mortality in the study areas.

Results / Discussion

Child Morbidity and Treatment

In this section, the study examined the prevalence of these diseases among children under- five years of age, as reported by their mothers. There is the assumption that the parentsô orientation and belief will determine the line of response to child sickness. To guide the analysis, the hypothesis: ***Infant and child mortality is higher among mothers who stick to culturally defined health belief about child diseases than among mothers with objective scientific perception of child disease,*** *was* formulated. Reports from the focus group discussions [FGD] held across the study areas show that in the area of disease etiology, majority of the people perceive child diseases as caused by human agents [witchcraft activities], ancestral spirits, and breach of taboos, than by infection and/or metabolic/nutritional disorders. To many, sickness and disease are natural occurrences. For a woman in an FGD; ***sickness comes when it wants to come*** (FGD with palm oil sellers in Umuahia main market, Umuahia.). To a handful of women in an FGDs in Bende area, child sickness is seen as an aspect of child development. A woman in this group said ***"to grow well, they have to be sick"*** (FGD with less educated women in Okputong, Bende). This kind of perception of sickness affects parentôs response to child sickness. Here, parents do not take a childôs sickness seriously until it is too late. To some others, ñthere is no smoke without fireò. A young woman in her own contribution said ***Satan is still alive; a wicked man can kill a child*** (FGD with educated women in Bende, Abia state).

Furthermore, there was a wide spread belief that some diseases are not curable with orthodox medicine. For many, convulsion cannot be treated with orthodox medicine. A man in one of the groups said ***"you do not need to waste your money using orthodox medicine to cure convulsion; simply rubbing of crude oil on a child with convulsion brings final solution to repeated convulsion"*** (FGD with men of the NURTW UMUMAS, Umuahia). A woman in one of the groups added her voice in support of the above position when she said that ***"convulsion is caused by evil spirit attack, why waste your money going to the***

hospital". This kind of perception on convulsion spells grievous consequences for child survival

Again it was observed that myths and misconceptions exacerbated the matter. For example, in the study area, loose stool during developmental stages such as teething, is often considered normal for that stage rather than a symptom of illness. This wrong perception often affects the parentôs response to the problem. This perception problem not only leads to wrong response including no response at all, it also leads to under estimation of the prevalence of diarrhoea among children in that developmental stage.

Furthermore, the perception of death and causes of death of infant and under-five children affects infant and child mortality rate in the study area. For many people in different groups, ***a child died because it is his\her destiny to die when he\she died***. Some others perceived death of a child as disappointment from God. Seen in another way, a woman in her own opinion said ***"it is a sacrifice after many births"*** (FGD with teachers at Ugba Primary School ,Umuahia).To another woman, death of a child is ***"God's design for the child and we cannot do anything"***(FGD with women aged 35 years and above in Okputong village, Bende).

Other beliefs surrounding infant\ child death include: **ogbanje or muo-uke,** which means a child coming and going over and over again. Family curse is seen as another possible cause of infant death. A man in one of the FGDs gave a clear illustration of family curse and reincarnation when he said ***"if you kill a pregnant woman, in your next incarnation, you will not survive beyond infancy"*** *(*FGD with educated men aged 30 years and above). To another man, death of a child through convulsion was conceived to be ***"caused by an aggrieved ancestor (mbamuo)*** (FGD with less educated men in Okputong, Bende). On breach of taboo, many believe that incestuous sexual relationship leads to infant death. A woman in one of the group sessions said: ***"if people who are related engage in sexual relationship that leads to child birth, if ritual (aja erim) is not performed, the child will die"*** (FGD with rural illiterate women, Bende). On health beliefs, a man among educated men in the urban area said ***"if a child is having fever and he is not treated for the mere belief that since the mother is pregnant the fever may be due to agwa (fever in a child when the mother's pregnancy is at advanced stage) the fever is usually considered a simple good fever which does not require treatment*** (FGD with educated male staff of National Population Commission, Abia state office). All these misconceptions and dangerous health beliefs affect the health seeking behaviour of parents and consequently the infant and child mortality rate.

Prevalence and Treatment of Diarrhoea

Dehydration resulting from severe diarrhoea is a major cause of illness and death among young children in Nigeria. To further enrich the discussion of this study, data from the 2003 Nigeria Demographic and Health Survey (NDHS) were adopted. Here mothers were asked whether any of their children under five years of age had diarrhoea any time, two weeks preceding the survey. Again, if any child had diarrhoea, mothers were asked about feeding practices during the diarrhoeal episodes and about what actions were taken to treat the diarrhoea.

Looking at the treatment of diarrhoea, about a quarter [21.5 percent] of children who had diarrhoea were taken to a health facility for treatment. Furthermore, in the treatment of diarrhoea, fluids prepared from ORS were given to at least one in every four children with

diarrhoea. While one in every six cases received recommended homemade solution of sugar, salt and water. The proportion that received ORS, RHF and increased fluids (40.4 percent) is comparable to 35 percent as reported in the in-depth review study of the Federal Ministry of Health and Social Services (FMH & S, 1992). Although the use of ORT in the treatment of diarrhoea in children has been well taught in child health clinics and the electronic media since the 1980s in Nigeria, with an average of about 65 percent of mothers who know about ORS packets, the revelations from Table 1 below show only a minimal success of the efforts.

One major factor limiting the success may probably be found in the conception of most mothers as to the cause of diarrhoea. These perceptions by the mothers were well captured in the FGD sessions with women both in rural and urban areas across the study area. There is great misconception among these women. This misconception invariably influenced their attitude towards the use of ORT in diarrhoea treatment. What mothers believed was the cause of diarrhoea in children was investigated using the FGD. In most of the FGD with women and men , altogether, majority of mothers whose children had diarrhoea believed that it was because they were teething. This is confirmed with this chorus statement ***"running stomach in infants is not a problem, it is only a sign that the baby will be teething soon"*** (FGD with rural illiterate women in Bende). Another handful of the women especially among the urban women believed and ascribed it to contaminated water and food. For another small minority opinion, diarrhoea was ascribed to such other factor as ñover-feedingò.

The proportion of women who ascribed diarrhoea in children to teething was more in the rural than in the urban areas. Again, Teenage mothers [under 20 years] and some below 30 years in their FGD groups than older mothers supported the view that diarrhoea in children is a sign of likelihood of teething. On the motherôs perception of diarrhoeal disease, more mothers among the urban FGD considered diarrhoeal disease as very dangerous more than the mothers in the rural areas.

Table 1: Percentage of children under five years of age who had diarrhoea in the two weeks preceding the survey taken for treatment to a health provider, percentage who received oral rehydration therapy [ORT], and percentage given other treatments by Mother's Education, Nigeria 2008.

TYPE OF TREATMENT

	Percentage taken to a health provider. [1]	ORS packets	RHF	Either ORS or RHF	Increased fluids.	ORS, RHS or increased fluids	Pill or syrup	Injection	Intravenous solution	Home remedy/other	Missing	No treatment	Number of children w ith diarrhea
Mothers education:													
No education	106 (16.6)	85 (13.2)	9 (15.0)	144 (22.5)	111 (17.3)	217 (33.9)	302 (47.1)	9 (1.4)	1 (0.1)	108 (16.8)	5 (0.8)	146 (22.7)	641
Primary	53 (24.7)	48 (22.4)	39 (18.2)	76 (35.0)	52 (23.8)	98 (45.3)	117 (54.3)	5 (2.2)	-	24 (10.9)	-	38 (17.5)	216
Secondary.	48 (35.3)	43 (31.1)	33 (24.4)	66 (48.0)	35 (25.9)	79 (57.9)	82 (60.0)	5 (3.9)	1 (0.4)	12 (8.9)	4 (2.6)	16 (11.7)	137
Higher	*	*	*	*	*	*	*	*	*	*	*	*	*

Source: 2008 NDHS Raw Data File.

Note: Oral rehydration therapy [ORT] includes solution prepared from oral rehydration salts [ORS] packets, recommended home fluids [RHF], or increased fluids. The figures in parentheses are based on 25-49 unweighted cases. An asterisk indicates that a figure is based on cases that have been suppressed.

[i] Excludes pharmacy, shops and traditional practitioner.

No doubt, motherôs view about diarrhoeal illness and response in terms of treatment, largely depend on the presumed etiology, and socio-cultural beliefs.

The use of antenatal care services (ANC) obviously gives great survival advantage to children especially at the first month of life (neonatal period). For this reason, only infant mortality rate and its components: neonatal (NN) and post neonatal (PNN) rates by motherôs use of ANC are presented in table below. From Table 2, we see that both neonatal and post neonatal mortality was reduced by about 14 percent due to the use of ANC.

However, large variations were observed in the effect of use of ANC on infant mortality by selected characteristics of mothers. In the urban areas, risk of neonatal mortality among children whose mothers did not receive ANC during pregnancy was 20 percent higher than the risk among those whose mothers received ANC. But among rural children, the excess risk dropped to 10 percent. This suggests that the use of modern ANC during pregnancy tends to attenuate the risk of neonatal mortality. In the rural areas, the non-use of ANC was associated with 20 percent excess risk of infant mortality (neonatal and post neonatal).

Regardless of maternal level of education, use of ANC reduced neonatal mortality among infants. However, among children of mothers with secondary education and above,

the mortality advantage continued into the post-neonatal period. This is the case because, motherôs education facilitates the use of health care services and gives access to mass media which gives mothers social and economic advantage that enhances survival into the post-neonatal period. However, children whose mothers had at least secondary education but did not use ANC during pregnancy were almost three times as likely to die in infancy as their counterparts whose mothers did use ANC.

Motherôs work status affects use of ANC and also affects neonatal mortality. Children whose mothers were not working at the time of the survey and who received no ANC experienced 60 percent higher neonatal mortality than children whose mothers though working but received ANC. The impact of differential use of modern antenatal care by mothers work status points to one important pathway of influence of economic factors on neonatal and post neonatal mortality low birth weight as a risk factor can be mitigated through giving a favourable economic condition that enhance use of modern antenatal care services, and improve maternal nutrition during pregnancy.

Table 2: Infant Mortality Rate for the Five-year Period before the Survey and the Relative Risk by Use of Modern Antenatal Care (ANC) Services some Socio-economic Characteristics of Mother

Mortality Rate (Per 1,000)							Relative Risk		
Characteristic	**Had ANC**			**No ANC**			**(Had ANC = 1.0)**		
	NN	PNN	$1q_0$	NN	PNN	$1q_0$	NN	PNN	$1q_0$
RESIDENCE									
Urban	37.0	33.1	70.1	42.9	(24.1)	67.0	1.2	0.7	1.0
Rural	43.2	38.7	81.9	49.6	44.7	94.3	1.1	1.2	1.2
MOTHER'S EDUCATION									
None	46.8	37.9	79.7	49.6	37.4	87.0	1.1	1.0	1.0
Primary	38.9	40.8	56.9	51.7	(29.5)	81.2	1.3	0.7	1.0
Secondary+	30.8	26.1	64.7	32.8	(118.5)	(151.3)	1.1	4.5	2.7
MOTHER'S WORK STATUS									
Not Working									
Working	42.6	41.5	77.6	66.3	47.1	113.4	1.6	1.1	1.3
	39.9	37.7	76.2	38.1	39.2	77.3	1.0	1.0	1.0

*: Excludes births to women who had never been in union.
( ) Parentheses indicate that the base is between 150 and 250 live births.

Source: 2008 NDHS Raw Data File.

Conclusion

The study concludes that the socio-cultural perception of disease, illness and death of children by parents in the study areas often run counter to the biomedical definitions. Mothers perceiving child diseases as caused by human agents (witchcraft activities), ancestral spirits, and breach of taboos than by infection, affected their response routes. The health-seeking behaviours of such parents were at best seen to be wrong response or no response at all; leading to high case fatality and death of children.

Recommendation

The study recommends that since the major reason many women did not use health care services was due to cultural barriers which mainly persist because of ignorance of the health benefits derivable from the use of modern ANC during pregnancy, there is need to address this problem through health education programs using appropriate local mass media. These measures will not only reduce the relatively high level of non-use of ANC observed in this study, but would help reduce the observed differentials among the subpopulations.

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